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Pediatric Primary Care Mental Health Specialist

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Question: 1842

A 5-year-old boy is referred for "uncontrollable movements." His mother describes repetitive, rhythmic hand-flapping and head-nodding that occur when he is excited or bored. These movements can be stopped if he is called by name or distracted by a toy. He has no history of vocalizations and meets all developmental milestones for social interaction and language. What is the most likely diagnosis?

A. Tourette Syndrome
B. Stereotypic Movement Disorder
C. Autism Spectrum Disorder
D. Motor Tic Disorder

Answer: B
Explanation: Stereotypic Movement Disorder is characterized by repetitive, seemingly driven, and nonfunctional motor behavior (e.g., hand flapping, body rocking). Unlike tics, stereotypes are rhythmic, have an earlier onset (usually before age 3), and can be easily suppressed by distraction or sensory input. Since the child has no social-communication deficits (ruling out ASD) and the movements are rhythmic and distractible (ruling out tics), Stereotypic Movement Disorder is the correct diagnosis.

Question: 1843

Parents of a 9-year-old with oppositional behaviors describe the child as “exactly like his uncle who had similar problems.” What comprehensive history step is indicated?

A. Defer history and proceed directly to medication evaluation.
B. Obtain only current behavioral rating scales from school.
C. Elicit a comprehensive developmental, behavioral, environmental, and health history including the caregivers’ perception and comparison to family members.
D. Limit questioning to the child’s diet and sleep only.

Answer: C
Explanation: A comprehensive developmental, behavioral, environmental, and health history that includes caregivers’ perception and family comparisons provides context on heritability, environmental modifiers, and family explanatory models. This supports accurate differential diagnosis and family-centered intervention planning.

Question: 1844

A 20-month-old child scores 9 on the M-CHAT-R (high-risk range). What action maximizes early identification while minimizing unnecessary evaluations?

A. Rely on clinical observation alone without standardized screening

B. Repeat the M-CHAT-R in 1 month before any action
C. Administer full follow-up interview despite high score and delay referral if negative
D. Bypass follow-up and refer directly for ASD diagnostic evaluation and early intervention

Answer: D
Explanation: The correct approach involves immediate referral for diagnostic evaluation and early intervention services for children scoring 8-20 on the M-CHAT-R, as this high-risk threshold indicates substantial concern for autism spectrum disorder even before follow-up, though the follow-up can still provide useful behavioral detail while expediting services to improve developmental outcomes.

Question: 1845

A 13-year-old girl is brought in because she refuses to go to school. She claims she has constant "brain fog" and "dizziness" that makes it impossible to concentrate. Despite normal neurological and cardiac evaluations, she insists she is too ill to function. She spends most of her day in bed. Her mother, who has a history of chronic fatigue syndrome, is very supportive of her daughter's "sick role." This dynamic is a significant factor in:

A. Illness Anxiety Disorder
B. Factitious Disorder by Proxy
C. Somatic Symptom Disorder
D. Separation Anxiety Disorder

Answer: C
Explanation: In Somatic Symptom Disorder, environmental factors and family dynamics often play a role in the maintenance of symptoms. The reinforcement of the "sick role" by a parent (especially one who has their own chronic illness) can inadvertently validate the child's impairment and discourage a return to normal functioning. The focus here is on the child's distressing symptoms and the resulting functional impairment, which aligns with SSD.

Question: 1846

A 12-year-old with oppositional defiant disorder (ODD) and school refusal has been offered a 12-week parent-management training in behavior (PMT) program, but the waitlist is 10 weeks. The family reports escalating conflicts at home and the child is already at risk of academic failure. Which intervention is most appropriate to initiate immediately while awaiting PMT?

A. Provide brief behavioral activation schedule and daily reward plan for school attendance
B. Refer urgently for inpatient psychiatric hospitalization
C. Prescribe sertraline 25 mg daily for school refusal anxiety

D. Start atomoxetine 25 mg daily for possible comorbid ADHD

Answer: A
Explanation: For school refusal and ODD-like behaviors, evidence supports early behavioral interventions (e.g., daily routines, graded exposure, and contingent positive reinforcement) as first-line while awaiting longer-term parent-training or therapy. Pharmacologic treatment is indicated only if a clear comorbid disorder (e.g., ADHD, depression, or anxiety) limits response to behavioral strategies. Inpatient hospitalization is reserved for safety or severe functional impairment.

Question: 1847

What is the role of the Pediatric Mental Health Specialist when counseling families about managing electronics for an ADHD patient?

A. Total prohibition of all electronics in the home
B. Teach parents to use electronics as a reward, not a right
C. Provide strategies to use screens as a "babysitting" tool
D. Ensure the child has no access to the internet at school

Answer: B
Explanation: Viewing electronics as a privilege—a reward earned for completing responsibilities—rather than an inherent right helps parents establish healthy boundaries. This structure teaches the child time management and delayed gratification, which are critical skills that are often underdeveloped in children with ADHD.

Question: 1848

A 17-year-old with depression and suicidal ideation (no plan) on fluoxetine requires close monitoring. What schedule and collaboration per GLAD-PC?

A. Daily phone checks
B. Weekly follow-up (in-person or phone) for first month, then biweekly; involve school counselor for safety planning
C. Refer all to ER
D. Monthly visits sufficient

Answer: B
Explanation: GLAD-PC guidelines stress prompt and frequent monitoring (weekly initially) after antidepressant initiation or dose change in adolescents with depression/suicidality. Collaborate with schools for safety and academic supports. Safety planning with family and resources is key. This prevents escalation while managing in primary/specialty collaborative model.

Question: 1849

3-year-old regression (3→0 words), head banging post-febrile illness. Normal MRI/metabolic. What urgent consultation?

A. Infectious disease encephalitis PCR
B. Epilepsy center continuous EEG
C. Geneticist exome sequencing
D. Child protective services environmental

Answer: B
Explanation: Post-infectious regression mandates seizure exclusion via prolonged EEG given behavioral epileptiform mimicry, Pediatric Mental Health Specialist emergent referral protocol preceding genetic workup. CPS neglect chronic; genetics static; ID acute CSF absent fever.

Question: 1850

A mother of a 4-year-old with severe ADHD symptoms is being pressured by the preschool to start the child on medication or he will be expelled. The Pediatric Mental Health Specialist believes the child should first try evidence-based behavioral parent training (BPT). How should the Pediatric Mental Health Specialist advocate for this family?

A. Write a letter stating the child has a disability and cannot be disciplined
B. Call the school and explain that BPT is the first-line treatment for this age group per the AAP
C. Agree with the school and prescribe the medication to prevent expulsion
D. Tell the mother to find a different preschool that is more "understanding"

Answer: B
Explanation: Advocacy often involves educating other systems (like schools) on clinical standards of care. For preschoolers, the American Academy of Pediatrics (AAP) explicitly recommends Behavioral Parent Training/Behavioral Classroom Management as the first-line treatment before medication. By advocating for this sequence, the Pediatric Mental Health Specialist protects the child from premature pharmacotherapy while providing the school with a constructive path forward.

Question: 1851

A 5-year-old with iron deficiency anemia (ferritin 8 ng/mL) in food-insecure household relies on processed

foods. What risk reduction education?

A. Vitamin C avoidance
B. Iron infusions
C. Oral iron supplements alone
D. Link food insecurity to anemia and provide WIC enrollment with heme-iron food demos

Answer: D
Explanation: Linking food insecurity as a social determinant to poor heme-iron intake, with WIC enrollment and cooking demos, educates on nutritional disparities and facilitates absorption via practical, culturally tailored strategies reversing anemia effectively.

Question: 1852

A 3-year-old toddler shows delays in gross and fine motor skills, language acquisition, and social engagement compared to peers on Ages & Stages Questionnaire (ASQ) screening, with no regression but failure to meet multiple developmental milestones. Comprehensive evaluation rules out sensory deficits, autism, and genetic syndromes. What is the appropriate classification and management priority?

A. Global developmental delay; refer to early intervention services for multidisciplinary therapies
B. Communication disorder; focus solely on speech therapy
C. Intellectual disability; initiate special education placement immediately
D. Specific learning disorder; provide classroom accommodations only

Answer: A
Explanation: Global developmental delay is diagnosed in children under 5 years when there is significant delay in ≥2 developmental domains (motor, speech, cognitive, social) based on standardized testing, prompting urgent referral to early intervention programs offering physical, occupational, speech, and developmental therapies. This maximizes neuroplasticity and prevents secondary complications. Intellectual disability requires deficits in both intellectual and adaptive functioning with onset in developmental period but is typically confirmed after age 5 with IQ testing. Specific learning disorders manifest later in academic settings.

Question: 1853

A 15-year-old boy with moderate-to-severe bipolar I disorder in mania has a YMRS score of 32, pressured speech, and decreased need for sleep. He has no prior psychiatric medication exposure. Which intervention best reflects first-line pharmacologic treatment in a pediatric bipolar manic episode?

A. Start lithium 300 mg twice daily and arrange weekly lab monitoring of lithium level, renal function, and thyroid.

B. Initiate aripiprazole 2 mg daily and titrate to 10 mg daily over 2 weeks.
C. Prescribe a benzodiazepine and delay mood-stabilizer initiation until a child psychiatrist evaluates him.
D. Begin valproate 500 mg twice daily and monitor for hepatotoxicity and weight gain.

Answer: A
Explanation: For adolescents with bipolar I mania, lithium remains a first-line mood stabilizer with strong evidence for efficacy and, when carefully monitored, acceptable safety. Starting at a moderate dose (e.g., 300 mg twice daily) and titrating based on serum level, renal function, and thyroid status is guideline-concordant. Aripiprazole and valproate are valid alternatives but do not replace lithium as the primary first-line agent in many protocols. Benzodiazepines alone are not sufficient for mood stabilization in mania and should be adjunctive at most.

Question: 1854

During ASQ-3 administration to a 36-month-old, communication 20th percentile, personal-social 10th percentile, with 4/15 red flags. Problem-solving fine motor normal. What Pediatric Mental Health Specialist-guided tool modification or adjunct is indicated?

A. Add ESPO (Early Screening of Psychotic Disorders)
B. ASQ:SE-2 for socioemotional specificity
C. Repeat ASQ-3 in 2 months
D. Bayley-4 cognitive composite

Answer: B
Explanation: ASQ:SE-2 complements ASQ-3 developmental delays with targeted socioemotional/behavioral items, standard Pediatric Mental Health Specialist practice for low personal-social domains to differentiate global vs. relational delays. ESPO irrelevant; Bayley diagnostic not screening; repeat delays intervention.

Question: 1855

A 9-year-old boy with visual impairment from retinopathy of prematurity and hearing loss exhibits tactile defensiveness, difficulty with noisy environments, and repetitive rocking behaviors that interfere with learning. Developmental testing confirms global delays without meeting full autism criteria.

A. Refer to occupational and sensory integration therapy while coordinating with vision/hearing specialists for environmental modifications
B. Initiate low-dose antipsychotic for stereotypic movements
C. Diagnose sensory processing disorder as primary and defer further evaluation
D. Recommend strict behavioral extinction techniques at school

Answer: A
Explanation: Neurosensory impairments such as combined vision and hearing loss in children often lead to compensatory repetitive behaviors and sensory modulation difficulties. Multidisciplinary intervention including occupational therapy for sensory integration, alongside adaptations for visual and auditory access, improves functional participation and reduces maladaptive patterns. This approach targets underlying processing challenges rather than suppressing behaviors in isolation.

Question: 1856

A 6-year-old boy recently diagnosed with autism spectrum disorder level 1 (ADOS-2 module 2 score in mild range, strong verbal skills but social challenges) and his parents disagree on priorities: the child enjoys his train collection and resists change, the father wants social skills training, and the mother seeks better routine tolerance. The provider uses a structured family meeting to synthesize preferences and functional assessments. What is the most effective collaborative strategy for establishing treatment goals?

A. Recommend intensive applied behavior analysis immediately and set goals post-referral
B. Facilitate consensus on hybrid goals incorporating the child's interest in trains as a motivator for social routines and tolerance-building, with measurable weekly targets tracked by all
C. Prioritize social skills training as the primary goal because it addresses core deficits identified on ADOS-2
D. Create separate goals for each family member without integration

Answer: B
Explanation: Collaborative goal-setting for neurodevelopmental disorders requires incorporating the child's strengths and preferences (e.g., special interests) as motivators, balancing caregiver priorities, and creating integrated, measurable objectives across domains. Using the child's interest facilitates buy-in, supports environmental adaptations, and allows team tracking, consistent with strengths-based, family-centered approaches in primary care mental health management.

Question: 1857

A 16-year-old female is preoccupied with a small, barely visible mole on her forearm, insisting it makes her look "monstrous" and "diseased." She has visited three different dermatologists to have it surgically removed, but all have refused, stating it is benign and cosmetically insignificant. She now refuses to wear short sleeves and has stopped attending gym class. Which feature is essential to distinguish this from typical adolescent vanity?

A. Request for a medical procedure to alter the appearance
B. The location of the perceived defect on an extremity
C. Presence of significant functional impairment in daily life

D. Occurrence of the preoccupation in a female patient

Answer: C
Explanation: A key diagnostic criterion for Body Dysmorphic Disorder (BDD) that separates it from normal appearance concerns or vanity is that the preoccupation must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Missing school and avoiding social situations due to the perceived defect are clear indicators of functional impairment.

Question: 1858

5-year-old with ADHD symptoms (Conners T-score 75) in food-insecure single-parent household. SNAP benefits lapsed. Caregiver perceives symptoms as "sugar crashes from cheap food." What evaluation incorporates social determinants?

A. Trial stimulant medication
B. Comprehensive history integrating food insecurity patterns, sleep arrangements in shared bedroom, and caregiver mental health screening with PSC-17
C. Eliminate artificial colors from diet
D. Order sleep study

Answer: B
Explanation: Integrating detailed food insecurity timelines showing SNAP gaps correlating with symptom exacerbation, shared bedroom sleep disruptions fragmenting attention regulation, and caregiver depression screening via PSC-17 reveals how social determinants amplify neurodevelopmental vulnerabilities beyond primary ADHD pathology. This contextualizes behavioral presentations, prioritizes resource navigation for nutrition stability and private sleep space, and differentiates environmental contributors requiring systemic intervention from medication-responsive core symptoms.

Question: 1859

A 30-month-old PEDS parent concern questionnaire positive development concerns (language, motor), positive relationship concerns (separation anxiety, peer play). Follow-up pathway B score elevated. Normal hearing screen. ASQ-3 borderline communication.

A. Speech therapy early intervention only
B. Normal developmental variation
C. Psychosocial risk comprehensive evaluation
D. Isolated language delay monitoring

Answer: A

Explanation: PEDS pathway B positive concerns across development and relationships identifies at-risk status requiring early intervention referral, as validated screener sensitivity 74%-92% captures children needing services regardless of medical etiology.

Question: 1860

Which of the following findings on a sleep study (polysomnography) would be most diagnostic of Narcolepsy in an adolescent complaining of excessive daytime sleepiness?

A. Total sleep time of 10 hours with a sleep efficiency of 98 percent
B. Increased percentage of Stage N3 sleep during the first half of the night
C. A sleep-onset REM period (SOREMP) occurring within 15 minutes of sleep onset
D. An apnea-hypopnea index (AHI) of 15 events per hour of sleep

Answer: C
Explanation: Narcolepsy is characterized by the brain's inability to regulate sleep-wake cycles, leading to REM sleep intruding into wakefulness or occurring immediately at the start of sleep. A Sleep-Onset REM Period (SOREMP) is a hallmark finding on the Multiple Sleep Latency Test (MSLT) or polysomnography, where the patient enters REM sleep much faster than the typical 90-minute cycle.

Question: 1861

A 7-year-old child presents with a BMI of $28\ kg/m^2$. The parents report the child frequently eats large amounts of food in secret, accompanied by feelings of guilt. What assessment tool is most appropriate to help clarify this behavior?

A. The PHQ-9.
B. The Eating Disorder Examination Questionnaire (EDE-Q).
C. The Vanderbilt ADHD Rating Scale.
D. The Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS).

Answer: B
Explanation: Given the clinical presentation of binge-eating symptoms and significant weight gain, an eating disorder screening tool like the EDE-Q is appropriate to assess for potential Binge Eating Disorder (BED). This demonstrates the integration of medical (BMI) and mental health indicators into the diagnostic decision-making process.

Question: 1862

A 17-year-old male is being treated for a severe Tic Disorder. He has failed to respond to alpha-2 agonists (Guanfacine) and behavioral therapy. You are considering a "typical" antipsychotic medication that is FDA-approved for Tourette Syndrome. Which of the following medications fits this description but requires close monitoring for extrapyramidal side effects and QTc prolongation?

A. Haloperidol
B. Ziprasidone
C. Quetiapine
D. Risperidone

Answer: A
Explanation: Haloperidol and Pimozide are "typical" (first-generation) antipsychotics that are FDA-approved for the treatment of Tourette Syndrome. While highly effective at suppressing tics, they are associated with significant side effects including dystonia, akathisia, and tardive dyskinesia. Haloperidol also carries a risk of QTc prolongation, requiring baseline and periodic EKGs. They are generally reserved for severe cases that have failed safer first-line treatments like Guanfacine or CBIT.

Question: 1863

A 7-year-old child presents with frequent tantrums, poor school focus, and sleep difficulties. The caregiver describes the behaviors as “out of control” and notes frustration with prior advice. The family recently moved to a neighborhood with limited resources. What is the most appropriate initial step for the Pediatric Mental Health Specialist?

A. Refer directly for neurodevelopmental testing before gathering any history.
B. Obtain a comprehensive developmental, behavioral, environmental, and health history while exploring the caregiver’s perception of the concern, its onset, triggers, and family impact.
C. Conduct a focused review of systems and order laboratory tests to rule out medical causes first.
D. Administer standardized behavioral rating scales immediately without further context.

Answer: B
Explanation: Obtaining a comprehensive developmental, behavioral, environmental, and health history, including the caregiver’s perception of the concern, establishes the foundation for accurate Pediatric Mental Health Specialist evaluation. This step captures symptom timeline, contextual triggers such as recent relocation, environmental stressors, and the family’s explanatory model, enabling targeted differential diagnosis, rapport building, and culturally sensitive planning while avoiding premature or incomplete assessments.

Question: 1864

A 13-year-old boy with bipolar disorder and history of seizures requires mood stabilization. He is currently seizure-free off antiepileptics but has had two prior episodes. Which medication offers dual benefit for mood and potential seizure threshold while requiring specific monitoring?

A. Lamotrigine with slow titration to minimize rash risk
B. Carbamazepine with CBC and level monitoring
C. Lithium with serum level, renal, and thyroid monitoring
D. Valproate with weight, liver, and hematologic monitoring

Answer: D
Explanation: The correct approach involves valproate for its established role in pediatric bipolar mania and aggression, plus its antiepileptic properties that may provide dual benefit in patients with seizure history. Monitoring includes weight, liver function tests, platelets, ammonia, and pancreatic enzymes due to risks of hepatotoxicity, thrombocytopenia, and pancreatitis. Lithium requires renal and thyroid surveillance but lacks direct antiseizure activity. Lamotrigine is useful for bipolar maintenance but requires very slow titration to avoid serious rash. Carbamazepine has more drug interactions and hematologic risks.

Question: 1865

A 15-year-old with anxiety reveals during a confidential visit that they are questioning their sexual orientation and fears parental reaction based on family religious beliefs. No safety concerns exist. Which action best upholds confidentiality regulations?

A. Maintain privacy regarding sexual orientation disclosure, offer resources tailored to LGBTQ+ youth with cultural and faith considerations, and support gradual family communication if desired by the patient
B. Maintain privacy regarding sexual orientation disclosure, offer resources tailored to LGBTQ+ youth with cultural and faith considerations, and support gradual family communication if desired by the patient
C. Share the information with parents to facilitate family support and acceptance
D. Share the information with parents to facilitate family support and acceptance

Answer: A
Explanation: Sexual orientation and related mental health discussions often fall under sensitive services where minor consent and privacy protections apply under HIPAA and ethical codes. Providers facilitate support without breaching trust, incorporating intersectional factors like religion and culture.

Question: 1866

SCARED total 25 in 13-year-old male: social phobia 10, panic 3, separation 4, GAD 5, school 3. Reports lunchroom avoidance, test tremor. Duration 6 months. GPA decline.

A. Social anxiety disorder primary diagnosis

B. Specific phobia school situations
C. Subclinical anxiety watchful waiting
D. Generalized anxiety disorder treatment

Answer: A
Explanation: SCARED social phobia subscale ≥8 with functional impairment (lunchroom avoidance, GPA decline) establishes DSM-5 social anxiety disorder diagnosis, as validated cutoff predicts 79% sensitivity requiring exposure-based CBT targeting performance fears.

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