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CASE SUMMARY

- Siu, an eight year old girl, lives in Chinatown with her family who speak predominantly Cantonese at home.
- During a regular check-up, Siu's mother reports that Siu is having difficulties in school and gets nervous about tests.
- Siu's mother also notes that Siu is very shy and does not spend much time with friends.
- During this visit, Siu appears distressed and hides when addressed directly by the pediatrician.
- To further assess these issues, the pediatrician schedules a follow-up appointment in one week and asks Siu's mother to bring in a report card and to complete the PSC-17, a shortened version of the PSC-35 with subscales for internalizing, attention, and externalizing problems.
- Siu has a positive score on the overall PSC-17, a positive score for internalizing problems, and a borderline score for attention problems.
- Due to the positive internalizing score and history, the pediatrician suspects an anxiety problem.
- While discussing the scores, the pediatrician learns that the family has experienced several recent stressors-on 9/11 Siu's family lost some friends and Siu's mother lost her job.
- The pediatrician also uses the PSC-17 scores to focus her assessment and administers the Vanderbilt Assessment Scale (Parent and Teacher versions) to further examine the borderline attention score.

KEY TEACHING POINTS

1. Siu's case may exemplify the experience of some children who have problems with learning, ADHD and/or anxiety disorders. Parents may experience shame if their child's academic work is poor and may not discuss the problem until it is at a more urgent level. This could occur, for example, after the school contacts the parent to discuss the child's academic progress. Parents may not volunteer this information unless asked specifically because they do not think school problems belong in the realm of a medical checkup. Scheduling a specific follow-up appointment to address psychosocial issues can convey the importance of these issues and help ensure timely follow-up.

2. Mental health problems, especially internalizing disorders like depression and anxiety, often go unrecognized. Families may believe that children are too young to have such problems and caregivers may not recognize that their own mental distress may transfer to their children. Parents may cope better with a concrete physical problem than with a mental health problem that needs prolonged counseling and/or may wax and wane with environmental changes. Parent-child-physician partnership in addressing these complex issues is critical.

3. Linguistic and cultural competencies are critical in any clinical encounter; this is particularly true when dealing with children's mental health issues. The vignette is presented in Chinese and English with the dialogue occurring directly between the parent or child and the clinician. In many clinical situations an interpreter may be needed, but it is vitally important that the interpreter not be the child. In addition, availability of screening tools in the parent and child's native language can also prove invaluable.

Case study derived with permission from the award-winning CD-ROM Feelings Need Check Ups Too ©2004, American Academy of Pediatrics
All children have some anxiety, fear, and worrying, and this can be a normal response to a stressful situation. Having an anxiety disorder is different from normal worry.

Children with anxiety problems have excessive fear and distress in response to "everyday" situations. This can be so severe that it causes significant distress to a child and interferes with a child's schoolwork, friendships, fun, or family relationships.

PREVALENCE

Anxiety disorders are the most common type of mental health disorder in childhood, affecting approximately 8% of all children and adolescents. There are many types of anxiety disorders that affect youth, the most common being Generalized Anxiety Disorder, Panic Disorder, Separation Anxiety Disorder, and Phobic Disorders.

SYMPTOMS

Symptoms of anxiety disorders can include:

- Recurring fears and worries about routine parts of every day life
- Physical complaints, like stomachache or headache
- Trouble concentrating
- Trouble sleeping
- Fear of social situations
- Fear of leaving home
- Fear of separation from a loved one
- Refusing to go to school

Co-morbid disorders, in particular ADHD and depression, are not uncommon.

DIAGNOSIS

A good diagnostic evaluation will include a complete history of symptoms to determine their severity and how long they have been present. Clinicians should assess for anxiety symptoms based on diagnostic criteria established in the DSM IV or ICD 10 and should use standardized anxiety tools to aid in the assessment.

TREATMENT

Anxiety disorders are treatable! Studies have shown that cognitive behavioral therapies (CBT) and medication treatments are both effective in treating anxiety disorders in youth. Parent involvement in treatment has also been shown to improve outcomes in some children. Early treatment can prevent future difficulties, such as academic or social difficulties and low self-esteem.

Remember...

- Review treatment options with the child and his/her family.
- Include the child and his/her family in the treatment plan.
CASE SUMMARY

- Doug is an 11-year-old boy and an only child of a married couple living in suburban New Jersey.
- Doug has always been healthy, had many interests, and had been doing well in school.
- In March 2002, Doug and his mother attend his annual check-up with the pediatrician who has seen Doug since the age of five.
- During this visit, the pediatrician learns that Doug’s grades have dropped due in part to more time being devoted to helping his mother with household chores.
- Upon further questioning by the pediatrician, Doug’s mother discloses that her husband was killed in the attack on the World Trade Center.
- Neither mother nor son initially volunteered information about the death of Doug's father on September 11th.
- The pediatrician continues the interview by asking how Doug and his mother first learned about his father's death, their reactions to date, and how they have started to adjust.
- To rule out signs of PTSD, depression, or anxiety Doug is interviewed privately by his doctor who asks Doug to describe the events of that day.
- Doug tells him that his father left a message on their phone machine on the morning of September 11th to say that he was all right; but then he never came home.
- Doug wondered if his father might still be alive if he had not gone to school that day and had been home to speak to him.
- To better assess what is going on at home, the pediatrician also speaks to Doug’s mother alone.
- She tells him that although she is close to falling apart and feels very sad and alone, she is getting great support from Doug.

KEY TEACHING POINTS

1. Eliciting what might have changed in a child/family's life since the last primary care visit is a critical step. Even with major life events, parents may ultimately be able to seek help or raise the issue with their physician, but many are reluctant or hesitant to do so. Openness to discussion can be communicated to families through active listening and open-ended questions that invite dialogue.

2. Loss of a parent is unfortunately experienced by about 5% of children by the age of 16. Primary care physicians should be prepared to counsel and support families through this difficult time. Concrete steps that can aid in this area are drawing upon the established relationship with the family, active listening, and providing guidance about the normal reactions to grief.

3. Grief and mourning are normative reactions to loss and by themselves do not require medication or traditional mental health services. However, a supportive environment in the primary care setting and availability of community resources can be exceedingly helpful for families struggling with a loss. Detecting more serious depression can be assisted by the use of a screening tool such as the PSC.
Experiencing the death of a family member or friend is one of the greatest stressors that children may face.

PREVALENCE
The vast majority of children will experience the death of a family member or friend sometime during their childhood. Five percent of children will experience the death of a parent by age 16.

RISK FACTORS FOR COMPLICATED GRIEF
- Sudden and unanticipated death (especially if traumatic or violent, or the result of suicide or homicide) or death after a very long illness
- Perception of death as being preventable
- Death when the child is less than 5 or during adolescence
- Other losses in the child's life or ongoing stressors
- Angry, ambivalent, or dependent relationship between the child and deceased
- If parent remarries and there is an unsupportive relationship between the child and stepparent
- Pre-existing mental health problem in the child
- Inadequate support within the family or community for the child

HOW CAN PEDIATRICIANS PROVIDE ASSISTANCE?
Pediatricians can draw upon their established relationship with the child and family in order to:
- Actively listen to the child and be with the child/family while they express their grief
- Provide guidance on normal reactions to grief
- Identify and address guilt reactions and misconceptions
- Provide concrete advice on how to support children, such as relates to funeral attendance
- Identify and address somatization
- Screen for rare but more serious reactions, such as depression
- Provide referrals to community resources (e.g., children's bereavement support groups)
- Provide follow-up - contact children after time has passed to see how they are doing

EXAMPLES OF COMMENTS TO AVOID
- DO NOT try to cheer-up children who are actively grieving (e.g., "I know it hurts very much right now, but I know you will feel better within a short period of time"). Allow children to grieve.
- DO NOT encourage the child or parent to cover up their emotions (e.g., "You need to be strong for your mother/son. You don't want them to see you crying, do you?").
- DO express your own feelings and demonstrate empathy (e.g., "I realize this must be extremely difficult for you" or "I can only begin to imagine how painful this must be"), but AVOID statements such as:
  - "I know exactly what you are going through" (You cannot know this.)
  - "You must be angry" (Let the individual express his/her own feelings. Do not tell him/her how to feel.)
  - "Both my parents died when I was your age" (Do not "compete" with the survivor for sympathy.)

ADVICE TO GIVE TO PARENTS ON FUNERAL ATTENDANCE
Children, just as adults, often benefit from participating in the funeral and other ceremonies. Explain to children concretely what to expect and invite them to participate to the level they feel comfortable. Do not coerce children to do something that makes them uncomfortable (e.g., kissing the deceased). Identify a "partner" to guide the child and monitor reactions throughout the event. He/She can answer the child's questions and allow the child to leave temporarily or permanently if the child so desires. He/She should be well known to the child, understand the child's developmental needs and preferably not be actively grieving so as to be able to attend to the child's needs.

Remember...
- Notify families that you are interested in learning about important events that may impact their child's life, such as the death of a family member or friend. Otherwise they may not contact you for support at such times.
- Help parents find support for themselves, so they are better able to support their children.
- Be sure to follow-up with families over time since grieving is a long-term process.

Developed by Reaching Children Initiative Faculty, 2006
KEY TEACHING POINTS

1. Research shows that the use of open-ended questions (e.g., “why,” “how,” or “what do you feel about”), is more effective than a yes-no format in eliciting parents’ and youth’s concerns. In addition, even if the clinician thinks that she/he understands the chief reason for coming to care, it is often useful to re-ask the open-ended question of what else does the patient need or want to discuss. These questions only take a few minutes and may result in actually saving time over the long run.

2. Primary care clinicians are well placed to address physical health issues in tandem with mental health issues. In fact, as illustrated in this case, the two may be linked and easier to address together.

3. Emergency mental health referrals for a true suicide attempt, with a clear and unambiguous wish to die or a specific plan, are quite appropriate and necessary. However, most adolescents have thoughts of death or dying in any given year, so thoughts or threats in and of themselves may not warrant an emergency mental health referral. Instead, one should determine the extent to which the child or youth actually intends to hurt him/herself, whether he/she has specific plans to do so, and his/her degree of impulsivity. Forming a contract with the youth to notify you or the parent if she/he has recurrent thoughts to hurt him/herself can be helpful.

4. While not the primary concern for this family, in the post 9/11 world it is not unusual for children who have had previous traumatic exposures to be more vulnerable to depressive symptomatology as a result of the events of 9/11 or other traumatic incidents.
Depression is a serious mental disorder that negatively affects overall functioning and may potentially lead to suicide.

The main characteristics of depression are excessive sadness, loss of interest in activities, sleeping problems, lack of energy, preoccupation with death or dying, feelings of worthlessness or excessive guilt, and difficulty in thinking, concentrating, or making decisions.

PREVALENCE
In the United States, it is estimated that up to 3 percent of children and up to 8 percent of adolescents suffer from depression. Estimates of lifetime prevalence are significantly higher at 18-20%.

SYMPTOMS
- Sadness
- Irritability
- Change in appetite
- Change in sleeping patterns (too much or too little)
- Loss of interest in activities
- Loss of energy
- Fatigue
- Feeling slowed down or "burned out"
- Excessive feelings of guilt
- Inability to concentrate
- Indecisiveness
- Feelings of hopelessness and helplessness
- Recurring thoughts of death and suicide
- Physical complaints (Stomachaches, Headaches)
- Behavioral changes
  - Conflicts with family and friends
  - Decline in school performance
  - Inappropriate sexual activity
  - Use of alcohol or drugs

DIAGNOSIS
A good diagnostic evaluation will include the following:
- A complete history of symptoms to determine how long and how often they have been present
- Questions about thoughts of death or suicide
- Inquiry about any family history of depression and other mental illnesses

Primary care clinicians should evaluate for depression in high-risk adolescents as well as those who present with emotional problems as the chief complaint. Clinicians should assess for depressive symptoms based on diagnostic criteria established in the DSM-IV or ICD 10 and should use standardized depression tools to aid in the assessment.

TREATMENT
Both psychotherapies and antidepressant medications can be effective in treating childhood and adolescent depression:

Psychotherapies proven to treat depression effectively in youth:
- Cognitive behavioral therapy
- Interpersonal therapy

Both are time-limited, structured therapies that are typically administered in either individual or group sessions.

Psychopharmacology shown to treat depression effectively in youth:
- Selective Serotonin Reuptake Inhibitors (SSRIs) (The most well known is Fluoxetine)

These medications target a chemical in the brain called serotonin, which is believed to play a major role in depression. Other therapies such as family therapy, play therapy, and other medication treatments are available but there is little evidence demonstrating their effectiveness.

Remember…
- Review these treatment options with the child and his/her family.
- Include the child and his/her family in the treatment plan.

Developed by Reaching Children Initiative, 2005. Materials adapted by RCI faculty (American Red Cross grant, Mount Sinai School of Medicine) in collaboration with the Center for the Advancement of Children’s Mental Health at Columbia University and from Bright Futures, MCHB
CASE SUMMARY

- Max is a boy nearly four years of age who lived with his family in Battery Park City, across the street from the World Trade Center.
- Prior to 9/11, he had already experienced numerous traumatic events including surgeries for a chronic condition and hospitalization for a minor burn.
- In December 2001, Max saw his pediatrician for the first time in several months and presented with vomiting and poor appetite.
- During this visit, the pediatrician learned that on 9/11 Max was exposed to various graphic images of seriously injured individuals and has shown symptoms consistent with acute stress reaction.
- To further assess his condition, the pediatrician asked Max’s mother to complete the PSC-17, a shortened version of the PSC-35 with subscales for internalizing, attention, and externalizing problems.
- Max had an overall positive score on the PSC-17 and a positive score for internalizing problems.
- Since 9/11, Max has reverted to wearing diapers at night, wears his shoes all the time, has become increasingly introverted and stopped wanting to go to school, although he enjoyed going to school in the past.
- Over time, pediatric visits grew more frequent as Max continued to experience stomachaches and difficulty breathing despite normal physical exams.

KEY TEACHING POINTS

1. It is important to help families distinguish between normal reactions to traumatic events and those trauma-related symptoms that persist and may be in need of intervention.

2. Using a “sick visit” to identify what has been happening emotionally and behaviorally with a child might offer distinct opportunities to elicit key events in families’ lives.

3. The need for a mental health referral can be a sensitive issue for a family. The literature indicates that about 50% of children referred to a mental health professional do not keep their appointments. Pediatricians play a central role in the well being of children and families in emotional distress by providing reassurance, securing the appointment, and arranging follow-up in primary care. In addition, primary care physicians are important sources of guidance and continuing support.

4. Parents can play a significant role in addressing symptoms of PTSD by reassuring a child that he/she is safe. Helping to reestablish routines and encouraging the child to hold onto toys may help allay some fears.

5. Parents should also be encouraged to speak with their child’s teacher about ways to offer support and reassurance in the classroom.

6. While this case exemplifies a situation where there is a need for referral outside the primary care setting, eliciting the trauma history and the use of the PSC-17 as a screening tool did help guide the clinician’s thinking. Identifying symptoms in the domains of internalizing (internal feelings of sadness, fear, distress), externalizing (outward behavior), and attention behaviors may be helpful in understanding how they relate to the clinical picture. Those findings may also be useful to the mental health specialist in his or her initial assessment.
**Post-Traumatic Stress Disorder**

*Post-Traumatic Stress Disorder is an anxiety disorder that occurs following a traumatic event. Such events include physical or sexual abuse, rape, bullying, criminal assault, community violence, war, a natural disaster or other injurious events.*

**PREVALENCE**

Among school-aged children, no published studies have addressed the overall prevalence of PTSD in primary care settings. However, specific studies have looked at the prevalence of PTSD related to specific traumas such as motor vehicle crashes (12.5%) and sexual abuse (range 43%-63.5%).

**SYMPTOMS**

While it is not unusual to have acute stress reactions occurring within 4 weeks of exposure to a trauma, persistence of symptoms beyond a month may signal PTSD. Symptoms of PTSD typically begin within 3 months after the traumatic event. However, it is also possible for the symptoms to appear years after the event, often in response to another life stressor. The symptoms in children often differ from those of adults.

**Symptoms in children may include:**

- Recurrent, distressing dreams or recollections of the traumatic event
- Generalized nightmares of monsters, of rescuing others, or of threats to self or others
- Difficulty sleeping alone
- Repetitive or disorganized play reliving the event
- Physical symptoms such as stomachaches and headaches
- Extra fears or aggressive behaviors in response to stress
- Separation anxiety

Co-occurring depression and substance abuse is not uncommon.

**DIAGNOSIS**

Primary care physicians should look to consistently identify a history of trauma and to link that trauma exposure to presenting symptoms. A brief trauma question derived from the UCLA PTSD Index (Pynoos, 1998) to be asked of children and adolescents is “Has anything ever happened to you that was really scary, dangerous or violent?” or “Have you ever seen something really scary, dangerous or violent happen to someone else?” If a trauma exposure is revealed, follow-up questions should elicit the full history, ask if the child thinks about the event, worries about the event, replays the event, has associated sleep disturbances, is withdrawn, or avoids activities and interactions with others. Child/Adolescent and parent should be involved in this dialogue. Mental health referral is indicated for symptomatic children.

**TREATMENT**

While there is minimal rigorous research supporting the effectiveness of current treatments for PTSD, treatment for traumatic stress appears to be better than no treatment. A recent research study has demonstrated that children with PTSD showed significant improvement in their symptoms after receiving cognitive-behavioral therapy, a time-limited form of “talk therapy.”

Other therapies such as family therapy, play therapy, and other medication treatments are available. However, there is little evidence demonstrating their effectiveness.

**Remember…**

- Review treatment options with the child and his/her family.
- Include the child and his/her family in the treatment plan.

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Developed by Reaching Children Initiative, 2005. Materials adapted by RCI faculty (American Red Cross grant, Mount Sinai School of Medicine) in collaboration with the Center for the Advancement of Children’s Mental Health at Columbia University and from Bright Futures, MCHB
Possible options for primary care practices include targeted screening or implementing systematic screening of all patients prior to the clinical encounter.
GLAD-PC CLINICAL ASSESSMENT FLOWCHART

Preparation for Managing Depression in Primary Care
Preparation through increased training, establishing mental health linkages, and increasing the capacity of practices to monitor and follow-up with patients with depression

Youth presents to clinic for urgent care or health maintenance visit
Youth or family presents with emotional issues as chief complaint

Early Identification
Systematically identify high-risk youth

1. Stop assessment
2. Repeat early identification as needed
If low risk
If high risk or presenting with emotional issues as chief complaint

Assessment
1. Refer to other treatment
2. Evaluate for depression at future visits
3. Book for follow-up visits
Evaluation Negative for Depression, but positive for other MH conditions
Evaluation Positive for Depression, but not psychotic or suicidal

Evaluation Positive for Depression: MILD, MODERATE, SEVERE, or Depression with COMORBIDITIES
1. Evaluate safety and establish safety plan
2. Evaluate severity of depression symptoms (See *)
3. Patient/Family Education (See *)
4. Develop treatment plan based on severity-review diagnosis and treatment options with patient/family

If Mild Depression
Active support & monitoring for 6-8 weeks (every 1-2 weeks) (See *)
If Moderate Depression
If Severe Depression or Comorbidities
Consider consultation by mental health to determine management plan

If Improved
If Persistent
If Partially Improved

Manage in Primary Care
1. Initiate medication and/or therapy in primary care (See *)
2. Monitor for symptoms and adverse events (See *)

If Improved
If Not Improved
If Not Improved After 6-8 weeks
1. Reassess diagnosis
2. Provide further education and review safety plan (See *)
3. Consult with mental health (See *) and consider:
   • If on meds: adjust to maximum dosage as tolerated
   • If no meds: begin meds
   • If no therapy: add therapy

If Partially Improved After 6-8 weeks
1. Reassess diagnosis
2. Provide further education and review safety plan (See *)
3. Consult with mental health (See *) and consider:
   • If on meds: change meds
   • If no meds: begin meds
   • If no therapy: add therapy

If Not Improved After 6-8 weeks
1. Continue medication for 1 year after full resolution of symptoms (based on adult literature only) or as per AACAP, monitor monthly for 6 months after full remission.
2. Continue to monitor for 6-24 months with regular follow-up whether or not referred to Mental Health
3. Maintain contact with Mental Health if such treatment continues

If Improved After 6-8 Weeks

*See guidelines for definition of mild, moderate, and severe depression. Please consult GLAD-PC toolkit for methods available to aid providers to distinguish between mild, moderate, and severe depression.
Psychoeducation, supportive counseling, facilitate parental & patient self-management, refer for peer support and regular monitoring of depressive symptoms and suicidality.
Negotiate roles/responsibilities between primary care and mental health, and designate case coordination responsibilities. Continue to monitor in primary care after referral. Maintain contact with MH.
Professionals should monitor for changes in symptoms and emergence of adverse events such as increased suicidal ideation, agitation or induction of mania. For monitoring guidelines please refer to guidelines/toolkit.

Adapted with permission from the Guidelines for Adolescent Depression in Primary Care, GLAD-PC Toolkit developed by the Center for the Advancement of Children’s Mental Health at Columbia University
Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child’s behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

<table>
<thead>
<tr>
<th>Statement</th>
<th>NEVER</th>
<th>SOMETIMES</th>
<th>OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fidgety, unable to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Feels sad, unhappy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Daydreams too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Refuses to share</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Does not understand other people’s feelings</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Feels hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Has trouble concentrating</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Fights with other children</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Is down on him or herself</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Blames others for his or her trouble</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Seems to be having less fun</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Does not listen to rules</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Acts as if driven by a motor</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Teases others</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Worries a lot</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Takes things that do not belong to him or her</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Distracted easily</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
INSTRUCTIONS FOR SCORING

- The PSC-17 is a shortened version of the PSC-35 and consists of 17 items.
- Each item is rated as “NEVER,” “SOMETIMES,” or “OFTEN” present and scored 0, 1, and 2 respectively.
- The total score is calculated by adding together the score for each of the 17 items.

Positive PSC-17 score ≥ 15

- Attention, externalizing and internalizing subscale scores are calculated by adding the score for each corresponding symbol:
  - ◆ = Attention, positive score ≥ 7
  - ❁ = Externalizing, positive score ≥ 7
  - ★ = Internalizing, positive score ≥ 5

HOW TO INTERPRET

- As with the PSC-35, the PSC-17 is not meant to be used as a diagnostic tool.

A positive score on the PSC-17 or any of the subscales suggests the need for further evaluation by a qualified health (e.g., M.D., R.N.) or mental health (e.g., Ph.D., L.I.C.S.W.) professional.

PSC-17 VALIDATION (GARDNER ET AL. 1999)

- The PSC-17 subscales have obtained reasonable agreement with validated and accepted parent-report instruments for internalizing, externalizing, and attention problems.
- Cronbach’s α was high for each subscale, i.e., the items in each subscale have similar meanings for a parent reporting his/her impressions of his/her child.
- Both false positives and false negatives occur, and only an experienced health professional should interpret a positive PSC health score as anything other than a suggestion that further evaluation may be helpful.
<table>
<thead>
<tr>
<th>Please mark under the heading that best fits you:</th>
<th>NEVER</th>
<th>SOMETIMES</th>
<th>OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>◆ Fidgety, unable to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>✧ Feel sad, unhappy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>◆ Daydream too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>□ Refuse to share</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>□ Do not understand other people’s feelings</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>✧ Feel hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>◆ Have trouble concentrating</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>□ Fight with other children</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>✧ Down on yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>□ Blame others for your troubles</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>✧ Seem to be having less fun</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>□ Do not listen to rules</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>◆ Act as if driven by a motor</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>□ Tease others</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>✧ Worry a lot</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>□ Take things that do not belong to you</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>◆ Distract easily</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Form adapted with permission for *Feelings Need Check Ups Too*, 2004
©1988, M. Jellinek & J.M. Murphy, Massachusetts General Hospital (PSC-17 created by W. Gardner & K. Kelleher)
and Bright Futures in Practice: Mental Health, 2002
INSTRUCTIONS FOR SCORING

- The PSC-17 is a shortened version of the PSC-35 and consists of 17 items.
- Each item is rated as “NEVER,” “SOMETIMES,” or “OFTEN” present and scored 0, 1, and 2 respectively.
- The total score is calculated by adding together the score for each of the 17 items.

Positive PSC-17 score ≥ 15

- Attention, externalizing and internalizing subscale scores are calculated by adding the score for each corresponding symbol:

  ◆ = Attention, positive score ≥ 7
  ☐ = Externalizing, positive score ≥ 7
  ⋆ = Internalizing, positive score ≥ 5

HOW TO INTERPRET

- As with the PSC-35, the PSC-17 is not meant to be used as a diagnostic tool.

  A positive score on the PSC-17 or any of the subscales suggests the need for further evaluation by a qualified health (e.g., M.D., R.N.) or mental health (e.g., Ph.D., L.I.C.S.W.) professional.

PSC-17 VALIDATION (GARDNER ET AL. 1999)

- The PSC-17 subscales have obtained reasonable agreement with validated and accepted parent-report instruments for internalizing, externalizing, and attention problems.
- Cronbach’s α was high for each subscale, i.e., the items in each subscale have similar meanings for a parent reporting his/her impressions of his/her child.
- Both false positives and false negatives occur, and only an experienced health professional should interpret a positive PSC health score as anything other than a suggestion that further evaluation may be helpful.
**MODIFIED PATIENT HEALTH QUESTIONNAIRE-9**

Name: ________________________  Clinician: ________________________  Date: __________

**Instructions:** How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an “X” in the box beneath the answer that best describes how you have been feeling.

<table>
<thead>
<tr>
<th></th>
<th>Not At All (0)</th>
<th>Several Days (1)</th>
<th>More Than Half The Days (2)</th>
<th>Nearly Every Day (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling down, depressed, irritable, or hopeless?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Little interest or pleasure in doing things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Poor appetite, weight loss, or overeating?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Feeling tired, or having little energy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things like school work, reading, or watching TV?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 8. Moving or speaking so slowly that other people could have noticed?  
Or the opposite – being so fidgety or restless that you were moving around a lot more than usual? |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way? |

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?  
[ ] Yes  [ ] No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?  
[ ] Not difficult at all  [ ] Somewhat difficult  [ ] Very difficult  [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?  
[ ] Yes  [ ] No

Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt?  
[ ] Yes  [ ] No

**If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.**

Office use only:  Severity score:

Modified from the PHQ-9 (Modified from PRIME-MD PHQ-9 ©. Copyright© 1999 Pfizer Inc. (Spitzer et al, JAMA, 1999)), Revised PHQ-A (Johnson, 2002), and the Columbia DDS (DISC Development Group, 2000)
Only questions 1-9 count in the scoring, but the other questions must be looked at to assess dysthymia and suicidality.

Add up all “X”ed boxes on the PHQ-9.

<table>
<thead>
<tr>
<th>FOR EVERY X:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>0</td>
</tr>
<tr>
<td>Several days</td>
<td>1</td>
</tr>
<tr>
<td>More than half the days</td>
<td>2</td>
</tr>
<tr>
<td>Nearly every day</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL SCORE</th>
<th>DEPRESSION SEVERITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>
Your behavioral health is an important part of your physical health. If you are experiencing any of these feelings, let your doctor know. You are not alone…not 1 in a 1000, but 1 in 10, because many kids have similar problems! Getting help is what counts. Help is available, and treatments work! Don’t wait. Talk with a helpful adult, such as your parents, doctor, school nurse or counselor, or minister/rabbi.

- Feeling very sad or withdrawn for more than 2 weeks
- Seriously trying to harm or kill yourself, or making plans to do so
- Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing
- Involved in many fights, using a weapon, or wanting to badly hurt others
- Severe out-of-control behavior that can hurt yourself or others
- Not eating, throwing up, or using laxatives to make yourself lose weight
- Intense worries or fears that get in the way of your daily activities
- Extreme difficulty in concentrating or staying still that puts you in physical danger or causes school failure
- Repeated use of drugs or alcohol
- Severe mood swings that cause problems in relationships
- Drastic changes in your behavior or personality

These warning signs were adapted from those developed under a grant from SAMHSA/HHS, number 520712. The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Jensen P, et al. The Warning Signs Project
INTRODUCTION

Cognitive Behavioral Therapy (CBT) is based on the principle that one’s thoughts, feelings, and behaviors affect one another.

Problematic thoughts regarding self, experiences, and the future can result in psychopathology.

Examples:

<table>
<thead>
<tr>
<th>PROBLEMATIC THOUGHTS</th>
<th>PSYCHOPATHOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Self-unworthy</td>
<td>Depression</td>
</tr>
<tr>
<td>• Environment is disapproving</td>
<td></td>
</tr>
<tr>
<td>• Future is uncertain</td>
<td></td>
</tr>
<tr>
<td>• Self-inadequacy</td>
<td>Anxiety</td>
</tr>
<tr>
<td>• Environment is dangerous</td>
<td></td>
</tr>
<tr>
<td>• Future is hopeless</td>
<td></td>
</tr>
</tbody>
</table>

One of the key principles in CBT is Cognitive Restructuring which involves modifying unrealistic assumptions, beliefs, and thoughts that lead to disturbing emotions and impaired functioning.

### STEPS IN COGNITIVE RESTRUCTURING

1. Identify a Situation  What happened that made me upset?
2. Feelings  4 Major Types of Upsetting Emotions:
   - Fear and Anxiety
   - Sadness and Depression
   - Guilt and Shame
   - Anger
3. Thought  What am I thinking that is making me feel this way? How is this thought a problem?
   - All-or-Nothing
   - Emotional Reasoning
   - Overgeneralizing
   - Overestimation of Risk
   - Must/Should/Never
   - Self-Blame
   - Catastrophizing
4. Challenge Your Thought  What evidence do I have for this thought? Is there an alternative way to look at this situation? How would someone else think about the situation?
5. Making a Decision  Do things mostly support my thought or do things mostly NOT support my thought?

Adapted from Brief Intervention For Continuing Postdisaster Distress (Hamblen J, et al.) developed by the National Center for PTSD
HOW TO IDENTIFY CBT PRACTITIONERS

Families should seek the following information when looking for a qualified cognitive behavior therapist:

- Valid license on state education department website (for all therapists)
- High volume of CBT cases in his or her practice
- Evidence of initial intensive training and supervision to learn CBT
- Evidence of ongoing professional education in CBT (recent workshops attended or reading of recent CBT publications/journals)
- Membership in professional organizations which promote CBT (e.g., AABT)
- Ability to clearly articulate examples about how CBT is used in his/her practice and to use CBT terminology in his/her discussion
- Evidence of specialty in CBT (e.g., CBT for phobias, ADHD)
- Authorship of professional or mass media publications on CBT
WHEN YOU SUSPECT ANXIETY IN A CHILD OR ADOLESCENT

- **Rule out** other causes of symptoms including learning disabilities, problems with attention, post-traumatic stress disorder, and depression
- **Psychoeducate** children and their families regarding anxiety—symptoms, duration, severity, impact on academic and social functioning, and the need for treatment
- **Educate** children and their families on treatment options such as cognitive behavioral treatment

### SIGNS OF ANXIETY AND TECHNIQUES THAT CAN BE USED

<table>
<thead>
<tr>
<th>SIGNS</th>
<th>TECHNIQUES</th>
</tr>
</thead>
</table>
| • Siu takes a long time to do her homework  
• Mom has to sit with her as she does homework | • **Coping skills**  
Examples: Deep breathing, muscle relaxation, positive “self-talk,” thought stopping, and thinking of a safe place  
Teach the same coping skills to parents so they can “coach” Siu if needed |
| • Siu often has test anxiety  
“I am going to fail” | • **Cognitive coping**  
Explain to the family how the way we think about situations affects how we feel and then behave in that situation  
• **Positive “Self-Talk”**  
Encourage Siu to change her attitude about tests from “I am going to fail” to “This is really hard for me, but I studied and I should do ok” |
| • Siu is very shy  
• Siu has no after school activities or plans with friends | • **Exposure**  
Encourage parents to involve Siu in after school activities and help make plans with friends that will be fun for her  
Suggest to parents to involve the parents of Siu’s friends in making these plans |
| • Parents do not speak about the events of 9/11  
“My husband and I are not used to talking about these things” | • **Psychoeducation**  
Explain to parents that at times it is beneficial to talk to their kids about traumatic events like 9/11, and that this can ease possible negative effects |
TECHNIQUES

• Cognitive Restructuring
  Teach Jose that he can learn to change his mood based on how he thinks about situations and that positive expectations often lead to positive outcomes.
  Ask Jose to monitor his negative “self-talk” about school and to come up with arguments to dispute these automatic thoughts.

• Role Playing and Modeling
  Ask Jose what advice he would give a friend who wants to better manage the impressions that others have of him.
  Have Jose share what his strengths are in social situations and explore with him the “small steps” he could take to increase his social status.

• Positive “Self-Talk”
  Have Jose come up with positive statements he can say to inoculate himself from the negative comments of others.

• Problem Solving Skills Training
  Teach Jose alternative ways to express his frustration and distress, such as talking to his parents about the feelings he keeps bottled up inside.
  Review the process of problem solving with Jose including ways to generate alternative solutions when he feels trapped.

• Positive “Self-Talk”
  Ask Jose to share his positive reasons for living, including his long-term goals for his life and his family.

• Feelings Identification
  Help Jose understand the connection between his feelings, thoughts and their impact on the body.
  Ask Jose to monitor what happens inside of him (e.g., thoughts of his grandmother’s murder) before feeling compelled to eat or sensing that an asthma attack is coming.

SIGNS OF DEPRESSION AND TECHNIQUES THAT CAN BE USED

<table>
<thead>
<tr>
<th>SIGNS</th>
<th>TECHNIQUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Jose has several school-related problems: disinterest in school, inability to concentrate, attendance issues</td>
<td>• Cognitive Restructuring</td>
</tr>
<tr>
<td>• Jose does not want to engage in usual social activities</td>
<td>• Role Playing and Modeling</td>
</tr>
<tr>
<td>• Jose reports being targeted by bullies</td>
<td>• Problem Solving Skills Training</td>
</tr>
<tr>
<td>• Jose exhibits suicidal ideation</td>
<td>• Positive “Self-Talk”</td>
</tr>
<tr>
<td>• Jose expresses emotional distress that exacerbates existing medical problems and weight gain</td>
<td>• Feelings Identification</td>
</tr>
</tbody>
</table>

WHEN YOU SUSPECT DEPRESSION IN A CHILD OR ADOLESCENT

• Rule out other causes of symptoms including general medical conditions and look for possible co-morbid conditions such as substance use and past trauma.

• Psychoeducate children and their families regarding depression—symptoms, duration, severity, response to treatment, and warning signs including suicidal or self-injurious thoughts.

• Educate children and their families on treatment options such as cognitive behavioral treatment and SSRIs.

Developed by Reaching Children Initiative Faculty and Mount Sinai School of Medicine, 2005
WHEN YOU SUSPECT POST-TRAUMATIC STRESS IN A CHILD OR ADOLESCENT

- Obtain a comprehensive trauma history
- Psychoeducate children and their families regarding post-traumatic stress—symptoms, impact on functioning, and need for treatment
- Educate children and their families on options available for treatment (e.g., generic vs. trauma-focused treatment) and seeking appropriate service providers for ongoing and complete treatment

### SIGNS OF PTSD AND TECHNIQUES THAT CAN BE USED

<table>
<thead>
<tr>
<th>SIGNS</th>
<th>TECHNIQUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Max draws and plays out the events repetitively</td>
<td>- <strong>Exposure</strong>&lt;br&gt;    Encourage parents to allow Max to express feelings through repetition of the drawing&lt;br&gt;    Ask parents to introduce a reparative element by giving positive feedback to Max about safety</td>
</tr>
<tr>
<td>Max exhibits separation anxiety and school aversion</td>
<td>- <strong>Exposure</strong>&lt;br&gt;    Explain to parents that Max needs to go to school even if he protests, and that the longer the child stays out of school, the harder it is to go back&lt;br&gt;    - <strong>Psychoeducation</strong>&lt;br&gt;    Reassure parents that once Max is in school, he will learn through experience that nothing bad will happen, and that after a traumatic event it is best to get children back to their regular routines as soon as possible</td>
</tr>
<tr>
<td>Max refuses to take off his shoes even when sleeping</td>
<td>- <strong>Psychoeducation</strong>&lt;br&gt;    Encourage parents to allow Max wear his shoes&lt;br&gt;    Explain to parents that wearing the shoes helps Max to feel safe and that he will be able to take them off when a sense of safety is restored</td>
</tr>
<tr>
<td>Max has regressed to wearing diapers at night</td>
<td>- <strong>Psychoeducation</strong>&lt;br&gt;    Explain to parents that regression is common among children after a traumatic event and that it usually remits with time and treatment</td>
</tr>
<tr>
<td>Max is withdrawn and does not interact with other kids</td>
<td>- <strong>Exposure</strong>&lt;br&gt;    Ask parents to plan play dates and social activities for Max&lt;br&gt;    Encourage the family to get Max back to his old social routines</td>
</tr>
<tr>
<td>Max has recurrent stomachaches</td>
<td>- <strong>Psychoeducation</strong>&lt;br&gt;    Explain to Max and his parents that the stomachaches are the body’s way of giving children the signal that they are feeling anxious&lt;br&gt;    Encourage the family to view the stomachaches as a “message” from the body to address the anxiety&lt;br&gt; - <strong>Coping Skills</strong>&lt;br&gt;    Teach Max deep breathing and/or progressive muscle relaxation exercises&lt;br&gt;    Teach the same coping skills to parents so they can “coach” Max if needed</td>
</tr>
</tbody>
</table>

Developed by Reaching Children Initiative Faculty and Mount Sinai School of Medicine, 2005
# RESOURCES FOR CHILDREN, PARENTS, AND FAMILIES

## BOOKS FOR PARENTS

### ANXIETY

### ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

### DEPRESSION

### PTSD

### OTHER

## BOOKS FOR CHILDREN

### ANXIETY

### ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

### DEPRESSION

### POST-TRAUMATIC STRESS DISORDER

### OTHER

## WEBSITE FOR FAMILIES
National Alliance on Mental Illness [www.nami.org](http://www.nami.org)

Adapted from *Healthy Kids, Happy Futures: Healing Children in the Aftermath of Tragedy* developed by the NYU Child Study Center and funded by Project Liberty
RESOURCES FOR PHYSICIANS

SUGGESTED READINGS ON SCREENING AND DIAGNOSTIC AIDS

PEDIATRIC SYMPTOM CHECKLIST


SCREEN FOR CHILD ANXIETY RELATED EMOTIONAL DISORDERS


PATIENT HEALTH QUESTIONNAIRE-9

  The PHQ-9 is a well validated and respected tool used to assess adult depression in primary care. For a clinical adolescent depression collaborative, the PHQ-9 was modified to better represent DSM-IV adolescent depression and to include questions on suicide attempts and adolescent dysthymia. These modifications have never been validated in a research setting.

WEBSITES

FINDING MENTAL HEALTH PROFESSIONALS

- Academy of Cognitive Therapy  www.academyofct.org
- Association for Advancement of Behavior Therapy  www.aabt.org
- Albert Ellis Institute  www.rebt.org

SCREENING AIDS

- Bright Futures in Practice Series: Mental Health—Volume II, Toolkit
  Visit www.brightfutures.org for PDFs of tools for health professionals

- Family Practice Network – Pediatrics Book, Neurology Chapter, Neurology Index
  Visit www.fpnotebook.com/PEDCh9.htm for information on different screening aids

- Massachusetts General Hospital, School Psychiatry Program and Madi Resource Center
  Visit www.massgeneral.org/madiresourcemcenter/schoolpsychiatry/index.asp for information on different screening aids and links for tools available online

- Massachusetts General Hospital
  Visit www.mgh.harvard.edu/allpsych/PediatricSymptomChecklist/psc_home.htm for the PSC-35 and YPSC-35 downloadable forms in various languages
ACKNOWLEDGMENTS

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