



DEPRESSION AND ANXIETY FUTURE OF PEDIATRICS

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OVERVIEW

○ Anxiety

- Types
- Presentation
- Description
- CAMS study
- Medication and CBT

○ Depression

- Epidemiology
- Presentation
- Diagnosis
- Suicide
- Treatment
- TADS
- Relapse



ANXIETY DISORDERS IN CHILDREN AND ADOLESCENTS

- Specific Phobia
- OCD
- Separation Anxiety Disorder
- Generalized Anxiety Disorder
- Social Phobia
- Acute Stress Disorder
- Post-traumatic stress disorder
- Panic Disorder



WHAT TO LOOK FOR

- **Physical complaints – headaches, stomach aches, dramatic presentations of pain.**
- Problems with falling asleep and middle of the night awakening, repeated visits to parents room
- Eating problems
- Avoidance of outside and interpersonal activities – school, parties, camp, sleepovers, safe strangers
- Excessive need for reassurance – new situations, bedtime, school, storms, bad things happening
- Inattention and poor performance at school
- Not necessarily pervasive – some areas of function remain



PHYSICAL SYMPTOMS – PROVOKED AND SPONTANEOUS

- Anxious children listen to their bodies
- Headache
- Stomachache – stomach and bowel problems
- Sick in the morning and can't fall asleep in the evening
- Frequent urge to urinate or defecate
- Shortness of breath
- Chest pain - tachycardia
- Sensitive gag reflex - fear of choking or vomiting
- Difficulty swallowing solid foods
- Growth inhibition
- Dizziness, lightheaded
- Tension and tiredness – exhausted and irritable after a school day
- Derealization and depersonalization
- Avoidance to prevent above physical symptoms



ANXIETY IS NOT A GREAT TERM

- Excessive interpersonal sensitivity
- Fear
- Apprehension
- Dread
- Excessive self-consciousness or shyness
- Worry



CHILD/ADOLESCENT ANXIETY MULTIMODAL STUDY (CAMS)

- NIMH-funded
- SAD, GAD and SoP, N=488
- 12 weeks; COMB vs Med vs CBT vs PBO
- Results
 - COMB 81%
 - CBT 59%
 - SRT 56%
 - PBO 24%



OTHER CAMS OUTCOMES

- Younger kids with anxiety do best with all treatments..
- Medication is well tolerated, but younger kids also have more side effects – endpoint dose **SRT 130-40 mg/day (highest safe dose)**.
- Technical expertise required for optimal dosing or risk **under treatment and poor outcome**
- Adolescents likely require psychosocial rehab.



CBT FOR PRIMARY CARE PROVIDERS

- The Anxiety Triad
 - Thoughts, feelings, behavior
- Can impact all three by starting with any one
 - Thoughts – anxious bias to neutral event
 - Feeling – discomfort and distress
 - Behavior – avoidance
- If you change the behavior the feelings and thoughts will follow.



KEY ELEMENTS FOR TREATMENT

○ Child buy in

- Anxiety is a problem that can be fixed, no need to suffer
- Identify how child is negative affected by anxiety – how it gets in the way.
- Make a friend – give the child credit when they are doing things even when it is very difficult for them.



CBT FOR PRIMARY CARE PROVIDERS

○ The Behavior Plan

- Make a list of things avoided
- Make a plan to do the simple things first
- Progress to more difficult challenges
- Lots of praise and support



DEPRESSION EPIDEMIOLOGY

- Childhood – 0.4 -2.5% prevalence
- Increases with age up to 4-8% in adolescent
- Cumulative incidence of major depression during adolescence is 15-20%
- Childhood female: male 1:1 Adolescents 2:1
- USPSTF recommends screening of adolescents (12-18) for major depressive disorder when systems in place
to ensure accurate diagnosis, psychotherapy and follow-up. B recommendation (March,2009)



PRESENTATION OF DEPRESSION

○ Young Children

- Physical complaints
- Depressed or irritable mood
- Withdrawn and sad appearance

○ Adolescents

- Commonly grouchy and sulky
- Restless
- Withdrawn
- Slowed physically
- Lack of enjoyment in activities



DIAGNOSTIC INTERVIEW

- Goal to establish diagnosis and assess severity
- Categories of questions:

General- things at home, school, friends, changes

Mood- negative, irritable, sad, hostility, mood reactivity

Anhedonia- boring, uninteresting, loss of initiation and participation

Physical- sleep, appetite, energy, discomforts, weight

Cognitive/Psychological/Social-concentration, apathy, self-critical, social isolation

Suicidal Ideation- morbid thought

Functional Impairment- symptom impact



SUICIDE ASSESSMENT

- Questions from general to specific:

I am wondering how bad things have got?

Have there been times when things felt completely hopeless?

Have you ever had times when things felt so bad you wished yourself dead?

Have you ever thought about harming yourself?

Have you ever tried to harm yourself?

Do you have thoughts of harming yourself at the moment?

Is it just a thought or do you actually have a plan?

What would you do?

What would stop you?



RISK FACTORS FOR SUICIDE

○ Individual

1. Psychiatric disorder including depression, anxiety, substance abuse and conduct disorder
2. Feelings of hopelessness, self-blame
3. Impulsivity and poor problem solving skills
4. Abuse – physical and sexual
5. History of self-harm (30%)



RISK FACTORS FOR SUICIDE



○ Family

1. Communication problems within family
2. Family history of mental illness
3. Parental divorce

○ Environment

1. Academic problems
2. Bullying
3. Difficulty in relationships esp. with peers
4. Sexual identity
5. Exposure to suicide or suicide attempts in friends



TREATMENT

- Supportive Therapy
- Pharmacotherapy – SSRI approved –fluoxetine, and Lexapro
- CBT – Cognitive Behavioral Therapy – 5 components
 - Mood monitoring-Relaxation techniques-
 - Cognitive Restructuring-Problem solving Skills-
 - Communication
 - Social engagement
- Treatment for Adolescent Depression Study (TADS) 440 mod. depressed teens – response
 - CBT-43.2%,Fluoxetine 60%, Combo-71%

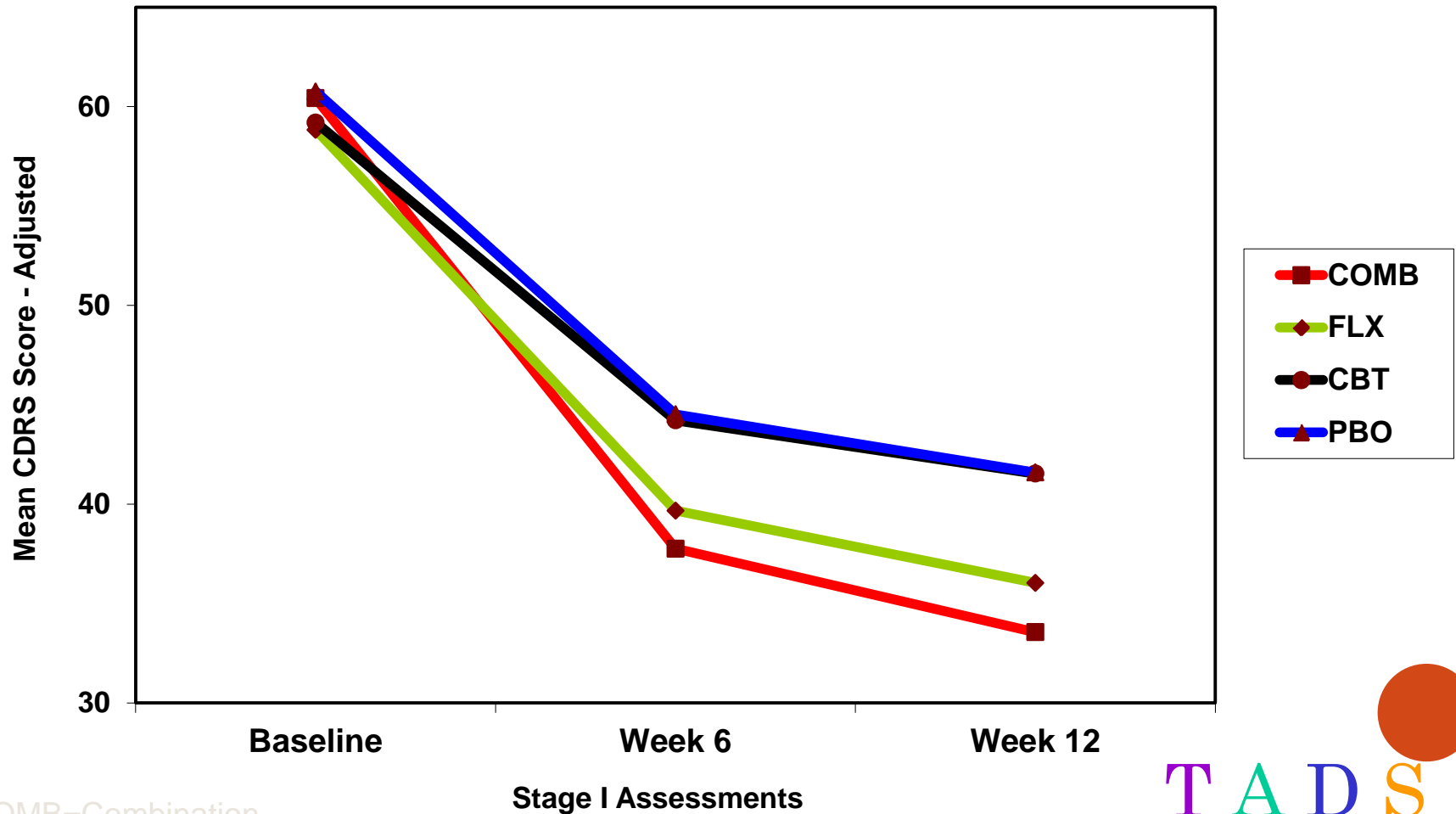


TREATMENT

- CBT weekly, individual, some family, education
- Pharmacotherapy –fluoxetine 10-40 mg first 12 weeks, up to 60 mg thereafter
- Combination
- Placebo



Children's Depression Rating Scale



COMB=Combination

TADS

RELAPSE PREVENTION

- Due to very high rate of relapse, length of therapy in general 6-12 months
- Patient should be seen monthly to assess functioning, remission status and if taking medication side effect and compliance monitoring
- Goal is complete resolution of symptoms to minimize sub-syndromal depression and recurrence
- Discontinuation of therapy should be at low stress time such as summer



QUESTIONS

