

Medical Home Telephone Conference
May 23, 2006

Depression and Anxiety in Children and Teens
**Lisa Samson-Fang, MD and Doug Grey, MD –
Director of Pediatric Psychiatry**

Childhood anxiety tends to be grouped together but it's important to look at specific anxiety disorders for each child. It is not uncommon for children to have two or three anxiety disorders together, but many times they have just a single anxiety disorder. The common anxiety disorders and the screening questions are:

Separation Anxiety: Does your child have stomachaches in the morning before school but not on weekends, do they panic when you leave them with babysitters.

Generalized Anxiety Disorder: Does your child worry more than other children, do they lay awake at night having trouble sleeping because of worries, are they tense and have trouble relaxing.

Post Traumatic Stress Disorder – Has the child had any trauma, (physical abuse, sexual abuse, a car accident).

Obsessive Compulsive Disorder: Washing, checking and counting. Does your child wash their hands over and over until their hands are raw, do they check the front door over and over worrying about burglars, do they count things such as counting tiles in a ceiling while waiting for you. Some children don't have compulsions but have ideas or images stuck in their heads that irritate them.

Panic Disorder: Does your child have five or ten minutes when anxieties are overwhelming and their heart pounds and their hands shake.

Phobias: Most parent and children know what phobias are.

Social Phobia: Do they have trouble talking at school, do they dread getting up in front of class, do they fear being the focus of attention.

If a Doctor gets some positive answers you can always look at the DSM criteria and go through those with the parents.

In terms of age, you generally see Separation Anxiety in young children (Kindergarten, 1st Grade, 2nd Grade), Panic Disorders you will see in older children, (15-18 years), Generalized Anxiety you can see at any age.

The primary treatment for anxiety is Cognitive Behavior Therapy. There is a 7-year follow up study on Cognitive Behavior Therapy and the results are good. However, that therapy is not available everywhere.

Lisa Samson-Fang asked: Can you help us, as pediatricians, understand what would happen in Cognitive Behavior Therapy?

Dr. Grey answered: It is usually done in a group or individually. You look at various specific situations. You break down the thoughts, feelings and behaviors that occurred

in those instances and write those down on paper. Patients have what they call “automatic thoughts”. You review those automatic thoughts and think about other possibilities and then train patients how to broaden the possibilities and not let anxieties get them into all or none thinking.

Cognitive Behavior Therapy (CBT) also involves homework. Patients are assigned projects that give them feedback. CBT is a way of examining thoughts and feelings to keep from having either all or none thinking or depressive thinking. CBT is most effective with 15 year olds, 18 year olds or 22 year olds rather than little children who are not interested in mental processes. If you have a 15 year old with bad anxiety, CBT can be a very powerful tool.

Medications: They will use SSRIs. Three are approved for OCD; Luvox, Prozac and Zoloft. No approvals for SSRIs for other types of anxieties. For Generalized Anxiety Disorder, SSRIs can be very helpful. For Generalized Anxiety or Sleep problems they will use an older medicine called Imipramine or Tricyclates or Benzos. They are cautious of substance abuse; they make sure there is no substance abuse in the family. Some children get disinhibited with Benzos. Behavioral treatments are hard on children so parents and doctors need to have empathy for them.

Questions:

Mike with the Redwood Clinic: He sees a lot of adolescents with depression and wondered how often a doctor should see a patient, weekly, monthly? Some children need it more than others.

Dr. Grey: Most psychiatrists can't see patients every week for three or four weeks, unless you are trying to keep a patient out of the hospital. For routine patients, who you expect to do well or don't have a lot of risk factors, it seems unnecessary. When you prescribe SSRIs to adolescents, there are 2% that get worse. Most of them are children who have bipolar disorder, but instead of presenting initially with mania or mood swings, their initial presentation is depression. To sort this out, if you are treating a child from depression with a SSRI what you want to do is ask about a family history of bipolar because that would be the child you want to see every week. But since families sometimes don't know, ask them if someone in their family had ECT or has had a nervous breakdown and had to be hospitalized and the family didn't know why. If there was a family member with either of those histories, those are red flags for Bipolar Disorder and if the child has had mood swings, but now is depressed, that is the child you want to see every week. One way around that is if you feel the patient needs a therapist or can benefit from a therapist and can see a therapist weekly. Give the therapist your email and if there are any problems have the therapist contact you and then you can see the child. In 14 industrial countries, when the use of SSRIs went up exponentially the suicide rate went dropped after steadily rising for decades. In the United States the suicide rate for teens doubled, tripled and quadrupled from 1960 to mid 1990s. In the mid 1990's the use of SSRIs went up four-fold in children and adolescents and the suicide rate dropped for the first time in decades. While 2% of children get worse on SSRIs the overall effect is that it reduces suicide risk and

completed suicides. As with any medical procedure, sometimes there is a higher focus on risks, so the 2% gets a higher focus based on the kind of anti-psychiatry movement out there.

Mike from Redwood Clinic: Would you treat that similarly if you had an adolescent that seemed to be more anxiety predominant?

Dr. Grey: Would start with a SSRI, do the same thing and get good family history. He finds in children that he treats, initially they may be dealing with depression and then the next thing he sees with them is explosive blowups. Typically these are children that are bipolar who haven't shown their colors yet. If you talk to adults that are bipolar, 50% of them say they started with the depression.

Jeff Schmidt: Do you have any instruments, questionnaires that you recommend? IHC has the mental health integration packet that is helpful. Do you have recommendations in that regard?

Dr. Grey: There are specific measures for ADHD, anxiety and depression and the psychologists are the experts in that area so he turns to them for the work measures used in his clinic. For pediatric practice or family practice, he prefers the Youth Outcome Questionnaire (YOQ) that is a 64- item scale filled out by a parent and can be used from one setting to the next. It doesn't measure for a specific diagnosis; it's like the vital signs of psychiatry. If you have schizophrenia that's getting worse, the YOQ goes up. If you have anxiety that gets worse, the YOQ goes up. The YOQ measures the stress and dysfunction, it doesn't matter which mental illness you're dealing with. He will be implementing the YOQ into the juvenile court system to determine which children have mental illness and treat them and then use it to follow them to make sure they are getting better and make sure they get intervention.

Dr. Samson-Fang: Is that something you can use with a 15 year for a well-child visit as a way of screening?

Dr. Grey: Yes. Have parents fill out the YOQ and look at what items are scored and use it to ask the right questions.

Dr. Samson-Fang: She and Barbara Ward will looking into getting information on the Youth Outcome Questionnaire and emailing out to everyone.

Barbara Ward: Children With Special Health Care Needs uses it already.

Jeff Schmidt: In terms of making the diagnosis are you still using the DCM for criteria and do you have questionnaires to help guide you and have psychologists help.

Dr. Grey: For diagnosis, he likes to get the parents view and the child's view. If a patient has seen a psychologist, he gets those records. If there is a resource teacher that knows the child well, he will ask for copies of those records. If he gets confused

about diagnosis or it's a difficult take he will have a psychologist do testing around the issue of diagnosis. In child and adolescent psychiatry, it takes a lot of time, but it gives him an advantage to look at a child at different angles. The most important part is the longitudinal history. An example of this is a child whose parents are divorcing and is experiencing anxiety, if you take the longitudinal history you may find that the child had very bad anxiety even when the parents got along – then it may be more biological. But, if the child's anxiety was low before the divorce, then they may be more inclined to psychotherapy.

Greg Nielson: For Panic Disorders specifically, do you use SSRIs? What is your approach to that?

Dr. Grey: Overall the best long-term treatment is a SSRI. However, panic is unique. Sometimes with a SSRI, panic attacks will get worse for one to two weeks and then they will get better. Sometimes you can make the person worse initially. What he does is start the person with a Benzo like Clonazepam, which is the least addicting of all the benzos, the long half life and there is not euphoria, and he will get their panic attacks under control within the first week or so. Then he will start a SSRI and get the dose up and within three or four weeks when they are doing well he will wean them off of the benzo. Some people need both, but often if you get a good dose of SSRI it will take care of panic attacks or at least reduce them significantly. There are some people who do well but once every month or two they end up in a situation such as getting on a plane or giving a speech where they can feel anxiety bubbling up. So unless the patient has trouble with substance abuse or a strong family history of substance abuse, he will give them 10 pills of Zanax to use over a six-month period. This gives them security in knowing that if they get in a situation where their heart starts pounding and they get sweaty they can step in a restroom take one Zanax and feel comfortable.

Barbara Ward: Dr. Builder said that if you had a patient with a history of Bipolar in the family that you should not start an SSRI. Is that your feeling as well?

Dr. Grey: I think she might mean that the pediatrician or family doctor would be better off sending the patient to a child psychiatrist because if you start the SSRI and they start having mood swings or get suicidal it might be good to have someone who has privileges to get them into psychiatric hospital or who could quickly get them started on some bipolar medications. If a patient has a very strong history of Bipolar in the family the parents may have seen some behavior that was erratic and concerning in the past and now the child is depressed. That might be a patient you would want to refer or else follow them closely, even weekly and pull them off meds if they go the wrong direction. There are children with a parent who is bipolar and they may get depressed and respond to antidepressants.

Dr. Samson-Fang: What is the youngest you can see anxiety disorder? Some kids are very resistant to being left alone in bed. How young do you think we can see manifestations of anxiety?

Dr. Grey: With younger kids we are more apt not to use medications or at least try everything else first. With young children he likes to set up what he calls "boring routines" that means reading the same book at the same time every night. Give them a bath an hour before every night. With a lot of the younger children who have anxiety, parents should get them into really boring routines every night where it's very predictable and while it may not be fun for the parents, it really seems to settle down some of the children. The younger a child is, the more inclined he is to work on environmental things first.

Dr. Samson-Fang: But probably the best push to separation anxiety at night would be to not say "cry yourself to sleep."

Dr. Grey: I don't think so. One fun thing to do like with grade school kids is set up a behavior program with some rewards that they really want to earn. The first thing they do is sleep in the parent's bed, then the next thing is sleep in a sleeping bag next to the parent's bed, the next thing is sleep in a sleeping bag on the other side of the room, the next is to sleep in a sleeping bag in the hallway in front of mom and dad's room, then just move the sleeping bag down the hall every two nights but in the process they are earning rewards. Sometimes you can gradually move that sleeping bag to their bed. It is nice to get them in their own bed and have them get a sense of security. Another thing he likes to do is to put them in their bed and then check on them; 5 minutes, 5 minutes, 10 minutes, 10 minutes, 15 minutes, 15 minutes, so they know you are going to come by to check on them and they have that security of knowing they are going to be checked on. Yet you keep them in their bed. It is hard when they get up in the middle up the night and come to your bed because you are sometimes too tired to do anything.

Attendees: Lisa Samson-Fang, Barbara Ward, Al Romeo, Chuck Norlin, Kathy Heferin, Jeff, Linda Cooper-Smith, Wendy, Avish, Budge Clinic, Bear Care, Clinic 6 U of U, South Main, IHC Sandy, UVP Cherry Tree, UVP Plaza Office, UVP Timpanogos, Montezuma Creek Pediatrics McKay Dee, Redwood Clinic, Park City

Next Phone Conference is June 27, 2006