October/2019

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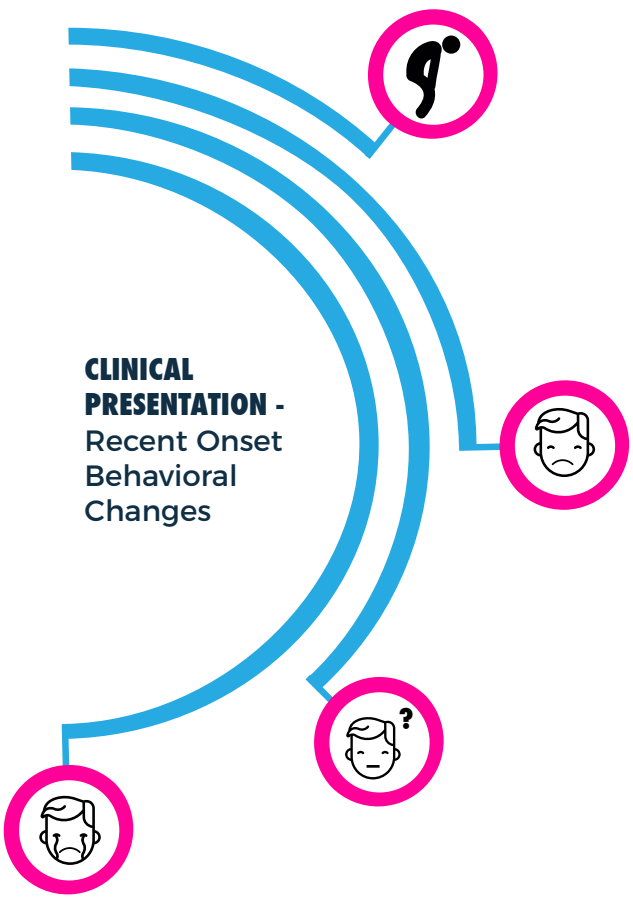
Standard Treatment Workflow (STW) for the Management of CHILDHOOD EMOTIONAL DISORDERS



CLINICAL PRESENTATION - Recent Onset Behavioral Changes

SOMATIC (PHYSICALLY UNEXPLAINED) SYMPTOMS
- Weakness and tiredness
- Aches and pains
- Headache
- Non-epileptic attacks of fainting
- Chest pain and stomach pain
- Hyperventilation- often triggered by stress or distress

SYMPTOMS OF DEPRESSION
- Loss of interest in usual activities
- Recent deterioration in school performance
- Wanting to be alone, withdrawn, not interacting with people
- Looks unhappy, "off mood", crying for trivial or no reason, irritable, sensitive to any criticism
- Decreased sleep, loss of appetite and weight loss
- Talking about death and dying, self harm (eg. self-cutting) or suicidal attempt

SYMPTOMS OF ANXIETY
- Always worrying, tense
- Exam tension, performance anxiety, worries about marks and ranks
- Excessive fear and avoidance of some objects or situations (insects, animals, ghosts)
- Reluctance or refusal to go to school
- Very shy, avoids social situations, scared of talking or interacting with strangers,
- Clinging to mother, scared of being separated from mother

DIAGNOSIS
- Persistent symptoms of emotional disturbance for several weeks, significantly affecting the child's life
- Unexplained by medical condition such as hypothyroidism
- Depression and anxiety symptoms can co-occur
- Depression more common in adolescents, may have features similar to adult onset depression

CAUTION
- Assessment of suicidal risk and a plan of action is important in children with emotional disorders, especially depression (refer to appropriate STW)
- Elicit h/o hypomania/mania in children with moderate to severe depression (consider diagnosis of bipolar disorder)
- Physical conditions can cause similar symptoms (anemia and thyroid disturbance)

ASSESSMENT

PARENT INTERVIEW AND HISTORY TAKING
- Onset, duration, severity and full range of symptoms
- Home environment, family life and relationships, parenting practices and stressors
- Information (from paretns and school) about school performance, behavior, school refusal, bullying experiences, peer relations and any recent change

CHILD INTERVIEW
- Develop rapport
- Ask subjective distress (low mood, irritability, sadness, lack of enjoyment of activities, worries, fears, tensions, autonomic symptoms)
- Stressful events (loss, death in the family, separation, frightening experiences, traumatic abusive or shocking events, humiliating experiences, bullying in school, academic stress) and interpersonal difficulties
- Explore parent-child relations and interactions and any undue punishment or criticism

PHYSICAL EXAMINATION
(Rule out)
- Post-viral syndrome
- Recurrent attacks of malaria
- Chronic infections, chronic physical illness, anaemia, PCOD or thyroid disturbance

MANAGEMENT

WORK WITH PARENTS
- PSYCHOEDUCATION:
  - Child is emotionally disturbed and not able to function well
  - Not the child's fault
  - Avoid undue criticism, over expectation, unfair comparison, scolding and punishment
  - Parents' support, encouragement and understanding is important
- Counsel about suicidal risk in depression and to be alert to pointers to suicidality
- Evaluation and management of the mental health issues in parents
- Discuss about specific steps to reduce undue stress the child is facing

WORK WITH THE CHILD
- Psycho-education of the child- explain they are suffering from an emotional problem and it is not their fault and they will get better with proper treatment
- Anxiety management and emotional regulation skills
  - Muscle relaxation
  - Deep breathing exercises
  - Praanaayaama / yoga
  - Substituting distressing thoughts with more comforting thoughts
- Counsel the child to confide any distressing thoughts, including thoughts of death and dying
- Encourage the child to gradually return to the usual life and activities in a step-by step manner with parental support and encouragement

WORK WITH SCHOOL
- Give feedback to the school about child's condition and stress, need for support, encouragement and school's cooperation.
- If school refusal, graded return to school: encourage child to return to school gradually with the support of family and cooperation of school (e.g. initially for a few minutes in school compound, later for 1 period in school and moving on to longer duration

MEDICATION (MODERATE CASE OF DEPRESSION OR ANXIETY IN ADOLESCENTS)
- Tab Fluoxetine - start at 10 mg OD morning, increase to 20 mg OD after 2 weeks depending on response
- Inform adverse effects: behavioral activation (marked restlessness and irritability), onset of hypomanic symptoms, and worsening of suicidal ideas. Stop drug if they are troublesome
- Avoid benzodiazepines (except as temporary measure for few weeks in severe anxiety attacks or panic attacks - Clonazepam 0.25- 1 mg /day)

REASONS FOR REFERRAL
- Frequent expression of suicidal ideation/ attempted suicide / self-harm behavior such as self-cutting
- Severe symptoms
- Complicated picture, or features of obsessive compulsive disorder (OCD)
- No response to interventions in 4-6 weeks

SECONDARY CARE (DISTRICT HOSPITAL)
- Review and reassess diagnosis through detailed clinical using Rutter's multi-axial system
- Review the treatment received and plan multi-modal treatment.
- Reconsider medications, and augmentation strategies
- Review child's and family's awareness of the illness and do psycho-education
- Ascertain the presence of psychosocial factors : disturbed home environment, parent-child relationships and severe stressors
- Screen parents for mental health problems and manage accordingly
- **Individual therapy** focussing on identifying and challenging negative thoughts, anxiety management and coping with stress, helping them face difficult situations in small steps, improving interpersonal relationships
- **Parent counselling** to address family issues, communication and interaction patterns
- Collaborate with school wherever necessary (get school report; explain problem in simple terms, and suggest ways by which school can help)
- Recognize and manage less common problems such as obsessive compulsive disorder, psychoses and bipolar disorders
- Manage adolescents with mild / moderate suicidal risk

TERTIARY CARE (MEDICAL COLLEGE / REGIONAL REFERRAL CENTRE)
- Thorough diagnostic evaluation
- Manage severe mental disorders – psychoses, recurrent mood disorders, adolescents with severe depression, & treatment resistant cases, persistent suicidality, recurrent self-cutting, if necessary in inpatient setting
- Family therapy for dysfunctional / discordant families contributing to child's condition
- Cognitive behavior therapy for older children with severe OCD, depression, and anxiety disorders
- ECT on case to case basis (older adolescents with severe depression, mania, psychosis or catatonia unresponsive to adequate pharmacological management)
- Appropriate psycho-social steps if there is abuse, maltreatment or neglect
- Neurology referral in suspected cases of epilepsy and organicity

KEEP A HIGH THRESHOLD FOR INVASIVE PROCEDURES