

“OH NO! A SAD CHILD/TEEN.
NOW WHAT?”:
KEY TIPS FOR MANAGING
CHILDHOOD AND TEEN DEPRESSION



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Disclosures

- No financial disclosures
- Off-label use of antidepressants will be discussed.

Case: Carla

16 yo female with mild intermittent asthma presents for unintentional wt. loss of 14lbs over 7 months. She eats 1 meal daily and is bothered by her wt loss. She reports depressed mood for months-"sometimes I just go sit in my car and cry." She endorses anxiety, poor sleep, difficulty focusing at work, not caring about how she looks, avoiding friends and feeling like a burden to her family. She hasn't told her parents because she doesn't want to worry them. Denies any desire to hurt herself or anyone else. You've ruled out eating disorders, pregnancy, thyroid disease, diabetes, and anemia. You are concerned about depression.

**** What do you do next?****

Learning Objectives

- Understand the importance of screening for depression and suicide in children and teens
- Learn who is at risk for depression and suicide
- Identify how to assess for depression and suicide
- Identify when and where to refer
- Identify when and how to treat

Importance of Screening

- At any one time, **1-2%** of pre-pubertal children and **3-8%** in adolescents have depression.
- **1** of every **5** children will have had a depressive episode by the time they reach 18 y.o.
- **2** in **3** depressed youth are not identified by their pediatrician and do not receive any kind of care.

Importance of Screening

- Depression is the **2nd** most common mental illness among youth.
- Suicide was the **2nd** leading cause of death among adolescents aged 12–17 years in 2010.
- **90%** of youth who completed suicide had a psychiatric illness and **50%** of the victims had a diagnosis of depression.

Importance of Screening:

Consequences of untreated depression

- ❑ Suicide attempts and suicide completions
- ❑ Substance abuse (incl. nicotine dependence)
- ❑ Legal problems
- ❑ Exposure to negative life events
- ❑ Physical illness
- ❑ Early pregnancy
- ❑ Poor work/school/social functioning
- ❑ Disrupted child-parent relationship

(Martin and Volkmar, 2007)

In short, ...





Who is At Risk?

Who is at Risk? ... *for depression*

- Personal or Family history of mood/anxiety disorders or suicidal behavior
- Family discord – including parental criminality, substance abuse, lack of family cohesion, marital discord increase risk for depression in pre-pubertal children in particular.
- Early onset of puberty in girls
- Chronic medical illnesses
- Neglect and child maltreatment-may result in earlier age of onset of depression
- Experimentation with tobacco, drugs and alcohol
- Decreased adult supervision
- Disrupted sleep
- Social stressors- bullying, loss of friends, school/home moves, financial strain, housing instability
- Association with deviant peers
- Bereavement – loss of a sibling or parental figure

(Martin & Volkmar 2007)

Who is At Risk? ...*for suicide*

- Suicide statistics and trends
 - ▣ Teens (15-19yo) > children (10-14yo)
 - ▣ Completions: Boys > Girls; Attempts: Girls > Boys
 - ▣ Highest suicide rates in American Indian/Alaskan Native youth then white males
 - ▣ Increasing suicide rates among black youth
 - ▣ High suicide attempt rates among Hispanic and African American females
 - ▣ The most common methods of suicide: firearms (45%), hanging/suffocation (40%), and poisoning (8%)

Who is At Risk? ...*for suicide*

- ▣ Past history of suicide attempt (#1)
- ▣ Psychiatric disorders (esp. Depression and Insomnia-modifiable risk factors)
- ▣ Chronic medical illness
- ▣ Impulsivity
- ▣ LGBTQ status and conflict re: sexuality
- ▣ Family history of suicidal behaviors
- ▣ Chaotic family situations/dysfunctional family/absent parents
- ▣ Substance abuse
- ▣ Barriers to accessing treatment for mental disorders
- ▣ Unwillingness to seek help
- ▣ Easy access to lethal methods

Who is At Risk?

- Protective factors
 - ▣ Connection to family and to school
 - ▣ Parental behavioral and academic expectations
 - ▣ Non-deviant peer group
 - ▣ Treatment for psych/physical/substance use d/o's
 - ▣ Support from ongoing medical and mental health care relationships
 - ▣ Family, peer, and community support
 - ▣ Religious involvement

(Martin & Volkmar 2007)

Key PCP visit goals for the depressed patient

- Screen for depression and comorbidity
- Assess level of severity
- Assess current safety
- Develop a safety plan
- Provide psycho-education
- Establish community links
- Develop treatment plan



How to Screen for Depression and Suicide

SIG: E CAPS x 2wks +impairment +change from baseline

Depressed/irritable* mood ... and ...*

- **S**leep changes...*difficulty falling or staying asleep, waking up early*
- **I**nterest in activities is reduced...*more isolative and withdrawn, not enjoying old hobbies aka “anhedonia”**
- **G**uilt/worthlessness...*“feeling like a burden, too hard on themselves, lower self-esteem”*
- **E**nergy decreased... *“feeling drained/out of it”*

* Cardinal symptoms

SIG: E CAPS

- **C**oncentration is reduced... *“grades dropped/can’t focus/not doing HW/daydreaming”*
- **A**ppetite changes... *“not eating as much” or “eating way too much/Wt. changes/Clothes don’t fit anymore”*
- **P**sychemotor retardation or agitation (restlessness)... *“dragging around the house, everything takes longer to do, feeling slowed (or keyed up/restless/can’t sit still b/c you feel agitated”)*
- **S**uicidal thoughts or behaviors

Depression nuances in youth

- Mood changes: numb, bored, sad, stressed, irritable, easily upset
- Irritability more often than sadness
 - Can present in conflicts with peers, sibs, parents (“behavioral problems”)
- More somatic symptoms than adults- headaches, stomachaches, etc.
- Mood lability/mood swings, easily frustrated, temper tantrums, emotional sensitivity (“touchy/easily annoyed/everybody gets on their nerves”), and social withdrawal (from family and friends)
- Sleep problems (ruminations about faults/errors), declining grades, not caring anymore, boredom in old hobbies and poor concentration/distractibility in school.

Depression mimickers...

- Rule out :
 - Anemia
 - Cancer
 - Chronic fatigue syndrome
 - Hypothyroidism or hyperthyroidism
 - Vitamin D and B12 deficiencies
 - Infectious etiologies (e.g. HIV, hepatitis)
 - Inflammatory bowel disease
 - Mononucleosis
 - Stroke, tumor, or other CNS disorder
 - Systemic lupus erythematosus or other collagen vascular disease
 - Medications: beta blockers, steroids, isotretinoin, OCPs, antipsychotics

So ask about...

- Mood:
 - ▣ Have you had any mood changes up or down since we last met?
 - ▣ On a scale of 1 to 10, if 10 is the best you have ever felt how would you rate your mood now? Over the last few weeks/months?
- Anhedonia:
 - ▣ What do you do for fun?
 - ▣ (If nothing...) Are you still interested in those activities? (If not...) When did that change?
- Free Screening tools: *PHQ-9 (Patient Health Questionnaire 9 for Adolescents and PHQ9 Modified for Teens), MFQ (Mood and Feelings Questionnaire), Beck Depression Inventory, CES-D (Center Epidemiologic Studies Depression Scale)

Other important details: severity and comorbidity

- Global areas of functioning: home, school, and with peers
- Overall decline in global level of functioning
- Consider and rule in/out mania, anxiety disorders, PTSD, disruptive behavior disorders (ODD, CD, ADHD), substance abuse, learning disorders, psychosis

Suicidal ideation and Safety

- Every PCP must know these things about suicidal ideation before a depressed patient leaves the office:
 - ▣ **Passive death wish:** *“Have you felt that life isn’t worth living?” Do you feel that way now? AND When was the most recent time?*
 - ▣ **Suicidal ideation:** *“Have you had thoughts about wanting to kill yourself? – Do you feel that way now? AND When was the most recent time? Have you ever tried to kill yourself? How? When?”*
 - ▣ **Imminent risk/Motivation to Live:** *If you had thoughts to kill yourself in the future, what would keep you from acting on those thoughts?*
 - ▣ **Access to lethal means:** *Do you have any weapons in your home(s)? Do have any access to weapons?*
 - ▣ **Willingness to seek help:** *Would you be willing to ask for help if you had thoughts to kill yourself in the future and felt you might act on them? Who would you get help from?*
 - Emphasize asking for “help for not feeling safe” -not divulging all their feelings.

Safety Plan (“Write it down and carry it with you.”)

- If your mood drops,
 - ▣ *What can you do yourself to help improve your mood?*
 - ▣ *Who can help you improve your mood? Who can you talk to?*

- If you have thoughts of killing yourself and you feel like acting on it, who can you ask for help before acting on the thoughts?
 - ▣ *Must include an adult, preferably a parent*
 - ▣ *Name the person and how you will contact them. Parent should confirm they are reliable.*
 - ▣ *Give local emergency room numbers, addresses, hotlines.*

- Ask parent to lock meds, administer medications, remove weapons (or at least unload and lock weapons and separate ammunition.)



When and Where to Refer

When and Where to refer:

□ Emergency Room

- Recent suicide attempt without psychiatric follow-up or recent serious SI and persistent significant depression
- Acute decompensation with severe depression symptoms or concern for psychosis for acute mania
- Inability to reliably safety plan in the office with current or recent SI (or HI)
- If you feel uncomfortable with the level of complexity/severity/current impairment

When and Where to refer:

- **Just Therapy** [*Cognitive Behavioral Therapy (CBT) or Interpersonal therapy (IPT)*]:
 - Mild depression: meets criteria but only mild impairment with school/social/family or unusual effort to accomplish the same tasks (w/PCP f/u Q1-2wks x 6wks for monitoring and “active support”-see **appendix and GLAD-PC Toolkit for how to do this**)
 - “Chaotic” social situation, recent loss or stressor + problem adjusting but no PDW or SI
 - Sub-syndromal depressive symptoms but +Impairment

- **Psychiatrist**
 - Persistent depression despite >2mo of therapy or 1-2 failed adequate SSRI trials
 - Moderate or severe depression without current desire to act on SI
 - Comorbid mental health problems (behavioral problems, mania, psychosis), physical health diagnoses, intellectual disability or significant medication burden
 - Any history of suicide attempt
 - Recent or current SI or PDW but no current plan and willing to seek help for SI
 - ...or “It’s just messy”...



When and How to treat

SSRIs are safe and effective treatments for depression

It only takes treatment of 10 youth for 1 to have improvement in depression (NNT)

but

treatment of 112 youth for 1 to have suicidal ideation from use of an SSRI (NNH).

- ~60% respond to SSRI treatment

Consider starting an antidepressant in the office in cases of...

- Moderate or severe depression while patient is awaiting an appointment with a psychiatrist
- With comorbid anxiety or ADHD without other mental health problems

Consider before starting an antidepressant:

- Past medical history and Allergies
- Current Medications (incl. psychiatric meds)
- Past antidepressant trials and effects
- Family history of bipolar disorder, depression, antidepressant use, medication sensitivity
- Reliability of patient medication use and follow-up
- Family desire for treatment and thoughts on reasons for current symptoms

Which med to start? ... an SSRI

- FDA approved SSRI's for MDD
 - Fluoxetine (Prozac)---ages 8-12yrs
 - Escitalopram (Lexapro)- ...ages 12-17yrs

- Titration schedule:
 - Week 1: Prozac 5mg po qam (<12yo), 10mg po qam (>12yo)
 - Week 2: Prozac 5mg po qam (<12yo), 20mg po qam (>12yo)
 - Week 4: Increase dose by 5-10mg if symptoms persist but no side effects

or

 - Week 1: Lexapro 2.5mg po qam (<12yo), 5mg po qam (>12yo)
 - Week 2: Lexapro 5mg po qam (<12yo), 10mg po qam (>12yo)
 - Week 4: Increase by 2.5-5mg if sx's persist but no side effects
 - By Week 6-8: Increase if previous but sub-optimal benefit, Switch, or Refer

- Follow-up: With PCP every two weeks if an SSRI is started. Call PCP with any persistent side effects (>1 wk). Go to ER if increased SI, worsening depression, or serious side effects.

When and How to Treat

TABLE 3 SSRI Titration Schedule

| Medication | Starting Dose, mg/d | Increments, mg | Effective Dose, mg | Maximum Dose, mg | Contraindication |
|--------------|------------------------|-------------------|-----------------------|---------------------|------------------|
| Citalopram | 10 | 10 | 20 | 60 | MAOIs |
| Fluoxetine | 10 | 10–20 | 20 | 60 | MAOIs |
| Fluvoxamine | 50 | 50 | 150 | 300 | MAOIs |
| Paroxetine | 10 | 10 | 20 | 60 | MAOIs |
| Sertraline | 25 | 12.5–25 | 50 | 200 | MAOIs |
| Escitalopram | 5 | 5 | 10 | 20 | MAOIs |

Note: Use of Fluvoxamine and Paroxetine should generally be deferred to child psychiatrists.

Which med to start? ... an SSRI

- May consider starting with a different SSRI if effective for a family member. Notify parent of off-label use.
- Prozac
 - ▣ Can be activating; consider if child is slow to engage, withdrawn, etc. but monitor for excessive activation/insomnia
 - ▣ Long half-life; consider if pt. might be med non-adherent
 - ▣ Multiple potential P450 drug-drug interactions
- Lexapro
 - ▣ Few drug-drug interactions. May be helpful for children on multiple meds from chronic medical illnesses.
 - ▣ Limited dose range potential if comorbid anxiety (max 20mg/day)

Which med to start? ... an SSRI

- Celexa
 - ▣ More potential drug-drug interactions than Lexapro (active metabolite of Celexa)
 - ▣ Cap effective dosing at 20mg po qday. QTc prolongation risk at higher doses.
- Zoloft
 - ▣ May need to have split dosing (BID) 2/2 quick metabolism in pts <16yo
 - ▣ Higher dose range potential so useful for anxiety treatment
 - ▣ Effective for treatment of anxiety disorders
- Paxil
 - ▣ Short half-life so generally avoided in children and teens
 - ▣ Multiple negative trials
- “Start low and go slow”
- Most come in liquid forms

SSRI side effects

- Anxiety, nervousness, agitation, akathisia (restlessness)- esp. after med started (lower dose and increase slowly)
- Headache, lightheadedness, dizziness
- Apathy, loss of motivation
- stomachache, diarrhea, nausea, sweating, tremor
- Irritability, agitation, “behavioral activation”-feeling energetic/keyed up
- Easy bruising or bleeding
- Sexual dysfunction
- Sleep disturbance or vivid dreams
- Serotonin syndrome-SSRI use with MAOIs, dextromethorphan, linezolid, ondansetron, meperidine, tramadol, triptans, St. Johns’ wort, LSD, ecstasy, ginseng. Sxs- restlessness, autonomic instability- HR/BP changes, nausea, vomiting, diarrhea, fever, incoordination, hyper-reflexia, hallucinations)
- Possible increased suicidal ideation or behaviors *Black box warning*

Black Box Warning

- FDA review of 24 studies: “2-fold increased risk” of suicidal behavior or suicidal ideation in SSRI-treated youth in a retrospective literature review (4% SSRI vs. 2% PBO) ... though there were no reported suicides.
- In a later review including 31 studies, there was a “small but increased risk of treatment-emergent suicidal ideation/suicide attempts” in teens younger than 19yo. treated with SSRIs for depression or anxiety (3% SSRI vs. 2% PBO)... but the risk was not statistically significant.

Black Box Warning

- Key points:
 - ▣ There may be a small increased risk of suicidal thinking or behaviors with SSRIs.
 - ▣ Monitor appropriately (see in office Q2wks x 2mos after starting or increasing SSRI).
 - ▣ Treating depression for at least 6mos reduces rates of suicide compared to those treating for 2mos or less.
 - ▣ Patients should notify MD of any increased SI and seek ER/911 support for SI with inability to stay safe.

Tricky situations, cont'd...

- What if they seem unlikely to return after SSRI initiation?...
 - ▣ Ask what the patient and family think would be helpful and focus on workable options (sleep, diet, exercise, supports, stress reduction and adding safe, pleasurable activities).
 - ▣ Find out what aspect of the depression most bothers the teen/family and propose treatment to alleviate that issue.
 - ▣ Ask if they think “talk therapy” may be helpful. Emphasize therapy’s goal of teaching them skills to manage the low/irritable moods by training THEM to manage their depressed thoughts (i.e. cognitive behavioral therapy).
Therapy is not necessarily lifelong.
 - ▣ Explore buy-in about meds, but focus on just getting them to come back to see you for monitoring first.

Tricky situations, cont'd...

- What if they have no psychiatrist after discharge from inpatient psychiatric hospitalization?
 - ▣ If no med lapse and med is effective → continue dose, setup with psychiatrist, and see them in 2wks (and Q2-4wks until they get a psychiatrist)
 - ▣ If no med lapse and med is ineffective → inquire about past utility & side effects.
 - If previously effective and no s/e's, increase dose by 5mg (Lexapro) or 10mg (Prozac) and monitor.
 - If NOT previously effective OR if s/e's, switch SSRI.
 - ▣ If +med lapse but med was effective at reasonable dose → Start at half effective dose x 1 wk then increase to full dose.
 - ▣ If too complicated...see back for monitoring & refer to psychiatrist

Tricky situations, cont'd...

- What if their psychiatric diagnoses and medications don't "match"? (e.g. h/o "depression, bipolar d/o, ADHD" and on an SSRI)
 - ▣ Gather more details from family, last psychiatrist about dx, medication indications/sx targets
 - ▣ Call for backup: DC MAPS or your local psychiatrist
 - ▣ Don't refill. Refer to a psychiatrist
 - ▣ If symptomatic but too complicated, follow for monitoring and f/u of connection with referrals.

Mentally healthy children grow up....



We don't just want kids to grow up.
We want them to grow up

STRONGER

Resources

- Guidelines for the Management of Adolescent Depression in Primary Care (GLAD-PC) Toolkit: <http://www.glad-pc.org/>
- AAP.org
 - ▣ → Implementing Mental health Priorities in Practices → Depression (Motivational Interviewing techniques to elicit depression and discuss recs for treatment)
 - ▣ The Resilience Project → Depression Fact Sheet
- AACAP Facts for Families about Depression
- National Suicide Prevention Lifeline: 1-800-273- TALK (8255)
- www.ParentsMedGuide.org (Antidepressant treatment for pediatric depression)
- CDC “Youth Suicide” page
http://www.cdc.gov/violenceprevention/suicide/youth_suicide.html

Local Resources

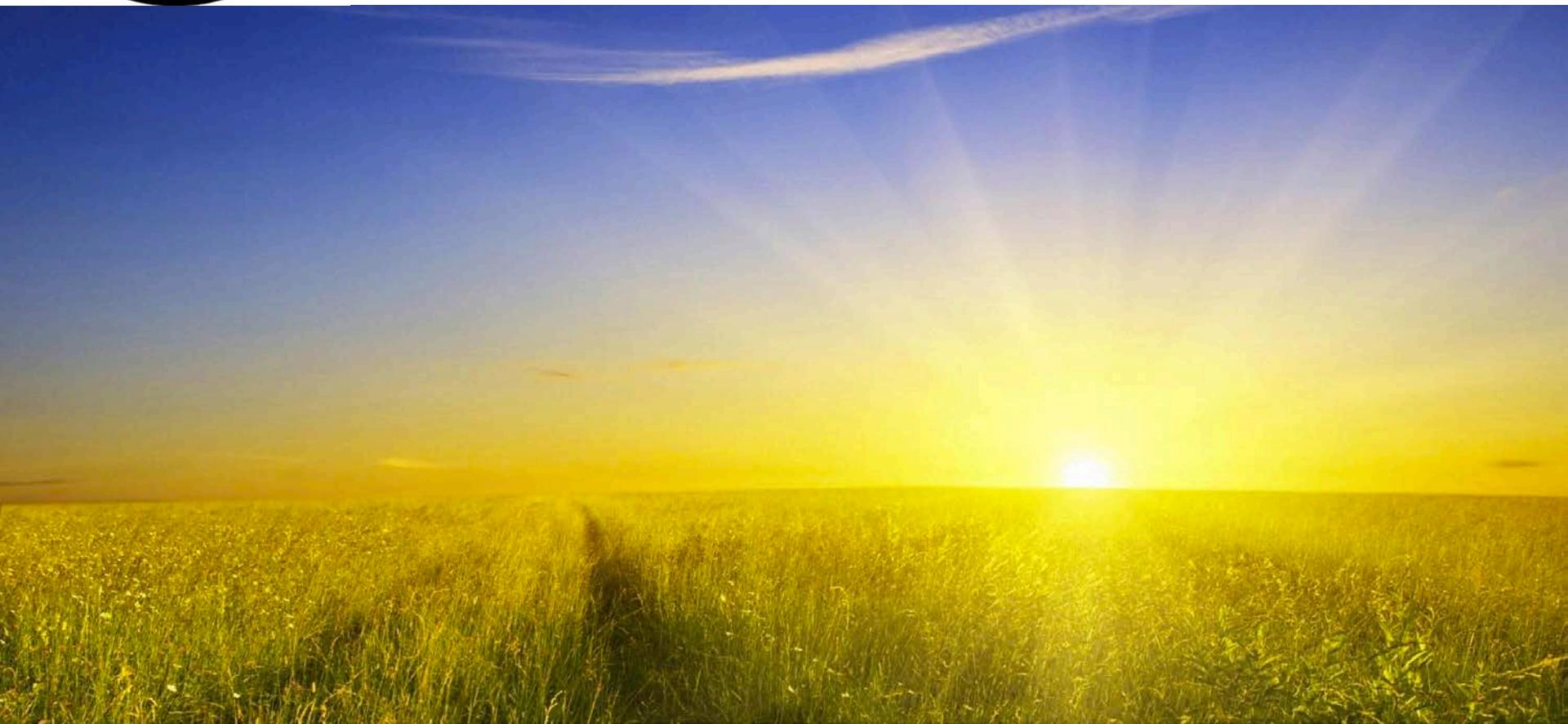
- DC Access Helpline (mental health service entry for DC residents)-1-888-793-4357 (1-888-7WE-HELP)
- CHAMPS Mental Health Crisis team (202 481-1440)- 24/7 mobile crisis assessment: <https://www.catholiccharitiesdc.org/champs>
- Prince George's County, MD Crisis services: 301-864-7161; local suicide hotline 301 864 7130. www.communitycrisis.org. 24hr call center for individuals in crisis or needing info on mental health services and social service organization
- Alexandria mental health emergency services- 703-746-3401 and ask to speak to an emergency services clinician who will return the call in 10min.
- Fairfax/Falls Church, Virginia emergency services: 703-573-5679/703-560-0224, TTY 711 (mobile crisis unit). Community Service Board entry and referral services- 703-383-8500

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Questions?

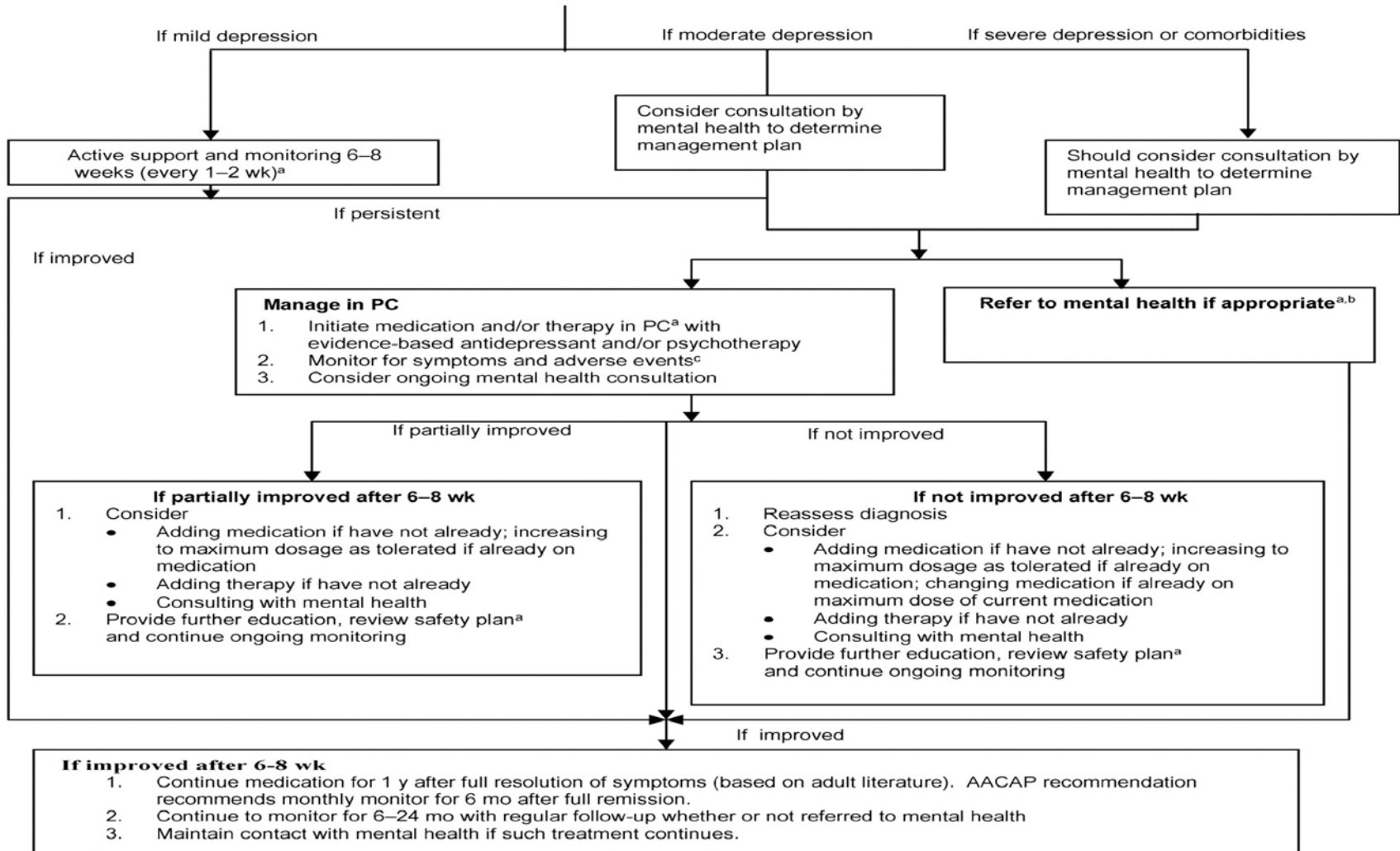




Appendix

Further Resources

Clinical management flowchart. a Provide psychoeducation, provide supportive counseling, facilitate parental and patient self-management, refer for peer support, and regularly monitor for depressive symptoms and suicidality. b Negotiate roles...





Further questions in suicide and safety assessment

Screening for Suicidal ideation

...does not mean you will cause the child/teen to have thoughts of suicide

Passive death wish/passive suicidal ideation

- Have you ever felt that life was so hard you wanted to:
 - ▣ Disappear?
 - ▣ Not wake up?
 - ▣ Not be alive/wanted to be dead?
- Have you ever wished you were dead?

Active death wish

- Have you ever thought about killing yourself, even if you brushed the thoughts away?
- How far did those thoughts go?
- Have you thought about how you might kill yourself?
- What plans have you considered?

Screening for Suicidal ideation

- When was the last time you thought about killing yourself?
- How close did you get to trying to kill yourself?
 - ▣ E.g. Researching plans, gathering materials, giving away belongings, writing a goodbye note
- Have you tried to kill yourself in the past? What did you do? What do you think led you to try to kill yourself that/those time(s)?
- When you've had thoughts to kill yourself in the past, what stopped you from moving forward on your thoughts to kill yourself?
- Have you ever injured yourself without wanting to actually die (e.g. cutting, burning, scratching)?

Screening for Suicidal Ideation

Current suicidality: Do you still want to kill yourself?
How close do you think you are to trying to kill yourself (0- not a chance to 10- definitely will try)?
Does life currently seem too hard to live now?

Help-seeking: What would keep you from acting on thoughts to kill yourself in the future if you had the thoughts again?

Perseverance: What motivates you to keep living when things get tough?

Screening for Suicidal Ideation

Spirituality: Do you consider yourself spiritual or religious? Do you have a faith/spiritual community? What gives your life meaning?

Social/Sports: Are you involved in cultural/community/sports activities that are meaningful?

Future orientation: What do you want to do in the future? Are you looking forward to anything in the future?

Support: Who do you lean on in times of difficulty?

Access to weapons: Do you have any access to weapons? Where? Which ones?

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How to give “Active Support”

Active Support- Psychoeducation

- Depression is both common and serious.
- Depression is an illness.
- Depression is often recurrent.
- Symptoms and common presentations of depression.
- Effective treatments are available- therapy (CBT or IPT) or medications (antidepressants).
- Risks and benefits of treatment options
- Fundamentals of self-care and mood hygiene- regular schedule, moderate exercise, staying productive, healthy diet, regular sleep.
- Importance of identifying and treating parental depression to child well-being.
- Find a therapist and psychiatrist and share with them what is important to you and your family (e.g. values, beliefs, hopes, expectations for your child).
- It is important to work with the medical/psychiatric team to monitor the child and be open about your desires and concerns for your child's treatment.

Active Support- Psychoeducation about therapy

TABLE 2 Components of CBT and IPT for Adolescents

| Therapy | Key Components |
|---------|---|
| CBT | <p>Thoughts influence behaviors and feelings, and vice versa. Treatment targets a patient's thoughts and behaviors to improve his or her mood.</p> <p>Essential elements of CBT include increasing pleasurable activities (behavioral activation), reducing negative thoughts (cognitive restructuring), and improving assertiveness and problem-solving skills to reduce feelings of hopelessness. CBT for adolescents may include sessions with parents/caregivers to review progress and increase compliance with CBT-related tasks.</p> |
| IPT-A | <p>Interpersonal problems may cause or exacerbate depression, and that depression, in turn, may exacerbate interpersonal problems. Treatment targets a patient's interpersonal problems to improve both interpersonal functioning and his or her mood.</p> <p>Essential elements of IPT include identifying an interpersonal problem area, improving interpersonal problem-solving skills, and modifying communication patterns.</p> <p>Parents/caregivers are involved in sessions during specific phases of the therapy.</p> |

Adapted from: Columbia University, Department of Child and Adolescent Psychiatry. *Columbia Treatment Guidelines Depressive Disorders (Version 2)*. New York, NY: Columbia University; 2002.

Active Support

- Explore family's treatment desires and progress toward establishing mental health treatment
- Explore barriers to them seeking formal mental health treatment
- Identify family stressors and provide community resources to address them. (e.g. WIC, parenting/grandparent classes, food pantry services, daycare voucher)
- Help the youth identify community and family supports and get involved in activities that develop self-worth and self-efficacy.
- If on an SSRI, explore symptom severity, side effects, level of function, passive death wish, suicidal ideation, homicidal ideation. Review safety plan.