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## **Background**

### Mental illness in pediatrics

Mental illness is common and results in significant morbidity and mortality. Uniquely, in children, psychiatric disorders impact development and therefore have profound long term consequences. The potential for effective treatment makes early diagnosis for children with new onset mental illness essential in order to maximize clinical outcomes.

You will come across children on the ward or in the ED who may present with serious mental health issues in addition to their medical illness. What do you do if a ten-year old girl with chronic kidney disease tells you she's hopeless and wants everything to end? How might you react to a teenage boy recovering from cardiac surgery who hears voices commanding him to flee the hospital? When should you consult psychiatry? How do you best interview the patient?

It is rare to have very young children present with these conditions. For younger children, you are more likely to see Pervasive Developmental Disorders like Autism or Asperger's, as well as common entities like ADHD. These disorders are often seen by primary care physicians or pediatricians and are unlikely to present in an emergent fashion.

### Suicide

About 10% of teenagers between 14 and 16 years of age experience thoughts about suicide. The background for children who attempt suicide is often one marked by an increased prevalence of psychiatric illness, social isolation, and family problems such as discipline issues or problems communicating feelings or needs. Suicide is a serious problem in adolescents and can be prevented. The HEADSSS assessment ([link](#)) is one useful screening tool to identify suicidal tendencies in adolescents

Remember that suicidal thoughts may be spurred on by medical ailments or underlying psychiatric conditions. While most children in hospital often exhibit

energy and playfulness, depression and emotional turmoil exist in all people who are suffering significant illness. The prevalence of mood disorders like depression is in the range of 20-40% in hospitalized children compared to 5% of kids in the community.

Outlined in this module are ways to approach a child with mental health concerns with a focus on those patients expressing suicidal concerns.

## **Presentation**

Younger children with thoughts of suicide may present with mood congruent auditory hallucinations, somatic complaints, a withdrawn or sad appearance, and poor self-esteem.

Adolescents with the same feelings often appear more similar to depressed adults with anhedonia, severe psychomotor retardation, delusions, and a sense of hopelessness. A sense of hopelessness is a red flag.

## **The Interview**

### Where to interview

If possible, interview patients and their families in their own room. In the ED setting you will likely have a 'quiet room' away from the rest of the department to conduct your thorough interview.

If patients are in a semi-private room, you can see if the other patient/family can step out to give you privacy or ask the ward unit clerk if there's a private place to do your assessment.

### How to ask

Don't forget children are not miniature adults. Kids need to know that you are not a threat. The following are important points to remember.

- Speak with the family as a whole first, introducing yourself and starting with open ended questions about the child's symptoms and stressors outside the hospital.
- Conduct your Mental Status Exam ([MSE link](#)) with the following features in mind: parent-child interaction and reaction to separation and reunion with the parent.
- Make time to speak to the child alone if possible. Start your discussion with an explanation that everything you discuss will be held confidential; except if you determine that that child's safety is at risk.
- Approach the HPI by probing for symptoms/signs of the most likely diagnostic area - mood disorder, developmental disorder, or anxiety.
- Assess for risks by asking about all forms of abuse, suicidality, aggression, and risky behaviours.

- Ask about past psychiatric assessments or concerns. Also enquire about a family history of mental illness.
- In most cases it is important to get a brief developmental history. As in all pediatric admissions you want to look at maternal health, pregnancy, delivery/birth, and general achievement of milestones.
- Remember children don't often seek help for mental illness and have a limited capacity for self-observation.
- Kids possess diminished ability for abstract thought depending on developmental age. Keep your questions concrete.
- Keep in mind the child's developmental age when assessing behaviour. For example, lack of stranger anxiety between 12-18 months raises concerns about psychosocial health.
- When in doubt, refer to a trained psychiatrist. There is often a low threshold in pediatrics for involving the subspecialist.

### What to do

Assess suicide risk using [SIGECAPS](#) or a number of good checklists (see appendix for [Attempters at Great Risk for Suicide](#))  
 Conduct a Mental Status Exam ([MSE](#))

Remember that the following risk factors for suicide:

- Previous suicide attempts especially with a lethal means (gun)
- Male gender
- Female who is pregnant and who has run away from home in the past
- Older than 12 years
- History of aggressive behaviour or substance use/abuse
- Major Depressive Disorder (MDD)
- Persistent suicidal ideation (SI)
- Stressful or chronic medical condition
  - Recent stressor like argument with family, breaking up with boyfriend or girlfriend, or anticipation of punishment
- Delusions and hallucinations

### When to call for help

If you are concerned about the suicide risk of your patient, call your resident. Ultimately, prompt referral to the psychiatry team provides the child with a proper assessment and evaluation.

### Who to involve

- Patient's family
- Residents
- Attending staff
- Psychiatry team

- Play services
- Social work
- Other medical subspecialties

## Differential Diagnosis

Most suicidal gestures are linked to depression with greatest incidence in Bipolar and Major Depressive Disorder. However, suicidal thoughts may be related to any mood or anxiety disorder and must always be further elucidated independent of the underlying diagnosis.

- Major Depressive Disorder
- Other depressive disorders including Major Depressive Episode, single episode and dysthymia
- Bipolar I and II, and cyclothymia
- Schizophrenia
- Anxiety disorders like Panic Disorder, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder
- Substance Use Disorders
- Eating Disorders
- Post-Traumatic Stress Disorder
- Adjustment Disorder
- Conduct Disorder
- Personality Disorders like borderline or antisocial (Cluster B)
- Gender Identity Disorder

## Investigations

The joy of psychiatry is that your investigation is your strong history taking skills. Nevertheless, any medical issues that may be contributing to the psychiatric problem should be further investigated. Depression may result from hormonal imbalances, an altered mental status from electrolyte abnormalities, or psychosis from toxic levels of pharmaceutical or illicit drugs. Make sure to approach the patient in the standard [Axis I-V](#) approach.

## Treatment

Anti-depressants, mood stabilizers, and anti-psychotics have all been used in the pediatric population, but unlike in adults, their use is less substantiated by clinical evidence. Approach pharmaceutical treatment of mental illness in children with caution and involve the professional mental health team if any uncertainty exists.

## **Appendix**

### SIGECAPS Acronym

An approach to depression

S = Sleep

I = Interest

G = Guilt

E = Energy

C = Concentration

A = Appetite

P = Psychomotor retardation

S = Suicide

### Components of the Mental Status Exam

- General appearance and behaviour
- Speech
- Mood
- Affect
- Thought form
- Thought content (hallucinations, delusions, paranoia's)
- Cognition

### The Axis I – V Diagnostic Approach

Axis I	Differential diagnosis of DSM-IV clinical disorders
Axis II	Personality disorders; mental retardation
Axis III	General medical conditions that are potentially relevant to the understanding or management of the mental disorder
Axis IV	Psychosocial and environmental issues
Axis V	Global assessment of functioning (GAF, 0 – 100) incorporating effects of Axis I-IV)

### Attempters at Great Risk for Suicide

From American Foundation for Suicide Prevention: Today's suicide attempter could be tomorrow's suicide (poster). New York, American Foundation for Suicide Prevention, 1999.

### Suicidal History

- Still thinking of suicide
- Have made a prior suicide attempt

### Demographics

- Male
- Lives alone

### Mental State

- Depressed, manic, hypomanic, severely anxious, or have a mixture of these states
- Substance abuse alone or in association with a mood disorder
- Irritable, agitated, threatening violence to others, delusional, or hallucinating

Do not discharge such patients without psychiatric evaluation.

### Look for signs of clinical depression:

- Depressed mood most of the time
- Loss of interest or pleasure in usual activities
- Weight loss or gain
- Can't sleep or sleeps too much
- Restless or slowed-down
- Fatigue, loss of energy
- Low self-esteem, disappointed with self
- Feels hopeless about future
- Can't concentrate, indecisive
- Recurring thoughts of death
- Irritable, upset by little things

### Look for signs of mania or hypomania

- Depressed mood most of the time
- Elated, expansive, or irritable mood
- Inflated self-esteem, grandiosity
- Decreased need for sleep
- More talkative than usual, pressured speech
- Racing thoughts
- Abrupt topic changes when talking
- Distractible
- Excessive participation in multiple activities
- Agitated or restless
- Hypersexual, spends foolishly, uninhibited remarks

### References

1. Behrman, Richard E., Robert M. Kliegman, and Hal B. Jenson. Nelson Textbook of Pediatrics 17<sup>th</sup> ed. Saunders. Philadelphia: 2004.

2. Goldbloom, Michael B. Pediatric Clinical Skills 3<sup>rd</sup> ed. Saunders. Philadelphia: 2003.
3. Kasper, Dennis ed., et.al. Harrison's Principles of Internal Medicine. 16<sup>th</sup> ed. McGraw-Hill Medical Publishing Division. New York: 2005.
4. McMillan, Julia A. ed. Oski's Pediatrics Principles and Practice 3<sup>rd</sup> ed. Lippincott Williams & Williams. Philadelphia: 1999.
5. Sadock, Benjamin James and Virginia Alcott Sadock. Kaplan and Sadock's Synopsis of Psychiatry: Behavioural Science/Clinical Psychiatry 9<sup>th</sup> ed. Lippincott Williams & Williams. Philadelphia: 2003.
6. Leonard, Blair J. N. and Jonathan C. Yeung eds. The Toronto Notes 2005 21<sup>st</sup> ed. Toronto Notes Medical Publishing Inc. Toronto: 2005.

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