Depression and Anxiety in Pediatrics:
A Primary Provider Focus

JOSEPH BECKER DO FAAP
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NJSSNA
Disclosures

No financial disclosures
I am a Pediatrician not a Psychiatrist
I am married to a nurse for 33 years
Learning Objectives

Participants will feel comfortable discussing anxiety and depression

Participants will be aware of the risks and benefits of SSRI antidepressants

Participants will be able to direct teens and families

Participants will know when to refer to Psychologists Primary Care Providers and Psychiatrists
A Few Questions of You

Do you encounter Children and Teenagers with Depression or Anxiety?

Are you comfortable identifying Anxiety or Depression symptoms?

Do you know what treatments are available?

Do you have a plan to help?
Why does Depression and Anxiety matter??

Impact on……every aspect of life
Personal relationship
Educational performance
Employment
Overall health and future health
Risk engagement
How I We got into doing this care

Shift of Pediatric Medical and Health Issues over Time
- 2017 New Morbidity and Mortality

Shift of School Nurse Role
- Lina Roger 1902 Absentees and Communicable disease
- 2017 Looks a lot different

Position Statement Mental Health of Students  NASN
A Childs Day and Who Interacts with them

- Parents
- Family
- Friends
- Teachers
- Coaches
- School Nurses
Mental Health in America

9.8 Million Adults with serious Mental Illness, 33.7 Million other disorders (43.6 Million)

Of US Adults 6.8% Social Phobia, 6.6% Major Depression, 3.1% GAD
2.7% Panic Disorder and 2.5% Bipolar

15.8% of College Students have an Anxiety Dx and 13.1% a Depression Dx

16-20% of the population of children and adolescents has some mental health disturbance

2-3% of early school age children and 5-6 % of all adolescents with Major Depression

25% of 13-18 year olds experience an Anxiety Disorder

6% will experience a severe Anxiety Disorder

50% of all lifetime case of MH Disorder begin by 14 years of age
Adverse Childhood Events

What are ACEs

Abuse: Physical-Emotional-Psychological

Neglect: Emotional-Physical

Household Dysfunction: Substance Abuse-MH-Violence-Criminal-Divorce

ACEs are common across sociodemographic backgrounds

ACEs impact health outcomes throughout the life cycle

Significant childhood trauma alters physiologic and molecular processes

Key factor is concept of stress and biology of stress

Certain populations at higher risk for significant childhood adversity
# Social Determinates of Health

**Figure 2**

**Social Determinants of Health**

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
</tr>
<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td>Provider availability</td>
</tr>
<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td></td>
<td>Community engagement</td>
<td>Provider linguistic and cultural competency</td>
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<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td></td>
<td>Discrimination</td>
<td>Quality of care</td>
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<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td></td>
<td></td>
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<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
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</tbody>
</table>

**Health Outcomes**
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
ACE and Your community

SoDH and Your community

Graded Relationship Between SoDH and ACE and Health Outcomes such as:

- Health Risk Behaviors
  - Smoking
  - Alcohol Abuse
  - Drug Abuse/Illlicit Drug Use
  - Depression
  - Anxiety
  - PTSD
  - Suicide

- Physical Health Conditions and High Risk Sexual Behaviors

Shift from “What is wrong with you” to “What happened to you”
Worth a Watch
The Need for Care

A nationally representative survey in the United States found that nearly 40 percent of teenagers with major depression or persistent depressive disorder were not treated (UpToDate)

2% of children less than 12 will have an illness of depression

6% of teenagers will have an episode of depression

Depressions is more likely when an early diagnosis of a chronic medical illness

Depression is more likely with hx of ACE

Depression is more likely with a + family history

The impact is on individuals families and society are huge and we know early care has the largest ROI for future
Pediatricians accurately dx depression, BUT treated only 26% of kids with moderate depression and 32% of kids with severe depression in a study of group practices.

Time - ?

Knowledge - diagnosis? medicine? therapy?

Fear - ?

Some Patients Barriers to Care:

Acceptance of Dx  Stigmata of Dx  Infrastructure of MH
Access to Care  Ease of Care  Cost of care
Financial Challenges

55% of Psychiatrist take private insurance, 89% of other Physicians do so

Patients pay 15.9% of mental health care compared to 11.4% for asthma

Claims denial rate for MH 29% versus 14% if medical

National Alliance for Mental Health 2015
Who can Help?

There are only 8,400 US practicing child/adolescent psychiatrists for the 15 Million needing their care…do the math

There is still stigma and access issues about seeing a psychiatrist.

Families trust you. Nurses topped Gallup’s Honesty and Ethics poll rankings for the 14th consecutive year – Leverage that!

If you, me we don’t advocate for treating depression and anxiety, then in many cases these kids will NOT get treatment

The AAP and AAFP have treatment guidelines that say primary providers can and should treat depression and anxiety, not just Psychiatrist

Is collaboration better? You Betcha….Value of the team
DSM V : Major Depression

A. 1. Depressed mood most of the day, almost every day, indicated by your own subjective report or by the report of others. This mood might be characterized by sadness, emptiness, or hopelessness.
2. Markedly diminished interest or pleasure in all or almost all activities most of the day nearly every day.
3. Significant weight loss when not dieting or weight gain.
4. Inability to sleep or oversleeping nearly every day.
5. Psychomotor agitation or retardation nearly every day.
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
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

B. Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

C. The episode is not due to the effects of a substance or to a medical condition

D. The occurrence is not better explained by schizoaffective or bipolar disorder schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders

E. There has never been a manic episode or a hypomanic episode
DSM V: Anxiety

The specific DSM-5 criteria for generalized anxiety disorder are as follows: 

Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

The individual finds it difficult to control the worry.

For children, the anxiety and worry are associated with one (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

- Restlessness or feeling keyed up or on edge
- Being easily fatigued
- Difficulty concentrating or mind going blank
- Irritability
- Muscle tension
- Sleep disturbance (difficulty falling or staying asleep, or restlessness, unsatisfying sleep)

The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

The disturbance is not better explained by another mental disorder.
Getting started when a child presents

Know your school policies

Try to talk to more than one person to get the full story - the child and parents, all the other players

Use the phone - call the providers or call the therapist

Send rating scales home or to the school
Depression: What to look for

Irritable (this can look like “mood swings”)
Negative thinking, pessimistic, glass half empty
Declining Grades
New behavioral concerns Screens substances
Sleeping and eating - too little or too much
Ill Defined medical complaints
More visits
Change in relationships
Change in interest
“What’s wrong question”
Still Looking:

- Drugs and Alcohol
- About abuse
- Sexuality LGBTQ “non-binary” teens - highest risk of depression & suicide attempt
- Bullying, especially on social media

If you don’t ask who will? Value of asking and opening communication

Ask alone

Teens not sure what is ok   World of Abnormal Rearing
Anxiety: What to look for

Anxious children manifest anxiety by age
- Separation anxiety --> school refusal --> specific phobias --> performance anxiety --> social anxiety --> panic --> generalized anxiety

Anxious children often have anxious parents, they worry more and make accommodations, fueling the symptom

Avoidance Worsens Anxiety

Teach the normal biology of Fight or Flight reaction
Follow by teaching them about not avoiding (fighting or fleeing) the things that make them anxious
this is the beginning of Cognitive Behavioral Therapy
**Screening Tools**

Bright Futures and the EMR

Validated Screening tools

PHQ 9, Beck Depression Inventory for Primary Care, etc.

Once established Dx ask “on a scale of 1-10, if 10 is the worst your depression anxiety could be, what is the worst yours has ever been? What is it now?” Use same question at serial encounters
# PHQ 9 Teen Depression Scale

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

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.**
PHQ 9 Scoring

Depression Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe.

Validity has been assessed against an independent structured mental health professional (MHP) interview.

**PHQ-9 score** ≥10 had a sensitivity of 88% and a specificity of 88% for major depression.
Scared

Screen for Child Anxiety Related Disorders (SCARED)
CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Developed by Boris Birmaher, M.D., Sumera Khetarpal, M.D., Marlene Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). E-mail: birmaher@upmc.edu

Name: __________________________  Date: __________________________

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you *for the last 3 months.*

<table>
<thead>
<tr>
<th></th>
<th>0 Not True or Hardly Ever True</th>
<th>1 Somewhat True or Sometimes True</th>
<th>2 Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When I feel frightened, it is hard to breathe.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2. I get headaches when I am at school.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3. I don’t like to be with people I don’t know well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4. I get scared if I sleep away from home.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5. I worry about other people liking me.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>6. When I get frightened, I feel like passing out.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>7. I am nervous.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>8. I follow my mother or father wherever they go.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>9. People tell me that I look nervous.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>10. I feel nervous with people I don’t know well.</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>11. I get stomachaches at school.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>12. When I get frightened, I feel like I am going crazy.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>13. I worry about sleeping alone.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>14. I worry about being as good as other kids.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>15. When I get frightened, I feel like things are not real.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>16. I have nightmares about something bad happening to my parents.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>17. I worry about going to school.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>18. When I get frightened, my heart beats fast.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>19. I get shaky.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>20. I have nightmares about something bad happening to me.</td>
<td>○</td>
<td>○</td>
<td>○</td>
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Scared

Screen for Child Anxiety Related Disorders (SCARED)
CHILD Version—Page 2 of 2 (to be filled out by the CHILD)

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<th>1 Somewhat True or Sometimes True</th>
<th>2 Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. I worry about things working out for me.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>22. When I get frightened, I sweat a lot.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>23. I am a worrier.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>24. I get really frightened for no reason at all.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>25. I am afraid to be alone in the house.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>26. It is hard for me to talk with people I don’t know well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>27. When I get frightened, I feel like I am choking.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>28. People tell me that I worry too much.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>29. I don’t like to be away from my family.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>30. I am afraid of having anxiety (or panic) attacks.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>31. I worry that something bad might happen to my parents.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>32. I feel shy with people I don’t know well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>33. I worry about what is going to happen in the future.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>34. When I get frightened, I feel like throwing up.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>35. I worry about how well I do things.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>36. I am scared to go to school.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>37. I worry about things that have already happened.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>38. When I get frightened, I feel dizzy.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don’t know well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>41. I am shy.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

**SCORING:**
A total score of ≥ 25 may indicate the presence of an Anxiety Disorder. Scores higher than 30 are more specific. TOTAL = [ ]
A score of 7 for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate Panic Disorder orsignificant somatic symptoms. FN = [ ]
A score of 9 for items 3, 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate Generalized Anxiety Disorder. GD = [ ]
A score of 5 for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate Separation Anxiety. SP = [ ]
A score of 8 for items 3, 10, 26, 32, 39, 40, 41 may indicate Social Anxiety Disorder. SC = [ ]
A score of 3 for items 2, 11, 17, 35 may indicate Significant School Avoidance. SH = [ ]

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatricpss.pitt.edu under instruments.

March 27, 2012
Options for Depression and Anxiety Treatment

Counselling and Therapy

Medication

Self Care

Other choices
Who is on the team?

School Nurses
School Counsellors
School Administrators and teachers
School based clinics
Local Therapist
Crisis Centers
Variety of Medical Providers
Co-located Therapist
Know your community resources
When to treat Anxiety and Depression?

Treat when symptoms are interfering with functioning
Treat when symptoms are interfering with development
Treat when the child is suffering and you know there are treatments that can “make life easier.”

In most cases, start with a referral for Cognitive Behavioral Therapy
Collaborate with therapist and providers, you can provide significant insight

SSRI’s + CBT are the treatment of choice
If the depression anxiety is severe, such as a child refusing school, then might medicate first while waiting for CBT
The combination of medication (fluoxetine) and psychotherapy (CBT) is the most effective treatment for adolescents with depression.

The clinical trial of 439 adolescents ages 12 to 17 with MDD compared four treatment groups—combination of fluoxetine and CBT, fluoxetine only, CBT only, placebo only.

After the first 12 weeks, 71 percent responded to the combination treatment of fluoxetine and CBT, 61 percent responded to the fluoxetine only treatment, 43 percent responded to the CBT only treatment, and 35 percent responded to the placebo treatment.

NIMH 2004, 2009
CAMS
The Child/Adolescent Multimodal Study

488 children and adolescents ages 7 to 17 years to assigned to one of four treatment options, 12 weeks

81% of children and adolescents receiving combination treatment improved (CBT + sertraline)

60% of them receiving CBT only improved

55% receiving antidepressant medication only (Sertraline) improved.

24% of those receiving only placebo improved.

CAMS 6 years, 6 sites
Psychopharmacology: SSRI
Selective Serotonin Re-Uptake Inhibitors

Depression:
SSRI antidepressants are the medication treatment of choice for both Depression and Anxiety.
SSRI’s are the only medication with evidence for treating depression in children and teenagers.

Anxiety:
SSRI’s use for Anxiety is the same as for depression.
Combination treatment: CBT + medication is best.
Anxious people are often very sensitive to side effects.
Where in the Brain?
SSRI Action

How do Anti-Depressants work?

- SSRI: selective serotonin reuptake inhibitor
- Pre-synaptic nerve ending
- SSRI blocking reabsorption of Serotonin
- Serotonin is released
- Synapse
- Post-synaptic nerve ending
- Receptor sites
SSRI Black Box Warning

Black box warning for suicidal thoughts for under 25yo

Black box warning is on all antidepressants

On SSRI there is a 2% increase in suicidal thoughts - 2% have suicidal thoughts on placebo, 4% have suicidal thoughts on drug

Depressed kids have suicidal thoughts, effective treatment decreases the chance of suicide

There is NOT an increase in completed suicide on SSRI
“If you get this side effect - stop the medicine and call the provider, in that order”

See or call all child and adolescent patients weekly for the first 3-4 weeks on SSRI antidepressants

You must ASK if the patient has thoughts of hurting or killing themselves

Black Box Warning should not deter use of SSRI
Assessing Suicidal Thoughts

Ask and Ask in different words and ways if you are at all suspicious

Ask details, “do you have a plans...how do you think about doing it... and do you have guns in the home... how do you know how to do that ...?”

Do not assume others will ask
SSRI Side Effects

The most common side effects are GI side effects.

Nausea, stomach pain or mild diarrhea/loose stools.

The GI side effects can occur with dose increases but resolve after a few days.

They should wait to increase the dose until the side effects have gone away.

Sometimes headaches.
SSRI Side Effects

SSRI’s make many teens more sensitive to alcohol

No endorsement of underage drinking, especially for teens with depression, but they need to know that they may get more drunk on less alcohol

Marijuana use increases the chances of psychosis in vulnerable individuals

SSRI’s have sexual side effects

Decreased libido, difficulty achieving orgasm, delayed ejaculation

Teens who are not sexually active may be masturbating

Teens might not bring this up; might not want Rx anymore
One more side effect to be aware of

Family history of bipolar or manic depressive disorder

Antidepressants can be “activating” or energizing, this is not necessarily bipolar disorder

Children “prone to mood swings” can move from depression to mania

Too much energy, difficulty sleeping, aggression, “the opposite of depression” but rarely happy

All can be seen in the school environment
SSRI Most Providers pick 2-3 and know how to use them

PROZAC (fluoxetine) is FDA approved for treating depression in children and adolescents age 8-18

LEXAPRO (escitalopram) is FDA approved for treating depression in children ages 12-17

ZOLOFT (sertraline) has double blind randomized placebo controlled evidence in the CAMS study of Anxiety

Medscape Dec 2016 Meta Analysis
Prozac (fluoxetine)

PROZAC (fluoxetine) is FDA approved for treating depression in children and adolescents.

20 mg is a full adult dose (max 60 mg)

The smallest pill is 10 mg and can be split in half = 5 mg

The liquid is 20 mg/5 ml - can start with very low doses

Good Rule of thumb Start low - Go slow

Prozac has a very long half-life (4-6 days for parent drug...9 days for active metabolite) so it accumulates, but it also self tapers.

Can be activating, so take in the morning?

You may hear complaints that it is as if the child has developed ADHD...comment of friends or teachers?
Celexa (citalopram)  
Lexapro (escitalopram)

A full dose of Celexa is 20 mg = Prozac 20 mg

Dosing of Celexa is like Prozac dosing

Escitalopram (Lexapro) is the s-isomer of citalopram (Celexa)

Lexapro is effective at half the dose of Prozac, so a full adult dose of Lexapro is 10 mg

Since Lexapro is only the active isomer it is meant to have fewer side effects.
Zoloft (Sertraline)

A full adult dose of Zoloft is 50 mg (max 200 mg)

The smallest pill is 25 mg and can be broken in half for a starting dose of 12.5 mg

The liquid is 20mg/ml

At doses up to 50 mg per day BID dosing may be necessary due to the faster metabolism in youngsters (12.5 BID and 25 BID)
Other medications for Anxiety?

Avoid benzodiazepines, even acutely, because potential for abuse
  IF they are prescribed, hopefully only 1 prescription for a few,
  smallest dose, max twice per week as a rescue medication

No evidence for other meds…But…
How Long to Treat Anxiety and Depression?

Expect Treatment for 6-12 months from the time they are in FULL remission

Remission not just response is key

Timing matters - don’t stop medication at stressful times or life transitions…planning ahead
How do they stop medication?

Children may often miss their medication. They will usually experience withdraw symptoms by day 3

- Upset stomach, anxiety, suddenly worse mood, even thoughts of suicide - that in itself is a deterrent, maybe that it why they are in your office?

When ready to discontinue, go slow. Depending on the dose, expect to see taper by half of the smallest pill monthly.

Adequate treatment to remission and slowly tapering off will both decrease the risk of relapse.
What if child or family refusing medications

Therapy

Complimentary and Alternative, Integrative, Homeopathic or any other treatment

Work with them

Talk about supplements, exercise and therapy

Follow them so you can reevaluate needs, Support
Psychotherapy

Remember the normal biology of Fight or Flight reaction
Then teach them about not avoiding (fighting or fleeing) the things that make them anxious
This is the beginning of Cognitive Behavioral Therapy
Cognitive Behavioral Therapy (CBT) is an evidence based treatment for Anxiety and Depression
What is CBT?

CBT was developed in the 1960s by Dr. Aaron Beck

**Cognitive behavioral therapy (CBT)** is a short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving. Its goal is to change patterns of thinking or behavior that are behind people's difficulties, and so change the way they feel.

CBT aims to help people become aware of when they make negative interpretations, and of **behavioral** patterns which reinforce the distorted thinking. **Cognitive** therapy helps people to develop alternative ways of thinking and behaving which aims to reduce their psychological distress.

Cognitive Behavior Therapy (CBT) is a time-sensitive, structured, present-oriented psychotherapy directed toward solving current problems and teaching clients skills to modify dysfunctional thinking and behavior.
CBT in your community

Just like medication - get to know 2-3 therapists and use that relationship

If they can't help, they know the landscape better and can help find other resources
Supplements

The evidence for supplements is not strong, but you can use them as the placebo effect in children and teens is strong:

- Fish Oil / Omega 3 fatty acids 1-2 grams per day.
- Vitamin D3 1000-2000 IU per day
- Melatonin for sleep ½mg to 3 mg ½ hour prior bed
Keep our brains SMART

S - sleep - get enough, help them get to sleep
M - meals and fluids - eat and drink regularly food is fuel
A - activity/exercise - Exercise 30 minutes 5 x week is equal to medication for mild to moderate depression. Works for anxiety
R - relax - Yoga, mindfulness, breathing....kids need to play
T - triggers - School? friends? Family? (what support do they need?)

CHOP Headache Clinic
Tech: It’s not all bad

Ask about the communities and support they find online.

Have them find a relaxation or breathing app or create a relaxing play list.

- Increases parasympathetic tone (rest and digest) and decreases sympathetic tone (fight of flight).
- Paced belly breathing (6 per second/prolonged exhale).
What does a Psychiatrist do with medications?

They fine tune drugs

They change medications - may try 2-3 SSRI’s

They augment medications - with Wellbutrin, Atypicals, Deplin, TCA’s...

They stabilize moods - with Atypicals, Lamictal, lithium, Depakote

They diagnose and treat co-morbid disorders - their typical patient may have 4-5 diagnoses, “poly-pharmacy”
When should primary provider refer to Child Psychiatrist and not treat?

Refer when they are not comfortable the child is safe

Refer when they are not sure what is going on

Refer when fail two antidepressants

Refer when multiple co-morbid diagnoses

Refer when a strong family history of bipolar disorder or concern about mood swings
One Stop for Resource

Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit

http://www.glad-pc.org/
Thank You and Questions

If I did my job...you will be better able to help one or more kids who would of slipped by

And then more and more....