



Feelings Need Check Ups Too!

Issues in Identifying and Managing Childhood Anxiety and Depressive Disorders in Primary Care

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Reaching Children Initiative Training

Depression & Anxiety in Children and Teens

Summarizing over studies:

- MDD is present in approximately 1% of children and 3-7% of adolescents;
- Anxiety disorders present in 8-10%
- Lifetime prevalence by age 18 of 15 – 20%
- Female gender becomes a substantial risk factor for depression in post-pubertal youth
- Anxiety disorders often precede development of MDD
- Co-morbidity is the rule, not the exception (ie., frequently co-occurs between anxiety and depressive disorders, disruptive behavior disorders, substance abuse, etc.)
- Young age onset usually portends more severe conditions, possible worse outcomes

Child/Youth Depression or Anxiety What are Your Biggest Challenges?

- Detection?
- Diagnosis?
- Differential diagnosis?
- Associated problems or family issues?
- Treatment?
- MH Referral Issues?

What are the Challenges in Identifying Depression or Anxiety in Pediatric Primary Care?

- 3/4ths of anxious/depressed youth missed by PCPs
- Depression intrinsically more variable in youth than adults
- Youth often do not actively disclose. Presentation may be varied...fears of losing face, showing symptoms in front of others
- Only reliable way to find anxiety/depression in children and youth is to implement direct, standardized screening

How Do Depression and/or Anxiety Present in Youth?

- Distinct and enduring mood / behavioral change
- School problems / underachievement / failure
- Family conflicts
- Illicit substance use and abuse
- Somatic symptoms
- Suicidal crises

The Diagnostic Process

- Standard evaluation procedure for children and adolescents involves more collection of collateral information than with adult patients
- Collateral information: parent reports, school reports, rating scales, psychological testing, r/o abuse, etc.
- Must involve face-to-face interviews of parent and child/youth, seeing each one alone under most circumstances. 1/2 of "true cases" identified via parent, another 1/2 via youth
- Clinicians must integrate the diverse information into a coherent picture of the child: What to do if there is significant disagreement between information sources?
 - "AND", "OR" approaches

Diagnostic Criteria: Major Depression

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

- (1) depressed mood. *Note: In children and adolescents, can be irritable mood.*
- (2) diminished interest or pleasure in all, or almost all, activities
- (3) appetite and weight changes
- (4) sleep pattern disruption
- (5) psychomotor agitation or retardation
- (6) fatigue or loss of energy
- (7) feelings of worthlessness or excessive or inappropriate guilt
- (8) diminished ability to think or concentrate, or indecisiveness
- (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Diagnostic Criteria: Major Depressive Episode

- DSM-IV criteria for depression in children and adolescents are essentially similar to adults except:
 - Irritability can be the primary mood symptom instead of sadness in individuals under the age of 18
 - Failure to meet normal expected growth milestones can be substituted for the weight loss criteria

Anxiety Disorder Diagnoses

Many Anxiety Disorders: SAD, GAD, Panic, Social Phobia

Symptoms of anxiety disorders can include:

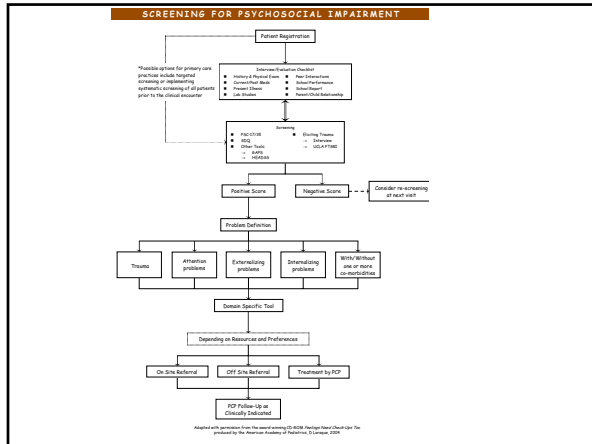
- Recurring fears and worries about routine parts of everyday life
- Physical complaints, like stomachache or headache
- Trouble concentrating
- Trouble sleeping
- Fear of social situations
- Fear of leaving home
- Fear of separation from a loved one
- Refusing to go to school

Diagnostic Aids

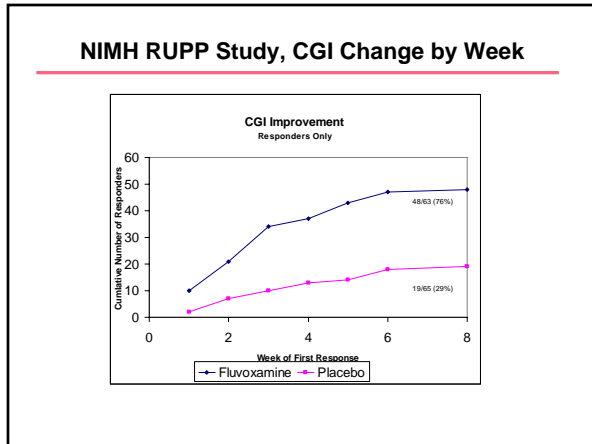
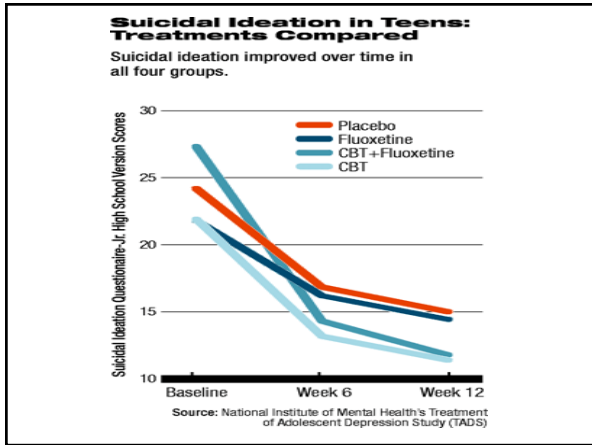
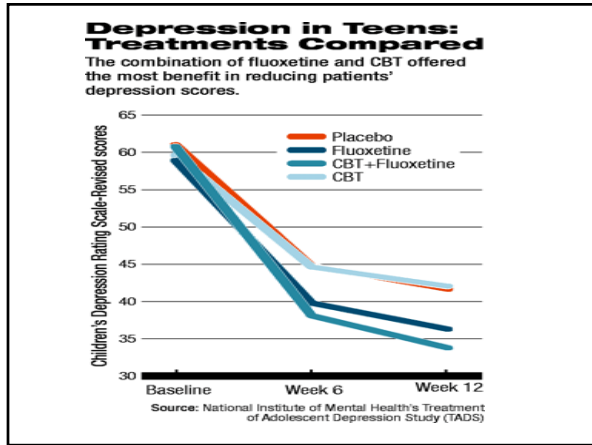
- Used commonly in research studies but are now not only "the state of the art," but also a "must" for good clinical assessment
- Psychometric properties of the commonly used instruments for anxiety/depression in youth are fair to good. Diagnoses more accurate and complete when used with such tools.
- Self-rated and clinician-rated instruments measuring anxiety or depressive symptoms are useful as "aides" but cannot substitute for interview and clinical diagnosis
 - Examples: BDI, BDI-PC, CES-D, PHQ-A, PHQ-9, DPS, MASC, SCARED
- Can be used to guide and augment the diagnostic interview.
- All instruments routinely require parent / other adult information as well as information given by the child

Probing Further

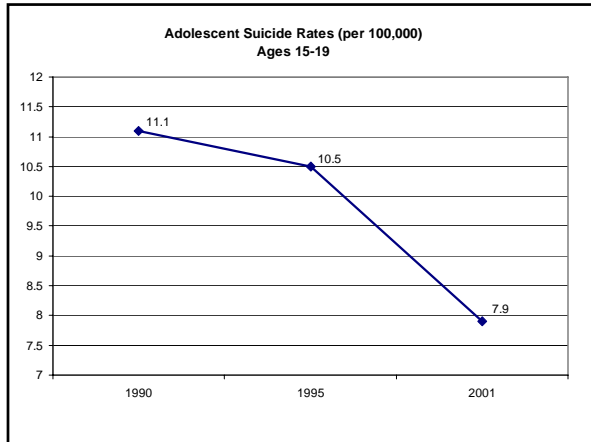
- The physician should use checklists to probe further, get specific examples for what the parent or child reports on the checklist
 - You said, (restate the item or question where they checked "yes"). "Can you give me a recent example of this? What was the last time?"
- The clinician must reconcile discrepancies in verbal and written information, and figure out what is really going on, and seems most likely.
 - Use caution in doing this jointly with child and parent
 - For sensitive issues that need to be brought to joint attention of parent and child, consider addressing the need to share jointly with the original informant
- Additional Probes to consider using:
 - What was the scariest thing that ever happened to you?
 - What was the saddest thing that has happened to you?
 - What things do you most worry about?



- ### The Case of Jose
- Variations in presenting problems: Jose
 - Subthreshold depression
 - Suicidal ideation
 - Follow-up with child/family
 - Importance of relationships and information from with child and family members, trust
 - Watchful waiting/active monitoring
 - Use of toolkit, combining measures, assessing comorbidity
 - PHQ-9M example



- ### Therapeutics for Adolescents with MDD and Anxiety Disorders: The state of the field in 2005
- Reasonable evidence for the short-term efficacy for group- and individually-delivered CBT and individually-delivered IPT for depression
 - Good evidence for short-term efficacy for group- and individually-delivered CBT for anxiety
 - Depression: Evidence for safety and efficacy of SSRI's (Fluoxetine FDA approved). Safety concerns may be overstated in media.
 - Anxiety disorders: Evidence for multiple SSRIs for managing anxiety and/or OCD. 3 SSRIs (Prozac, Zoloft, Luvox) FDA approved for OCD, plus clomipramine



Depression Treatment Issues

GLAD-PC (Guidelines for Adolescent Depression in PC)

- Provide family psychoeducation and support.
- 6-8 weeks of acting monitoring for milder cases
- When to Treat:
 - Persistent symptoms > 6 weeks
 - Significant impairment in home, school, peer settings
 - PHQ > 9, Columbia DISC Depression Scale > 20, CGAS < 60
- With other disorders, treat substance abuse, ADHD, and Conduct Disorder FIRST (or refer to MH specialist)

SSRI Treatment Issues

- Use SSRIs (start with Prozac, 10-20mg, 10-20mg increments q. weekly, up to 60mg). In larger youth may start with 20mg
- Discuss SEs with parents, youth: appetite, GI sx, sleep disturbance, sexual dysfunction
- Monitor weekly for SEs, response, mood/suicidality
- Consider Celexa, Zoloft, Wellbutrin, if Prozac does not work
- When to exert caution: family history of bipolar disorder, and youth history of severe mood swings, (“highs”) and going without sleep, or other major comorbidities
 - Get additional consultation

SSRI Medication Dosing Issues

Medication	Starting Dose	Increments	Effective dose	Maximum Dosage	Contraindicated
Citalopram	10 mg qd/od	10 mg	20 mg	60 mg	MAOI's
Fluoxetine	10 mg qd/od	10-20 mg	20 mg	60 mg	MAOI's
Fluvoxamine	50 mg qd/od	50 mg	150 mg	300 mg	MAOI's
Paroxetine	10 mg qd/od	10 mg	20 mg	60 mg	MAOI's
Sertraline	25 mg qd/od	12.5 - 25 mg	100 mg	200 mg	MAOI's

Additional Treatment Issues

- SSRI treatment duration: 6 months to 1 year
- Discontinue SSRI gradually to avoid rebound effects
- Alternative treatments:
 - St. John's Wort
 - Light therapy
 - Omega-3 fatty acid supplements

Suicidality

FREQUENCY: YBRS, 2003

- Felt so sad or helpless, 2 weeks or more that you stopped usual activities in last year: 29% of US teens
- Considered attempting suicide: 17% (13% male, 21% female)
- Made suicide plan: 17% (14% male, 19% female)
- Attempted suicide: 9% (5% male, 12% female)
- Needed medical attention for suicide attempt: 3% (2% male, 3% female)
- Ingestions most common method
- Lethal Means: boys > girls

Suicidality

RISK FACTORS

- Pre-existing psychiatric disorder
- Substance/EtOH use
- Previous attempt
- Family suicidal behavior
- Stress events: legal, family, or academic problems
- Gay/lesbian youth, sexual abuse

Suicidality

ASSESSMENT

- AVOID “only a gesture” characterizations
 - “benign”
 - “cry for help”
 - “manipulation”
- Assess ROPES
 - Rational thinking lost
 - Organized plan
 - Previous Attempts
 - Ethanol abuse
 - Social supports

Suicidality

STRATEGIES

- Assess immediate safety
 - Determine access to lethal methods (guns, razors, meds)
 - Evaluate Adult supervision
- Involve parents and other family members in plan
- Remove firearms, sharps, razors, drugs from house
- Monitor new onset agitation, silliness, risk taking behavior (disinhibition)
- Contract not to hurt self, come to ER, tell parents or others when feelings resurface
- Follow-up to mental health AND TO YOU

Child/Youth Depression or Anxiety Dealing with Your Challenges

ROLE PLAYS

- Using Scales to Improve Diagnosis
- Discussing Major Depression Diagnosis
- Discussing Suicidal Ideation, Making a Suicide Contract
- Making a MH Referral

Management Issues

- Chart documentation
 - Brief mental status: homicidal, suicidal, plan, and willingness to contract to not hurt self or to notify others, come to ER
 - Side effects discussion with family (including disinhibition)
 - Additional consultation (e.g., phone call to consultant, etc.)
 - Advice to family to seek out additional treatment, referral sources for psychotherapy, etc.
- Refer or obtain consultation on which comorbid cases?
 - Refer
 - Conduct disorder, significant aggression
 - Substance abuse
 - Psychotic symptoms
 - Tourettes; OCD
 - Severe mood instability, mood swings, or significant bipolar concerns in youth or family
 - Treat:
 - Anxiety disorder
 - ADHD
 - Treat the most impairing condition first
 - Consider what type of impairment remains before starting treatment for the other problem

Summary

- Childhood and adolescent depression and anxiety disorder are very serious illnesses, not benign.
- They affect lots of kids.
- Kids need a comprehensive evaluation and an accurate diagnosis.
- Medication can be an important component of treatment, but medication alone is rarely the answer, nor is it acceptable as the starting point for most families.

Summary, cont.

- Any child on medication needs to be monitored closely
- Parents need access to as much information as possible about the safety and efficacy of all treatment interventions
- Parents need to be advocates for their children, and physicians need to enable and empower them in this process
- More research needed, but “waiting for Godot” is not a good option for a significantly impaired child or youth

Med Management Considerations: I

- Medications should not be used as a substitute for necessary environmental modifications and psychotherapeutic approaches
- For maximum effect, medications should usually be used in combination with therapy, and may enhance therapy effects
- Medications must be titrated; this requires close follow-up & clarity re: effects you want to see
- If a child does not respond to a medication, re-examine diagnosis, co-existing conditions, treatment, & adherence

Medication Management: II

- “Try it and see” approach unavoidable
- Ensure adequate dose and duration before changing meds or adding another
- Less is more. Avoid (but don’t shun) polypharmacy
- Regular follow-up with physician who is expert in use of the meds

Medication Management: III

- Careful monitoring of target symptoms and side effects, use of scales, diaries, and checklists, etc. Train parents and kids to be active observers and reporters
- If multiple drugs in combination have little effect, consider “wash-out” of all meds, starting over. Some meds may cause SEs that mimic psychiatric symptoms
- Beware over-reliance on previous labels/diagnoses

Discussion with Child and Family: I

- Discuss range of proven therapeutic options
- Explain positives and negatives of medication and other treatments to the family and youth
- Address stigma/misconceptions
- Assist family in arriving at a choice of treatment options. Encourage combined treatment options in severe cases or when one form of treatment has failed

Discussion with Child and Family: II

- Determine target behaviors of concern to family and child with input from teachers and others
- Explain to child/youth that meds are not to control behavior, but to help increase self-control
- Encourage self-management, tracking of symptoms, education, and awareness of side effects