The iCAMH Training

International Child and Adolescent Mental Health Training

Session 6 – Moderate and severe depression

Build on IACAPAP Textbook of Child and Adolescent Mental Health, Goodman/Scott Child Psychiatry and WHO mhGAP Intervention Guide

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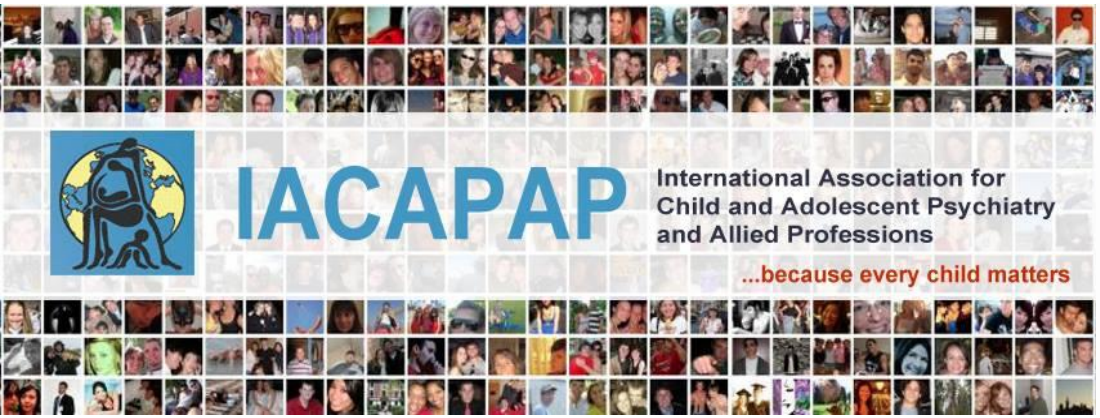

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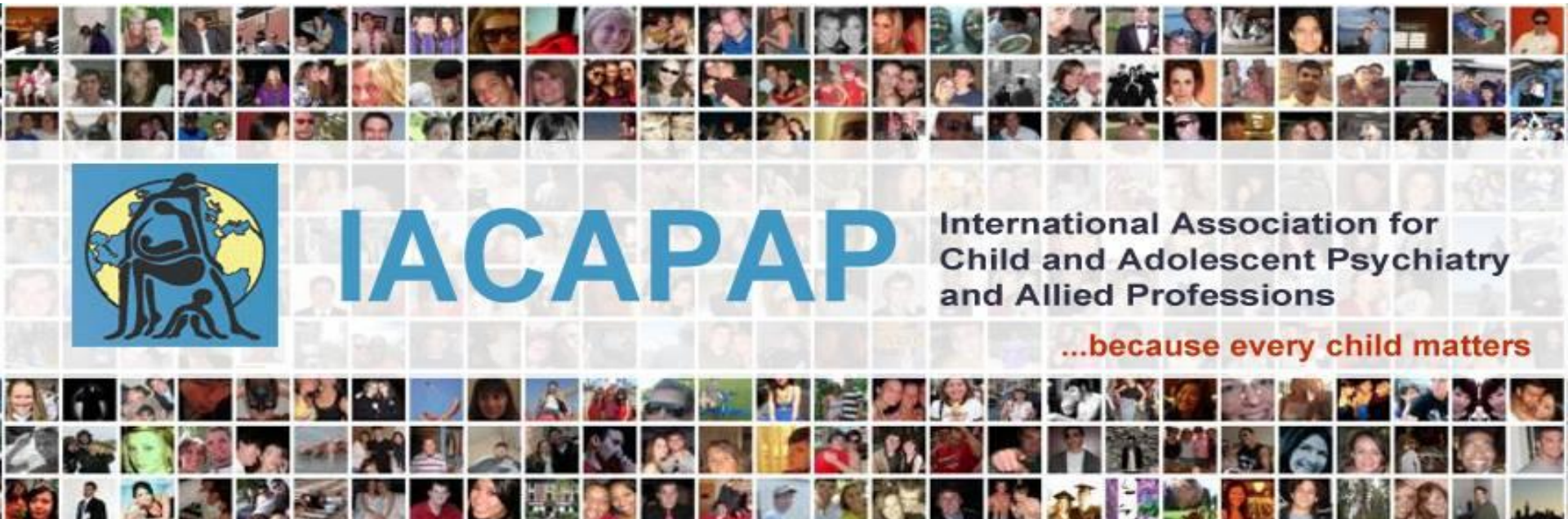


To begin: General Considerations Classification of Emotional Disorders:

- Worries, fears, misery and unexplained physical symptoms tend to overlap in individuals
- Current classification systems define a large number of specific anxiety and depressive disorders (see textbooks)
- For practical/clinical purposes aimed at 2nd line clinicians (and partly following mhGAP) here we differentiate:
  - Moderate and severe depression (this module)
  - Anxiety disorders
  - "Other significant emotional or medically unexplained complaints" (OTH, including mild depression and mild somatization also called "common mental disorders")

Build-up of module (1 1/2 hours)

- Introduction 10 min
- Interactive teaching 20 min
- Practical skills in Assessment 20 min
- Practical skills in Management 20 min
- Own case(s) 10 min
- Next Steps/Implementation 10 min

Objectives:
At the end of this session you will be able to

- Screen patients/parents for an emotional disorder
- Differentiate and diagnose
  - moderate-severe depression
  - anxiety disorders
  - “other significant emotional or medically unexplained complaints”
- Treat or manage through
  - Psycho-education
  - Basic and advanced psycho-social interventions
  - Pharmacotherapy for moderate-severe depression
- Have basic knowledge about EB psychotherapies CBT and IPT
- Know when to refer a patient to a child psychiatry specialist

Practical Competencies
Assessment of emotional disorders

- Basic assessment skills (mhGAP: DEP, SUI, OTH)
  - Establish communication and build trust
  - Take relevant history
  - Assess (suicidal) risk
  - Perform general physical/mental health assessment
  - Assess psycho-social problems and assets (incl. parental MH)
  - Identify/diagnose DEP, SUI or OTH
- Advanced assessment skills (2nd line) in addition:
  - Reevaluate (or perform) assessment from primary care
  - Expand physical work-up as appropriate
  - Differentiate different types of depression/anxiety disorders
  - Use basic screening/diagnostic tools as appropriate

Practical Competencies
Interventions for emotional disorders

- Basic interventions (mhGAP: DEP, SUI, OTH)
  - Psychoeducation
  - Addressing psychosocial stressors
  - Reactivate social networks/physical activities
  - Acute care for person with self-harm/ Pesticide intoxication
  - Prevention of suicide
- Advanced interventions (2nd line) in addition:
  - Recap (or perform) interventions from primary care
  - Basic CBT techniques (e.g. behaviour activation)
  - Problem solving training (individual and/or with family)
  - Relaxation training
  - Antidepressant medication for adolescents

Introductory Discussion

- What is the relevance of emotional disorders in children and adolescents in your country/your personal practice?
- Tell us about any cases you encountered
- Do local people recognize depression and/or anxiety as (medical) problems?
  - How do they call these problems?
  - How do they express low mood and anxiety?
  - How do they treat them?
- Are there any points you want to discuss today that were not mentioned in the objectives?

Interactive teaching

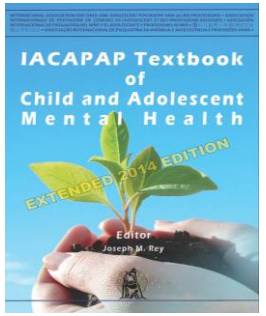
MODERATE TO SEVERE DEPRESSION IN CHILDREN AND ADOLESCENTS

Why do you need to know? Depression in Children and Adolescents?

- It is **common** especially in primary care
- Prevalences are even higher in those with physical illness
- It reduces adherence to treatment for chronic diseases, incl. HIV and TB
- It is **serious** and can lead to severe impairment in educational and social functioning with long lasting consequences
- It can lead to suicide, one of the leading causes of death in adolescents

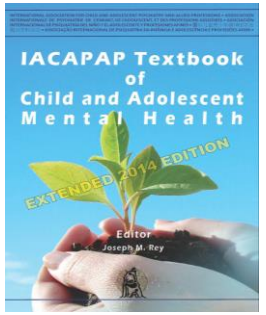
The Basics
Depression in Children and Adolescents

- Definition
- Core symptoms
- Associated symptoms
- Variations
- Appropriate terms



Epidemiology:
Depression in Children and Adolescents

- Pre-pubertal children: 1-2%
- Adolescents: 5%
- Cumulative prevalence
  - Girls: 12%
  - Boys: 7%
- Much higher in those with physical illness

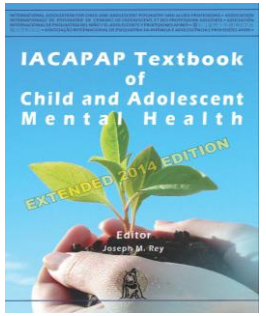


Differences by Age: Depression in Children and Adolescents

Table E.1.1 Differences in the presentation of depression according to age. These symptoms can all be present at any age but are more common in the age group specified.

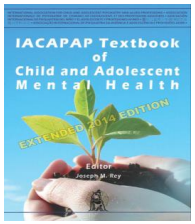
Pre-pubertal children	Adolescents	Adults
• Irritability (temper tantrums, non-compliance) • Affect is reactive* • Frequently comorbid with anxiety, behavior problems, and ADHD • Somatic complaints	• Irritability (grumpy, hostile, easily frustrated, angry outbursts) • Affect is reactive* • Hypersomnia • Increased appetite and weight gain • Somatic complaints • Extreme sensitivity to rejection (e.g., falsely perceived putdown or criticism) resulting, for example, in difficulties maintaining relationships.	• Anhedonia • Lack of affective reactivity • Psychomotor agitation or retardation • Diurnal variation of mood (worse in the morning) • Early morning waking

*Ability to be momentarily cheered up in response to positive events (e.g., visit by peers).

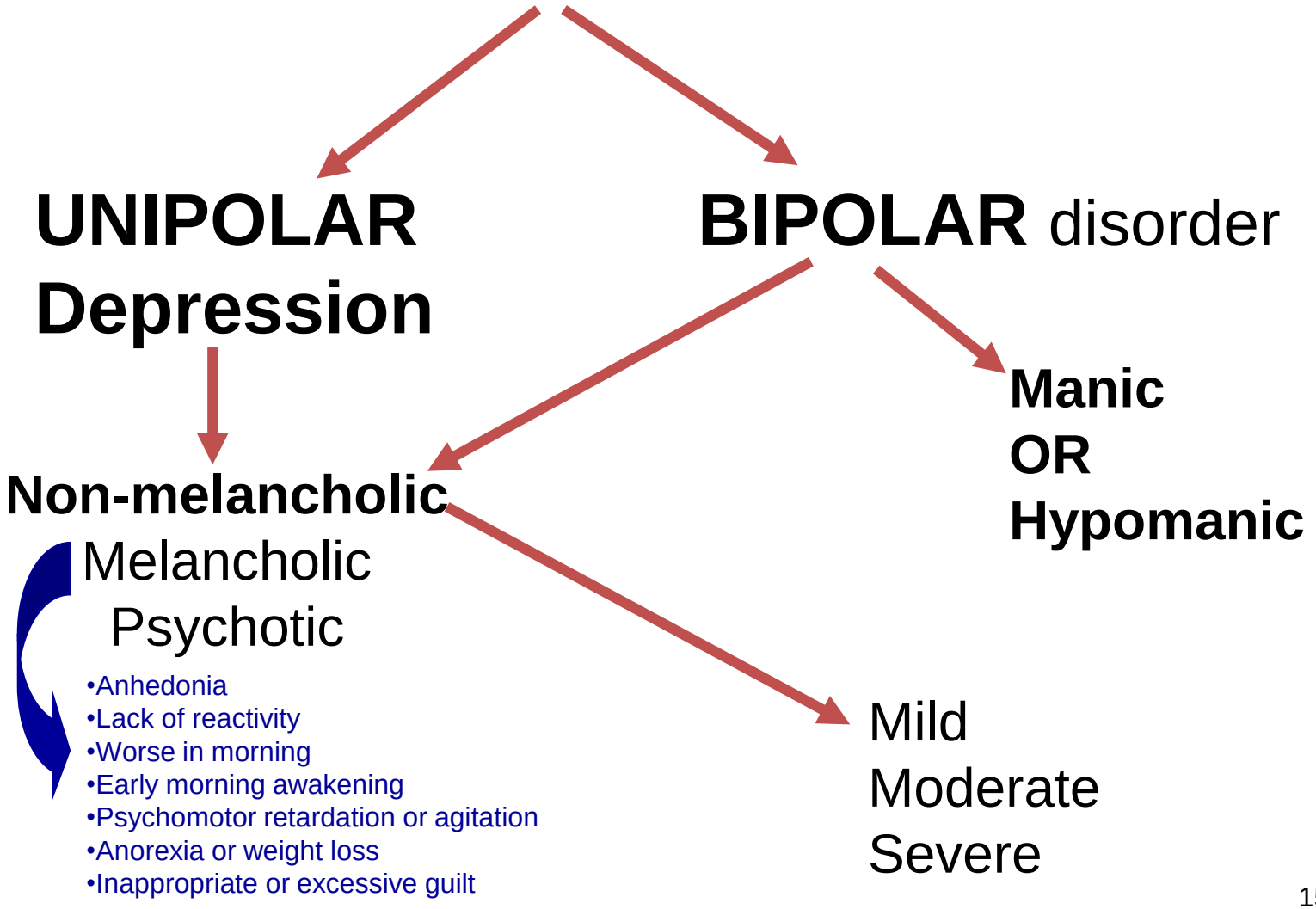


Course:
Depression in Children and Adolescents

- Recurring, spontaneously remitting
- Average episode: 7-9 months
- 40% probability of recurrence in 2 yrs
- 60% likelihood in adulthood
- Predictors of recurrence:
  - poorer response, greater severity, chronicity, previous episodes, comorbidity, hopelessness, negative cognitive style, family problems, low SES, abuse or family conflict

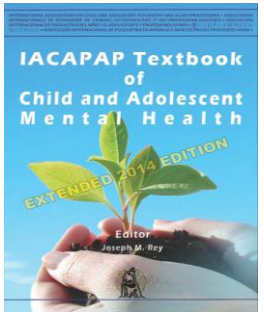


TYPES OF DEPRESSION

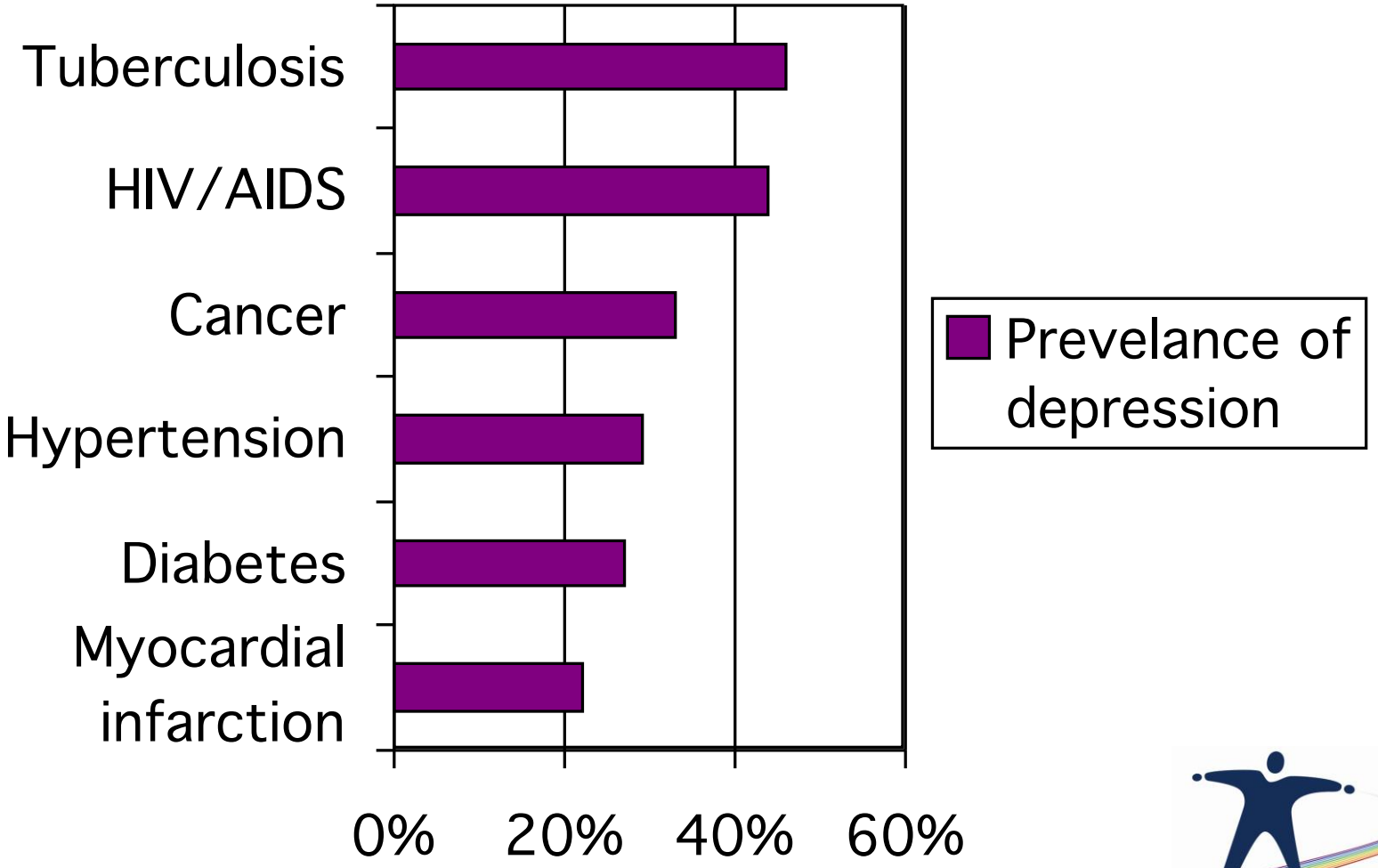


Etiology: Depression in Children and Adolescents

- Genetics
- Prenatal factors
- Family relationships
- Cognitive style
- Stressful life events
- Lack of parental care and rejection
- Physical illness (see following slide)

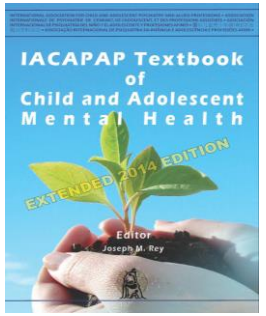


Average prevalence of depression in people with physical diseases (70 countries)



Comorbidity (n.b. up to 50%): Depression in Children and Adolescents

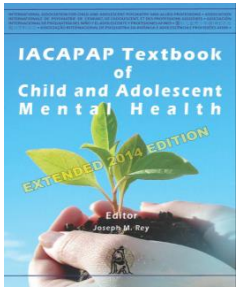
- Anxiety disorders (very common!)
- Post Traumatic Stress Disorder
- Conduct problems
- Attention Deficit Hyperactivity Disorder
- Obsessive Compulsive Disorder
- Substance abuse
- Learning difficulties



Suicidal Behavior: Depression in Children and Adolescents

- Suicidal thoughts:
  - 1/6 girls
  - 1/10 boys
- 100:1 ratio of attempts to completions
- 60% depressed youth have thoughts of suicide
- 30% depressed youth make a suicide attempts
- Risk factors:

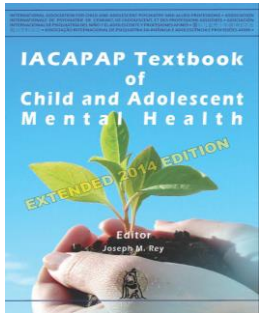
  family history, previous attempts, comorbidities, aggression, impulsivity, access to lethal means, negative life events



Diagnosis:
Depression in Children and Adolescents

- Core symptoms
- Associated symptoms
- Pervasiveness
- Duration
- Impairment or distress

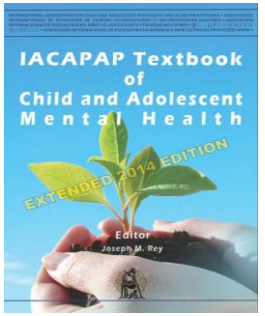
Symptoms are often hidden from parents. See young person alone and with parent.



Cross-Cultural Differences: Depression in Children and Adolescents

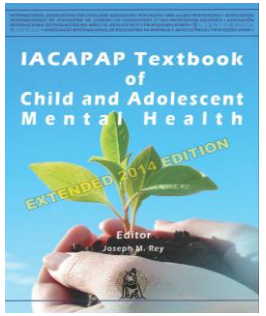
- Afghanistan – more passive death wishes
- Japan – more difficult to express emotions verbally
- China – express boredom, pressure, dizziness
- Turkey – guilt feelings related to SES not religion
- Hispanic populations – somatizations

And in your country?



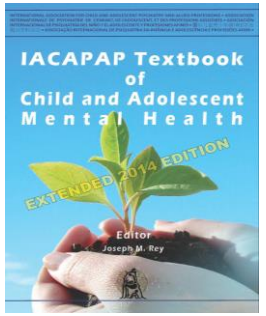
Medical Differential diagnosis: Depression in Children and Adolescents

- Medications
- Substances of abuse
- Infections
- Neurological disorders
- Endocrine



Psychiatric Differential Diagnosis
Depression in Children and Adolescents

- Unipolar vs. bipolar
- Psychotic depression vs. schizophrenia
- Depression vs. substance use
- Depression vs. adjustment disorder with depressed mood
- Depression vs. demoralization from disruptive disorders



Further Differentials/Consideration Depression in Children and Adolescents

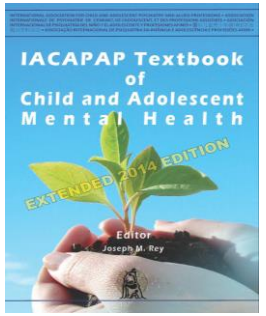
- Bereavement, loss or trauma within the past two months
- Parental mental health issues
- Severe marital discord or recent divorce
- Domestic violence
- Child abuse or neglect
- Severe bullying or exclusion by peers
- Severe deprivation or poverty

Free Rating Scales: Depression in Children and Adolescents

- ❖ PHQ-A: Patient Health Questionnaires-- Adolescent
- ❖ SDQ: Strengths and Difficulties Questionnaire
- CES-DC: Ctr. for Epidemiologic Studies-Depression Scale
- MFQ: Mood and Feelings Questionnaire
- DSRS: Depression Self-Rating Scale
- KADS: Kutcher Adolescent Depression Scale

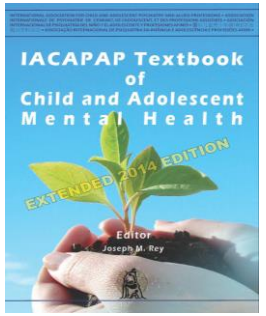
❖ Amharic versions available

(check for PHQ-A, PHQ -9 is widely used)

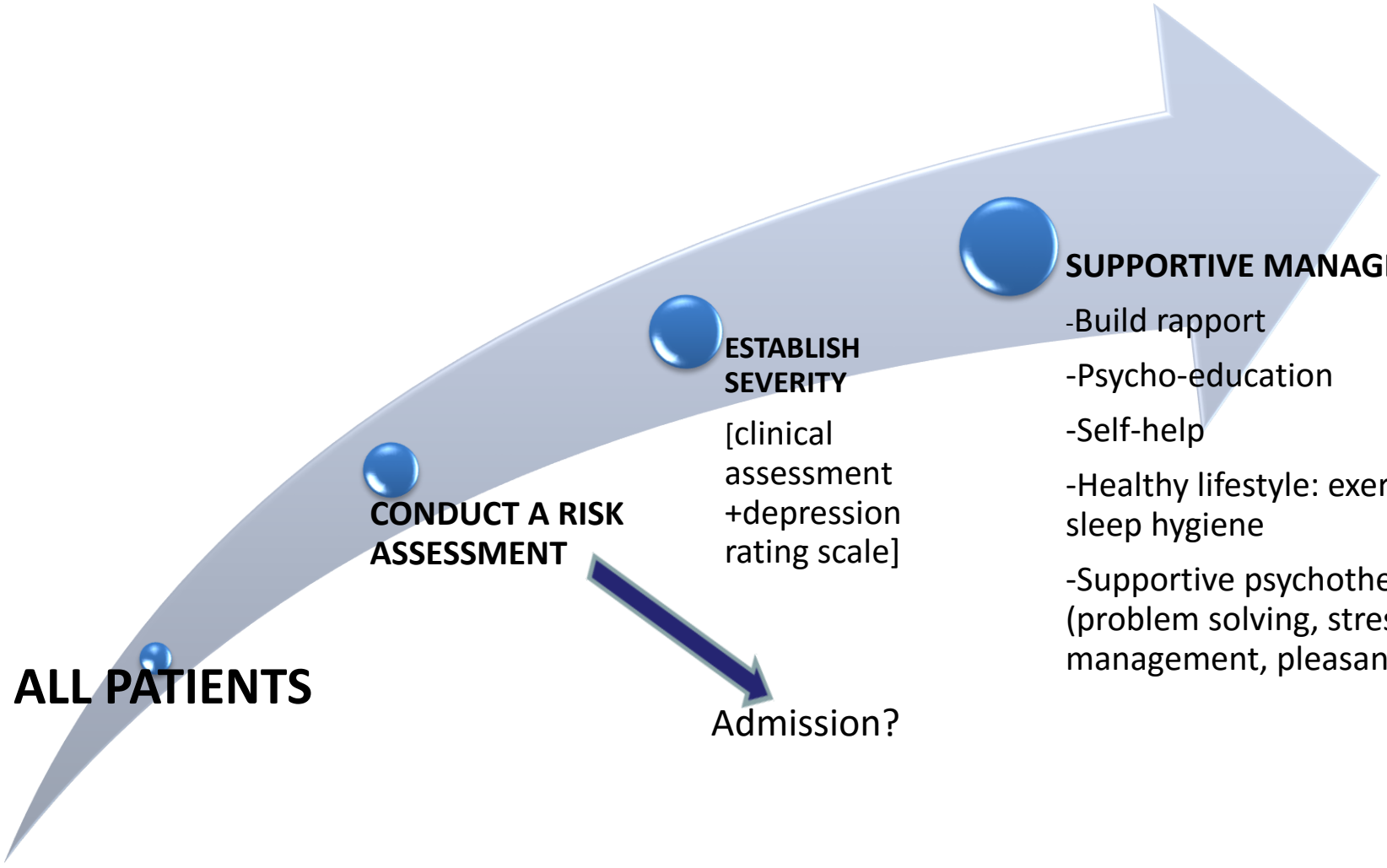


Treatment Aims: Depression in Children and Adolescents

- Reduce symptoms and impairment
- Shorten episode
- Prevent recurrences



PRINCIPLES OF MANAGEMENT FOR ALL CASES
Depression in Children and Adolescents



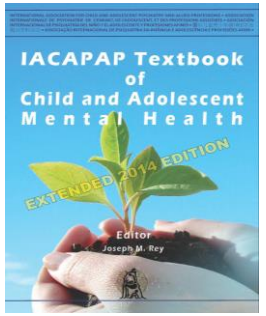
What works? Evidence based treatments
Depression in Children and Adolescents

Most robust evidence of effectiveness for:

- Medication (moderate and severe depression)
  - Fluoxetine (best evidence in adolescence)
  - Do not use TCAs in child/adolescent depression
- Psychotherapy
  - Cognitive behaviour therapy (CBT)
  - Interpersonal psychotherapy (ITP)

Medication: Depression in Children and Adolescents

- Strong placebo effect
- Evidence different for adults
- Key aspects for informed consent
- Undertreatment is common
- Most evidence for Flouxetine (SSRI) from WHO-list of essential medicines

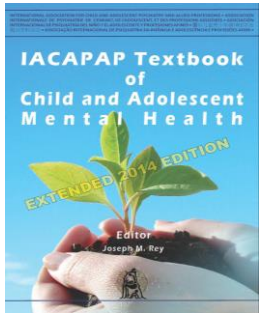


When to refer/consult with 3rd line services Depression in Children and Adolescents

- Depressed patient is pregnant or breastfeeding
- Persisting suicidal plans/serious thoughts
- Suspected bipolar disorder/manic conversion
  - If no 3rd line specialist available consult mhGAP BPD
- Psychotic depression
  - If no 3rd line specialist available consult mhGAP PSY
- Treatment resistance after 2 EB treatments

Prevention: Depression in Children and Adolescents

- Cognitive restructuring
- Social problem-solving
- Interpersonal communication skills
- Coping
- Assertiveness training



Assessment Skills training

MODERATE TO SEVERVE DEPRESSION IN CHILDREN AND ADOLESCENTS

Recap: Practical tips from mhGAP
What are the common features of depression?

- **For at least 2 weeks, has the person had at least 2 of the following core depression symptoms:**
  - Depressed mood (most of the day, almost every day), *(for children and adolescents: either irritability or depressed mood)*
  - Loss of interest or pleasure in activities that are normally pleasurable
  - Decreased energy or easily fatigued

- **During the last 2 weeks has the person had at least 3 other features of depression:**
  - Reduced concentration and attention
  - Reduced self-esteem and self-confidence
  - Ideas of guilt and unworthiness
  - Bleak and pessimistic view of the future
  - Ideas or acts of self-harm or suicide
  - Disturbed sleep
  - Diminished appetite

Recap: Practical tips from mhGAP

Does the presentation change if the person is a child or adolescent?

- Presentations vary according to the age of the child
- Children may present with more somatic symptoms
- Eating and sleeping difficulties are common in young children
- Older children may have trouble with school performance or play less than usual
- Adolescents may express feelings of sadness, boredom or inadequacy

Role-Play Assessment
Depression in Children and Adolescents

Sarah, a 13 year old girl was admitted to pediatrics the previous night after having taken an overdose of bleach. She is now medically fit for discharge. You are the resident the following day and you are asked whether it is safe to discharge her and whether she needs any follow-up. Her parents are about to arrive.

Role-Play: Assessment
Depression in Children and Adolescents

Form groups of three – choose one role each:

- **The physician**: assess patient for depression, screen for suicidal risk
- **The patient:** play a depressed patient using experiences of own cases as much as possible. You are depressed but no longer suicidal.
- **The assessor:** Using the record sheet check whether all areas of assessment are covered

Role-Play: Assessment
Depression in Children and Adolescents

Stay in your group of three:

- **The assessor > You are now the physician:** Summarize and present the case you just heard to your two colleagues. Take no more than 10 minutes. End with a formulation.
- As colleagues measure timings and add any missing information

Role-Play: Assessment
Depression in Children and Adolescents

Stay in your group of three:

- **The patient > You are now the physician:** Present a management plan for further diagnostic procedures to your colleagues.
  - Which medical causes for depression do you want to exclude? Specify any physical examinations and lab investigations you might do.
  - Which psycho-social factors do you want to assess? Specify the most important aspects of the history to take from parents.
- As colleagues add any missing information

Treatment and Management Skills training

MODERATE TO SEVERVE DEPRESSION IN CHILDREN AND ADOLESCENTS

N.B. FURTHER TECHNIQUES WILL BE PRACTICED IN OTHER SECTIONS

Practical tips from mhGAP
What is psychosocial support?

- Psychoeducation
- Addressing current psychosocial stressors
- Reactivating social networks
- Communicating well can be a form of support in itself
  - Be genuine and respectful
  - Listen well and show your understanding

Practical exercise from mhGAP
Questions for group: psycho education

1. What would you tell Sarah and her parents about her condition?

2. What advice would you give her?

3. What would you tell her and her parents about antidepressant treatment?

Practical tips from mhGAP
RECALL: Addressing psychosocial stressors

- Offer the person an opportunity to talk in private
- Ask about current stressors
- Ask about available resources for support
- Assess for abuse (e.g. domestic violence) and neglect
- Brain storm together for solutions or for ways of coping
- Involve supportive family members as appropriate
- Encourage involvement in self-help and family support groups

Practical tips from mhGAP

How do you address psychosocial stressors in children and adolescents

» **In children and adolescents:**

- Assess and manage **mental, neurological and substance use problems** (particularly depression) in parents (see mhGAP-IG Master Chart).
- Assess **parents' psychosocial stressors** and manage them to the extent possible with the help of community services/resources.
- Assess and manage **maltreatment, exclusion or bullying** (ask child or adolescent directly about it).
- If there are **school performance problems**, discuss with teacher on how to support the student.
- Provide culture-relevant parent skills training if available. **» INT**

Addressing psychosocial stressors in parents

If time watch the last video on this website:
“Supporting a parent with many social problems”

http://www.open.edu/openlearnworks/mod/oucontent/view.php?id=51898

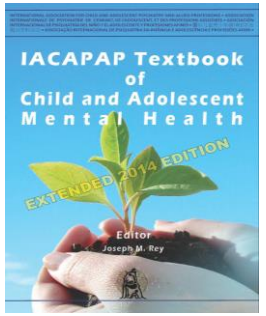
Practical tips from mhGAP
Reactivate social networks

- Identify social activities that provide psychosocial support
  - family gatherings
  - outings with friends
  - visiting neighbors
  - sports
  - community activities
- Encourage the person and family to pursue these activities as they can be effective in helping a person overcome depression
- Help them to choose one activity to try next week

Advanced Treatments: Cognitive Behavioral Therapy: Depression in Children and Adolescents

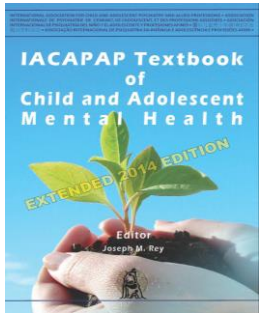
- Identify links between mood, thoughts, activities
- Challenge negative thoughts
- Increase enjoyable activities
- Build skills to maintain relationships

Discuss behavioural activation as a basic CBT technique suitable for depression



Advanced treatments: Interpersonal Psychotherapy: Depression in Children and Adolescents

- Similar to CBT
- Focus on the present
- Premise=Interpersonal conflicts→ loss of social support→ depression
- Improvement of interpersonal skills
- Psychoeducation about depression
- Increase enjoyable activities

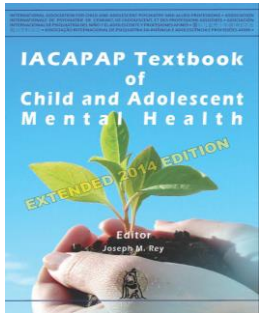


Evidence-Based Psychotherapy: Depression in Children and Adolescents

- Cognitive Behavioral Therapy (CBT)
- Interpersonal Psychotherapy (IPT)

For more information

Watch Neal Ryan youtube clip: https://www.youtube.com/watch?v=DT6biKxqotw

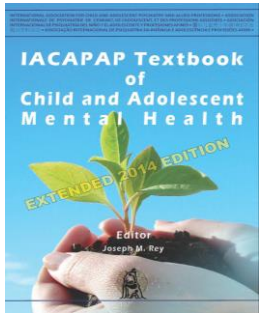


Practicalities antidepressant treatment Depression in Children and Adolescents

- Begin SSRI fluoxetine
  - Start with 10mg of fluoxetine (or 20mg every 2 days)
  - Increase to 20mg after one week
  - In adolescents to 30-40mg if little response after 6 weeks
- Warn about delayed action (2-6 weeks)
- Warn about potential serious side-effects
  - Emergence of suicidal ideation
  - Mania (teach family to identify symptoms)
- Warn about withdrawal symptoms on missing doses
- Monitor weekly for 1st month then less frequently
- Continue treatment 6 months after recovery

Adverse Side Effects of SSRIs: Depression in Children and Adolescents

- **Suicidality* - ca. 2%**
- **Manic switch**
- Akathisia
- **Agitation**
- **Irritability**
- Disinhibition
- Nightmares/sleep disturbances
- **Gastrointestinal**
- Weight gain
- Sexual Bleeding



Monitoring adolescents on antidepressants: Depression in Children and Adolescents

- Manic conversion: Stop medication immediately
- Marked/prolonged akathisia
  - Consider 5-10mg diazepam (max. for 1 week)
- Poor adherence:
  - Check reasons: side effects, costs, availability, beliefs
- Poor response:
  - review Dx, co-morbidity, social adversity
  - Increase dose (max. 30-40mg for adolescents)
  - Add other treatment (e.g. IPT/CBT)

Discussion of own cases
Depression in Children and Adolescents

- Read report or view video of patient or family submitted by participant
- Discuss:
  - Assessment: What is the differential diagnosis? What assessment would you suggest to confirm?
  - Management: What management do you suggest? If that doesn't work, what would you do next?
- Patient management problems:
  - Do you have any questions about the management of depression in patients you have encountered?

Any Questions?

WHAT WILL YOU DO NEXT WEEK TO IMPLEMENT WHAT YOU LEARNED?