BRIEF INTERVENTIONS: DEPRESSION (assuming no suicidality)

BI-PED PROJECT (BRIEF INTERVENTIONS: PEDIATRICS)
Emotional Health Committee Maryland Chapter American Academy of Pediatrics

Sharon Richter D.O.

The primary care clinician has many first line options in actively providing care for the depressed child or adolescent:

- **The diagnosis of depression can be made with a good behavioral history (see Behavioral Interview module) and the use of validated depression questionnaires such as the PHQ-9 Modified for Adolescents in combination with ASQ (Ask Suicide Screening Questions), CES-DC, CDS Teen**

- **The next step after diagnosing childhood or adolescent depression is to provide education to the child and family about depression**

    a. **Depression is an *illness* (analogous to other forms of chronic disease with both exacerbations and remissions)**
        i. **Typical course is 9 months**
        ii. **20-40% relapse in 2 years, 70% relapse in adulthood**

    b. **Interpersonal therapy (IT) has been shown to be effective in treating depression in adolescents and cognitive behavioral therapy (CBT) have both been shown to be effective in treating depression in both children and adolescents**

    c. **SSRIs are the first line of pharmacologic treatment for depression. Fluoxetine has FDA approval for depression in children age 8 years and above and Escitalopram is approved for children age 12 years and above**

    d. **Seasonal affective disorder may be helped with a light box**

    e. **The goals of treatment are to:**
        i. **Shorten the acute episode and minimize impairment**

ii. **Facilitate remission and recovery**
iii. **Prevent recurrence**

f. **Address perpetuating factors:**
    i. **Family discord and personal stressors can exacerbate depression**
    ii. **Discourage harsh punishments, which can exacerbate depression**

- ***The basics: nutrition, exercise and sleep***
    a. **Emphasize the need for good nutrition**
    b. **Fish oil supplementation may be helpful**
    c. **Daily exercise may improve mood**
    d. **Ensure adequate sleep: recommended average sleep times (adapted from Ferber, "solving your child's sleep problems")**
        i. **>/= 17 years old: 8 ¼ hours minimum**
        ii. **14-17 years old: 8 ½ to 9 hours**
        iii. **9-14 years old: 9-10 hours**
        iv. **5-9 years old: 10-11 hours**

- ***Limit the amount of dysfunction caused by the depressive episode at school and home***
    a. **Keep teachers informed regarding the diagnosis and alert them to depression symptoms such as irritability which may be misinterpreted as disruptive behavior**
    b. **Consider working with the school to develop a 504 classroom accommodation plan**
    c. **Improve communication in the home and avoid arguments caused by a child with a depressed or irritable mood (see Communication module)**

- ***Help the patient to cope with depression***
    a. **Encourage the patient to list out and prioritize the things that are most bothering them and help them to problem solve how they will deal with these issues.**
    b. **Try to identify situations or stressors that lead to low mood and try to avoid them or learn to respond to them in a different way.**
    c. **Recount *positive* events that have happened during the day. The practitioner can also instruct parents to have their children tell them 1-2 good things for every bad thing that they mention**
    d. ***Journaling* may be helpful for adolescents; writing down concerns as well as writing something positive on a daily basis may help to put things into perspective**
    e. **Help the patient identify supportive family and friends that they are comfortable turning to when needed**

- ***Normalize activities*: advise *behavioral activation* that helps patients re-engage with rewarding meaningful activities**
    a. **Encourage activity and monitor mood**
        i. **avoid letting the patient stay home alone or spend excessive time in their room**
        ii. **make sure they go out and participate in fun activities or things that they do well**
        iii. **have them document their mood on a scale from 1- 10 before and after the activity**

- ***Encourage positive and pro-social behaviors***
    a. **Encourage the patient to do something good for someone else (help others) in a situation where they can receive praise**
        i. **Help a neighbor carry something, rake a lawn, shovel snow, walk a dog, watch a child (if mature enough), volunteer**
    b. **If the family has a pet, encourage the patient to take a more active role in caring for it (especially walking for exercise and daylight, or giving comfort to the pet)**

- ***Family Interventions***
    a. **Help parents understand that depression and the resulting behavior is *not* a choice their child is making that can be easily changed with logic or punishments**
    b. **Encourage marriage counseling if there is parental discord**
    c. **Identify parental depression and encourage treatment**
    d. **Improve communication in the family (see Communication module)**

- ***Manage daily behavior***
    a. **Limit internet use and monitor for cyber bullying and sexting**
    b. **Provide *positive reinforcement* for all positive behaviors (e.g. helping around the house, acting nicer to a sibling, re-engaging with school work, returning to sports, etc.) starting with 1-2 behaviors at a time**
    c. **Avoid punishment or harsh consequences**
        i. **Depressed children are more sensitive to criticism and negative consequences**
        ii. **Reframe the time out method as "quiet time to cool off", rather than as a punishment (use with 1, 2, 3 Magic technique- see Discipline module)**

- ***Establish a safety plan***
    a. **Inquire about *suicidality* in front of the parents to set an example for them and also inquire with the patient alone.**
        i. **Assess for suicidal ideation: "Do things ever get so bad you have thought about killing yourself?"**
        ii. **Does the patient have a plan? "What have you thought about doing?" and if so, assess means to stated plan.**
        iii. **Assess for history of suicide attempt and parents' response**
    b. **Suicide contract?: no evidence this works**
    c. **Remove or secure weapons (firearms), sharp objects, rope and ligature materials, medications and alcohol that are in the home**
    d. **If the patient has a plan and/or history of suicide attempt, consider immediate referral for psychiatric care**

e. **Keep in mind that many suicidal attempts particularly in younger teens are impulsive and therefore unexpected**

- ***Identify and address co-existing problems***
  a. **Is there an underlying *learning disability* resulting in stress due to poor academic performance?**
  b. **Identify and treat *co-morbidities* such as anxiety, ADHD or substance use- Relaxation training such as deep breathing, progressive muscle relaxation, and visual imagery may be helpful in reducing co-existing anxiety (see anxiety module)**

  c. **Identify and address *social skills deficits*- does the child have difficulty with peer interactions or being subjected to bullying? Parents can:**
     i. **Help improve play skills if needed by encouraging one on one activities with peers (with adult supervision for younger children)**
     ii. **Plan activities that are attractive to other children**

  d. **Assess whether contributory social determinants of health or adverse childhood experiences are posing a risk for depression**

- ***Help the patient to identify and address cognitive distortions***
  Some patients view their lives through a filter of cognitive distortions that lead to self-defeating, erroneous perceptions and conclusions. Patients with depression often have a pessimistic view that "anything that can go wrong will go wrong". They may predict negative outcomes regardless of contrasting evidence. This in turn may lead to a self fulfilling prophecy of negative outcomes which further reinforces the belief that things always go wrong.
  There are several common cognitive distortions seen in depressed patients:
  a. **<u>Overgeneralization</u> (i.e. "I *can't* make friends" , " I *always* mess up", "*No one* cares about me", " I can *never* be happy")**
  b. **<u>All or Nothing Thinking</u>: Patients with depression may place themselves in either/or categories. Failing a test makes them**

totally stupid, not being athletic makes them a total wimp, and being teased makes them a total loser.

c. **<u>Internal attributions for failures and external attributions for success</u>: A depressed girl may blame herself for the fact her team lost a lacrosse game. However, when her team wins, she downplays her part in the victory.**

The practitioner can help patients to *recognize* when they are using cognitive distortions.

i. The practitioner can *challenge* such thinking by asking questions such as "What evidence do you have that you always mess up? "Do you have any evidence to the contrary, that you can do things successfully?" "Can you think of a time when you did something well?"

ii.The practitioner can also instruct parents to have their children tell them 1-2 good things for every bad thing that they mention (and provide positive reinforcement for this)

- ***Assist families in seeking mental health resources* in the community and work to collaborate with mental health consultants. (see Making a Mental Health Referral module)**

  a. **Mental health referrals are appropriate if:**
     i. **patient has moderate to severe depression**
     ii. **patient is suicidal or engaging in risk taking behavior**
     iii. **parents are displaying significant marital discord or psychopathology**
     iv. **practitioner is not comfortable managing the patient**
     v. **patient or family request a referral**
     vi. **patient is not responding to brief primary care interventions**

<u>Reference:</u>

Lester T et al. Anxiety and Depression Treatment in Primary Care Pediatrics. *Pediatrics* (2023) 151 (5): e2022058846. <u>https://doi.org/10.1542/peds.2022-058846</u>