

# GOALS AND OBJECTIVES

- By the end of this talk, the audience will be able to:
  1. Name 4 areas of distress causing children to present in a mental health crisis
  2. Utilize the 8 domains of Psychological First Aid to assist these children
  3. Highlight in greater detail common psychiatric complaints in children and adolescents
  4. Expand their own knowledge base using web and print resources



# PSYCHIATRIC ISSUES IN PEDIATRIC EMERGENCY SERVICES

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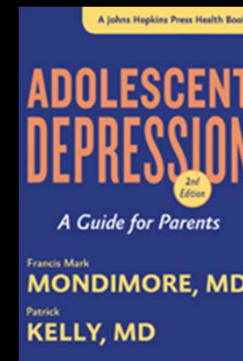
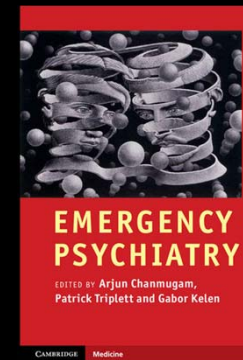
Division of Child and Adolescent Psychiatry

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# CONFLICTS OF INTEREST <sup>3</sup>

- Commercial
  - None
- Other
  - "Issues in Pediatric Psychiatric Emergency Care."  
In Emergency Psychiatry
  - Adolescent Depression, A Guide for Parents



# TOPICS TO COVER

- Why these kids come to us
- What you can do to help kids in crisis - PFA
- A little more on what's going on in the background
  - Psychiatric Illnesses
  - Depression/Bipolar – what?
  - Suicide
- PRN Medications for Agitation/Aggression, if we have time

# REASON FOR PSYCHIATRIC PRESENTATION

- Psychiatric Illness (20% of children and adolescents)
  - Psychosis
  - Depression
  - Anxiety
  - Severe ADHD
  - Autism Spectrum Disorder
- Social Maladjustment
  - Bullying
  - Behavioral reinforcers to ED presentation (reduces stress, alleviates "emotional expression," video games, etc.)
- Inadequacy of Outpatient Resources
  - No outpatient available
  - Parental frustration with outpatient
  - Lack of follow-through: "Crisis-Mode"
  - Placement "unable to handle"
- Mismatch between child temperament and parent ability to cope

# AGE-BASED PRESENTATIONS

- Pre-school
  - 10% of all psychiatric cases
  - Typical Reasons for Presentation
    - Developmental Disabilities
    - ADHD/Inattention
    - Anxiety
    - Trauma
    - Inadequate care/Parenting challenges

# AGE-BASED PRESENTATIONS

- School Age
  - ADHD/Inattention
  - Disruptive Behavior
  - Anxiety
  - Trauma
  - Developmental Disabilities (frequently not new, but suddenly outstrip the care providers resources)
  - Mood Disorder
  - Psychosis (extremely rare, more likely to represent DD or anxiety)

# AGE-BASED PRESENTATIONS

- Adolescence
  - The above plus...
  - Substance abuse
  - Antisocial behavior
    - (possibly w/ malingering: becoming suicidal during an arrest...)
  - Higher rates of Mood Disorder, Psychosis potentially present



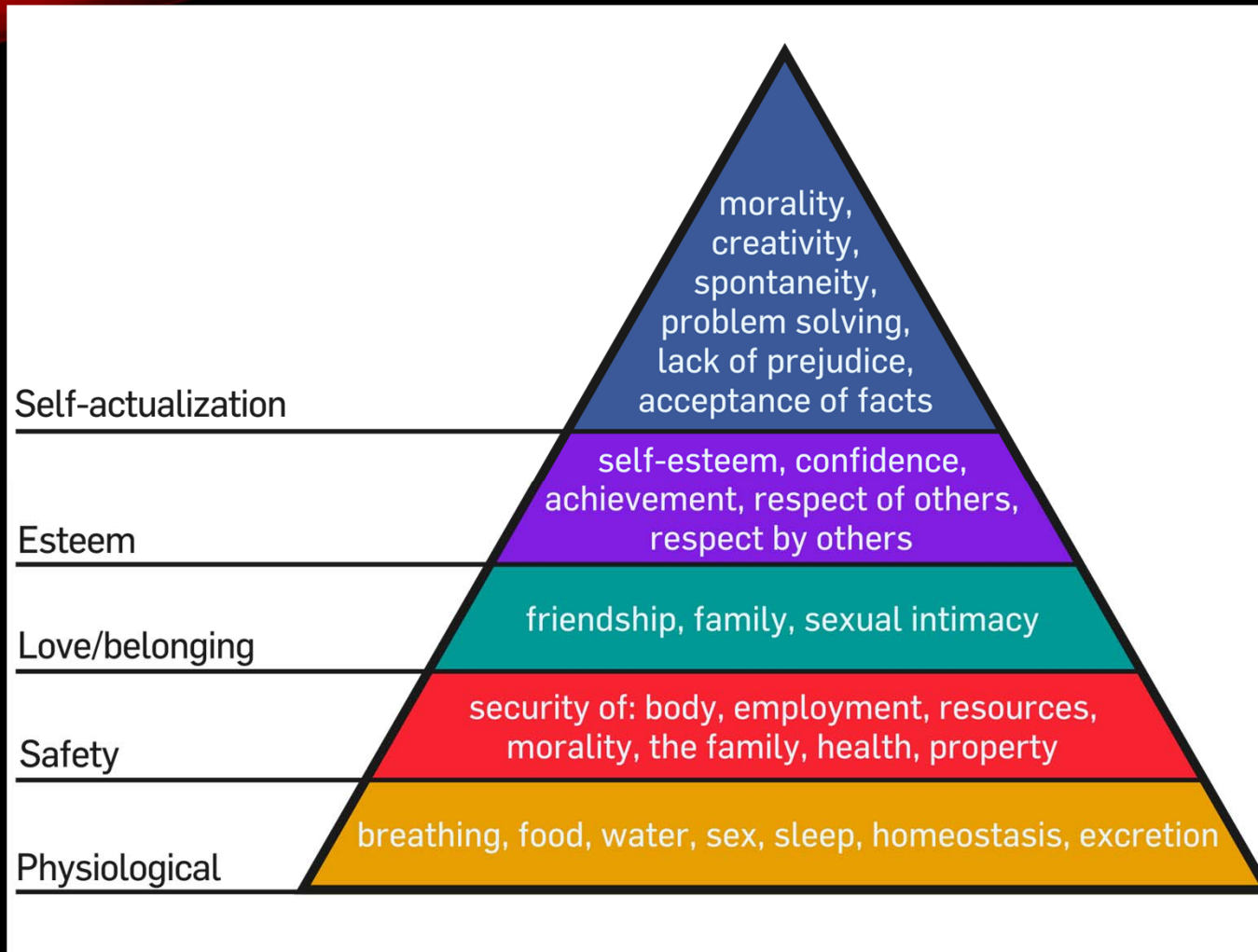
# HOW TO HELP

- EMS training geared towards physical injury
- Looking for an algorithmic way to approach mental health
- Modified Psychological First Aid (PFA)

## 5 PRINCIPLES

- Create a sense of Safety
- Calming
- Self-efficacy
- Community-efficacy & Connectedness
- Hope

# MASLOW'S HIERARCHY OF NEEDS



### Physiological

- Water, Food
- Clothing, Shelter

### Safety

- Address chaotic nature of the crisis, assure patients they are in a safe place where nothing bad will happen to them

### Love and Belonging

- Allow contact with loved ones (phone, etc.) Do not attempt to unnecessarily isolate patient
- Allow (safe!) interactions with other patients

### Esteem

- "Lower" needs (external): Respect patient and make them feel respected (many violent/aggressive acts are defensive against demoralization)
- "Higher" needs (internal – need for self respect): Re-moralize patient

### Self Actualization

- The need to "be all that one can be": the best parent, the best patient, etc. Not typically directly addressed, a largely internal process, but can be a source of depression/treatment failure

# 8 CORE ACTIONS

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1. Contact and Engagement
  - Respond to patients in a non- intrusive, compassionate, and helpful manner.
2. Safety and Comfort
  - Assure immediate and ongoing safety, and provide physical and emotional comfort.
3. Stabilization (if needed)
  - Calm and orient emotionally overwhelmed or disoriented patients.
4. Information Gathering
  - Identify immediate needs and concerns.
5. Practical Assistance
  - Address immediate needs and concerns.
6. Connection with Social Supports
  - Identify and connect with primary support persons (parents, DCFS workers, staff, etc.)
7. Long-Term Coping
  - Provide information about stress reactions and coping to promote adaptive functioning.
8. Linkage with Collaborative Services
  - Help link survivors with available services needed at the time or in the future.

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# CONTACT & ENGAGEMENT<sup>14</sup>

- Observe first, before introducing yourself or actively engaging
  - Traumatized/anxious children can react like caged animals
  - Watch for signs of
    - Agitation
    - Intoxication
    - Psychosis/disorganization
    - Extreme fear/anxiety
    - Cultural differences (in some cultures it is inappropriate for a male to approach a young female without their parent present)
- If traumatized, **DO NOT** engage by asking about details of the trauma
- Use developmentally appropriate language
- Pay attention to both verbal and non-verbal communication
- Use verbal de-escalation as appropriate and necessary



# TIPS FOR WORKING WITH KIDS<sup>5</sup>

- Meet at child's eye level.
- Help expression of feelings; provide simple labels for common emotional reactions (mad, sad, scared, worried).
- Listen and reflect
- Understand that developmental regression is normal.
- Match your language to the child's development.
- Talk to adolescents "adult-to-adult"



# VERBAL DE-ESCALATION

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- American Association for Emergency Psychiatry (AAEP) De-escalation Workgroup
  - **Respect personal space.**
  - Do not be physically provocative, do not posture or intimidate.
  - Use concise, simple language
  - As necessary, set clear and firm limits.
  - Offer choices – “Would you rather talk here or in the ambulance?” Patients feel empowered if they have some choice in matters.
  - Debrief



# DE-ESCALATION NO-NO'S

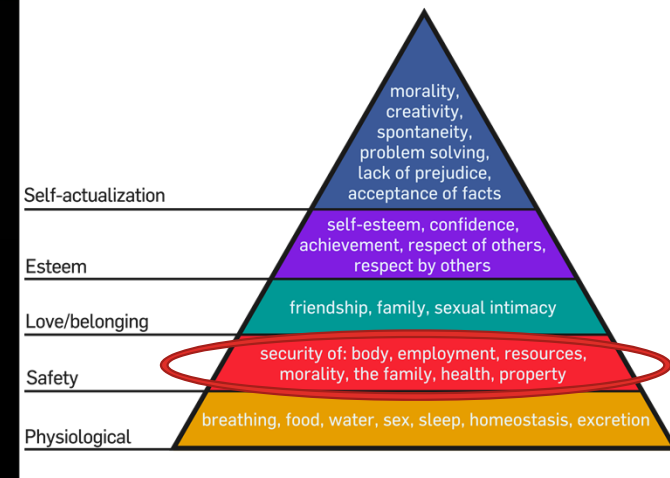


- Arguing, machismo, condescension, or commanding the patient to calm down (Patients often interpret such approaches as a challenge to "prove themselves." A threat to call security personnel also invites aggression)
- Criticizing or interrupting the patient
- Never lie to a patient (e.g., "I am sure you will be out of here in no time" when this is not the case). Once the lie becomes apparent, the patient may take out frustrations violently
- Take all threats seriously. It is especially important not to deny or downplay threatening behavior.

# SAFETY & COMFORT

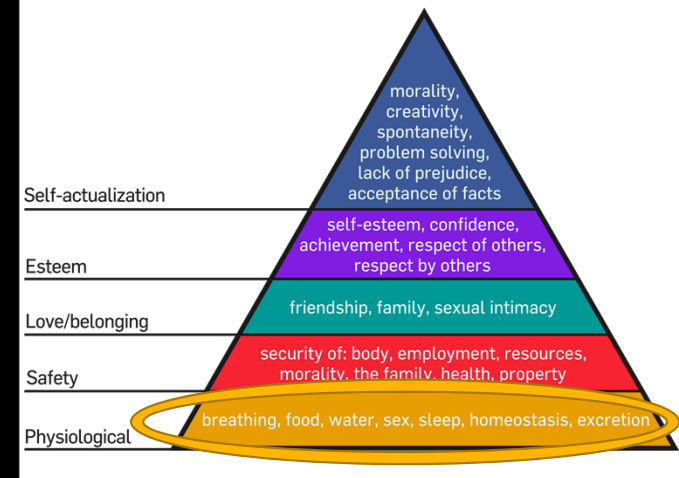
- Safety

- Ensure immediate physical safety
- Reinforce that patients are now safe and that the crisis is over.
- Reinforce that kids are “not in trouble” for what they did
  - Going to the hospital is **NOT** a punishment
  - You are just here to understand and help in any way you can
- Provide information (as safe and appropriate)
  - Inform patient and parents what you are going to do BEFORE you do it
  - Let patients know what to expect
  - Tell parents how they can advocate for kids



# SAFETY & COMFORT

- Comfort
  - Attend to physical and emotional comfort
    - Blankets, pillows, towels
    - Food, water if not in a medical crisis
    - Transitional object/comfort object if not harmful
  - Minimize ongoing trauma and trauma reminders
  - Reduce stimuli
    - Some kids need to be by themselves to calm down – respect that
    - Others will want to talk – let them do so, don't shush them
    - Consider turning off lights, noises, or putting soothing music on the radio



# STABILIZATION (DEALING WITH STRONG EMOTIONS)<sup>20</sup>

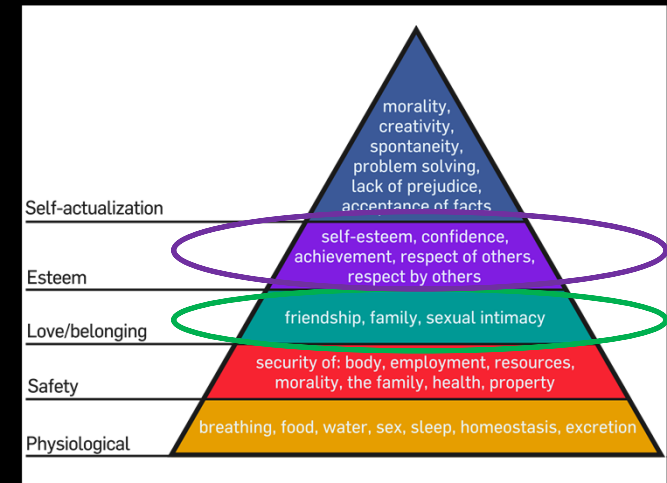
- Most self-regulate with time and space
- Parents can help kids calm down
  - Sometimes they need to be reminded that this is their role
- Check yourself first
  - Remain calm and collected
  - Even if you aren't "doing anything," your calm presence may be helpful
- Techniques
  - Ask kids if they have "coping skills" or how they calm themselves down
    - Most kids in CBT or DBT will have such a list
  - Deep Breathing
  - "Grounding" (distraction/mindfulness)
    - PFA app/Mindfulness app

# INFORMATION GATHERING

- Identify immediate needs or concerns
- Identify need for additional interventions / services

# PRACTICAL ASSISTANCE <sup>22</sup>

- Predictors of resilience/positive response
  - Optimism
  - Confidence/self-empowerment
  - Availability of resources (including parents)
- Steps to help
  - List of needs (from information gathering)
  - Clarify/order need with patient
  - Create and discuss action plan
  - Act to address needs



# CONNECTION WITH SOCIAL SUPPORTS

- Encourage family presence/meetings
- Allow connections with supportive friends
  - Discourage blasting on social media

# ANTICIPATORY COPING <sup>24</sup>

- Validate: stress reactions are normal
- Normalize physical responses (elevated heart rate, feeling short of breath, etc)
- Reinforce basic coping skills, plan for what they can do
  - Ask what kids use to cope
    - Breathing (<https://youtu.be/UAylAS6-X7s>)
    - Music
    - Coloring/drawing
    - Distraction (TV, movies)
    - Self time-out (helpful to make a sign indicating that the person is in a self time-out)
    - Taking a walk
    - More complex:
      - Progressive Muscle Relaxation (<https://youtu.be/aaTDNYjk-Gw>)
      - Mindfulness Meditation (<https://youtu.be/SEctySiCol0>)
    - Ask them to demonstrate or teach them to you (forcing them to use the techniques in the moment)
  - Help kids anticipate stressful experiences



# LINK WITH COLLABORATIVE SERVICES

- Don't assume that the ER, hospital, etc. will do this!
- Inform parents of how critical this is to do, and to do early, given wait lists, etc.
- Other resources
  - Educational Advocates
  - Specialized psychotherapy
  - Outpatient clinics
  - DCFS voluntary support services
  - Regional centers
- Get to know what's available in your county/community

# SELF-CARE (CALLED "PROVIDER CARE")

- "Self-care is **NOT** selfish, and it is **NOT** optional!"
- Foster and participate in a supportive work environment
- Find ways to relax/take breaks on the job
- Schedule personal time and activities
- Stress management practices
- Mindfulness and Deep Breathing ain't just for kids

## Provider Worksheets

### Survivor Current Needs

Date: \_\_\_\_\_ Provider: \_\_\_\_\_

Survivor Name: \_\_\_\_\_

Location: \_\_\_\_\_

This session was conducted with (check all that apply):

☐ Child ☐ Adolescent ☐ Adult ☐ Family ☐ Group

Provider: Use this form to document what the survivor needs most at this time. This form can be used to communicate with referral agencies to help promote continuity of care.

#### 1. Check the boxes corresponding to difficulties the survivor is experiencing.

Behavioral	Emotional	Physical	Cognitive
<input type="checkbox"/> Extreme disorientation <input type="checkbox"/> Excessive drug, alcohol, or prescription drug use <input type="checkbox"/> Isolation/withdrawal <input type="checkbox"/> High risk behavior <input type="checkbox"/> Regressive behavior <input type="checkbox"/> Separation anxiety <input type="checkbox"/> Violent behavior <input type="checkbox"/> Maladaptive coping <input type="checkbox"/> Other _____	<input type="checkbox"/> Acute stress reactions <input type="checkbox"/> Acute grief reactions <input type="checkbox"/> Sadness, tearfulness <input type="checkbox"/> Irritability, anger <input type="checkbox"/> Feeling anxious, fearful <input type="checkbox"/> Despair, hopelessness <input type="checkbox"/> Feelings of guilt or shame <input type="checkbox"/> Feeling emotionally numb, disconnected <input type="checkbox"/> Other _____	<input type="checkbox"/> Headaches <input type="checkbox"/> Stomachaches <input type="checkbox"/> Sleep difficulties <input type="checkbox"/> Difficulty eating <input type="checkbox"/> Worsening of health conditions <input type="checkbox"/> Fatigue/exhaustion <input type="checkbox"/> Chronic agitation <input type="checkbox"/> Other _____	<input type="checkbox"/> Inability to accept/cope with death of loved one(s) <input type="checkbox"/> Distressing dreams or nightmares <input type="checkbox"/> Intrusive thoughts or images <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Difficulty remembering <input type="checkbox"/> Difficulty making decisions <input type="checkbox"/> Preoccupation with death/destruction <input type="checkbox"/> Other _____

## Parent Tips for Helping Infants and Toddlers after Disasters

If Your Child	Understand	Ways to Help
... has problems sleeping, doesn't want to go to bed, won't sleep alone, wakes up at night screaming.	<ul style="list-style-type: none"> <li>When children are scared, they want to be with people who help them feel safe, and they worry when you are not together.</li> <li>If you were separated during the disaster, going to bed alone may remind your child of that separation.</li> <li>Bedtime is a time for remembering because we are not busy doing other things. Children often dream about things they fear and can be scared of going to sleep.</li> </ul>	<ul style="list-style-type: none"> <li>If you want, let your child sleep with you. Let him know this is just for now.</li> <li>Have a bedtime routine: a story, a prayer, cuddle time. Tell him the routine (every day), so he knows what to expect.</li> <li>Hold him and tell him that he is safe, that you are there and will not leave. Understand that he is not being difficult on purpose. This may take time, but when he feels safer, he will sleep better.</li> </ul>
... worries something bad will happen to you. (You may also have worries like this.)	<ul style="list-style-type: none"> <li>It is natural to have fears like this after being in danger.</li> <li>These fears may be even stronger if your child was separated from loved ones during the disaster.</li> </ul>	<ul style="list-style-type: none"> <li>Remind your child and yourself that right now you are safe.</li> <li>If you are not safe, talk about how you are working to keep her safe.</li> <li>Make a plan for who would care for your child if something did happen to you. This may help you worry less.</li> <li>Do positive activities together to help her think about other things.</li> </ul>
... cries or complains whenever you leave him, even when you go to the bathroom.  ... can't stand to be away from you.	<ul style="list-style-type: none"> <li>Children who cannot yet speak or say how they feel may show their fear by clinging or crying.</li> <li>Goodbyes may remind your child of any separation you had related to the disaster.</li> <li>Children's bodies react to separations (stomach sinks, heart beats faster). Something inside says, "Oh no, I can't lose her."</li> <li>Your child is not trying to manipulate or control you. He is scared.</li> <li>He may also get scared when other people (not just you) leave. Goodbyes make him scared.</li> </ul>	<ul style="list-style-type: none"> <li>Try to stay with your child and avoid separations right now.</li> <li>For brief separations (store, bathroom), help your child by naming his feelings and linking them to what he has been through. Let him know you love him and that this goodbye is different, you'll be back soon. "You're so scared. You don't want me to go because last time I was gone you didn't know where I was. This is different, and I'll be right back."</li> <li>For longer separations, have him stay with familiar people, tell him where you are going and why, and when you will come back. Let him know you will think about him. Leave a photo or something of yours and call if you can. When you come back, tell him you missed him, thought about him, and did come back. You will need to say this over and over.</li> </ul>
... has problems eating, eats too much or refuses food.	<ul style="list-style-type: none"> <li>Stress affects your child in different ways, including her appetite.</li> <li>Eating healthfully is important, but focusing too much on eating can cause stress and tension in your relationship.</li> </ul>	<ul style="list-style-type: none"> <li>Relax. Usually, as your child's level of stress goes down, her eating habits will return to normal. Don't force your child to eat.</li> <li>Eat together and make meal times fun and relaxing.</li> <li>Keep healthy snacks around. Young children often eat on the go.</li> <li>If you are worried, or if your child loses a significant amount of weight, consult a pediatrician.</li> </ul>

## Parent Tips for Helping Preschool-Age Children after Disasters

Reactions/Behavior	Responses	Examples of things to do and say
<u>Helplessness and passivity:</u> Young children know they can't protect themselves. In a disaster, they feel even more helpless. They want to know their parents will keep them safe. They might express this by being unusually quiet or agitated.	<ul style="list-style-type: none"> <li>Provide comfort, rest, food, water, and opportunities for play and drawing.</li> <li>Provide ways to turn spontaneous drawing or playing about traumatic events to something that would make them feel safer or better.</li> <li>Reassure your child that you and other grownups will protect them.</li> </ul>	<ul style="list-style-type: none"> <li>Give your child more hugs, hand holding, or time in your lap.</li> <li>Make sure there is a special safe area for your child to play with proper supervision.</li> <li>In play, a four year old keeps having the blocks knocked down by hurricane winds. Asked, "Can you make it safe from the winds?" the child quickly builds a double block thick wall and says, "Winds won't get us now." A parent might respond with, "That wall sure is strong," and explain, "We're doing a lot of things to keep us safe."</li> </ul>
<u>General fearfulness:</u> Young children may become more afraid of being alone, being in the bathroom, going to sleep, or otherwise separated from parents. Children want to believe that their parents can protect them in all situations and that other grownups, such as teachers or police officers, are there to help them.	<ul style="list-style-type: none"> <li>Be as calm as you can with your child. Try not to voice your own fears in front of your child.</li> <li>Help children regain confidence that you aren't leaving them and that you can protect them.</li> <li>Remind them that there are people working to keep families safe, and that your family can get more help if you need to.</li> <li>If you leave, reassure your children you will be back. Tell them a realistic time in words they understand, and be back on time.</li> <li>Give your child ways to communicate their fears to you.</li> </ul>	<ul style="list-style-type: none"> <li>Be aware when you are on the phone or talking to others, that your child does not overhear you expressing fear.</li> <li>Say things such as, "We are safe from the earthquake now, and people are working hard to make sure we are okay."</li> <li>Say, "If you start feeling more scared, come and take my hand. Then I'll know you need to tell me something."</li> </ul>
<u>Confusion about the danger being over:</u> Young children can overhear things from adults and older children, or see things on TV, or just imagine that it is happening all over again. They believe the danger is closer to home, even if it happened further away.	<ul style="list-style-type: none"> <li>Give simple, repeated explanations as needed, even every day. Make sure they understand the words you are using.</li> <li>Find out what other words or explanations they have heard and clarify inaccuracies.</li> <li>If you are at some distance from the danger, it is important to tell your child that the danger is not near you.</li> </ul>	<ul style="list-style-type: none"> <li>Continue to explain to your child that the disaster has passed and that you are away from the danger</li> <li>Draw, or show on a map, how far away you are from the disaster area, and that where you are is safe. "See? The disaster was way over there, and we're way over here in this safe place."</li> </ul>
<u>Returning to earlier behaviors:</u> Thumb sucking, bed-wetting, baby-talk, needing to be in your lap.	<ul style="list-style-type: none"> <li>Remain neutral or matter-of-fact, as best you can, as these earlier behaviors may continue a while after the disaster.</li> </ul>	<ul style="list-style-type: none"> <li>If your child starts bedwetting, change her clothes and linens without comment. Don't let anyone criticize or shame the child.</li> </ul>

## Parent Tips for Helping School-Age Children after Disasters

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Reactions	Responses	Examples of things to do and say
<u>Confusion about what happened</u>	<ul style="list-style-type: none"> <li>Give clear explanations of what happened whenever your child asks. Avoid details that would scare your child. Correct any misinformation that your child has about whether there is a present danger.</li> <li>Remind children that there are people working to keep families safe and that your family can get more help if needed.</li> <li>Let your children know what they can expect to happen next.</li> </ul>	<ul style="list-style-type: none"> <li>"I know other kids said that more tornadoes are coming, but we are now in a safe place."</li> <li>Continue to answer questions your children have (without getting irritable) and to reassure them the family is safe.</li> <li>Tell them what's happening, especially about issues regarding school and where they will be living.</li> </ul>
<u>Feelings of being responsible:</u> School-age children may have concerns that they were somehow at fault, or should have been able to change what happened. They may hesitate to voice their concerns in front of others.	<ul style="list-style-type: none"> <li>Provide opportunities for children to voice their concerns to you.</li> <li>Offer reassurance and tell them why it was not their fault.</li> </ul>	<ul style="list-style-type: none"> <li>Take your child aside. Explain that, "After a disaster like this, lots of kids—and parents too—keep thinking, 'What could I have done differently?' or 'I should have been able to do something.' That doesn't mean they were at fault."</li> <li>"Remember? The firefighter said no one could save Pepper and it wasn't your fault."</li> </ul>
<u>Fears of recurrence of the event and reactions to reminders</u>	<ul style="list-style-type: none"> <li>Help identify different reminders (people, places, sounds, smells, feelings, time of day) and clarify the difference between the event and the reminders that occur after it.</li> <li>Reassure them, as often as they need, that they are safe.</li> <li>Protect children from seeing media coverage of the event, as it can trigger fears of the disaster happening again.</li> </ul>	<ul style="list-style-type: none"> <li>When they recognize that they are being reminded, say, "Try to think to yourself, I am upset because I am being reminded of the hurricane because it is raining, but now there is no hurricane and I am safe."</li> <li>"I think we need to take a break from the TV right now."</li> <li>Try to sit with your child while watching TV. Ask your child to describe what they saw on the news. Clarify any misunderstandings.</li> </ul>
<u>Retelling the event or playing out the event over and over</u>	<ul style="list-style-type: none"> <li>Permit the child to talk and act out these reactions. Let him know that this is normal.</li> <li>Encourage positive problem-solving in play or drawing.</li> </ul>	<ul style="list-style-type: none"> <li>"You're drawing a lot of pictures of what happened. Did you know that many children do that?"</li> <li>"It might help to draw about how you would like your school to be rebuilt to make it safer."</li> </ul>

## Parent Tips for Helping Adolescents after Disasters

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Reactions	Responses	Examples of things to do and say
<u>Detachment, shame, and guilt</u>	<ul style="list-style-type: none"> <li>Provide a safe time to discuss with your teen the events and their feelings.</li> <li>Emphasize that these feelings are common, and correct excessive self-blame with realistic explanations of what actually could have been done.</li> </ul>	<ul style="list-style-type: none"> <li>"Many teens—and adults—feel like you do, angry and blaming themselves that they could have done more. You're not at fault. Remember even the firefighters said there was nothing more we could have done."</li> </ul>
<u>Self-consciousness</u> : About their fears, sense of vulnerability, fear of being labeled abnormal.	<ul style="list-style-type: none"> <li>Help teens understand that these feelings are common.</li> <li>Encourage relationships with family and peers for needed support during the recovery period.</li> </ul>	<ul style="list-style-type: none"> <li>"I was feeling the same thing. Scared and helpless. Most people feel like this when a disaster happens, even if they look calm on the outside."</li> <li>"My cell phone is working again, why don't you see if you can get a hold of Pete to see how he's doing."</li> <li>"And thanks for playing the game with your little sister. She's much better now."</li> </ul>
<u>Acting out behavior</u> : Using alcohol or drugs, sexually acting out, accident-prone behavior.	<ul style="list-style-type: none"> <li>Help teens understand that acting out behavior is a dangerous way to express strong feelings (like anger) over what happened.</li> <li>Limit access to alcohol and drugs.</li> <li>Talk about the danger of high-risk sexual activity.</li> <li>On a time-limited basis, keep a closer watch on where they are going and what they are planning to do.</li> </ul>	<ul style="list-style-type: none"> <li>"Many teens—and some adults—feel out of control and angry after a disaster like this. They think drinking or taking drugs will help somehow. It's very normal to feel that way—but it's not a good idea to act on it."</li> <li>"It's important during these times that I know where you are and how to contact you." Assure them that this extra checking-in is temporary, just until things have stabilized.</li> </ul>
<u>Fears of recurrence and reactions to reminders</u>	<ul style="list-style-type: none"> <li>Help to identify different reminders (people, places, sounds, smells, feelings, time of day) and to clarify the difference between the event and the reminders that occur after it.</li> <li>Explain to teens that media coverage of the disaster can trigger fears of it happening again.</li> </ul>	<ul style="list-style-type: none"> <li>"When you're reminded, you might try saying to yourself, 'I am upset now because I am being reminded, but it is different now because there is no hurricane and I am safe.'"</li> <li>Suggest, "Watching the news reports could make it worse, because they are playing the same images over and over. How about turning it off now?"</li> </ul>

## Tips for Adults

Reactions/Behavior	Responses	Examples of things to do and say
<u>High anxiety/arousal:</u> Tension and anxiety are common after disasters. Adults may be excessively worried about the future, have difficulties sleeping, problems concentrating, and feel jumpy and nervous. These reactions can include rapid heart beat and sweating.	<ul style="list-style-type: none"> <li>Use breathing and/or other relaxation skills.</li> <li>Take time during the day to calm yourself through relaxation exercises. These can make it easier to sleep, concentrate, and will give you energy.</li> </ul>	<ul style="list-style-type: none"> <li>Breathing exercise: Inhale slowly through your nose and comfortably fill your lungs all the way down to your stomach, while saying to yourself, "My body is filled with calm." Exhale slowly through your mouth and empty your lungs, while silently saying to yourself, "My body is letting go." Do this five times slowly, and as many times a day as needed.</li> </ul>
<u>Concern or shame</u> over your own reactions. Many people have strong reactions after a disaster, including fear and anxiety, difficulty concentrating, shame about how they reacted, and feeling guilty about something. It is expectable and understandable to feel many emotions in the aftermath of an extremely difficult event.	<ul style="list-style-type: none"> <li>Find a good time to discuss your reactions with a family member or trusted friend.</li> <li>Remember that these reactions are common and it takes time for them to subside.</li> <li>Correct excessive self-blame with realistic assessment of what actually could have been done.</li> </ul>	<ul style="list-style-type: none"> <li>When talking with someone, find the right time and place, and ask if it is okay to talk about your feelings.</li> <li>Remind yourself that your feelings are expectable and you are not "going crazy," and that you are not at fault for the disaster.</li> <li>If these feelings persist for a month or more, you may wish to seek professional help.</li> </ul>
<u>Feeling overwhelmed</u> by tasks that need to be accomplished (housing, food, paperwork for insurance, child care, parenting).	<ul style="list-style-type: none"> <li>Identify what your top priorities are.</li> <li>Find out what services are available to help get your needs met.</li> <li>Make a plan that breaks down the tasks into manageable steps.</li> </ul>	<ul style="list-style-type: none"> <li>Make a list of your concerns and decide what to tackle first. Take one step at a time.</li> <li>Find out which agencies can help with your needs and how to access them.</li> <li>Where appropriate, rely on your family, friends, and community for practical assistance.</li> </ul>
<u>Fears of recurrence and reactions to reminders:</u> It is common for survivors to fear that another disaster will occur, and to react to things that are reminders of what happened.	<ul style="list-style-type: none"> <li>Be aware that reminders can include people, places, sounds, smells, feelings, time of day.</li> <li>Remember that media coverage of the disaster can be a reminder and trigger fears of it happening again.</li> </ul>	<ul style="list-style-type: none"> <li>When you are reminded, try saying to yourself, "I am upset because I am being reminded of the disaster, but it is different now because the disaster is not happening and I am safe."</li> <li>Limit your viewing of news reports so you just get the information that you need.</li> </ul>
<u>Changes in attitude, view of the world and of oneself:</u> Strong changes in people's attitudes after a disaster are common, including questioning one's spiritual beliefs, trust in others and social agencies, and concerns about one's own effectiveness, and dedication to helping others.	<ul style="list-style-type: none"> <li>Postpone any major unnecessary life changes in the immediate future.</li> <li>Remember that dealing with post-disaster difficulties increases your sense of courage and effectiveness.</li> <li>Get involved with community recovery efforts.</li> </ul>	<ul style="list-style-type: none"> <li>Getting back to a more structured routine can help improve decision-making.</li> <li>Remind yourself that going through a disaster can have positive effects on what you value and how you spend your time.</li> </ul>



## CORE ACTIONS













*Contact &  
Engagement*



*Safety  
&  
Comfort*

## REMEMBER:

-  Work within a team.
-  Protect survivors from harm.
-  Be calm and compassionate.
-  Listen and be flexible.
-  Respect culture and diversity.
-  Give clear and reliable information.
-  Know local available resources.
-  Help survivors help themselves.
-  Know your limits.
-  Take care of yourself.

NCTSN

The National Child  
Traumatic Stress Network



*PFA Mobile™* can be downloaded on  
mobile Apple and Android devices

This project was also funded by SAMHSA,  
US Dept. of Health and Human Services  
*Illustrations by Dr. Bob Seaver*

## PSYCHOLOGICAL FIRST AID

*Are you ready to respond?*

GET **P**REPARED

GET **F**OCUSED

GET INTER **A**CTIVE

GET

**PFA**®



[www.NCTSN.org](http://www.NCTSN.org)  
[learn.nctsn.org](http://learn.nctsn.org)

**CORE ACTIONS**



*Stabilization*

**CORE ACTIONS**



*Practical Assistance*



**CORE ACTIONS**



*Information on Coping*



*Information Gathering*

*Connection with Social Supports*



*Linkage with Collaborative Services*

## Core Actions

The following are the 8 core actions of PFA. Be flexible, and base the amount of time you spend on each core action on the survivors' specific needs and concerns. Goals and key actions are provided for each.



Contact and  
Engagement



Safety and Comfort



Stabilization



Information Gathering



Practical Assistance



Links to  
Social Supports



Information  
on Coping



Links  
to Services

# REVIEW

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11/1/2016



# PSYCHIATRIC DIAGNOSES

- Disorders first usually diagnosed in Infancy, Childhood and Adolescence
  - PDD/ASD
  - ADHD / Disruptive Disorders
- Childhood presentation of general psychiatric disorders
  - Mood
  - Anxiety
  - Psychosis

# Remember: Children are not just miniature adults

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Though children suffer from the same illnesses as adults, the presentation and treatment can be very different



11/1/2016

# TOPICS

- Disorders first usually diagnosed in Infancy, Childhood and Adolescence
  - **PDD/ASD**
  - ADHD / Disruptive Disorders
- Childhood presentation of general psychiatric disorders
  - Mood
  - Anxiety
  - Psychosis

# PERVASIVE DEVELOPMENTAL DISORDERS

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- DSM-IV includes the following under PDD:
  1. Autism
  2. Rett's Disorder
  3. Childhood Disintegrative Disorder
  4. Asperger's Disorder
  5. PDD, not otherwise specified
- DSM-V includes only Autism Spectrum Disorder, with specifiers
  - Severity Level (1, 2, 3 depending on the "support" required)
  - Rate social communication and restricted behaviors separately
  - With or without Intellectual Impairment
  - With or without Language Impairment
  - Associated with a known medical/genetic/environmental factor
  - Associated with a neurodevelopmental, mental, behavioral disorder
  - Associated with Catatonia

# AUTISM: DIAGNOSTIC CRITERIA

## A. Impairment in Reciprocal Social Interaction

- Marked lack of awareness of others' feelings
- No or abnormal comfort-seeking
- No or impaired imitation
- No or abnormal social play
- Gross deficits in making friendships
- Impaired non-verbal behavior (e.g. eye contact, body postures)



## AUTISM: DIAGNOSTIC CRITERIA

### B. Impaired Verbal and Nonverbal Communication

- Delay or lack of spoken language
- Impaired ability to initiate or maintain conversation
- Stereotypic, repetitive or idiosyncratic use of language
- Impaired ability to converse with others

# AUTISM: DIAGNOSTIC CRITERIA

## C. Restricted Repertoire of Activities

- Stereotyped or repetitive body movements (e.g. hand flapping)
- Inability to tolerate change, with insistence on routines
- Narrow interests
- Unusual attachments to objects
- Preoccupation with object parts



# TOPICS

- Disorders first usually diagnosed in Infancy, Childhood and Adolescence
  - PDD/ASD
  - **ADHD / Disruptive Disorders**
- Childhood presentation of general psychiatric disorders
  - Mood
  - Anxiety
  - Psychosis



# ADHD - DSM-IV CRITERIA

- Onset with impairment < 7 years old (12 in DSM 5)
- Impairment in  $\geq 2$  settings
- Inattentive and / or hyperactive symptoms

# "EXTERNALIZING DISORDERS" IN CHILDREN (ODD, CD)

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- Behavioral disorders with +/- biological basis (diagnosis is descriptive and says nothing about etiology)
- Therefore, require behavioral treatments +/- medication



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# TOPICS

- Disorders first usually diagnosed in Infancy, Childhood and Adolescence
  - PDD/ASD
  - ADHD / Disruptive Disorders
- Childhood presentation of general psychiatric disorders
  - **Mood**
  - Anxiety
  - Psychosis

# TYPES OF DEPRESSION

- DSM-IV & 5
  - Major Depressive Disorder
  - Dysthymia
  - Adjustment Disorder
  - Bipolar Affective Disorder, MRE depressed
  - Secondary to an organic cause: Low TSH, anemia, delirium, etc.
  - Depressive Disorder NOS
- New to DSM-5
  - Pre-Menstrual Dysphoric Disorder
  - Disruptive Mood Dysregulation Disorder
- Not a formal diagnosis
  - Bereavement
  - Demoralization

# MAJOR DEPRESSIVE EPISODE

- S • **Sleep changes** (insomnia or hypersomnia) nearly every day
- I • markedly **diminished interest** or pleasure in all, or almost all, activities most of the day, nearly every day
- G • feelings of **worthlessness** or excessive or inappropriate **guilt** nearly every day
- E • **fatigue** or loss of energy nearly every day
- C • diminished ability to think or **concentrate**, nearly every day
- A • significant change in **weight** (loss or gain), or in **appetite** nearly every day.
- p • **psychomotor** agitation or retardation nearly every day
- s • recurrent **thoughts of death** (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- **depressed mood** most of the day, nearly every day



# DEPRESSION

- DSM Modifications for children:
  - irritable mood (vs. depressive mood)
  - observed apathy and pervasive boredom (vs. anhedonia)
  - failure to make expected weight gains (rather than significant weight loss)
  - somatic complaints
  - social withdrawal
  - declining school performance

# SUICIDALITY

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- Passive death wish
  - “Wished you would go to sleep and never wake up again?”
- Suicidal Ideation
  - With or without intent
  - With or without a plan (SLAP)
    - Plan is **S**pecific
    - Plan is **L**ethal
    - Plan is **A**vailable
    - Plan has low **P**roximity to helpful resources

<u>Suicide Attempt</u>	Low Lethality	High Lethality
Low Intent	Superficial cutting	OD on Tylenol
High Intent	Taking 4 Aspirin, but believing that it will kill you	Hanging, firearms

# COMPLETED SUICIDES

- >90% have a psychiatric condition
  - Depression and substance abuse
  - Psychosis (small percentage, but high risk)
    - Impaired judgment, hallucinations, delusions of persecution
- 1/3 have made previous attempts
- 1/2 have been ill for over 2 years
- Family history of suicide
- History of physical or sexual abuse
- Bullying

# BIPOLAR AFFECTIVE DISORDER

- No true estimates due to controversies over diagnosis.
- 20% of adults with BPAD had their first manic or mixed episode in adolescence
- Prospective study: 10-15% of children diagnosed with “depression” went on to develop bipolar disorder as adults.
- This puts the estimate of prevalence at about **0.4%** or lower (1 in 250 kids), and almost exclusively in adolescence.

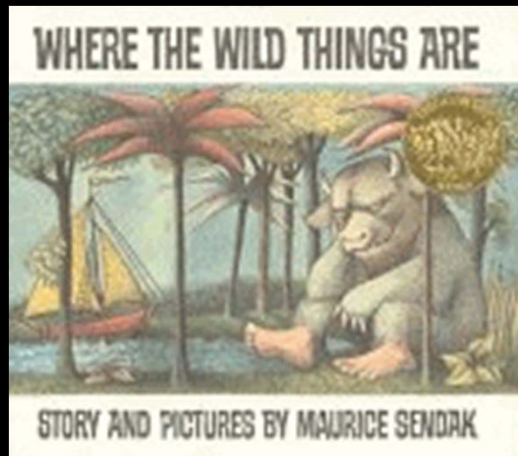
# RESOLVING THE CONTROVERSIES

- 80% of children diagnosed BPAD have no true bipolar spectrum illness
  - Set up for a lifetime of medications and inability to regulate their own mood
- New category in DSM-5: “disruptive mood dysregulation disorder”

# TOPICS

- Disorders first usually diagnosed in Infancy, Childhood and Adolescence
  - PDD/ASD
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  - Mood
  - **Anxiety**
  - Psychosis

# SPECIFIC PHOBIAS



- Marked and persistent fear of a specific object or situation
- Animal phobias > dark > imaginary creatures
- In older children, fears are more focused on health, social and school problems
- One-year community prevalence estimated at 11%
  - In general, decreases with age

# GENERALIZED ANXIETY DISORDER



- Excessive anxiety and worry for at least 6 months
  - Worry about performance at school and sports
- Featured on the TV program "Nurse Jackie,"
  - Daughter has GAD
  - However, the treatment with "pediatric doses of Xanax" was HORRIFYING to child psychiatrists everywhere!



# OBSESSIVE COMPULSIVE DISORDER

- Presence of obsessions (thoughts) and/or compulsions (behaviors)
- May have no insight
- 0.3-1.0% of kids
- C Y-B OCS
- Specific treatments
  - HIGH dose SSRI
  - E/RP



# POST-TRAUMATIC STRESS DISORDER (PTSD)

58

- Occurs 3 months or more after the event (before that, called “acute stress disorder”)
- **Extreme** response to an **extreme** stressor
  - Demoralization < adjustment disorder < acute stress disorder < PTSD
- Re-experiencing the traumatic event
  - Flashbacks
  - Nightmares
  - Avoidance



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# TOPICS

- Disorders first usually diagnosed in Infancy, Childhood and Adolescence
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  - Anxiety
  - **Psychosis**

# SCHIZOPHRENIA

- Need two of the following five symptoms over six months:
  - Delusions
  - Hallucinations
  - Disorganized speech
  - Disorganized behavior
  - Negative symptoms
- Onset in childhood is rare (<1 in 10,000 children)
- Prodromal symptoms may include attention deficits, poor executive functioning, social isolation – may look like ADHD or depression



# HALLUCINATIONS

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- “Perception without a stimulus”
  - Illusion
  - Pseudohallucination
  - Hallucination
- Primary concerning characteristic for schizophrenia, but this is actually the LEAST likely explanation
- More likely differential
  - Anxiety (pseudohallucinations)
  - PDD (pseudohallucinations)
  - Delirium
  - Organic cause (seizures, etc.)
  - Intoxication
  - Mood-related brief psychosis
  - Malingering



# INDICATIONS FOR MEDICATION USAGE

- Post physical restraint
- Decrease anxiety/discomfort
- Treat underlying cause
- Minimize dangerous behavior
- Minimize disruptive behavior
- Prevent escalation of behavior



# RISKS OF MEDICATIONS

- May cloud MSE and prevent further assessment
  - (though, by treating the underlying cause, may help in the long term)
- May exacerbate underlying condition if misdiagnosed





# SPECIFIC MEDICATIONS

- No universal agreement in ideal PRN cocktail
- Components
  - Benzodiazepines
  - First generation antipsychotics\*
  - Second generation antipsychotics\*
  - Sedating antihistamines
  - Ketamine??

(\*remember, the antipsychotic properties of most neuroleptics take 7-10 days to become maximally effective, so in the ER they are essentially alternative sedatives)



# IDEALLY GUIDED BY ETIOLOGY

- Psychosis
  - Antipsychotic +/- Benzodiazepine
- Drug intoxication
  - Antipsychotic +/- Benzodiazepine
- Drug withdrawal
  - Benzodiazepine
- Severe Anxiety
  - Anti-histamine/Benzodiazepine
- Delirium
  - Atypical antipsychotic
- Most of the time, etiology unclear



# ORAL OR PARENTERAL?

- Many staff prefer parenteral
  - Feeling of control over the situation
- Some patients prefer parenteral
  - Injection substance users
  - Psychodynamic giving over of control to external influence
- Generally, oral is preferred
  - Invokes participation by patient
  - Prevents possible further trauma

- Knott JC, Taylor DM, Castle DJ. Randomized clinical trial comparing intravenous midazolam and droperidol for sedation of the acutely agitated patient in the emergency department. *Ann Emerg Med* 2006; 47:61.
- Martel M, Sterzinger A, Miner J, et al. Management of acute undifferentiated agitation in the emergency department: a randomized double-blind trial of droperidol, ziprasidone, and midazolam. *Acad Emerg Med* 2005; 12:1167.
- Nobay F, Simon BC, Levitt MA, Dresden GM. A prospective, double-blind, randomized trial of midazolam versus haloperidol versus lorazepam in the chemical restraint of violent and severely agitated patients. *Acad Emerg Med* 2004; 11:744.
- TREC Collaborative Group. Rapid tranquillisation for agitated patients in emergency psychiatric rooms: a randomised trial of midazolam versus haloperidol plus promethazine. *BMJ* 2003; 327:708.
- Salzman C, Solomon D, Miyawaki E, et al. Parenteral lorazepam versus parenteral haloperidol for the control of psychotic disruptive behavior. *J Clin Psychiatry* 1991; 52:177.

# BENZODIAZEPINES

- Preferred agent by many adult practitioners and pediatricians
- Second line to many child and adolescent psychiatrists due to risk for disinhibition
- In studies\*, led to more rapid sedation than antipsychotics but frequently required re-administration
- Lorazepam
  - Rapid onset (10 min)
  - Short half-life (10-20 hrs)
  - Dose: 0.5 to 2 mg IV or IM (or **0.05-0.1 mg/kg/dose for children < 12**).
  - Repeat: q 10-30 minutes (sometimes shorter)
- Midazolam
  - Quicker onset
  - Shorter half life (1-2 hours)
  - Dose: 2.5 to 5 mg IV or IM.
  - Repeat: q 5-10 minutes
- Risks
  - Respiratory depression (in one study of 150 patients, 3 required intubation post treatment with benzos for agitation)
  - Paradoxical disinhibition
  - Physicians worry about rewarding aggression in drug seeking individuals, but evidence suggests low risk

# FIRST GENERATION ANTIPSYCHOTICS

- Haloperidol
  - Preferred by adult practitioners.
  - Onset: 30-60 minutes
  - Half-life: 15-30 hours
  - Dose: 2.5 to 10 mg (**0.025-0.075 mg/kg/dose** for those < 12)
  - Repeat: 15-30 minutes
  - High potency, significant risk for EPS, dystonia, NMS particularly in children and adolescents. (GIVE WITH DIPHENHYDRAMINE)
- Chlorpromazine
  - Onset: 30-60 minutes
  - Half Life: 30 hours
  - Dose: 25-100 mg (**0.5-2 mg/kg/dose**)
  - Repeat: 15-30 minutes
  - Low potency alternative (more sedating, lower risk of EPS)
- Risks
  - QTc prolongation (droperidol carries black box warning, at least one sudden cardiac arrest noted in literature), EPS, NMS, dystonia
- Consider ECG to minimize risks, if feasible
- Avoid in:
  - cases of alcohol withdrawal
  - benzodiazepine withdrawal
  - anticholinergic toxicity
  - Patients with seizures
  - Pregnant female

1. Hsu WY, Huang SS, Lee BS, Chiu NY. Comparison of intramuscular olanzapine, orally disintegrating olanzapine tablets, oral risperidone solution, and intramuscular haloperidol in the management of acute agitation in an acute care psychiatric ward in Taiwan. J Clin Psychopharmacol 2010; 30:230.

# SECOND GENERATION ANTIPSYCHOTICS

- Less EPS, though less sedation
- In one study, intramuscular/ODT olanzapine and oral risperidone were as effective as IM haloperidol.<sup>1</sup>
- Choices are typically
  - Olanzapine
    - Onset: 15-45 minutes
    - Half life: 2-4 hours
    - Dose: 2.5-5 mg IM/ODT
    - Repeat at 10 minutes
  - Risperidone
    - Onset: 10-30 minutes
    - Half-life: 3-20 hours
    - Dose: 0.5-2 mg
    - Repeat at 10 minutes
  - Ziprasidone IM
    - Onset: 15-20 minutes
    - Half life: 3-6 hours
    - Dose: 10 - 20 mg,
    - Repeat: 10 minutes

1. Chan EW, Taylor DM, Knott JC, et al. Intravenous droperidol or olanzapine as an adjunct to midazolam for the acutely agitated patient: a multicenter, randomized double-blind, placebo-controlled clinical trial. Ann Emerg Med 2013; 61:72.

## COMBINATION TREATMENT

- Frequently used together
  - Midazolam (5 mg IV or IM) or Lorazepam (2 mg IV or IM)
  - AND haloperidol (5 mg IV or IM)
  - "5,2,50"; "Dr. HAL"
- More rapid sedation than either drug alone
- Multicenter, randomized, double-blind controlled trial:
  - Droperidol (5 mg IV) / olanzapine (5 mg IV) and midazolam provided more rapid sedation than midazolam alone, without an increase in adverse events
  - Mean times to sedation were 21.3 minutes for the droperidol group, 14 minutes for the olanzapine group, and 67.8 minutes for the midazolam only (ie, control) group<sup>1</sup>



# RESOURCES

- Organizations

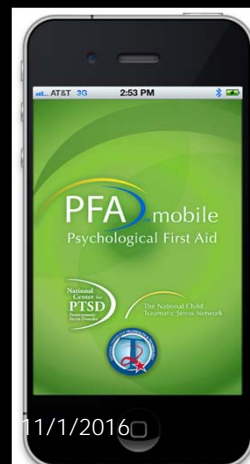
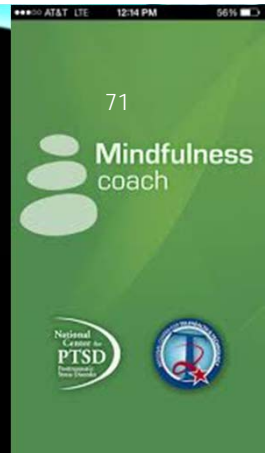
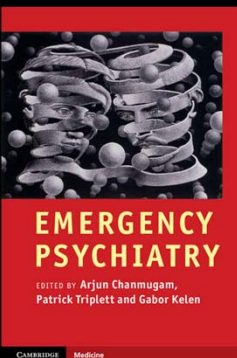
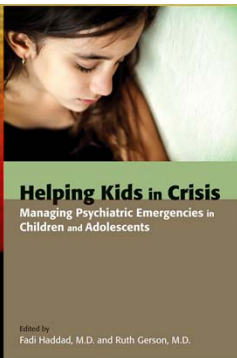
- American Association for Emergency Psychiatry
  - Project Beta
- NYU Annual Conference: "Managing Psychiatric Emergencies in Children and Adolescents"
- American Academy of Child and Adolescent Psychiatry, Emergency Psychiatry Committee (listserv)
- American Academy of Pediatrics

- Apps

- Psychological First Aid online training and app
- Mindfulness Coach (even has audio you can play for the youngster - "mindful breathing," "emotional discomfort")

- Books

- Helping Kids in Crisis
- "Issues in Pediatric Psychiatric Emergency Care." In Emergency Psychiatry



# QUESTIONS?

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