Depressive Disorders in Children and Adolescents: Information for Psychiatry Residents

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Child Case: 5-yo Danica, Part 1

You are seeing Danica, a 5-yo female referred by her paediatrician for problems with depressed mood. Your assessment shows that indeed, she meets criteria for major depression. Mother has had longstanding struggles with depression as well, along with post-partum depression following the birth of Danica. She loves her daughter, but life has not been easy for the mother...

Adolescent Case, Part 1

D. is a 15-year old female referred to see you by her family physician for depressed mood.
She lives with both parents, and is seeing you just a few months after having started high school.
You ask about her mood, and she breaks down crying, saying that she has felt sad for the past few months.
Symptoms include problems with sleep, appetite, energy and concentration since the school year started
You meet alone with her, and when you ask about safety, she reports that she thinks daily that “life would be better if I weren’t around...” What are you going to do?

Epidemiology

Prevalence

- 1% of preschoolers (age 3-5) (Luby, 2010)
- 2% children (i.e. under 12) (Birmaher, 2007)
- 4-8% adolescents (age 12-18) (Birmaher, 2007)

More common than asthma and most other chronic medical problems in this age group) (Jackson, & Lurie, 2006)

- Gender: 2:1 female:male ratio

Risk factors include:

- Family history of depression especially parents with depression

Prognosis

- Preschool depression has 50% persistence rate
- Mother with mental health issues is a negative prognostic factor
- Etiology of Wellness

Normal Development

Infants require various things for well being which include:

- Healthy attachments with caregivers,
- Basic needs such as sleep, nutrition, exercise (i.e. movement),

Children and youth require various elements which include

- Healthy attachments with caregivers,
- Basic needs such as sleep, nutrition, exercise (i.e. movement),
- Purpose (e.g. work, school, or the other things we do in life that keep us busy)
- Meaning (i.e. knowing that our life has meaning)
- Hope (e.g. knowing that will continue to go well, or will get better in the future)

Mental wellness occurs when one's needs are met.

When the above needs are unmet (e.g. such as having problems with attachments and basic needs), there is a risk of mental health problems.

Clinical Presentation / Signs and Symptoms

There are similarities and differences on how signs/symptoms of depression present over the lifespan.

Depression in infants / toddlers

When "depressed", infants and toddlers may present with 'depressive equivalents', such as

- Failure to thrive
- Problems with attachment, i.e. insecure attachment. When faced with parental separation, the infant/toddler may be:
    - Avoidant: Doesn't seem to react when caregivers leave ; Doesn't cry, nor turn to parents for his/her needs
    - Anxious : Overly anxious with parental separation, "clings on" to parents
    - Disorganized: Odd or ambivalent behavior with separation or reunion, e.g. When parent returns, may initially seek out parent but then run away, curl up in a ball, hit the parent (i.e. fight/flight/freeze)

Depression can present in preschoolers (age 3-5)

Depressed preschoolers may appear (Luby, 2000)

- Less joyful;
- More prone to guilt;
- Fail to enjoy activities and play;
- Changes in sleep, appetite, and activity as compared to healthy peers.
- Often undetected by parents/caregivers, as symptoms less disruptive (than in older children).

Depression in Children/Adolescents (aged 6-17)

Children may have

- Sad mood, and express they are sad/depressed
- Mood lability,
- Irritability /anger, temper tantrums,
- Low frustration tolerance,
- Somatic complaints (e.g. unexplained physical symptoms (such as headaches, fatigue, stomach aches, nausea) which do not have any obvious medical cause)
- Social withdrawal

History / Interviewing Questions

Children

Start with parents and the child together.

Ask about:

- When did the problems with the mood start?
- Any particular stresses?
- Mood
    - "How has your mood been these days?"
    - "On a scale between 0 and 10, if 10 is the best mood possible, and 0 is the worst mood, how is your mood between 0 and 10?"
    - Non-depressed patients tend to report report moods between 5-10
    - Patients with major depression may report moods <5, and as low as 1 if severely depressed.

Later, meet alone with the child to ask about sensitive topics such as suicidal ideation, abuse, drug use.

Later, meet alone with parent(s) to ask about sensitive topics such as parental mental health, parental trauma, or even the child's symptoms — some children become distressed hearing their parent(s) say negative things about the child.

Adolescents

Usually start with the adolescent and parent(s). However, if there is extremely high conflict between adolescent and parent, consider stopping the joint meeting, and meet alone instead with the adolescent, given higher adolescent needs for autonomy.

Meeting alone with the adolescent: Start by asking, "Now that we are alone, is there anything in particular you'd like to discuss?" Topics when meeting alone with the adolescent include: suicidal ideation, substance use, drug use.

Diagnosis

Diagnostic Criteria for Preschool Major Depressive Disorder (Age 3-5)

The problem with using standard DSM-IV criteria for depression in preschoolers (aged 3-5), is they miss 76% of preschoolers that were felt to be depressed (Luby, 2002). Thus, the following modified criteria have been developed and validated for preschoolers (Luby, 2002):

Five (or more) of the following symptoms have been present but not necessarily persistently over a 2-week period and represent a change from previous functioning: at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure in activities or play. If both (1) and (2) are present, a total of only four symptoms are needed.

1. Depressed mood for a portion of the day for several days, as observed (or reported) in behaviour. Note: May be irritable mood.

2. Markedly diminished interest or pleasure in all, or almost all, activities or play for a portion of the day for several days (as indicated by either subjective account or observations made by others).
3. Significant weight loss when not dieting, or weight gain or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) that may be evident in play themes.
8. Diminished ability to think or concentrate or indecisiveness, for several days (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without specific plan, or a suicide attempt or a specific plan for committing suicide. Suicidal or self-destructive themes are persistently evident in play only.

DSM-5 Criteria for Major Depressive Disorder

A. At least five of the following symptoms for at least two weeks duration; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure:

1. Depressed mood or loss of interest/pleasure
2. Anhedonia
3. Weight change; in children, consider failure to make expected weight gain
4. Sleep problems such as insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive guilt
8. Concentration problems
9. Suicidal thoughts, whether passive or active

B. Symptoms cause distress or impairment in function
C. Episode is not due to substance use or a medical condition
D. Not better explained by other conditions such as schizoaffective disorder, schizophrenia, or other psychotic disorders.
E. There has never been a manic episode or hypomanic episode.

- Specify:
- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern

DSM-5 Childhood Persistent Depressive Disorder (formerly known as Dysthymia, Dysthymic Disorder)

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others.
In children and adolescents, mood can be irritable and duration must be at least 1 year (vs. 2-years for adult dysthymia)

B. Presence, while depressed, of two (or more) of the following:

- Poor appetite or overeating
- Insomnia or hypersomnia
- Low energy or fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Feeling of hopelessness

During the 2 year period (1 year for children of adolescents) of the disturbance, the individual has never been without symptoms in Criteria A and B for more than 2 months at a time. Criteria for a major depressive disorder may be continuously present for 2 years.

Differential and Comorbid Diagnoses (DDx)

Normal moods	Children/adolescents may describe mood is ‘sad’, ‘depressed", yet this does not necessarily they have clinical depression Adolescents can have labile moods, and their moods may be a result of various stressors For this reason, monitoring the mood at a follow-up visit is important, along with other indices such as neurovegetative symptoms, and suicidal ideation
Other Mood Disorders	
• Seasonal depression	Is there a seasonal component? Are moods worse during seasons with less light, e.g. winter?
• Major depressive disorder with psychotic features	Seeing or hearing other things that others cannot? Any extremely strong beliefs, e.g. feeling paranoid about others?
• Adjustment Disorder with Depressed Mood	Patient has depressed mood, but without significant neurovegetative symptoms
• Persistent depressive disorder (formerly known as dysthymic disorder)	Depressive symptoms along with some neurovegetative symptoms, but without having enough symptoms to meet criteria for major depressive disorder Note that despite being a “minor” depression, dysthymic disorder can be just as impairing as major depression
• Bipolar Disorder, Manic Phase	Are there big swings in mood? Mania: Are there periods of high energy? During these high energy periods, is there: decreased need for sleep, increased activity level, grandiosity; increased talkativeness? Do high energy periods alternate with extreme low periods?
• Anxiety	
• Generalized anxiety	Any problems with anxiety? What are your biggest worries?
• Social anxiety	Are you really shy? Does it prevent you from doing things? Or make things difficult?

Medical Differential Diagnosis

Are there any medical conditions that are contributing to poor mood, or perhaps which contribute to neurovegetative symptoms (such as fatigue, inattention, appetite problems) such as:

Iatrogenic / Medication induced	Stimulants, corticosteroids, contraceptives (particularly progesterone) can worsen mood and irritability
Neurologic	Space occupying lesions, e.g. brain tumors Multiple sclerosis Sleep disorders, such as: • Sleep apnea: Problems breathing or with snoring when asleep? • Restless legs: Is it hard to sleep because your legs feel uncomfortable and restless? Is it worse at night? • Narcolepsy: Is there irresistible sleepiness? Cataplexy? (weakness in knees with strong emotions)
Cardiovascular	Postural orthostatic tachycardia syndrome (POTS): Symptoms include incapacitating fatigue; symptoms worse when upright; hyperflexible joints; symptoms better when patient is lying or sitting down. Simple to rule out by doing postural vitals.
Endocrine	Hypothyroidism: May be hard to distinguish on history alone, hence importance of testing thyroid hormones.
Infectious	Meningitis, Infectious mononucleosis
Hematologic	Anemia: Are there risk factors such as low iron, vegetarianism, or menstruation? Porphyria: Are there episodic symptoms?
Neoplastic	Pancreatic cancer: Are there other signs such as unexplained weight loss?
Metabolic	Wilson’s Disease Heavy Metal Toxicity (e.g. Lead, Mercury)
Autoimmune	Lupus

Comorbid Conditions

Common comorbid diagnoses with depressive disorders include:

Condition	**Possible Screening Questions**
Anxiety disorders	
• Generalized anxiety disorder	Any problems with anxiety? What are your biggest worries?
• Social anxiety disorder	Are you an excessively shy?
Disruptive behaviour disorders	Does your child tend to be defiant and oppositional?
Attention-deficit/hyperactivity disorder (ADHD)	Does your child have troubles paying attention at school/home? Any problems sitting still? Does your child need to fidget/home?
Substance use disorders (in adolescents)	How much alcohol do you drink? How often do you use substances, such as marijuana? If initial is positive, consider using the CRAFFT screening questionnaire to screen for alcohol or substance use problems C: Ever ridden in a C)ar driven by someone who was high or using drugs? R: Ever use alcohol/drugs to R)elax, feel better or fit in? A: Ever use alcohol/drugs while you are A)lone F: Ever F)orget things you did while on drugs F: Do your F)amily/F)riends ever say that you should cut down on your drinking or drug use? T: Ever gotten into T)rouble while using alcohol/drugs?

Physical Exam (Px)

There are no specific physical exam findings to major depressive disorder, however physical exam is important to help rule out medical conditions that may mimic, or contribute to a mental health condition.

Investigations

General screening tests

• CBC with differential	Anemia
• Electrolytes, glucose	Diabetes
• Ca, Mg	
• Renal function (e.g. BUN/Cr)	Kidney problems
• Thyroid screen, e.g. TSH	Thyroid problems
• Urinalysis with drug screen	Drug use
• Liver enzymes	
• Iron screen, e.g. serum transferrin	Low iron
• B12 / folate	B12/folate deficiency

If suspected

• HIV antibody screen	
• ESR	Chronic inflammatory condition
• Mg	Mg deficiency
• 24-hr urine porphyrin levels	Porphyria
• Serum copper/ceruloplasmin	Wilson’s disease
• Blood/urine heavy metals (e.g. lead, mercury)	Heavy metal toxicity
• Auto-antibody screen, Igs	Auto-immune illness
• Cultures for infectious agents	Infection
• Blood alcohol; GGT; triglycerides	Alcohol use disorder
• Urine catecholamine	Phaeochromocytoma
• Head CT / MRI	Structural brain problems
• Genetic testing, e.g. Fragile X	Genetic syndromes
• Sleep study	Sleep disorders
• EEG	Seizure disorders
• EKG	Cardiac issues, including QT prolongation

Management/Treatment: Psychoeducation

Provide the family with basic education about depression, such as:

- “Thank you for coming in today. I have bad news and good news... The bad news it appears your child has symptoms of depression. The good news is that there are many things we can do to support, and treat the depression."

Provide handouts to help with recall of key materials such as:

- Depression in Children/Youth: Information for Parents https://www.ementalhealth.ca/index.php?m=article&ID=8879
- Depression in Youth: Information for Youth https://www.ementalhealth.ca/index.php?m=article&ID=23584

Address Comorbid Conditions

Any comorbid conditions? Ensure these are addressed:

Attention deficit hyperactivity disorder (ADHD)	Ensure that there are appropriate school modifications/accommodations If symptoms persist despite non-medication interventions, consider treatment with ADHD medications
Addictions, such as alcohol, substance use or technology addiction	If possible, provide care for the patient’s addiction. If this is not possible, then ensure that addiction services are in place.
Any contributing medical conditions?	Ensure medical issues are being addressed. Stop any medications that might be contributing to depressive symptoms.

Management/ Treatment: Lifestyle strategies

Start with the following lifestyle strategies

- Ensuring healthy sleep hygiene, with a goal of 8-11 hrs/sleep at night. For more information [link to eMH handout]
- Ensure proper nutrition. In particular, studies show that Mediterranean diets that are low in processed foods, low in fast foods, low in added sugar foods, and high in fruits and vegetables may be helpful for depression. For more information [link to eMH handout]
- Ensure regular nature time: For proper eye health, a minimum of 10 hrs outdoors per week has been suggested. Note that some studies suggest that recommending nature time is even more important than recommending physical activity, because as long as kids get outside, they will be physically active. For more information [link to eMH handout]
- Physical activity: Standard guidelines recommend at least 1-hr daily of physical activity for children. For more information [link to eMH handout]
- Limits on screen time: No more than 1-2 hrs day of screen time for the average child (Canadian Paediatric Society Screen Guidelines). In children with emotional/behavioural issues however, circumstances might warrant less screen time. For more information [link to eMH handout]
- Ensure the child spends face-to-face time with fellow humans, such as caregivers, and friends/family.

Management/ Treatment: Relationship Interventions

Ask the youth who they feel they can turn to, and try to engage those people as part of the youth’s support network. Usual options in order of priority might include parents, aunts/uncles, grandparents, friends of the family, neighbours, teachers, guidance counselor, coach, etc. In social prescribing, identifying possible adults, and then teaching them how to provide support is a key intervention.
Teach adult caregivers on how to co-regulate their child’s feelings, which are key strategies in numerous interventions, such as interpersonal psychotherapy (IPT), attachment therapy, and dialectical behaviour therapy

(DBT).

Specific teaching points for caregivers are:

- When your child expresses difficult feelings to you, remember “connection before direction” or “support not solutions”.
- Start first with listening and validation.
- Do not start first with giving advice, minimizing or invalidating your child’s concerns.
- Don’t give advice until the child is feeling calm, or asking for advice. Especially with teens, it is best to cautiously ask them if they are ready for advice.

An example might be:

- Child: “I’m sad.”
- Parent: “Let’s sit down and tell me how you’re feeling.”
- Child: “The kids were mean to me at school…”
- Parent: “I’m so sorry… tell me more…”
- Child explains more.
- Parent: “That sounds really tough. I am so sorry. Let me give you a hug…”
- Child starts crying; parent gives child a tissue paper so the child can cry. Crying is particular good, as it helps human beings regulate difficult feelings, and then accept difficult situations that have happened.
- Parent: “How can I help? Do you just need me to listen? Or would you like some advice?”

Teach parents / caregivers to build regular time in the daily or weekly schedule for emotional support. Consider asking other adults as well, to commit to spending specific times with the child.

For example:

- Clinician: “It will help to build in regular times in your schedule to check in with your child emotionally. There should be time every day. On weekends, longer periods. Like a morning or afternoon, where you can spend longer periods of quality time. This will give your child a chance to confide and share their emotions with you, and feel your acceptance and validation of their emotions.

Management/ Treatment: School Intervention

Involving the school can be helpful because:

- If the youth is having depression, most likely there is some impairment at school.
- Or school may be one of the contributing stresses that could be addressed.
- Even if there are no problems with school, attachments with school figures can be strengthened, providing an additional resiliency factor.

During an appointment, ask for the patient’s permission to call the school, then call the school.

For example:

- Clinician: “I am Dr. ___, and I’d like to speak to you regarding your student ___. Do you have any concerns regarding? Anything I can do to be helpful?”

Most of the time, the school will be open and/or ask for your recommendations. Discuss these, and then write a school letter to formally document your recommendations.

For a sample letter:

- Visit “Depression in Children and Youth “ at http://primarycare.ementalhealth.ca/index.php?m=fpArticle&ID=18300 > click on “School/Workplace Letters”

Problem-Solving Stressors

Identifying and solving specific problems or stresses is important, and is a key part of problem-solving therapy (PST).

Step	What a clinician might say
1. Explore what possible stresses or problems the child/family is facing	Clinician: “Everyone has stresses. Typical stresses include home stresses, such as stresses with home routines, expectations, parents, siblings. Typical school stresses include teachers, schoolwork and classmates, including peer pressure and bullying.
2. Choose a specific problem or stress to address	Clinician: “What is a problem/stress that we should address?”
3. Set a realistic goal	Clinician: “What would you like to see different or better?” Examples include therapeutic strategies such as improving sleep, getting more activity; or dealing with stresses
4. Generate multiple possible solutions; start with the patient/family’s preferences first	Clinician: “Let’s see if we might come up with some possible solutions. First, let’s start off with your thoughts first.” After that, one might ask, “Would it be okay if I made some suggestions?”
5. Compare the different possible solutions, and pick one to try out.	Clinician: “Let’s review all the possible solutions to try. Which one would you like to try first?” If the solutions are complicated, consider writing out pros/cons for each.
6. Wrap up the session, and	Clinician: “Okay, so you’ll try out this solution and see how it goes. At our next visit, we’ll talk about how it goes.
At the next visit	
1. Evaluate the strategy tried and see if it was helpful.	Clinician: “Let’s review how things went with ___. How did things go with ___?”
2. If helpful, great.	Clinician: “It sounds like the strategy worked. That’s wonderful!”
3. If not, then try a new strategy.	Clinician: “I’m sorry to hear things didn’t work out as well as hoped. Let’s talk more about that…”

Management of Depression: Specific Interventions for Children (aged 0-12)

For aged 5-11 year olds

- Is mild depression persisting despite 2-weeks of watching waiting?
- Recommendations (NICE, 2019)
    - Less intensive
        - Online cognitive behavioural therapy (CBT)
        - Group CBT;
        - Group non-directive supportive therapy (NDST)
        - Group interpersonal psychotherapy)

Parent interventions:

- For depressed children (aged 0-12), consider parent interventions (as opposed to starting with child interventions such as individual therapy). Given that children have less developed reasoning skills (compared to adolescents), and given the stronger role of parental influences at this age, it makes sense that parent-child interventions are high yield. Studies confirm that group and individual CBT with children (under aged 12) are less effective. [NEED REFERENCE]

Parent Child Interaction Therapy-Emotion Development (PCIT-ED)

- Is the child aged 3-7? If available, PCIT-ED is an evidence-based treatment for depression in age 3-7 yo. It consists of 18 sessions, in which parents receive coaching and guidance on how to support their child with negative emotions.
- If PCIT-ED is not available, provide other interventions to improve parent's ability to meet the child's emotional needs, e.g. Triple P; Circle of Security; Watch, Wait and Wonder, or other attachment-based parenting programs.

Parent mental health services:

- Does the parent have unmet mental health needs? If the parent has ongoing mental health difficulties, then ensuring supports for the parent's mental health may be particularly high yield as well.

Management of Mild to Moderate Depression: Specific Interventions for Adolescents (aged 12-17)

Is patient aged 12-18?

- Are symptoms of mild depression continuing after 2 weeks of watchful waiting, and without significant comorbid problems or active suicidal ideas or plans?
- Recommendation (NICE, 2019)
- Trial of one of the following for 2-3 months
    - Digital CBT
    - Group CBT
    - Group NDST
    - Group IPT
    - Dialectical behaviour therapy (DBT)

Management of Moderate to Severe Depression

For moderate to severe depression, or for depression that has not yet responded, consider medications **in addition to psychotherapy/counselling.**

- For depression in children, some evidence exists for fluoxetine
- For depression in adolescents, there is good evidence for fluoxetine (TADS study); some evidence for escitalopram, citalopram and sertraline

First Line SSRI		
Fluoxetine (Prozac)	Child: Start 5 mg daily; target 10-20 mg daily Youth: Start 5-10 mg daily; target 10-60 mg daily	Max 60-80 mg daily
Second-line SSRI		
Escitalopram (Cipralex or generic)	Child: Start 5 mg daily; target 10 mg daily Youth: Start 5-10 mg daily;	Max 10-20 mg daily
Citalopram (Celexa or generic)	Child: Start 5-10 mg daily; target 10-40 mg daily Youth: Start 10 mg daily; target 10-40 mg daily for most	Max 40-60 mg daily
Sertraline (Zoloft or generic)	Child: Start 25 mg daily; target 50-200 mg daily Youth: Start 50 mg daily; increase by 50 mg/day every 2-weeks until satisfactory clinical response or maximal dosage Target 50-200 mg daily	Max 200 mg daily
Fluvoxamine (Luvox or generic)	Child: Start 25 mg daily; target 25-200 mg daily Youth: Start 25-50 mg daily; target 50-300 mg daily	Max 200-300 mg daily

Paroxetine (Paxil or generic)	Child: Start 5 mg daily; target 5-40 mg daily Youth: Start 10 mg daily; target 60 mg daily Not usually used due to short half-life	Max 40-60 mg daily

Do NOT use the following in “children and young people” (NICE, 2019)

- Paroxetine
- Venlafaxine
- Tricyclic antidepressants (TCA)

Monitoring / follow-up

- Have weekly follow-up or monitoring q one weekly for the first four weeks
- Is there new onset suicidal ideation, that seems associated with the new medication?
- If so, then stop the new medication

Duration of treatment

- Has the child/youth responded to treatment?
- If so, then continue treatment for at least 6-months after remission

Reference

- GLAD-PC, 2018

Switching from one medication to another? Consult this guide for switching medications

- http://wiki.psychiatrienet.nl/index.php/SwitchAntidepressants

Management of Depression with Psychotic Features

Is the patient have symptoms of depression plus depression?

- Children and young people prescribed a second-generation antipsychotic medication should be monitored carefully for side effects. [2005]

Deciding on Treatment Setting: Outpatient, Inpatient, Day Hospital

Is there acute suicidal ideation ? If so, consider inpatient treatment.
Are there persistent depressive symptoms, despite intensive outpatient treatment?
If so, consider:

- More intensive treatment, e.g. more frequent appointments; day hospital treatment.
- Elective admission to inpatient unit for diagnostic clarification.

Child Case: 5-yo Danica, Part 2

You are seeing Danica, a 5-yo female brought by her mother for problems with depressed mood. Your assessment shows that indeed, she meets criteria for major depression. Mother has had longstanding struggles with depression as well, along with post-partum depression following the birth of Danica. She loves her daughter, but life has not been easy for the mother.

You do the following :

- Refer mother (and father) to the local publicly funded children’s mental health agency that provides a program in positive parenting (Triple P program). Mother learns new ways to meet her daughter’s needs, that she never experienced during her own upbringing, and Danica’s mood improves.

1. What do you recommend in order to help Danica's depression?

- ○ Cognitive behaviour therapy (CBT)
- ○ Start SSRI to improve likelihood of response to psychotherapy
- ○ Start both SSRI plus CBT as shown in the TADS study
- ○ For parents to receive education on how to parent an anxious child, such as through parenting / attachment programs such as Triple P and Circle of Security.
- ○ Omega 3 fatty acids
- ○ Start child on an SSRI.

2. You've referred the child to mental health services, but the waitlist is excessively long. What is the best option in the meanwhile?

- ○ Start mother on an SSRI.
- ○ Refer the mother to adult mental health services for support with her mental health needs
- ○ Recommend Omega 3 fatty acids for both mother and child
- ○ Start an SSRI for both mother and child

Adolescent Case: 13-yo T., Part 2

You ask about stresses and she reports:

- She was dating a boyfriend and "he was the first person who really understood me", but unfortunately he broke up with her
- Since the breakup, "There will never be anyone else who will understand me again"
- She skips school often because he is in many of her classes, and it is just too difficult to have to continue seeing him every day

You ask about her relationships and supports and she reports:

- Mother/father: She does not feel that she can confide in her mother nor her father – "they never understand, they just want to lecture me"
- Friends: She does not feel she can confide in them since they have a tendency to share everything on social media.

You do the following:

- Diagnose depression, and give the patient and mother basic information about depression.
- Provide short-term course of psychotherapy for the patient and mother.
- You teach mother how to provide emotional support through providing empathy, validation and unconditional acceptance, rather than lecturing her daughter. This allows the patient to start confiding in her parents, and their support helps her deal with her stressors.

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About this Document

Written by members of the eMentalHealth.ca Psychiatry Team.

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