Psychological and Behavioral Concerns in Childhood & Adolescents

Albrey Berber DNP, CPNP-PC

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Learning Objectives

Upon completion of this review, the course attendee should be able to:

- Identify screening tests appropriate to adolescents.
- Recognize red flags or factors that suggest that adolescents are at risk for or experiencing a mental health disorder.
- Identify presentation and management for mental health problems commonly seen in adolescents.
- State pharmaceuticals and their associated side effects commonly utilized in mental health disorders.

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Presentation Outline

I. Risk Factors

II. Screening Tests

III. Red Flags

IV. Common Mental Health Disorders

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Anorexia Nervosa

- **Key Characteristics**:
  - Has the highest mortality rate of all MH disorders
  - Symptom onset usually occurs during mid to late adolescence
  - Athletes more likely to develop (wrestlers, dancers, gymnast, etc)
  - Depressed mood, social withdrawal, insomnia
  - OCD related to food, body shape, weight
  - FMH + for AN, alcoholism, or affective disorder

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Anorexia Nervosa

- **S/S**:
  - Obsessed with thoughts of food
  - Underweight (< 85% of expected for age; BMI <17.5)
  - Wt loss through dieting, fasting, exercise
  - Intense fear of gaining weight
  - Significantly distorted body image
  - Maybe have amenorrhea
  - Hypotension
  - Heart arrhythmias
  - Constipation (GI distress)
  - Cold intolerance
  - Dry skin
  - Dental erosion/caries

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Bulimia Nervosa

- **Key Characteristics:**
  - Symptom onset usually occurs during mid to late adolescence
  - Episodes of binging &/or purging
  - Must occur at least once a week for ≥ 3m
  - **Weight is often average or overweight**
  - Self criticism/depressed mood
  - Vomit from gag reflex, diuretics, laxatives
  - Course chronic or intermittent

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Bulimia Nervosa

- **S/S:**
  - Diarrhea (laxatives)
  - Dental caries (loss of enamel from vomiting)
  - Menstrual irregularities or amenorrhea
  - Esophageal tears, gastric rupture, cardiac arrhythmias
  - Mood disturbances and/or anxiety disorders
  - May have FMH of obesity

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Anorexia & Bulimia Nervosa

- **Evaluation:**

  SCOFF Questionnaire

  - Do you make yourself Sick because you feel full?
  - Do you worry that you have lost Control over what you eat?
  - Have you lost Over 10 lbs in the last 3 months?
  - Do you believe you are Fat when other say you are thin?
  - Would you say Food dominates your life?

- Lab testing could include:

  CBC (anemia) Electrolytes, Fasting Glucose (diabetes) LFTs, Thyroid (hypothyroidism) FSH, LH, UA, ECG (PVCs, Long QT)

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Anorexia & Bulimia Nervosa

- **Management:**
  - Role of PCP is primary screening & early identification
  - Comprehensive – medical care/monitoring (SSRIs, Atypical Antipsychotics), psychotherapy (CBT), & nutritional counseling
  - Expected weight gain is 1.1 lbs (0.5 kg) per week (during refeeding)

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Indications for Treatment

Red Flags	Signs
Reads diet books/articles	Regularly fast/skips meals
Visits pro eating disorder websites	Stops eating around family/friends
Intense focus on diet/exercise	Misses monthly cycles
Acute onset vegetarian	Reports binge eating
Acute picky eating	Reports purging
Regular bathroom visits	Parents find laxatives/diet pills
Showers several times daily	Excessive amounts of exercise
Skips meal “I already ate”	Refuses to eat non diet foods
Large amounts of missing food	Refuses to eat meals prepared by others

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Depression

- **Key Characteristics:**
  - 3 Categories

Major Depressive Disorder (MDD)	Markedly depressed or irritable mood/diminished interest in usual activities for a period > 2 weeks
Dysthymic Disorder	Depressed or irritable mood for the majority of days in the past 2 years less intense but more chronic then depressed episodes
Adjustment Disorder w/Depressed Mood	Occurs within 3 months of a major life stressor less severe symptoms usually mild and brief

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Major Depressive Disorder (MDD)

- **S/S:**

School-Age	Adolescents
Sadness	Sadness
Irritability	Hopelessness
Impulsive	Self-hatred
Crying spells	Anger
Loss of pleasure or interest in activities	Withdrawn
Somatic complaints	Loss of pleasure/ interest in activities
Externalizing behaviors (acting out)	Neurologic vegetative symptoms
Comorbidity w/anxiety is common	Decrease sleep, appetite, concentration
Often misdiagnosed as ADHD	Drug/alcohol use common
	Comorbidity common

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Major Depressive Disorder (MDD)

- **Evaluation:**
  - Recommended Screening for age 12 and older

Scale	Appropriate Ages
CES-DC: Center for Epidemiologic Studies: Depression Scale for Children	6-18
PHQ-9: Patient Health Questionnaire	6-10 & 11-Adolescent
CBCL: Child Behavior Checklist	1.5-5 & 6-18
PSC: Pediatric Symptom Checklist	4-Adolescent

- Labs: Thyroid Panel, LFTs, CBC, EBV, UPT, Tox screen (hypothyroidism, anemia, pregnancy, substance use)

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Major Depressive Disorder (MDD)

- **Management:**
  - Role of PCP is screening & identification of suicidal risk

Mild	Moderate	Severe
Impacts daily life still able to function & complete normal tasks	Decreased interest becomes complete lack of interest & show inability or concern of inability to function/complete tasks	Increased agitation, psychosis, & suicidality, often demonstrates all the depressive symptoms **Suicide Plan = Emergency**
CBT	CBT + possibly SSRIs	CBT + SSRIs

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Major Depressive Disorder (MDD)

- **Management:**
  - Referral to MH Provider
  - If Medication Indicated:
    - Fluoxetine (Prozac): SSRI, FDA approved for children ≥ 8 years
    - Sertraline (Zoloft): SSRI, FDA approved in adults
    - Fluvoxamine (Luvox): SSRI, approved in adults
    - Escitalopram (Lexapro): SSRI, FDA approved in ages ≥ 12 years
  - Medications should be used 1 year past resolution (relapse prevention)
  - Start Low: Go Slow
  - Common SE: Excitation, agitation, N/V/D, dizziness, chills
  - **SEROTONIN SYNDROME**
  - **Contract for Safety (if suicidal ideations/risk)**

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Suicide Warnings

Suicide risk is greatest during the first 4 weeks of a depressive episode

Changes in Behavior	Accident prone or risk taking, drug and alcohol abuse, physical violence towards self or others, loss of appetite, sudden alienation, decline in work or school performance, loss of interest in personal appearance, writing letters notes, or poems, buying a gun or weapon
Changes in Mood	Expressions of hopelessness or impending doom, explosive rage, crying spells, dramatic mood swings, sleep disturbance/disorders, talking about suicide
Changes in Thinking	Preoccupation with death, difficulty concentrating, irrational speech, hearing voices, seeing visions, sudden interest or loss of interest in religion
Major Life Changes	Death of family member or friend (especially by suicide), separation or divorce, public humiliation or failure, serious illness or trauma, loss of financial security, recent loss of relationship

Ask about suicidal ideations

- Do you ever wish you were dead?
- Do you ever think about death or hurting yourself?
- Have you ever hurt yourself?
- Do you have a plan? **(If answer is YES = Emergency)**

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Bipolar Disorder

- **Key characteristics:**
  - **Majority of people with BPD report depression as initial symptom**
  - 4% of children meet the diagnostic criteria for BPD
  - The **risk of suicide** in BPD is **highest** of all psychiatric disorders (1/3)
  - **Characteristic pattern of manic episodes before or after major depressive episodes**
  - Parents with BPD have larger risk of children with BPD
  - **Most common onset of symptoms occur between 15-19**
  - Onset before age 10 is rare

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Bipolar Disorder

- **S/S:**
  - Severe mood changes
  - Grandiosity
  - Decreased need for sleep
  - Compulsion to talk
  - Attention moving from one thing to next
  - Physical agitation
  - Risk taking behaviors
  - Hyper-sexuality
  - Suicidal thoughts or behaviors

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Bipolar Disorder

- **Evaluation:**
  - The child or adolescent who has **depression but also manifests symptoms of ADHD** that seem moderate/severe should be evaluated by **psychiatrist** with experience in bipolar disorder
  - **Assessment for comorbid condition is important**
    - CD, Substance abuse, ODD, disruptive behavior disorder, personality disorders

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Bipolar Disorder

- **Management:**
  - **Mental health provider is critical**
  - Mood stabilizers (Lithium) alone or with an anticonvulsant medication (Valproate)
  - Lithium has been shown to prevent relapse
  - Antipsychotics (Respiradone)
  - **Antidepressants alone may potentiate manic response**
  - **Stimulants may worsen manic symptoms**

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Question 1

A 14-year-old female comes to the clinic with amenorrhea for 3 months. A pregnancy test is negative. The adolescent's body weight is at 82% of expected for height and age. The mother reports that her daughter often throws up and refuses to eat most foods. Which condition does the primary care pediatric nurse practitioner suspect?

1. Bulimia nervosa
2. Anorexia nervosa
3. Depression
4. Substance abuse

Question 1

A 14-year-old female comes to the clinic with amenorrhea for 3 months. A pregnancy test is negative. The adolescent's body weight is at 82% of expected for height and age. The mother reports that her daughter often throws up and refuses to eat most foods. Which condition does the primary care pediatric nurse practitioner suspect?

Answer: Anorexia nervosa

Question 2

During a well-child assessment of a preschool-age child, the parent voices concerns that because the child has behavior problems at school, the child may have a mental health disorder. Which initial approach will provide the best information?

1. Ask a parent whether other caregivers have voiced similar concerns.
2. Take time to actively listen to the parent's child perceptions of the problem.
3. Interview the child separately from the parent to encourage sharing of feelings.
4. Use a validated screening tool to ensure that all aspects of behaviors are evaluated.

Question 2

During a well-child assessment of a preschool-age child, the parent voices concerns that because the child has behavior problems at school, the child may have a mental health disorder. Which initial approach will provide the best information?

Answer: Take time to actively listen to the parent's child perceptions of the problem.

Question 3

A 13-year-old child has exhibited symptoms of mild depression for several weeks. The parent reports feeling relieved that the symptoms have passed but concerned that the child now seems to have boundless energy and an inability to sit still. What will the primary care pediatric nurse practitioner do?

1. Administer an ADHD diagnostic scale and consider an ADHD medication
2. Refer the child to a child psychiatrist for evaluation of bipolar disorder
3. Consult with a child psychiatrist to prescribe an antidepressant medication
4. Reassure the parent that this behavior is common after mild depressive symptoms

Question 3

A 13-year-old child has exhibited symptoms of mild depression for several weeks. The parent reports feeling relieved that the symptoms have passed but concerned that the child now seems to have boundless energy and an inability to sit still. What will the primary care pediatric nurse practitioner do?

Answer: Refer the child to a child psychiatrist for evaluation of bipolar disorder

Question 4

An adolescent has recently begun doing poorly in school and has stopped participating in sports and other extracurricular activities. During the history interview, the adolescent reports feeling tired, having difficulty concentrating, and experiencing a loss of appetite for the past few weeks but cannot attribute these changes to any major life event. Which is an important next step in managing this patient?

1. Determining suicidal ideation and risk of suicide
2. Administering a diagnostic rating scale for depression
3. Considering a short-term trial of an antidepressant medication
4. Referring the adolescent to a mental health specialist

Question 4

An adolescent has recently begun doing poorly in school and has stopped participating in sports and other extracurricular activities. During the history interview, the adolescent reports feeling tired, having difficulty concentrating, and experiencing a loss of appetite for the past few weeks but cannot attribute these changes to any major life event. Which is an important next step in managing this patient?

Answer: Determining suicidal ideation and risk of suicide

Anxiety

- Normal part of development experienced by everyone
- Somatic symptoms include:
  - Increased HR & BP, tremor, sweating, enhanced vigilance/reactivity
- Separation Anxiety
  - Typically first appear in the preschool years
  - Separation anxiety- Normal development- 7 months
  - Separation anxiety disorder- manifests 5-16 most common onset at 9
- Generalized Anxiety Disorder (GAD)
- Obsessive Compulsive Disorder (OCD)
- Post-Traumatic Stress Disorder (PTSD)

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General Anxiety Disorder

- **Key characteristics:**
  - "worrier"
  - Most prevalent psych disorder
  - Diagnosed most often ages 9-18

- **S/S:**
  - Worry about events
  - Poor sleep
  - Irritability
  - Over concern about competence
  - Significant self consciousness
  - Restlessness
  - Difficulty concentrating
  - Somatic complaints
  - Muscle tension
  - Unexplained fatigue

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General Anxiety Disorder

- **Evaluation:**
  - Spielberger State-Trait Anxiety Inventory for Children (STAIC)
    - 20 self-reported items
    - 9-12 year-olds
  - Screen for Child Anxiety Related Disorders (SCARED)
    - 41 self-reported item
    - 8-18 year-olds

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General Anxiety Disorder

- **Management:**
  - **Symptoms relief is 1st priority for school-age children**
    - **80-90% respond to CBT + parental education/training**
  - Mental health referral
  - Behavioral and family interventions
  - CBT
  - Medications
    - Not particularly helpful in reducing symptoms
    - Use if fails to respond to non-pharm interventions and/or impaired functioning
    - SSRIs

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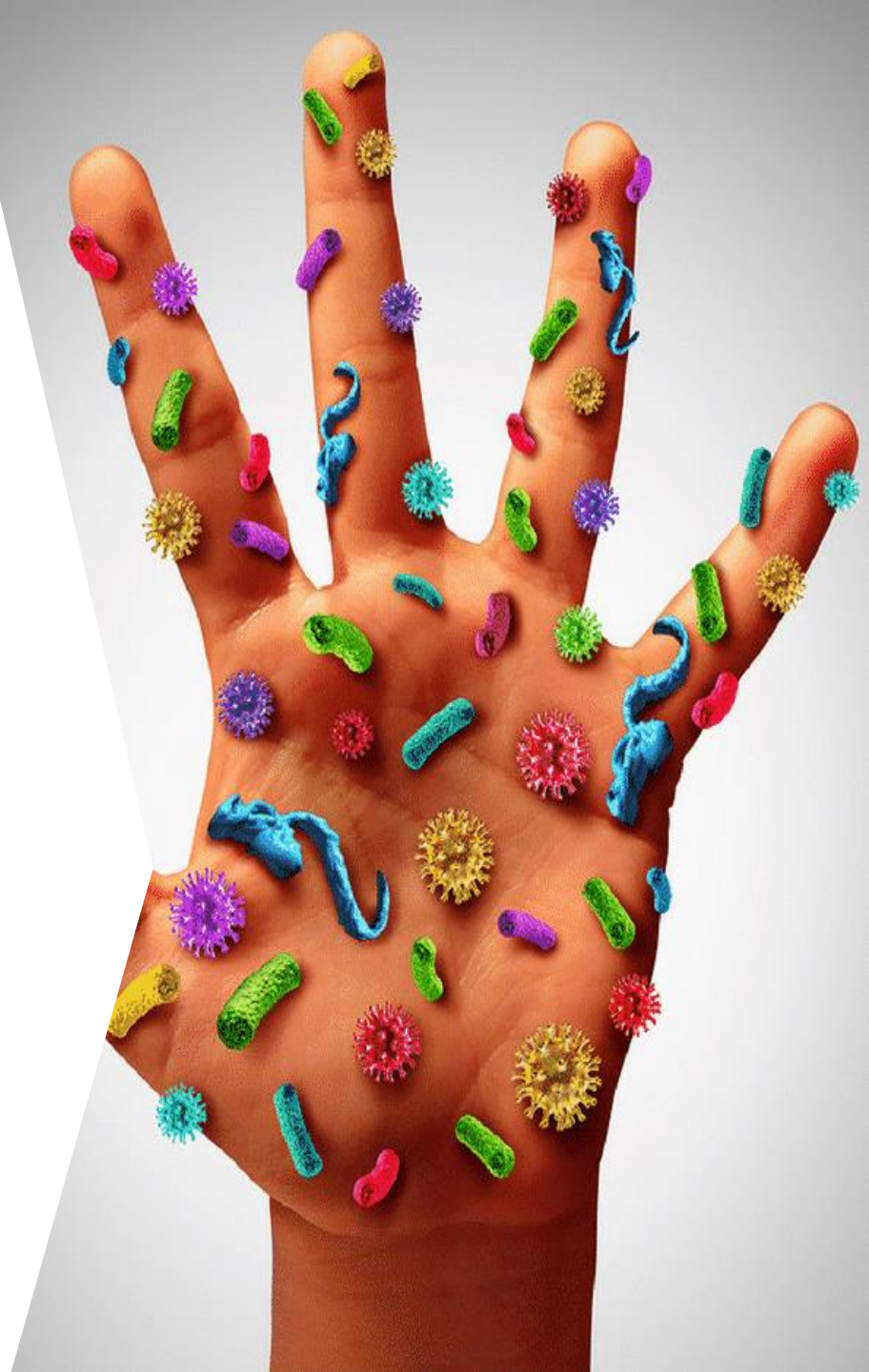
Obsessive Compulsive Disorder

- **Key Characteristics and S/S:**
  - Differs from normal behavior in that it:
    - Results in distress
    - Time-consuming
    - Interferes with social, family, academic function
  - Characterized by obsessions and compulsions
  - No pleasure from ritualistic behavior



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Obsessive Compulsive Disorder

- **Evaluation:**

Assessment should include: **symptom description, frequency, impact on daily functioning**

- Do you wash your hands or clean more than most people?
- Do you feel the need to check or double check things often?
- Do you find yourself spending a lot of time doing things?
- Does it bother you when things are lines up or are not in order?
- Do these problems bother you?

If PANDAS is suspected/unclear history of recent URI either throat culture/ASO titer

Clinical findings that differentiate PANDAS from classic OCD:
Urinary frequency, hyperactivity, impulsivity, worsening handwriting

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Obsessive Compulsive Disorder

- **Management:**
  - Treatment should center on degree of impairment
  - Mild- moderate (CBT)
  - Moderate-severe (CBT + pharmacologic management)
    - Fluoxetine, Sertraline, & Fluvoxamine

CBT = 1st line therapy & provides best long term effectiveness

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Schizophrenia

- **Key Characteristics & S/S:**

  - Syndrome-range of cognitive, behavioral & emotional dysfunction
  - In children, delusions/hallucinations may be less elaborate, **visual hallucinations more common**
  - Disorganized speech & behavior occur in many childhood disorders-rule out more common
  - Typically develops between late teens-mid-30s; onset prior to adolescence is rare
  - The onset can be abrupt or insidious, around ½ will have complains of depressive symptoms

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Schizophrenia

- **Evaluation:**
  - Asking questions such as:
  - “does your mind play tricks on you?
  - Do you hear voices when no one is there?
  - Does your mind ever feel confused?”

Prodromal phase: Before psychosis- experience deteriorations (unusual behaviors, academic failure, social withdrawal, dysphoria)

- **Management:**
  - Decrease psychotic symptoms, Direct child to normal development, Reintegrating child to home and school
  - Pharmacotherapy: Haloperidol, Risperidone, Aripiprazole, Quetiapine, Paliperidone, Olanzapine are FDA approved for 13 years and older

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Post-Traumatic Stress Disorder

- **Key Characteristics:**
  - Symptoms that develop after a severe stressful event
  - Exposure to trauma
  - Recurrent or intrusive memories of the trauma
  - Nightmares
  - Distress caused by cues of trauma

- S/S:
  - Unexplained injuries
  - Bedwetting
  - Fear of going home
  - Changes in behavior
  - Appetite changes
  - Sleep disturbances
  - Anxiety
  - Self-harm
  - Suicidal ideations

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Post-Traumatic Stress Disorder: Evaluation

Infancy	Feeding problems, FTT, sleep problems, irritability
Preschool	Sleep problems, nightmares, developmental regression, aggression, extreme temper tantrums, anxiety symptoms, sudden worsening of fears, irritability, avoidance symptoms
School age	Sleep problems, nightmares, development regression, repetitive themes in play, social withdrawal, new onset anxiety or fears, panic attacks, impaired concentration, impaired school performance, avoidance symptoms, somatic complaints
Adolescence	Acting out, nightmares, insomnia, extreme startling, social withdrawal, tears, anxiety, depression, panic attacks, anger or rage, internalizing, suicidal ideation, impaired concentration, impaired school performance

Has anything ever happened to you that was really scary, dangerous, or violent?

Have you ever seen anything happen to anyone else that was really scary, dangerous, or violent?

If "YES" continue with:
PTSD Index
MH Referral
Emergency if Suicidal Risk

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Post-Traumatic Stress Disorder

- **Management:**
  - **Mental health services are critical (CBT + Psychopharm)**
  - **Social Services for under 18 who have experience/witnessed violence**
  - Beta-blockers (Propranalol) for somatic complaints (HR, hyperpnea)
  - SSRIs for depression/anxiety related to PTSD

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Attention-Deficit/Hyperactivity Disorder

- **Key Characteristics:**
  - Symptoms affect domains where children/adolescent are working on mastery (school, peers, family life, sports, & recreational activities)
  - Symptoms must exist in two or more domains

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Attention-Deficit/Hyperactivity Disorder

- **S/S:**
  - Cardinal features
    - Inattention
    - Distractible
    - Impulsive
    - Overactive
    - Concerns can also be related to memory, emotional control, organization, planning/inhibiting thoughts/actions, following rules

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Attention-Deficit/Hyperactivity Disorder

- **Evaluation:**
  - Behavioral rating scales- from several sources (Connors, Vanderbilt)
  - Physical history
    - Dysmorphic features?
    - Café au lait, signs of abuse?
    - TM scarring? Allergy signs? Enlarged tonsils?
    - Abnormal heart sounds/murmur, hx?
    - Abnormal neuro/dev findings?

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Attention-Deficit/Hyperactivity Disorder

- **Management:**
  - Stimulants (1st line for age 6 & up-Ritalin, Concerta, Focalin)
  - Mix salts of Dextro- and Levo- amphetamines (Adderall, Vyvanse, Dexedrine)
  - Selective norepinephrine reuptake inhibitors (Straterra)
  - Intuniv to be used in addition to other medications
  - CBT (1st line for under 6, and as combination w/meds 6 & up)

If cardiac history/physical exam are – no further tests are recommended before starting ADHD meds, if + consultation with cardiologist is necessary

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Conduct Disorder

- **Key Characteristics**:
  - Repetitive/persistent pattern of behavior in which basic rights of others and rules are violated
  - Onset of behavior in toddlerhood, early onset are diagnosed 4-6
  - Formal diagnosis typically around age 7
  - Frequently associated with a history of harsh discipline, abuse, neglect
  - High rate of comorbidity w/depression (leading to substance abuse & suicide)

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Conduct Disorder

- **S/S**:
  - Falls in to four main groups:

a) Aggressive behavior that threatens or results in physical harm to others or animals

b) Nonaggressive behavior that causes damages to property

c) Lying or stealing

d) Serious violation of rules or laws

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Conduct Disorder

- **Evaluation & Management:**
  - If aggressive behaviors are identified before CD develops, a multifaceted program is recommended (parent-directed, social-cognitive skills training, classroom management, group therapy)
  - **Safety is a priority** (child with CD & others)
  - **Due to strong correlation of abuse/neglect critical to determine if the child is safe**

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Oppositional Defiant Disorder

- **Key Characteristics & S/S:**
  - Open defiance/noncompliance w/authority
  - Symptoms occur during preschool years
  - Typically diagnosed in school-age
  - Must persist minimum of 6 months
  - Recurrent pattern negative, defiant, disobedient, hostile behavior
  - Typically directed at family members, teachers, or peers known well to child
  - Exhibits behaviors to extent it impairs function

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Oppositional Defiant Disorder

- **Evaluation & Management:**
  - Child does not usually see themselves as the problem (blames others) referral is indicated
  - Parenting strategies, healthy discipline
  - Similar approach to a child with CD

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Substance Abuse

- **Key Characteristics**:
  - Comorbid most often with CD, depression, anxiety
  - Distinguished from social drinking by the presence of:
    - Compulsive use
    - Craving
    - Substance-related problems

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Substance Abuse

- **S/S:**
  - Weight loss
  - Red eyes
  - Extremely dilated or constricted pupils
  - Accidents, trauma, injuries
  - Evidence of IV tracks
  - Odor of alcohol or inhaled substances
  - Emaciation/dental caries
  - Unexplained lethargy

Infants & Young Children	Older Children & Adolescents
Excessive crying	Decreased school performance
Poor feeding	Lethargy
Failure to thrive	Hyperactivity
Irritability	Hypervigilance
Jitteriness	Decreased attention
Excessive lethargy	Disinhibition
Poor eye contact	Risk-taking behavior
Sleep disorders	Repeated absences/suspensions
	Loss of interest in previously enjoyed activities
	Withdrawal from family & friends
	Exaggerated mood swings
	Hyper sexuality
	Sleep disturbances

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Substance Abuse

- **Evaluation & Management:**
  - CRAFFT Questionnaire
  - Interview adolescent with & w/o parent present
  - Substance abuse must be treated & referral is crucial
  - Urine toxicology
    - + can verify truthful but does not indicate dependence
    - - does not rule-out substance abuse

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Question 5

A newly divorced mother of a toddler reports that the child began having difficulty sleeping and nightmares along with exhibiting angry outbursts and tantrums 2 months prior. The primary care pediatric nurse practitioner learns that the child refuses to play with usual playmates and often spends time sitting quietly. What will the nurse practitioner do initially?

1. Consult with a child psychiatrist to prescribe medications
2. Ask the mother about the child's relationship with the father
3. Recommend cognitive behavioral or psychodynamic therapy
4. Refer the family to a child behavioral specialist for counseling

Question 5

A newly divorced mother of a toddler reports that the child began having difficulty sleeping and nightmares along with exhibiting angry outbursts and tantrums 2 months prior. The primary care pediatric nurse practitioner learns that the child refuses to play with usual playmates and often spends time sitting quietly. What will the nurse practitioner do initially?

Answer: Ask the mother about the child's relationship with the father

Question 6

The parent of a school-age girl reports that the child has difficulty getting ready for school and is often late because of a need to check and recheck whether her teeth are clean and her room light has been turned off. What will the primary care pediatric nurse practitioner recommend to this parent?

1. Deferral of treatment until symptoms worsen
2. Medication management with an SSRI
3. Referral to a child psychiatrist
4. Cognitive-behavioral therapy

Question 6

The parent of a school-age girl reports that the child has difficulty getting ready for school and is often late because of a need to check and recheck whether her teeth are clean and her room light has been turned off. What will the primary care pediatric nurse practitioner recommend to this parent?

Answer: Cognitive-behavioral therapy

Question 7

A middle-school-age child is skipping school frequently and getting poor grades since the child's father was killed while deployed in the military. How will the primary care pediatric nurse practitioner manage this situation?

1. Prescribe short-term antidepressants for this situational depression
2. Refer the child to a mental health specialist for evaluation and treatment
3. Schedule extended appointments for counseling and mental health intervention
4. Suggest that the child have close follow-up by a school counselor

Question 7

A middle-school-age child is skipping school frequently and getting poor grades since the child's father was killed while deployed in the military. How will the primary care pediatric nurse practitioner manage this situation?

Answer: Refer the child to a mental health specialist for evaluation and treatment