Child & Adolescent Mental Health

A Practical, All-in-One Guide

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Foreword by Harvey Karp, MD, FAAP

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For my mother, Joyce, who showed me the wonder of childhood; and for my father, Eugene, whose dinner table stories about his patients kept me on the edge of my seat.

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Acknowledgments

Upon completion of my residency in general psychiatry and my fellowship in child and adolescent psychiatry at the UCLA Neuropsychiatric Institute, I found myself in central Arkansas providing care to both children and adults as a National Health Service Corps scholar. I had sought out this opportunity while still a medical student, signing on to work as a physician in a federally designated Health Professional Shortage Area in exchange for educational loan support—a decision driven by both idealistic and financial considerations. Once away from the safe confines of the university and the big city, I immediately had two realizations. First, although I was equipped to provide a wide range of patient care, I was still really a novice in the field of child, adolescent, and family mental health. Second, most of the mental health care for youth in our country is provided by individuals who are not specifically trained to do this work.

As I began seeing children and families at the Western Arkansas Counseling and Guidance Center in Fort Smith, I felt the need to codify my knowledge. I reviewed my notes from residency. I reached for other sources as well and read avidly. I started teaching family practice residents in Fort Smith at the local community hospital. I met with a group of therapists at my clinic each week and learned a great deal from them as we reviewed our cases together. I also met regularly with primary care practitioners in and around Fort Smith and found that they felt poorly equipped to treat child and adolescent mental illness, even though they were often called upon to do so.

After completing my service in Arkansas, I moved to Pittsburgh and took my first academic position as an assistant professor at the Western Psychiatric Institute and Clinic at the University of Pittsburgh. Now two

years into my career, I felt more knowledgeable, and for the next three years I continued to expand both my clinical experience and my teaching. The book you have before you began in Pittsburgh with the lectures and seminars that I gave to the general psychiatry residents, developmental-behavioral pediatric fellows, child and adolescent psychiatry fellows, and psychotherapists whom I supervised and taught in my role as medical director of the Center for Children and Families. In 2005, I moved to New York University, where I took a newly created position as director of education and training. I have continued to see patients and teach about child and adolescent mental health to trainees, medical students, psychotherapists, and undergraduate and graduate students.

The first I need to thank are my former teachers from UCLA. Although they are far too numerous to name them all, Mark DeAntonio, David Feinberg, Fred Frankel, James McCracken, Caroly Pataki, James Spar, and Michael Strober deserve special mention for training me and even now continuing to share their wise counsel and friendship with me. At the University of Pittsburgh, I worked alongside Boris Birmaher, David Brent, David Kupfer, Martin Lubetsky, Ken Nash, Harold Pincus, and Neal Ryan, each of whom generously mentored me. At the New York University Child Study Center and Bellevue Hospital Center, where I currently work, there are too many to thank, but I am particularly indebted to Lori Evans and Matthew Cruger for educating me on the finer points of behavioral therapies and neuropsychological testing. Surely, few child and adolescent psychiatrists are so fortunate as to count among their friends and colleagues such a star-studded cast of characters.

I must also thank the many therapists, primary care practitioners, general psychiatry residents, pediatric residents, family medicine residents, child and adolescent psychiatry fellows, and undergraduate and graduate students who have participated in my seminars on psychopathology and evidence-based treatment over the past decade. They have taught me, challenged me, and helped me to sharpen my teaching, contributing immeasurably to this book, although I alone bear the fault of any shortcomings. I would also like to thank the children, adolescents, parents, and teachers who have shared their stories with me and allowed me a privileged glimpse into their lives.

There are a number of individuals who have directly supported this project. Harold S. Koplewicz, founder and director of the NYU Child Study Center, who brought me to NYU and whose mentorship and encouragement are enormously appreciated, was instrumental in starting me on this book. Completing all the research and references was a monumental task, and the assistance provided by Zoe Scott, Nadia Addasi, and Elana Bloomfield was simply outstanding. Regis Scott demonstrated

remarkable patience as she designed (and countless times redesigned!) the graphics for this book. Kalma Mitchell deserves special mention for her expert transcription of the first draft and her undying support for my efforts. At W. W. Norton, I would like to thank my editor, Andrea Costella, who believed in this project and was kind, patient, encouraging, and at her desk every single time I called, and Kristen Holt-Browning, who thoughtfully guided me through every step of the editing process.

Four individuals who represent the target audience of this text have given generously of their time by reading each chapter and providing me with comments, critique, and areas for further consideration: my best friend, Charles J. Mayer, MD, MPH, a family practitioner in Seattle, Washington, with whom I took an oath in fifth grade that we both would one day become physicians; my best friend-in-law, Mira Renchner-Kelly, LCSW, a psychotherapist in Mt. Kisco, New York; my colleague and friend, Rahil Jummani, MD, a child and adolescent psychiatrist at NYU; and my father, Eugene P. Shatkin, MD, a pediatrician and child and adolescent psychiatrist in Novato, California. My goal in writing this book has been to translate the core knowledge of this wonderful and vibrant field, and the essential material that a high-functioning clinician must understand (as I have learned it myself), into a digestible and useful format. These four individuals have helped me considerably with that task.

Finally, and most importantly, I wish to thank my wife, Alice Jankell, our daughter Parker Tillie, and our son Julian, who constantly distracted me with games, theater, swimming, piano practice, wrestling, reading, movies, baseball, gymnastics, chess, tall tales, and all manner of shenanigans, and without whom I would have completed this book far sooner. May it always be so.

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As with the first edition of this book, many thanks are due to colleagues, residents, students, and, most importantly, the patients who continue to teach me each day. I also want to thank Gabrielle Lasher, whose thorough literature review was essential in helping me to update this edition. Nicole Aujero also deserves heartfelt thanks for her assistance with references and publisher approvals, not to mention her extraordinary kindness. Andrea Costella, my editor at W. W. Norton, continues to believe in this book, and I am grateful for her support and passion for the material. I also wish to thank the entire Department of Child and Adolescent Psychiatry at New York University School of Medicine, my home for the past nine years, where I have been encouraged to flourish as a clinician, edu-

cator, administrator, researcher, and learner. I thank Harvey Karp, whose foreword beautifully lays out my best intentions for this book (*and would make any mother proud!*), and owe him a large debt of gratitude. Finally, I wish to once again thank my wife, Alice Jankell, and our now teenage children, Parker Tillie and Julian. It only becomes more clear to me with each passing year how much you influence my every thought and how lost I would be without you.

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Preface

Emerging evidence continues to point to an increase in the prevalence of mental health problems among children, adolescents, and young adults. The surgeon general reports that 20% of children and adolescents within the United States—15 million youth—have a diagnosable psychiatric or developmental disorder (U.S. Department of Health and Human Services, 1999). Whether this increase is due to better diagnosis, an actual increase in prevalence, or both is unknown, but half of all lifetime cases of mental illness are now recognized to begin by age 14 and three quarters by age 24 (R. C. Kessler, Berglund, et al., 2005). Despite effective treatments, however, there are typically long delays, sometimes decades, between when individuals first experience clinically significant symptoms and when they first seek and receive treatment. In fact, the median amount of time between when children first experience a psychiatric disturbance and when they first receive treatment is nine years (R. C. Kessler, Berglund, et al., 2005).

Diagnosable anxiety disorders affect approximately 32% of adolescents aged 13 to 18 years; disruptive behavior disorders impact 19%, mood disorders impair over 14%, and substance use disorders affect over 11% (Fleming & Offord, 1990; Kashani, Sherman, Parker, & Reid, 1990; R. C. Kessler & Walters, 1998; Merikangas, He, Burstein, et al., 2010; D. Shaffer et al., 1996). Other mental illnesses, such as attention-deficit/hyperactivity disorder (ADHD, with a prevalence of 3% to 11%), affect smaller numbers but are ubiquitous among children, adolescents, and young adults, causing an untold amount of suffering and lost productivity for both children and their parents (Lewinsohn, Klein, & Seeley, 1995; Visser et al, 2014). Although federal government spending on antidrug measures increases each year and in 2014 totaled over $25 billion, more than 50% of high school seniors have experimented with an illicit drug, 25% have used an

illicit drug within the past 30 days, and over 20% have engaged in binge drinking (e.g., consumed five or more alcoholic drinks in a row) within the past 14 days (Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2013). Traumatic childhood experiences, such as being abused, witnessing abuse, or being raised in a home with a mentally ill member, affect over 50% of children and greatly increase the likelihood of later-onset substance abuse, mental illness, smoking, sexually transmitted disease, and obesity, all leading causes of death among adults (Felitti et al., 1998). Suicide, the most feared and tragic outcome of mental illness, has remained for many decades the third most common cause of death among adolescents and young adults, preceded only by accidents and homicide (R. N. Anderson & Smith, 2005; Centers for Disease Control and Prevention, National Vital Statistics System, National Center for Health Statistics, 2010).

In addition to simply documenting the epidemiology of mental illness and engaging in treatment, the field of child and adolescent psychiatry is currently making major strides in uncovering the etiology of some of the illnesses affecting our youth. Through basic scientific research and clinical investigation, our understanding of the neurobiological basis of mental illness has grown immensely over the past three decades. Putative genes have been identified for Tourette's syndrome, ADHD, and many syndromes resulting in intellectual disability, and advances in neuroimaging have allowed us to better understand many of the neural networks involved in ADHD, schizophrenia, autism, obsessive-compulsive disorder, and dyslexia (Abelson et al., 2005). As our understanding grows, so will our ability to target treatments for these illnesses. Concurrent with the research advances, the growth in evidence-based treatments, including medications and psychotherapies, has already advanced our ability to treat specific symptoms, such as psychosis, mania, tics, anxiety, hyperactivity, and depression, allowing many individuals to lead healthy, happy, and productive lives.

To be mentally ill in the United States is to be keenly aware of the lack of sufficient services and practitioners. In fact, an adult in the midst of a psychotic episode is three times more likely to end up in jail than in a hospital. It is estimated that more than 300,000 mentally ill people are in jails and prisons and another 500,000 are on court-ordered probation, where they generally do not receive the care they need. Perhaps most shocking, the largest public mental health facility in America is not a hospital, but rather the Los Angeles County Jail, which typically houses 3,000 mentally ill inmates on any given day (Earley, 2006). As previously noted, mental illness generally begins in childhood, and studies of youth in juvenile detention have found remarkably high rates of mental illness. Teplin, Abram, McClelland, Dulcan, and Mericle (2002) found that nearly two thirds of males and three quarters of females met

diagnostic criteria for one or more psychiatric disorders, and others have shown similarly high rates (Duclos et al., 1998; McCabe, Lansing, Garland, & Hough, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). Further complicating the lack of appropriate services is the lack of adequately trained practitioners.

Mental health practitioners who treat children and adolescents—including social workers, psychologists, educational specialists, and psychiatrists—are in short supply. The United States' Federal Bureau of Health Professions has named child and adolescent psychiatry as the most underserved of all medical subspecialties. The current workforce consists of approximately 8,300 child and adolescents psychiatrists, whereas the need has been estimated to be over 30,000 (American Medical Association, Physician Masterfile, 2012; W. J. Kim, 2003; Thomas & Holzer, 2006). Child and adolescent psychiatrists are not alone, however, as the national need for child and adolescent social workers, educational specialists, and psychologists is equally great. Even worse, the distribution of child and adolescent psychiatric services disproportionately favors those in urban areas with an elevated socioeconomic status (American Medical Association, Physician Masterfile, 2012).

The disparity in service delivery is also notable. While one in three Caucasian children receive the mental health care they need, the same is true for only one in five African American children and only one in seven Latino children nationwide. Many have advocated that we provide mental health care to our children by establishing clinics in public schools. Such clinics have repeatedly demonstrated themselves to be effective in accessing youth, yet fewer than 10% of our 80,000 public schools provide comprehensive mental health services at this time (U.S. Department of Health and Human Services, 1999). Equally concerning is the fact that although we have many effective treatments, only approximately 20% of youth with a diagnosable mental illness receive care, and of these individuals, only 2% receive a treatment known to be effective (Merikangas, He, Brody, et al., 2010).

In the face of service demands that overwhelm our ability to provide care for the many children and families in need, we face a potentially crippling trifecta—first, children represent an underserved and disenfranchised group with no voice of their own when it comes to policy and organizational decision-making; second, although our society has taken great strides, there remains significant stigma attached to those with mental illness and to families with a child who is ill; and finally, within the medical establishment itself, psychiatry (and particularly child psychiatry) suffers an undeserved reputation as an ineffectual and weak discipline couched within soft science. This book represents an effort to address these concerns and is aimed at an audience of first-line treatment providers.

Few texts currently exist that explain the core scientific knowledge and clinical application of this knowledge for an audience of primary care practitioners and psychotherapists. While the requirements for training child and adolescent psychiatrists are formally circumscribed by the Accreditation Council for Graduate Medical Education, the vast majority of child and adolescent mental health services worldwide are provided by primary care physicians, psychologists, and all manner of therapists, ranging from master's-level social workers to marriage and family therapists (Accreditation Council for Graduate Medical Education, 2007). In the United States, nearly 85% of all prescriptions for psychotropic medications for children, including stimulants, antipsychotics, antidepressants, anxiolytics, and mood stabilizers, are written by primary care practitioners, yet these individuals generally receive virtually no formal training in child and adolescent mental health (R. Goodwin, Gould, Blanco, & Olfson, 2001). Understandably, most primary care physicians and therapists do not feel comfortable treating child and adolescent mental illness, but given the paucity of trained specialists, they have little choice.

Consequently, this text has been written as a comprehensive but user-friendly guide for those practitioners who provide the vast majority of child mental health care but who have the least amount of training. This book describes the basics of child and adolescent mental health and psychopathology and the treatments that have been shown to work, including medications, psychotherapies, and psychosocial interventions. I am hopeful that it will have great value for a variety of health care practitioners, including pediatricians, family practitioners, nurse practitioners, general psychiatrists, psychologists, occupational therapists, speech and language therapists, social workers, and marriage and family therapists, who all too often find themselves confronted with a mentally ill child whom they feel ill equipped to help. This book also provides the core clinical knowledge necessary for entry-level child and adolescent psychiatry residents and psychology interns, and as such I am also hopeful that it will serve as a useful primer for these trainees as well. In addition, this book will have utility as a reference for schoolteachers, school counselors, and concerned parents. Finally, there are a host of undergraduate and graduate courses in child and adolescent psychopathology at colleges and universities nationwide for which this book could serve as a core text. My greatest wish for this book is that it be a "call to arms" of sorts, encouraging those who work with, care for, and treat mentally ill children and adolescents to utilize the material within these pages to advocate more research, expanded efforts at prevention, earlier screening, and better treatment of our children.

A Note About Clinical Studies

Throughout this book, numerous treatment studies will be referenced. To properly interpret these studies, it is important for the reader to have a grasp of various types of methodologies employed in clinical investigations.

Randomized, double-blind, placebo-controlled trials are the gold standard or best type of clinical intervention study, regardless of whether it is a medication, psychotherapy, or community intervention that is being investigated. In these studies, participants are randomly assigned to treatment groups. In one group, the subjects receive an active treatment—for example, a medication under study. In the other group, the subjects receive a placebo or sham treatment. Neither the subject nor the practitioner dispensing the treatment is aware of which treatment is being given, thus the "double-blind" component. There are numerous other types of studies that can be performed, but none provides us with data as reliable as the randomized, double-blind, placebo-controlled trial.

Sometimes a single randomized, controlled study does not provide adequate information about a treatment, and the best answer to the study question can be found by combining the results of numerous trials. Systematic reviews report the results from many studies. A meta-analysis combines many randomized, controlled trials and reanalyzes the data by putting it into summary form. Meta-analyses are limited in their utility by the "worst" or most limited study among the group, but the results from such pooled analyses often remain very useful.

When it is impossible, unethical, or too expensive to employ a blinded approach, we sometimes engage in treatment studies in an open-label fashion, such that both the subjects and the practitioner know

which treatment is being delivered. Open-label studies do not employ a placebo, and therefore it is impossible to determine how many subjects improve simply because they are taking a medication or receiving a therapy, regardless of its effect. Still, open-label studies are often utilized for medications and treatments that are new to the market and provide useful results for the later construction of more detailed and sophisticated studies.

Randomized, controlled trials are expensive and take a great deal of time and effort. Consequently, researchers often use observational studies in which groups of people are followed or observed over time. Observational studies may take many forms, including case-control studies, cohort studies, chart reviews, and case reports. In a case-control study, two groups of individuals are viewed retrospectively to determine what caused the disorder or illness. The "cases" are those who have a certain disorder or illness under study, whereas the "controls" are an otherwise similar group who do not have the disorder or illness. By contrast, cohort studies prospectively follow a group of individuals who have experienced a similar exposure or share a common characteristic. They are followed over time to substantiate or refute an association between a given exposure or characteristic and a health outcome. Chart reviews and case reports similarly describe the experiences of individuals who have received certain treatments, but these analyses are highly subjective and open to numerous types of bias. Thus, while observational studies are often quicker to complete and are certainly less expensive, their results are generally not highly reliable.

Many studies will be discussed throughout this book. While our greatest power comes from multicenter randomized, double-blind, placebo-controlled trials, we have relatively few of these studies among children and adolescents. Consequently, we must often draw inferences from among the remaining open-label studies and observational data that are available to us, in addition to our clinical experience and evidence from studies of adults.

Foreword

As every primary care provider knows, the impact of mental illness on children, adolescents, and families is staggering. Diagnosable anxiety disorders affect one third of adolescents, disruptive behavior disorders affect one fifth, mood disorders affect one seventh, and substance dependence affects one tenth. Roughly 5% to 10% of children struggle with ADHD, and traumatic childhood experiences, which significantly increase the risk of substance abuse, mental illness, smoking, sexually transmitted infections, and obesity, affect over 50% of our children. Pediatricians are commonly the first line of defense for a child's mental health concerns, but they often lack sufficient training and experience in how to handle these problems. Similarly, therapists, another line of defense, are often not educated in the complexities and broad needs of children with psychiatric disorders.

If I suspect a child in my care has diabetes, I run a few simple blood tests. If I am concerned about strep throat, asthma, or an ear infection, I administer a few other tests. But when I visit with a child who is irritable, hyperactive or inattentive, sad, angry, shy or withdrawn, I have no blood test or other instrument to guide me. Unfortunately, this absence of straightforward psychological metrics is a daily problem for those of us caring for children. Study after study finds that between 25% and 50% of pediatric office visits involve an emotional, behavioral, or learning concern. Yet the training of pediatricians and family doctors is so focused on the many pressing medical problems they may face in practice that they end up receiving woefully little training in caring for the behavioral and emotional problems of the children and families they will care for in their communities. Equally concerning is the fact that most psychotherapists are not trained to work specifically with children and adolescents, even though they are often called on to do so in daily practice.

Enter Dr. Shatkin's *Child & Adolescent Mental Health: A Practical, All-in-One Guide*.

Flip through a few pages, and you will see that Dr. Shatkin, one of the leading child and adolescent psychiatry educators in the United States, has culled the most relevant and useful data from thousands of sources and over two decades of clinical experience to provide the reader with an up-to-date, accessible, and compelling understanding of not only what goes wrong for kids, but also how to fix it. This guide is intended for all first-line workers in the battle against child and adolescent mental illness—pediatricians, family docs, psychologists, social workers, school counselors, and teachers. Medical students and residents in pediatrics and psychiatry in particular will find a wealth of valuable information in these pages that will help them with each of their patients every single day.

In 2013, a new version of the *Diagnostic and Statistical Manual of Mental Disorders* was published by the American Psychiatric Association. This "bible" of psychiatric diagnostics, now in its fifth edition, is extremely helpful in identifying the symptoms that are typical in depression, ADHD, anorexia nervosa, and so forth. However, the *DSM* doesn't tell you how to take a patient from symptoms to wellness. Dr. Shatkin's book does.

Following two introductory chapters, Dr. Shatkin takes the reader on a tour through the most common disorders facing children, adolescents, and families, and what can be done about them. Evidence-based and extremely readable, *Child & Adolescent Mental Health: A Practical, All-in-One Guide* delivers exactly what it promises—a thorough, fascinating, and, most of all, essential toolkit for those who work with children, adolescents, and their families.

For the last five years, Dr. Shatkin's first edition of this book, *Treating Child and Adolescent Mental Illness*, has helped thousands of practitioners and families to understand what's gone wrong and how to get kids well. And it's no wonder—Dr. Shatkin leads the educational efforts of the Child Study Center at the NYU Langone Medical Center, one of the world's leading centers of clinical care, research, and education in the field of child and adolescent mental health. Dr. Shatkin spends his days teaching college and medical students, psychiatry and pediatric residents, and subspecialty fellows in child and adolescent psychiatry. He also engages in research in medical education, sleep, and mental health promotion and disease prevention. But most importantly, Dr. Shatkin provides clinical help to those who need it every single day, and he is sharing his "toolkit" with you here. Whether you read it cover to cover or use it as a case-by-case reference, this book will change how you clinically practice for the better.

—Harvey Karp, MD, FAAP