A TO Z: EVALUATION, ASSESSMENT & TREATMENT OF COMMON MENTAL HEALTH DISORDERS IN ADOLESCENTS

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LEARNING OBJECTIVES

- At the conclusion of this workshop, each participant will be able to:
  1. Understand the epidemiology of common mental health disorders in the adolescent population

  2. Identify and diagnose common mental health disorders in the adolescent population

  3. Utilize appropriate assessment tools to identify and classify adolescent mental health disorders

  4. Apply appropriate treatment regimens for adolescent mental health disorders

TOPICS COVERED TODAY

- Depression
- Anxiety
- Eating Disorders (Briefly)

POLL QUESTIONS

DEPRESSION & SUICIDE

EPIDEMIOLOGY

- Depression is the leading cause of disability for young people, aged 10-24
  - In 2020, 4.1 million adolescents aged 12 to 17 in the US had at least one depressive episode, 2.9 million had a severe impairment
  - In 2020, 41.6% with depression had received treatment in the past year, 46.9% with severe impairment had received treatment
- Adolescence is the lifetime peak period for the onset of major depressive disorder, >20% of adolescents will have an episode of depression in their lifetime
- Early onset diagnosis can lead to poor academic, occupational, and social outcomes
- Only 50% are diagnosed before adulthood, with 2 out of 3 not being diagnosed by PCP

EPIDEMIOLOGY

- 2019 Youth Risk Behavior Surveillance Survey (Nevada vs US Results)
  - 42.5% felt sad or hopeless, 36.7%
  - 18.4% seriously considered attempting suicide, 16.6%
  - 15.6% made a plan about how they would attempt suicide, 15.7%
  - 8.3& attempted suicide, 8.9%
  - 2.3% of suicide attempts resulted in an injury that needed treatment, 2.5%
- Prevalence is higher amongst adolescent females (25.2%) compared to males (9.2%)
- Highest age group 16-17 at 21.9%, mixed race 29.9%
- Suicide frequency increases in adolescence, the second leading cause of death in adolescents aged 15-19

RISK FACTORS FOR SUICIDE

- Psychiatric Illness
- Previous suicide attempt/behavior/ideation/NSSI
- Substance Abuse
- Social Stressors
- Sexual or physical abuse
- Sexual orientation/identification – LGBTQIA
- Bullying
- Unsafe home environment
- Relationship Discord – family, friends
- Poor Physical Health/Chronic Illness
- Family history of suicidal behavior
- Access to Firearms
- Media Exposure

Suicide Warning Signs

TALK

- Being a burden to others
- Experiencing unbearable pain
- Killing themselves
- Feeling trapped
- Having no reason to live

BEHAVIOR

- Increased use of alcohol or drugs
- Withdrawing from activities
- Giving away prized possessions
- Isolating from friends & family
- Looking for a way to kill themselves, such as searching online for materials or means
- Sleeping too little or too much
- Visiting or calling people to say goodbye
- Acting recklessly
- Aggression

MOOD

- Depression
- Loss of interest
- Irritability
- Anxiety
- Humiliation
- Rage

afsp.org/signs

American Foundation for Suicide Prevention

DIAGNOSTIC CRITERIA

- Depression – DSM-V Criteria
  - Experiencing ≧5 symptoms most of the day, nearly every day during the same 2-week period with one being either a (1) depressed mood or (2) loss of interest or pleasure
    - Depressed mood most of the day, nearly every day
    - Markedly diminished interest or pleasure in all, or almost all, activities
    - Significant weight loss or weight gain, decrease or increase in appetite
    - Slowing down of thoughts, reduction of physical movement, or constant movements (restlessness, sluggishness, fidgetiness)
    - Fatigue or loss of energy
    - Feelings of worthlessness, excessive or inappropriate guilt
    - Diminished ability to think or concentrate, or indecisiveness
    - Recurrent thoughts of death, active or passive suicidal ideation, suicidal attempt, plan for suicide

DIAGNOSTIC CRITERIA

- Depression
  - Mild:
    - No impairments in school, work, family or peer relationships
    - Functioning well
  - Moderate-to-Severe
    - Poor functioning at school, work, family or peer relationships
      - Not all need to be affected

SCREENING TOOLS

- History
  - S: Sleep
  - I: Interests
  - G: Guilt
  - E: Energy
  - C: Concentration
  - A: Appetite
  - P: Psychomotor retardation or agitation
  - S: Suicide
- SIGECAPS
  - Can be used on any age, tailor questioning/word choice to age group, can be patient- and/or parent-reported
  - >5 positives including feelings of sadness, suffice for DSM-V Criteria

SCREENING TOOLS

- Social History
  - HEADSS Exam
    - 'S': Suicidality/Depression
      - On most days, do you feel happy, sad, or somewhere in between?
      - If sad, are there specific things that bring on your sadness?
      - Have you ever thought of hurting yourself or someone else?
      - If SI, do you have a plan?
      - Do you think of harming yourself, not necessarily to kill? If so, in what way?

SCREENING TOOLS

- Beck Depression Index (BDI-II)
  - 21 questions, 10 min, age 14+, patient-reported
  - >19 is positive
  - High internal consistency, content validity, and sensitivity
  - Some studies show efficacy in an emergency room setting

- Patient Health Questionnaire (PHQ-2/PHQ-9)
  - PHQ-2 serves as initial screening, if positive, proceed to rest of the questionnaire
  - 9-item questionnaire, 5 min, used on any age
  - >5 positive to indicate depressive symptoms
    - 5-9 = mild, 10-14 = moderate, 15-19 = moderately severe, 20-27 = severe

SCREENING TOOLS

- Columbia Suicide Severity Rating Scale (C-SSRS)
  - 11-item questionnaire, 5 min, accessible online
  - 75% sensitivity, 83% specificity, 99% NPV
  - Can be used monitor improvement in symptoms

- Beck Hopelessness Scale (BHS)
  - 20-item questionnaire, 10 min, accessible online
  - 82-93% reliable
  - Typically used in age 17+, but has been tested in adolescents and shows high reliability and validity

SCREENING TOOLS

- Ask Suicide-Screening Questionnaire (ASQ)
  - 4-item questionnaire, ~20 sec, readily accessible online
  - 97% sensitivity, 88% specificity, 97-100% NPV
  - Has been well tested in the emergency setting

- Suicidal Ideation Questionnaire (SIQ/SIQ-JR)
  - 15-30 item questionnaire, ~5-10 min, must pay the publisher for access
  - Up to 97% reliable
  - Used in a community-based setting

TREATMENT

- Treatment for Mild depression
  - Cognitive Behavior Therapy (CBT)
  - Interpersonal Therapy (IPT)
  - Safety Plan
- Treatment for moderate-to-severe depression
  - Therapy: CBT, IPT, Family Therapy
  - Medications
    - Selective Serotonin Reuptake Inhibitors
    - Trial two before considering transferring care to psychiatrist
    - Most commonly used in adolescents: Prozac, Zoloft, Lexapro

TREATMENT

- If trialing therapy alone
  - Should see the patient back in 8-12 weeks
  - Discuss coping mechanisms
  - Utilize apps, consider support groups, and school counselor to add extra support
- If starting a medication
  - Should see the patient back in 4 weeks
  - Do not expect improvement until 4-6 weeks of treatment
  - Can increase dose every 4-6 weeks if needed
    - Prozac/Fluoxetine: max dose 60-80 mg
    - Zoloft/Sertraline: max dose 100-200 mg
    - Lexapro: max dose 20 mg
  - Should continue treatment for at least 9-18 months

TREATMENT - MOBILE APPS

- CBT for Teens
- Calm
- Breathe
- Cardia
- Depression CBT
- Breathe2Relax
- Optimism
- Intellicare
- Positive Thinking
- MoodKit
- Happify
- iCBT
- MoodTools
- Headspace
- Pacifica
- T2 Mood Tracker

SELECTIVE SEROTONIN REUPTAKE INHIBITORS

- Help to increase levels of serotonin in the brain (helps improve the transmission of messages to neurons)
- Commonly used: Prozac/Fluoxetine, Zoloft/Sertraline, Escitalopram/Lexapro, Citalopram/Celexa
- Potential Side Effects
  - Nausea, vomiting, diarrhea
  - Headaches
  - Drowsiness or Insomnia
  - Dry Mouth, Dizziness
  - Nervousness, Agitation, Restlessness
  - Decreased sexual desire, difficulty with orgasm, erectile dysfunction
  - Impact on appetite
  - Serotonin Syndrome (anxiety, agitation, fever, sweating, confusion, tachycardia, tremors, lack of coordination)
  - Increase in suicidal thoughts

SAFETY PLAN

- Step 1: Warnings Signs
  - Thoughts
  - Images
  - Thinking Processes
  - Mood
  - Behavior
- Step 2: Internal Coping Strategies
  - Distraction
    - Listening to Music
    - Going for a Walk
    - Hanging out with Pets
  - Remember to Discuss Potential Roadblocks

SAFETY PLAN

- Step 3: Individuals Who Can Help
  - Utilize if Step 2 wasn't enough
  - Who can be called to help support patient
    - Best Friend
    - Family Member
    - Calling up a friend to go and do something Overcoming Roadblocks
- Step 4: Support System
  - Utilize if Step 3 doesn't work
  - Call Parent and/or Guardian whoever is identified as familial support system
    - Discuss obstacles to contacting
    - What to do if they don't respond

SAFETY PLAN

- Step 5: Professional/Agency Help
  - Utilize if Step 4 doesn't work
  - Contact Information for Physician/Therapist
  - Contact Information for ER/UC Services, Mobile Crisis Unit
  - Don't forget National Suicide Prevention Lifeline (800-273-TALK), Trans Lifeline (877-565-8860), LGBTQ Lifeline (866-488-7386)

- Step 6: Safe Environment
  - Identify access and means to drive suicide plans
  - Modify risk by creating safe environment
  - Involvement of parents can be helpful for this step

- Implementation: KEY TO SUCCESS
  - Location of Safety Plan
  - Likelihood to Use
  - Barriers and Overcoming them
  - Parental Support

ANXIETY

EPIDEMIOLOGY

- Anxiety disorders are largely undertreated
- 31.9% have ever had an anxiety disorder
- 8.3% have a severe impairment
- Higher in females 38%, compared to males 25.1%
- Increased since COVID-19
- Commonly presents with depression
- Highest in the 12-17-year-old age group

DIAGNOSTIC CRITERIA

- Anxiety – DSM-V Criteria
  - Excessive anxiety and worry occurring more days than not for at least 6 months
  - Difficult to control the worry
  - Associated with three or more of the following, with some being present more days than not in the 6-month period:
    - Restlessness, feeling keyed up or on edge
    - Being easily fatigued
    - Difficulty concentrating or mind going blank
    - Irritability
    - Muscle tension
    - Sleep disturbance
  - Distress or impairment in social, occupational, or other important areas of functioning

SCREENING TOOLS

- SCARED: Self-Report for Childhood Anxiety Related Emotional Disorders
  - Subsections for Separation Anxiety, Social Phobia, School Avoidance, GAD, Panic Symptoms
  - Can be useful at age 8+, 41 items, 5-10 min
  - >25 is diagnostic
  - Use if suspicious to increase reliability

- Generalized Anxiety Disorder (GAD-2/GAD-7)
  - GAD-2: brief, easy to perform, use at any age
    - Cut off >3, 86% sensitive, 83% specific
  - GAD-7: easy to perform, few minutes to complete, >8 is diagnostic
    - 5-9 = mild, 10-14 = moderate, >15 = severe
    - 89% sensitivity, 82% specificity

TREATMENT

- Mild Anxiety
  - Therapy alone: CBT, exposure therapy
  - Social and parental support
  - School assistance: 504 plan

- Moderate to Severe Anxiety
  - SSRI
    - Commonly used: Lexapro/Escitalopram, Celexa/Citalopram, Prozac/Fluoxetine, Zoloft/Sertraline
  - Similar timing as if treating for depression
  - Treat for at least 9-18 months

EATING DISORDERS

EPIDEMIOLOGY

- 2019 Youth Risk Behavior Surveillance Survey
  - 16.2% did not eat breakfast the week before, 70.4% did not eat breakfast all 7 days the week before; 16.7 and 66.9% in US, respectively
- Three most common eating disorder are AN, BN, BED
- Eating Disorder lifetime prevalence in adolescence 2.7%, specifically 0.3% in AN, 0.6% BN, and 1.6% BED
- Two times more likely in females compared to males

EPIDEMIOLOGY

- Adolescents with anorexia are 10 times more likely to die compared to aged counterparts
- Mean age of onset 12.5 for AN, peak age of incidence is 16-20 for BN, evenly distributed for BED
- Increasing prevalence in males, patients of color, patients with obesity, pre-adolescents, lower SES, patients with chronic illness, sexual minority youth
- BED underrecognized and undertreated

DIAGNOSTIC CRITERIA

- Anorexia Nervosa
  - (1) Restricted caloric intake relative to energy requirements, leading to significantly low body weight in context with age, sex, developmental trajectory, and physical health. *Significantly low weight is defined as a weight that is less than minimally normal or minimally expected*
  - (2) Intense fear of gaining weight or behaviors that consistently interfere with weight gain, even though at a significantly low weight
  - (3) Altered perception of one's body weight or shape, excessive influence of body weight or shape on self-value, or persistent lack of recognition of the seriousness of one's low body weight

  - Subtypes
    - **Restricting type**: During the last 3 months, no recurrent episodes of binge eating or purging behavior; weight loss primarily through dieting, fasting, and/or excessive exercise
    - **Binge-Eating/Purging type**: During the last 3 months, recurrent episodes of binge eating or purging behavior (self-induced vomiting, laxatives, diuretics, enemas)
- Atypical Anorexia Nervosa
  - All of the criteria for anorexia nervosa, except that despite significant weight loss, weight is within or above the normal range

DIAGNOSTIC CRITERIA

- Bulimia Nervosa
  - (1) Recurrent episodes of binge eating. An episode of binge eating includes:
    - Eating, in a discrete period of time, an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances
    - A sense of lack of control over eating during the episode (cannot stop eating or control what or how much one is eating)
  - (2) Recurrent inappropriate compensatory behaviors in order to prevent weight gain (self-induced vomiting, misuse of laxatives, diuretics, other medications, fasting, excessive exercise)
  - (3) Above two behaviors occur at least once a week for 3 months
  - (4) Self-value is influenced by body shape and weight

DIAGNOSTIC CRITERIA

- Binge-Eating Disorder
  - (1) Recurrent episodes of binge eating as previously described for Bulimia Nervosa
  - (2) Distress regarding binge eating
  - (3) Binge-eating episodes are associated with ≥3 of the following:
    - Eating much more rapidly than normal
    - Eating until feeling uncomfortably full
    - Eating large amounts of food when not feeling physically hungry
    - Eating alone because of feeling embarrassed by how much one is eating
    - Feeling disgusted with oneself, depressed, or very guilty afterward
  - (4) Occurs at least once a week for 3 months
  - (5) Not associated with recurrent use of inappropriate compensatory behavior

SCREENING TOOLS

History/Information	Questions
Weight History	Highest? Lowest? Weight loss in what time frame? Goal weight? Satisfaction if achieved?
Body Image	How do you see yourself or compared to others? Body checking? Body areas that cause you stress? How much of your day is spent thinking about your body?
Diet History	24 hr diet recall? Behaviors around food? Calorie counting, macro/micros? Food avoidance? Guilt around eating? Compensatory behaviors? Lack of control?
Exercise History	Type and how long? Stress if unable to exercise?

SCREENING TOOLS

History/Information	Questions
Binge eating-Purging	Food types? How much or often? Triggers? Timing of vomiting after eating? Products for purging?
Family History	Eating disorder pathology? Mental health diagnoses? Dieting in family? Obesity? Meds used by family?
ROS	Neuro (dizzy, faint, weakness, fatigue)? Bruising, cold intolerance, thirst (endo, heme)? Hair loss, dry skin? GI symptoms? Chest pain, palpitations? Muscle cramps, joint pain? Menstrual complaints?
HEADSS	Bullying? Family/Social/Environmental circumstances? Drugs? Psych history?

SCREENING TOOLS

- Labs
  - CBC
  - CMP (Renal Panel, Mg, Ca, LFTs)
  - UA
  - +/- TSH
  - Vitamin D (other vitamins based on history)
  - +/- ESR/CRP
  - Urine pregnancy test, hormone levels, prolactin (if amenorrheic)
- Studies
  - EKG
  - DEXA Scan

TREATMENT

- Eating Disorders
  - Food is the medicine required for recovery
  - Outpatient Management
  - Imperative that Pediatricians are comfortable with caring for these patients
    - Coordination of care
    - Screening for complication
    - Recognizing when to transfer care of eating disorder to those with expertise (Adolescent Medicine, Psychiatrist)
  - Three-Pronged Approach
    - Physician
    - Mental Health Provider (Psychologist, Therapist): FBT/CBT
    - Dietitian
  - Close Follow-up
    - Some patients require weekly visits especially at diagnosis
    - Learning to manage mental health and nutrition while performing physician duties can be a difficult task
    - Knowing when to suggest and start medication
      - SSRI v Zyprexa

TREATMENT

- Dos/Don’ts

PROTECTIVE FACTORS

- Access to Mental Health Services
- Family Stability
- Positive Connections at School and Home
- Cultural/Religious/Spiritual Connectedness
- Lack of access to weapons
- Good relationship with peers
- Sense of worth/confidence
- Learned skills – problem-solving, conflict resolution, impulse control, stress management

BEST PRACTICE RECOMMENDATIONS

- USPSTF, AAFP, AAP, SAHM recommend screening for adolescents aged 12-18, so implement screening into your EMR for visits in this age group
- Increase comfort and confidence in the treatment of moderate-to-severe depression with an SSRI
- Know mental health resources in your area
- Develop relationships with psychiatrists and therapists
- Utilize the UNLV Psychiatric Access Line

CASE PRESENTATION

- 14-year-old female presents to the clinic with a history of depression. She has been exhibiting similar symptoms for the last few weeks. She had been treated with Fluoxetine but did not feel it was effective. She stopped taking it after three months and never started medication again. She is not sure her symptoms ever went away. What would you do next?

CASE PRESENTATION

- 16-year-old male with a history of high functioning Autism and depression has recently been having violent outbursts. He is taller and weighs more than his mom, so she is concerned about these outbursts. He feels terrible about his outbursts but cannot control them. He had been stable on his Fluoxetine 40 mg. What could you do next?

CASE PRESENTATION

- 13-year-old female who presents to the clinic after a panic attack at school. Patient was found in a bathroom stall crying with her heart racing, chest tightness, sweating, and dizziness. Patient reports that symptoms came on suddenly after taking an exam. Patient typically does well in school, gets straight As, and is captain of her basketball and debate teams. She desires to become a scientist or physician in the future. What would you do next?

CASE PRESENTATION

- 15-year-old male who presents to the clinic with recent weight loss. Mom notes that he has been preparing for a wrestling competition and has decreased his intake. She had noticed it in the past, but it resolved independently. She states that it seems to be more prolonged now, and patient is constantly making comments about his weight.

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