Treating Childhood Depression in Pediatrics

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Objectives

- The learner will:
- Describe the signs and symptoms of childhood and adolescent depression.
- Describe the use of SSRIs and the precautions that need to be taken.
- List the signs and symptoms of potential suicide.
- Describe cognitive behavioral therapy, relaxation and visualization

Statistics

- 2.5% of children and 8.5% of adolescents experience depression
- The cumulative incidence by age 18 years is approximately 20% in the community
- 9 months is the average length; 20% remain depressed at 1 year
- 40% have another episode within 2 years; 70% have additional episode in 5 years

Statistics

- 50% depressed adults report having their first episode before 20 years of age
- 28% of depressed teens used alcohol, 23% smoked cigarettes,and 21% used drugs

Suicide Statistics

- Suicide becomes the 3rd leading cause of death at time of puberty.
- Suicide is the 6th leading cause of death in the 10 to 24 year old.

Goal

- At the first signs of depression to take early action to make the recurrence of a depressive episode less likely.

DIAGNOSIS

- Depressed Mood
- Irritable Mood (80% of children)
- Marked decrease in interest or pleasure in all of their activities
- Increase or decrease in appetite leading to an increase or decrease in weight

Diagnosis

- Increase sleep or insomnia
- Psychomotor agitation or psychomotor retardation
- Fatigued most days
- Feelings of worthlessness and significant amount of inappropriate guilt

Diagnosis

- Decrease concentration leading to indecisiveness
- Reports of thoughts of death, suicidal ideation (with or without a plan), and suicide attempts

Relationship Problems

- Poor peer relations (e.g. when making friends; maintaining friends; and playing with friends)
- Family discord

Other signs

- Auditory or visual hallucinations
- Physical complaints
- Sadness or hopelessness
- Excessive worrying
- Crying

Other signs

- Hostility and aggression
- High school absenteeism
- Drop in grades
- Running away

Differential and co-morbid diagnoses

- Bipolar
- Dysthymia (81% of eventually develop MDD)
- Anxiety Disorders
- Oppositional Defiant Disorder
- Conduct Disorder
- ADHD

Differential and co-morbid

- Eating Disorders
- Learning Disabilities
- Substance Abuse
- Physical and/or sexual abuse
- Post traumatic Stress Disorder

Differential Medical Diagnoses

- Infections (e.g.Infectious Mononucleosis)
- Neurological (e.g. Seizures;)
- Endocrine (e.g. diabetes; hypothyroidism; electrolyte imbalance)
- Auto-immune Disorders (e.g. lupus; vasculitis;)

- Medications
- Alcohol Abuse
- Substance Abuse

Treatment

- Preference is to refer for an evaluation and therapy
- Medication should be used after a thorough evaluation and followed very closely
- FDA recommends that Paxil not be used in children or adolescents
- Prozac is the only SSRI approved for use in children and adolescents.

FDA

- SSRIs were found to increase suicidal ideation in 4000 children and adolescents.
- None of these children or adolescents actually committed suicide.
- Prozac is the only one researched and approved by the FDA for children.
- Paxil should not be used. It has many interactions with other drugs..

When SSRI is used

- Follow-up very closely for suicide ideation
- Team up with a therapist
- CDI
- Suicide Prevention Contract
- Educate the patient and parents about the side effects such as induction of mania, hypomania, suicide ideation or behavioral activation (impulsive, silly, agitated, and daring)

At Risk Children/Adolescents for SSRIs

- Bi-polar illness
- Family history of bipolar illness
- A suicide attempt
- A family history of suicides or attempts
- A recent family member, friend or idol that has committed suicide

Follow-up

- Once a week for 4 weeks
- Every 2 weeks for the next 4 weeks
- At the end of the 3rd month
- More often if any problems occur

Watch for!

- Watch for anxiety panic attacks
- Hyperactive and hypomania
- Impulsiveness
- Suicidality
- Agitation, restlessness, irritability
- Worse depression

Side Effects

- GI; Headaches; Restlessness; Headaches; Diaphoresis; Bruising; Appetite Change; Fatigue; etc.
- Watch use with other medications

  DO NOT MIX WITH MAO-I MEDICATION

Suicide

- Any statement about wanting to die must be taken seriously….no matter what age.
- Drug use; Watch for use of pain killers; drug cocktails
- A co-morbid diagnosis of ADHD with impulsivity
- A recent suicide of someone that means a lot to this child.
- Abuse

- Grief from and death, divorce, or recent diagnosis of a life limiting illness
- FIRE ARMS IN THE HOME ARE THE NUMBER 1 RISK FACTOR
- Feeling better after treatment started
- A prior suicide attempt
- Art and writing morbid

- Change in grades
- Fatigue or insomnia
- Anorexia or overeating
- Lonely
- Spending a lot of time in his/her room

- START LOW AND GO SLOW

Essential Chart Notes

- Note with a copy of suicide prevention contract
- Discussed the removal of firearms from the home
- Discussed the dispensing of the medication by the parent
- Medications are locked up

Therapy

- Cognitive Behavioral Therapy is 2-3times more effective than comparison treatments

  Harrington et. al., 1998

  Reinecke, Ryan, & DuBois, 1998

Treatments

- CBT (Cognitive Triad; Schemas; Cognitive Errors; and connect feelings to thoughts)
- Deep Breathing and Progressive Muscle Relaxation
- Visualization
- Parent Education re: behavior management and self-esteem improvement techniques
- Social Skills Training

Other Interventions

- Exercise
- Proper Nutrition
- School Involvement (Other Health Impaired Classification; IEP; groups etc.)
- Reading "Helping Your Depressed Child" by Martha U. Barnard

Places for Therapy

- Private Practices
- County Mental Health Clinics
- University Settings (pediatrics and psychiatry) and Children's Hospitals
- Interactive Televideo and Outreach clinics

Summary

- **FEEL FREE TO CALL OUR DEPARTMENT FOR PHONE CONSULTATION AT ANY TIME. (913-588-6323) OR EVENING OR WEEKENDS CALL PAGE OPERATOR FOR THE PSYCHOLOGIST ON CALL.**

- **Thank you!**