



Depression in Ugandan Adolescents



Makerere and Columbia Universities, (MUCU) are pleased to publish the third issue of our newsletter. We are excited to update you on all the interesting advances that have occurred over the past six months in the area of adolescent medicine in Uganda. We are delighted that you have continued interest in the care of the adolescent patient and look forward to hearing about the work you are doing related to adolescent health.

OUR MISSION is to provide a forum to share member news, interesting program updates, clinical cases, and discuss the latest in “hot” adolescent topics.

THIS ISSUE is dedicated to **DEPRESSION IN UGANDAN ADOLESCENTS**.

FUTURE TOPICS will include: Contraception; Sexual Coercion/Violence; Taking a Psychosocial History; Managing the Confidential Visit: Parents and Teens; Bullying; Substance Abuse; Young Men’s Health.

Issue 3, May 1st 2014

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Meet the Newsletter Editorial Board



Co-Editors in Chief:

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Betsy Pfeffer, M.D., Assistant Professor of Pediatrics at Columbia University Medical Center and New York Presbyterian Hospital, New York, U.S.A. Dr. Pfeffer is an Adolescent Medicine clinician who sees teens in an outpatient and inpatient setting, teaches medical students and residents and lectures internationally on multiple topics related to adolescent health care. She has been working together with Dr. Kitaka for over seven years and is committed to their efforts to help improve health care delivery to teens in Uganda.



Editorial Team



Denis Lewis Bukenya BSWSA, MPA is a social worker and an Adolescent Health Training Specialist and the Training Manager at the Naguru Teenage Information and Health Center, a pioneer Adolescent Sexual Reproductive Health and Rights program in Kampala, Uganda that provides advocacy and youth-friendly reproductive health and related services. Denis has nine years of progressive involvement in Adolescent Sexual Reproductive health services' delivery and Trainings, psychosocial and behavioural support for children and youth, specifically on Adolescent Sexual Reproductive Health and Rights (ASRHR) and HIV/AIDS. He has been highly involved in developing of innovative and replicable models of youth and children empowerment programs, leadership and professional collaboration based on research and client voice. Denis has also been involved in building the Makerere-Columbia University Collaboration and presented at all four adolescent health conferences.



Godfrey Zari Rukundo M.D. (MBChB, M. Med Psych, CFCAP, PhD)

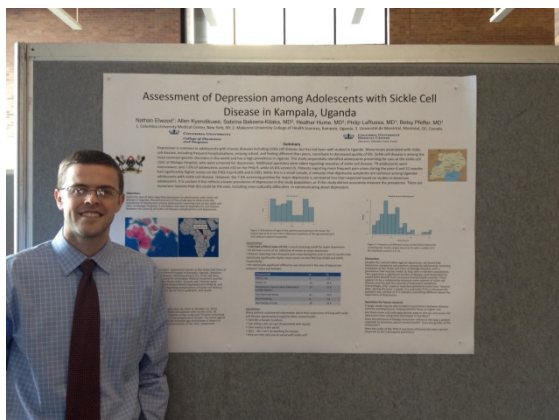
Dr. Rukundo is a Child & Adolescent Psychiatrist and Senior Lecturer in the Department of Psychiatry at Mbarara University of Science and Technology/Mbarara Regional Referral Hospital. Dr. Rukundo is a clinician, health sciences educator/trainer, supervisor and mentor. He has more than ten years of experience in training/teaching and research. He is also the current national coordinator of training in Child and Adolescent Psychiatry, with the aim of developing mental health services for children and adolescents in Uganda.

NEWSLETTER SUBMISSIONS: The next newsletter will focus on contraception use in Ugandan adolescents and will be published in November 2014. SAHU members are encouraged to submit member news, program updates and interesting cases related to this newsletter topic with all patient identifiers removed. The editorial board will conduct a peer review process for all submissions. Submissions will be accepted from July 15th – September 15th, 2014. Please e-mail all submissions to: sabrinakitaka@yahoo.co.uk. Thank you in advance for your participation.

Interesting News

AN ASSESSMENT OF DEPRESSION AMONG ADOLESCENTS WITH SICKLE CELL DISEASE IN KAMPALA, UGANDA Sept-Oct, 2013

Nathan Elwood, Columbia University College of Physicians and Surgeons NYC, USA Class of 2014



Adolescents with chronic illness are susceptible to depression and other mental health problems. Many issues associated with chronic illness, including frequent hospital admissions, missing school, and feeling different than their peers contribute to decreased quality of life. Sickle cell disease is among the most common genetic disorders in the world and has a high prevalence in Uganda. Depression in adolescents with sickle cell disease has not been well studied in East Africa, and the burden of depressive disease in patients with sickle cell disease remains unknown.

Patients were identified in an open, sequential manner at the Sickle Cell Clinic of Mulago Hospital in Kampala, Uganda. Exclusion criteria included the need for urgent medical treatment and the absence of a parent/guardian for patients aged less than 18 years. Patients were evaluated for depression using the Patient Health Questionnaire (PHQ-9), which was administered by the study coordinator and translator. The PHQ-9 is a screening tool for depression developed in the United States and has been validated in several populations in

Africa, including Nigerian university students and Kenyan adults with HIV. Additional questions were asked regarding medical complications of sickle cell disease, including pain crises, acute chest syndrome, and hospital admission. 81 patients were approached for participation in this study, and 79 were consented and interviewed of which 53% were female. 7.6% had a PHQ-9 score of ≥ 10 , an accepted screening cutoff for major depression, while 45.6% had a score of ≥ 5 , indicative of either minor or major depression. Patients reporting more frequent pain crises during the prior 6 and 12 months had statistically significant higher mean scores on the PHQ-9 ($p=0.009$ and $p=0.039$, respectively). The number of episodes of severe chest pain was also associated with a PHQ-9 score of ≥ 10 ($p=0.025$). There was no significant difference in the rate of depression based on gender or age.

Depressive symptoms are common among the adolescents receiving treatment at the sickle cell clinic at Mulago Hospital, although the number scoring ≥ 10 was less than expected based on US studies done in adolescents with sickle cell disease. Nevertheless, depressive symptoms represent a significant burden of disease, and these patients would likely benefit from increased access to mental health services. There appears to be a relationship between some aspects of sickle cell disease severity and the severity of depressive symptoms.

Awarded Grants

CONGRATULATIONS TO DR. SABRINA KITAKA who was awarded two grants for a 3-year grant cycle beginning January 2014 and extending through the end of 2016:

- **The American Academy of Pediatrics International Community Access to Community Health (ICATCH) grant** for “**Promoting Adolescent Medicine in Uganda.**” Funds will be used to enrich the Makerere-Mulago-Columbia-Adolescent Health Clinic (MMCAHC).
https://www2.aap.org/sections/ich/i_catch.htm
- **The Freidland Foundation grant** will help partially support the operational costs of the MMCAHC. <http://friedland-foundation>

Breaking News: SAHU Website Goes Live on June 1st

THE SOCIETY OF ADOLESCENT HEALTH IN UGANDA (SAHU) IS PROUD TO ANNOUNCE THE SAHU WEBSITE
PLEASE VISIT US ON JUNE 1st AT: www.sahu.ug

Program Updates

SMALL BEGINNINGS IN IMPROVING MENTAL HEALTH SERVICES FOR CHILD AND ADOLESCENTS IN UGANDA

Submitted by Dr. Godfrey Zari Rukundo

Background

More than 50% of Ugandans are children and the mental health needs of this population largely go unmet. Children with mental health problems often have a multitude of difficulties including rejection by their families and communities, low educational achievement, poor self-esteem and dysfunctional relationships. Despite the glaring need for mental health services for children and adolescents in Uganda, there is only one child and adolescent psychiatrist for more than four million children. The need to promote development of mental health services for children and adolescents is imperative.

Uganda has taken a step to train a multi-disciplinary team of mental health workers to cover the treatment gap. The training is at two levels: certificate program and diploma program. The training curricula for both the certificate

and diploma programs have been developed and funded by the United Kingdom Government for the initial two years of training. Funding was through The Department for International Development and The Tropical Health Education Trust with support from Ministry of Health, Ministry of Education, Makerere College of Health Sciences and Mbarara University of Science and Technology. Both trainings are six one-week teaching modules (240 hours) given by child and adolescent mental health specialists from the United Kingdom and Uganda at the Butabika Psychiatric Clinical Officers' (PCO) School. There also is 30 days of intensive clinical work (240 hours).

Certificate Training Program

The aim of this one-year specialist certificate is to provide knowledge and skills in: child development and family

assessment, common neurological disorders like epilepsy, developmental disorders, behavior disorders, child trauma assessment and treatment, child protection and inter-agency liaison. The goal is for the graduates to appropriately assess the child, adolescent and family, provide basic interventions and make appropriate consultations and referrals.

So far, one cohort of trainees has completed the certificate training. Fifty applications were received, and 24 were selected due to limited funding (3 psychiatrists, 1 social-worker, 2 psychologists, 2 occupational therapists, 9 psychiatric clinical officers and 7 nurses). The trainees were from two national and seven regional referral hospitals (Butabika, Mulago, Mbarara, Gulu, Kabale, Masaka, Arua, Jinja and Mbale). Twenty-three of the trainees (95.8%) successfully completed the programme and were awarded certificates on November 29, 2013. The graduates were already working with children/adolescents with mental health problems in Uganda. They were already employed and have continued to work in their organisations. We hope to admit another cohort of trainees in January 2015.

Diploma Training Program

This is a one year specialist diploma training with the aim of providing knowledge and skills in: psychological and behavioural treatments for mental disorders in children/adolescents, service development, paediatric liaison, supervision of other health professionals, child and adolescent research, and teaching. The goal is for these graduates to be able to provide appropriate treatments for the children/adolescents and their families, conduct research, function as a paediatric liaison, and train and supervise

other health workers in child and adolescent mental health.

For diploma selection, key factors included: performance at certificate level, commitment and ability to teach. The goal was also to create a group of varied professional with regional representation. All the graduates of the certificate program applied for the diploma programme. Only 15 (65%) were selected (from Butabika and Mulago national referral hospitals and Mbarara, Gulu, Kabale, Jinja and Arua regional referral hospitals). To date they have completed two modules: family therapy & research methodology and behavioral approaches & service development. The next module is May 21-25 on individual therapy, attachment, & paediatric liaison.

Improvements after the Training

Before conducting the trainings, a baseline survey was done looking at the number of patients seen, child and family assessments completed, the prevalence of psychological therapies, and medications used. We found that few children were being seen, most of the assessment information was scanty, and there was over prescribing of medication like haloperidol for attention deficit hyperactivity disorder. After the certificate training, we repeated the survey and key findings included that more children had complete assessments and less psychotropic medication (e.g. haloperidol) was being prescribed.

Conclusion:

Our hope is that the Ugandan government will continue to support these trainings. The goal is that children and adolescents with mental health disease can be appropriately identified and treated and grow into healthy adults.

ADOLESCENT MENTAL HEALTH SERVICES AT MULAGO HOSPITAL- UGANDA

Submitted by Dr. Joyce Nalugya



Joyce Nalugya is a consultant psychiatrist with special training in child and adolescent mental health. She heads the Child and Adolescent Mental Health Service at Mulago Hospital

“Do your little bit of good where you are. It's those little bits of good put together that overwhelm the world” Desmond Tutu

Mulago Hospital, the National referral and teaching hospital for Makerere University was founded in 1917 by Albert Ruskin Cook and has a bed capacity of 1500. The current facility was completed in 1962. The Department of Psychiatry was established in 1974 with a mission of offering service as well as training and research. The inpatient unit has a bed capacity of 50, of which 10 beds are for children. Over 10000 patients are admitted yearly and treated in the various clinics and wards in the department, of which over 1700 are children and adolescents.

All our clinical services are provided free of charge to patients and their families. The unit currently offers general outpatient and inpatient services as well as specialized mental health services that include: emergency, consultation liaison service, geriatric service, community service, as well as the *child and adolescent mental health service*. Our mission is to

become a center of psychiatric excellence in service delivery, training and research in Uganda and the region.

The Child and Adolescent Mental Health Service (CAMHS) team is currently comprised of one child psychiatrist, two clinical psychologists, one psychiatric clinical officer and two nurses. We work closely with the Departments of Pediatrics and Child Health, speech and language therapy, occupational therapy, social workers, Community Mental Health Initiative- Uganda (CoMHI), the Befrienders who support us in suicide prevention work, laboratory and pharmacy staff as well as the adult mental health service.



Staff sharing information with parents

We started with one weekly clinic day, but as demand increased, we now have three specialized outpatient clinic days for children and adolescents. We offer inpatient service as well as consultation liaison service. We try to bring families of children with similar problems together. For example, families of children with autism meet every Monday, parents and caregivers of children with epilepsy and intellectual disability meet every Tuesday, and Thursday is reserved for adolescent groups. We offer child and family assessments, psycho-education, behavior treatments and other psychological plus pharmacological treatments if required.

Parents share experiences and learn from each other.

We also started a service for deaf people supported by Sign Health Uganda, and now all staff at the unit have increased awareness on deafness and sign language; we also have access to interpreter services.

In addition to the clinical work, we offer a one month training course to residents in pediatrics and child health, a three month course to residents in psychiatry, and expert lectures on mental health issues to 4th year medical students. About 70 undergraduate and 30 post-graduate students go through the department each year. I have found how fruitful it is mentoring young people! Two residents from the Department of Pediatrics are doing their research in child psychiatry and two psychiatry residents are considering training in child psychiatry.

As a result of these trainings we now receive increased referrals from pediatricians. Examples include children referred with behavior problems (who used to be mainly treated with medication), somatoform disorders, and autism.



In 2013 we attended to 514 new patients of whom 278 (54%) were adolescents age 9 to 17 years. The majority of these were treated for: epilepsy (107; 20.8%), depression (38; 7.4%), conversion disorder

(35; 6.8%), intellectual disorder (22; 4.2%), bipolar disorder (21; 4.0%), conduct disorder (11; 2.1%), post-traumatic stress disorder (13; 2.5%), HIV related psychosis (8; 1.6%), schizophrenia (7; 1.4%), attention deficit hyperactivity disorder (5; 0.97%), enuresis (5; 0.97%), alcohol and/or substance abuse (4; 0.77%), and autism (2; 0.3%).

It's often exciting to see how fast young people with supportive parents, caregivers and teachers improve! Last year we decided to develop a proper information system to help us measure our work and to follow our clients better. We liaise with schools and early intervention programs as well as volunteers and Non- Governmental Organizations working with children.

The United Kingdom government through the East London NHS foundation trust - Butabika link supports the training of clinical officers and nurses in CAMH. This link was established in 2006 initially to support services at Butabika National referral mental hospital, but it extended to support CAMHS in other hospitals in the country.

Our greatest challenge is limited human resources, lack of educational programs for adolescents with autism spectrum disorders, limited CAMH scholarships and CAMH related research.



KITEBI TEENAGE CENTRE, BRINGING SERVICES CLOSER TO THE YOUTH OF LUBAGA THROUGH PARTNERSHIP WITH NAGURU TEENAGE CENTRE

Submitted by Bukenya Gilbert Sseguya, Youth Coordinator, KCCA Kitebi Teenage Centre

For the past three years, Kitebi Teenage Center (KTC) and Naguru Teenage Information and Health Center have delivered a minimum package of adolescent sexual reproductive health youth- friendly services at Kitebi Teenage Centre located in Kitebi Health Centre, a public health centre in Kitebi, Lubaga. The health centre delivers the highest level of health care next to the hospital. Services offered include reproductive health talks to hard-to-reach young people living in slums and on the streets, info-tainment, voluntary counseling and testing for HIV, medical screening for sexually transmitted diseases, and a range of recreational activities. Key to this program is that these services are further extended to notable areas where young people, especially those out of school, are involved in all kinds of work that include brick laying sites, bodaboda stages, markets, motor machine workshops and garages, music and Ludo clubs, and local drinking joints.

As of June 2013, 9 medical service providers and 13 peer educators have been trained in Youth Friendly Adolescent Sexual and Reproductive Health service delivery to support the delivery of quality services. Assorted drugs and supplies are procured and supplied whilst peer educators and health workers are facilitated to carry out outreaches and clinical services delivery. Between October 2011 and June 2013, a total of 8,764 teens have been reached by the various services of Kitebi Teenage Centre.

Despite the remarkable progress registered by this partnership, some challenges have been experienced.

These include the shortage of human resource primarily for the medical team where there are few trained health workers in Youth Friendly Services. Because of such shortages, the few trained medical teams in Youth Friendly Services get involved in the other general health centre activities and thus are not effectively able to use their expertise to treat the large numbers of young people visiting the facility and seen in outreach settings.

The space for effective Youth Friendly Service delivery is still limited thus compromising the needed separation of young people services from adult services. Also, key principles like confidentiality and privacy remain lacking.

But even with the above bottlenecks, this partnership has helped extend these key services to such a vulnerable group of society, and measures are in place to ensure that such bottlenecks are addressed. These include annual trainings of health workers and peer educators and continuous advocacy and lobbying to allocate space for Youth Friendly Services in Kitebi from the Kampala Capital City Authority, the facility leadership and the health team that manages public health facilities in Kampla.



TRANSITIONING ADOLESCENTS TO ADULT CARE AND TREATMENT CENTRE (CTC)-BAYLOR TANZANIA EXPERIENCE

Submitted by Alex Massawe Social Worker, Baylor Tanzania -Mwanza COE

Baylor College of Medicine Children's Foundation Tanzania is part of the BIPAI (Baylor International Pediatric AIDS Initiative) network dedicated to care and treatment of HIV-infected children and adolescents in Tanzania. The Baylor Tanzania programme is unique because it has two Centres of Excellence (COEs): Southern Highlands COE in Mbeya and Lake Zone COE in Mwanza. Since January 2014, Lake Zone COE has successfully started transitioning adolescents into adult care by preparing adolescents for transfer to Bugando Medical Centre (our host referral hospital) and other CTCs.

Before we developed a transition plan, adolescents were reluctant to leave Baylor because they thought adult clinics would be less adolescent-friendly. Consequently, Baylor became concerned that transitioning might negatively impact on adherence to treatment. Baylor and Bugando started discussions on how to address the observed challenge. They decided to form a committee to develop a smooth transition process. As part of providing adolescent-friendly services, Bugando CTC established a youth clinic on Saturdays. The clinic targets adolescents and youth who are in school but remains open to all 18 -24 year olds. Adolescents and youth love this clinic because the friendly clinic staff is conversant with adolescent issues. Baylor continues to offer psychosocial support to transitioned adolescents and works very well with staff at the clinic.

Transition process:

We have divided transition into two phases developed by Baylor Tanzania (Mwanza COE). Phase one is for those 15-17 years and phase 2 is for those 17 years and above. Counsellors and social workers conduct the majority of tasks.

Both transition phases are guided by age-specific questions, which are entered into a transition access database. Transfer to the adult clinic occurs at age 18 years.

Clients are asked questions to assess knowledge about their current CD4 count and viral load, medication names and timing of doses, and availability of treatment support at home. Other examples of questions include: status of disclosure, current sexual activity, knowledge about family planning methods and the risks of unprotected sex. On the final day, a transition doctor makes sure that all the required steps have been fulfilled. A checklist, a government transition form and all relevant documents are presented to the new team to help ensure excellent patient management. Preparing teens before transition is crucial because the process helps the health worker be sure that client's understanding is good, and that he/she can manage to take care of him/herself responsibly.

Some of the concerns raised by teens before transitioning:

Many teens ask whether they will be allowed to continue participating in adolescent psychosocial support activities (Teen Club) run by Baylor. They are allowed to attend the monthly club which provides psychosocial support to adolescents through education, life skills and recreation sport.

Conclusion:

The youth clinic has addressed the reluctance of HIV-positive adolescents to transfer to adult care by creating a supportive and comfortable space with adolescent friendly staff that successfully facilitates this transition.

SAHU'S First Clinical and Scientific Meeting



The Society of Adolescent Health in Uganda, SAHU, held its first Scientific and Clinical Meeting in Kampala, Uganda on December 4th and 5th. The theme of the meeting was promoting adolescent health in Africa. Makerere and Columbia University Departments of Pediatrics, SAHU, The Makerere University School of Public Health and The Rakai Project sponsored the meeting. Although this was SAHU's first Scientific Session, this meeting was the continuation of the ongoing Makerere University and Columbia Universities (MUCU) collaboration to help scale up Adolescent Health in Uganda. This was the **FOURTH** annual conference that MUCU has organized and sponsored; the previous three meetings were workshops in Kampala, Uganda that addressed Adolescent Health topics. 137 participants from Uganda, Ethiopia, Tanzania and Kenya attended this year's meeting. The aim was to provide practitioners with up-to-date, evidence-based information related to adolescent health care in Africa. Presentations were given by senior professionals including lawyers, physicians, PhD's, program managers, and by faculty from the Rakai project. There was an adolescent panel in which young HIV-positive adolescents from the Ariel club, Elisabeth Glaser Paediatric AIDS Foundation spoke out about their lives and how they coped with situations in high school. There were 10 oral abstracts presented and 10 poster presentations. To view a few meeting excerpts, the complete agenda and the abstracts click this link: [Complete Agenda](#) and [Excerpts](#). **PLANS FOR THE 5th ANNUAL CONFERENCE IN KAMPALA, UGANDA ARE IN PROGRESS. STAY TUNED FOR UPDATES ON DATES AND MEETING CONTENT!**

Adolescent Health in Uganda

The Society of Adolescent Health in Uganda (SAHU) was launched in November 2012, following a regional training in Kampala, Uganda, that was led by experts from Columbia, and Makerere Universities and the Naguru Teenage Center. Uganda's population is young with 52% under the age of 15 yrs and 25% aged 10-19 yrs. To help optimize the health of adolescents, reduce their risk-taking behaviors and guide them into thoughtful decision making that can capitalize on their strengths; access to comprehensive health education and reproductive, physical and mental health care is essential. **A Healthy Adolescent: A Healthy Nation!**

SAHU's Mission Statement:

SAHU exists to promote comprehensive adolescent health, growth and development in Uganda through knowledge dissemination, research, advocacy and affiliation with other societies and bodies involved in adolescent health.

The Vision of SAHU:

Each and every adolescent will be provided the opportunity to access their potential and grow into healthy, responsible and independent adults.

SAHU'S Web Site: www.sahu.ug

GOOD NEWS: SAHU membership will initially be FREE

SAHU MEMBERSHIP: You can join SAHU by E-mailing:

adolhealthuganda@gmail.com. Please include the following information in your

E-mail: § Name, title § Job title § Institution /Affiliations § E-mail address

Adolescent Mental Health Case

Submitted by Dr. Randi Teplow-Phipps

Third Year Adolescent Medicine Fellow, Columbia University Medical Center, New York, U.S.A

Mike is a 16-year-old male who is on vacation from boarding school. His mother brings him to see his pediatrician, Dr. Lang, for vaccine update and because she is slightly worried about Mike's recent behavior. Mike's mother explains that since Mike has been home from school she has noticed that he does not always want to participate in his normal activities, is less interested in seeing his friends, sleeps a lot and has been eating much less. Although she is a bit worried, she states, "I am sure these are normal teenage behaviors, but I thought I would ask". He is an A student who excels at school and has high hopes of attending University and would like to study law. He comes from a loving and supportive family and has 2 younger brothers. Mike has no previous medical or surgical history and his family history is significant only for a grandfather with heart disease and an uncle with depression.

At the beginning of the visit Dr. Lang discusses the nature of the confidential visit with both Mike and his mother. She explains that each teen is given the time to speak with her privately and that almost everything discussed is kept confidential. Confidentiality would only be broken if the patient is deemed to be unsafe (suicidal, homicidal), and then the parent would be the first to be informed. Dr. Lang explains that the goal of this private time is to get to know her patients, have the chance to answer their questions, address their concerns and reinforce healthy decision-making. Dr. Lang also reassures the mother that she will address all of her concerns as well.

After Mike's mother steps out of the room, Dr. Lang asks Mike about his mother's worries. He says he is fine. Dr. Lang reinforces to Mike that everything

they discuss will remain confidential unless his safety is at risk. Dr. Lang explains that she will ask some personal questions in the service of learning more about him so she can then offer him appropriate services. He says he understands, but is not very forthcoming with many of his answers. She uses the HEADDDSSS acronym (Home; Education; Activities; Drugs; Diet; Depression; Safety; Sex; Suicide) to take the psychosocial history.

He denies any drug or alcohol use. He also states that he is not yet ready to be in a relationship and has never been sexually active. He feels safe in all environments. He says things are good at home but he is afraid he has disappointed his parents. When asked if he could explain this further, he looks away and remains silent. Dr. Lang decides to move on and ask about school. Although he says, "school is going fine" he is still looking away and he begins to nervously pick at his nails. Dr. Lang responds in an empathetic way, "Although you say things at school are fine, by the way you look, it seems like something might be bothering you. I would be very interested in hearing about what you are feeling." There is a moment of silence then he quietly says that he is working really hard at school but over the past several months he has been very stressed-out and anxious all the time. He is afraid to tell his parents, he thinks they may be disappointed in him for feeling this way. Dr. Lang says, "I can see how much you care about your parents and how hard this is for you." She follows that up by asking if he ever feels sad or depressed, and he admits that sometimes he does get really sad but is not sure if this means he is depressed. When asked if he is ever so upset that he thinks about harming or killing himself, he says that he

has never wanted to die but that sometimes he is so sad that he cuts himself with a scissor to relieve the pain. He says this temporarily helps. He then moves a bracelet covering his left wrist and shows Dr. Lang several healed straight scars and one fresh one. He has never told this to anyone before. Dr. Lang applauds him for disclosing this information and mentions that other teens also engage in cutting for the same reason, reinforcing that he is not alone. She explains that there are safer and more productive ways of dealing with sad feelings and suggests that together they come up with healthy plan to help manage his pain. He looks down but smiles. Dr. Lang asks him if he would like to discuss this with his mother. He says, no, his mother has always been a support to him and loves him very much, and he does not want to upset her. After some discussion, pointing out the pros and cons of sharing this information with his mother, Mike agrees to tell her; he asks Dr. Lang to stay in the room.

Although Mike's mother does get upset, she is very thankful that she has been told. Mike feels a sense of relief. Dr. Lang explains that Mike's recent behaviors are likely a reflection of his struggle with depression. They all agree that Mike would benefit from seeing a mental health counselor. A follow-up appointment is scheduled in 2 weeks to see how things are going.

Three-Month Follow-Up:

Mike went to see a mental health specialist and was able to work through some of his stress and develop some very helpful and healthy coping strategies. He began feeling much better, sleeping and eating better and enjoying time with family and

friends. He was very thankful that Dr. Lang was able to help him.

If you identify an adolescent in Uganda with possible mental health issues and want to discuss the case, PLEASE contact:

Dr. Godfrey Zari Rukundo, Senior Lecturer, Mbarara University of Science and Technology, Child & Adolescent Psychiatrist, Mbarara Regional Referral Hospital

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OR

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Istockphoto.com

Reflections On This Case

Dr.'s Randi Teplow-Phipps, Margaret Ray and Betsy Pfeffer
Columbia University Medical Center, New York, U.S.A

1. Providers working with adolescents could benefit from learning about adolescent specific care: Dr. Lang is a general pediatrician who had the interest and took the time to learn about the care of the adolescent patient. Not all providers are comfortable managing adolescent issues. If this is the case, then knowing where to refer their adolescent patients for adolescent sensitive care is advantageous.

2. Confidentiality: As done with this patient, it is important to discuss the concept of confidentiality at each visit with both the patient and the parent. This helps to build the trusting relationship with the teen and continues to keep the parent involved with care. It is crucial to be clear that you may have to break confidentiality if you worry about the patient's safety.

3. Assess mental health at every visit: Ask specific and directed questions relating to the patient's mental health. Mike may not have shared this information with the provider if not asked about it. As Dr. Lang did with Mike, if the patients' answers don't match the body language, discuss what you see with the patient. This will show the patient that you are genuinely listening and concerned and help the patient feel more comfortable in disclosing their feelings.

4. Ask about a specific family history of mental health issues: We often forget to ask about mental health when we talk about family history. Many people do not consider these issues as a medical illness and will not offer this information unless specifically asked.

5. Educate parents about good communication with their adolescent:

Even teens that are high functioning and successful at school may still engage in high-risk behaviors or may be in need of help. Mom did recognize and was concerned that her son was sleeping more than usual, had a decreased appetite, and did not have his usual interest in activities, but she thought these were likely "normal teenage behaviors". It is ideal to include caregivers in the care of their adolescent as long as they can create a supportive and healthy environment for the teen. Mike's mother was able to do that. If this was a mother who would have likely been angry and punished Mike for sharing this information, it might have been best to keep Mike's feelings confidential and then worked exclusively with Mike.

6. All adults (providers, parents, teachers, caregivers) can be encouraged to offer support: Let teens know that you are there for them unconditionally. Don't barrage teens with questions; they may feel patronized. It may be hard to talk about feelings and teens may not know why they feel the way they do; it is best to respect this. This can best be accomplished by: being gentle but concerned, not giving up, and building a relationship to help them feel support and respect.

7. Listen and avoid lecturing or passing judgment: Don't try to "fix it" or talk him/her out of the feelings; you can't. Validate feelings, acknowledge the pain and confirm that you take the feelings seriously. Let the teen know that feelings of depression can happen to anyone and that, with help and time, depression can improve.

8. Young adults have been self-injuring for a long time: Karl Menninger was the first to recognize the clinical significance of self-injury in 1938. Armando Favazza's 1987 book, *Bodies Under Siege*, described self-mutilation practices across cultures and time, and importantly distinguished socially sanctioned self-injury, such as rituals, from non-socially sanctioned self-injury, as in Mike's case. At that time, researchers began to give the topic serious attention. Studies over the past 10 years have shown steadily increasing rates of self-injurious behaviors in the US and Europe, with prevalence ranging from 24% in the US to as high as 38% in some countries [1, 2]. However, we know very little about rates of self-injury in teens in developing countries.

Self-injury includes a large range of behaviors, from skin cutting, burning, or carving, to pin scratching, head banging, or interfering with wound healing. Teens typically injure themselves on their extremities, forearms and thighs, but may also cut on their chest, face, and genitals. Onset of self-injurious behavior is rarely pre-pubertal, and seems to peak in mid-adolescence. There is a significant association with psychiatric disorders, particularly depression, anxiety, post-traumatic stress disorder, and substance abuse disorders. Most importantly, there is significant overlap between populations of teenagers who self-injure and those who attempt suicide [3].

Increased clinician recognition and awareness of the problem has contributed to identification of teenagers who self-injure and allowed clinicians to provide appropriate support and help. It is so important to be aware of and ask about self-injury in adolescents—if we ignore the problem, it will never be addressed.

For a more complete discussion on this topic please click the hyperlink below to view a powerpoint presentation prepared by Dr. Margaret Ray:

[NSSI “Non -Suicidal Self Injury in Adolescents”](#)

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Latest in... Depression in Ugandan Adolescents

Dr.'s Betsy Pfeffer and Godfrey Zari Rukundo

Overview of Depression:

Worldwide, up to 20% of children and adolescents suffer from a disabling mental illness [1]. Depression is a common mental disorder. Globally, depression is one of the major causes of disability and disease burden effecting more than 350 million people of all ages worldwide [2]. The World Health Organization (WHO) projects that by the year 2020, worldwide, childhood neuropsychiatric disorders will increase by over 50 percent to become one of the five most common causes of morbidity and mortality among children [3]. Sub-Saharan Africa has been racked by conflict for years and rates of post-traumatic stress disorder (PTSD), anxiety, and depression reportedly range from 20 to 60 percent [4]. Fischer *et al* reviewed thirty studies that evaluated mood disorders either limited to or including adolescents aged 10–19 years in resource-constrained settings. Evidence was available from 15 (13%) of the world's 112 low- and lower-middle-income countries. Evidence from those 15 countries suggested that depression and other emotional disorders are prevalent in adolescents living in low resource environments [5].

In the USA, although depression can occur in children of all ages, adolescents are at the highest risk. Depressed adolescents carry an increased risk of substance abuse, recurrent depression, and other mental health problems in adulthood [6]. Clinical depression in teenagers is often difficult to diagnose because varying moods mark normal adolescent behavior. Also, in contrast to adults, teenagers more often rely on caregivers to recognize that they are suffering and bring them for care.

Depression in adolescents can present differently from depression in adults. Depressed adolescents may have an irritable or angry mood; somatic

complaints; increased sensitivity to criticism; and withdraw from some, but not all, people as opposed to adults who tend to become more globally isolated [7].

Depression affects twice as many women as men across different countries and settings [8]. However, some researchers suggest that males typically respond less well to stressful situations and face greater risks than females do. Because of gender socialization, males are less likely than females to seek social support during stressful life events and are more likely to respond to stress with aggression and to deny or ignore stress and problems[9].

Diagnosis of Depression:

According to the International Classification of Diseases 10 (ICD) which is endorsed by the WHO, criteria for depression include: low mood; reduced energy, decreased activity, decreased capacity for enjoyment, interest, and concentration, increased fatigue, poor self-esteem, presence of guilt or worthlessness, agitation, decreased sleep and appetite. Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate or severe [10]. The *Diagnostic and Statistical Manual of Mental Disorders* is printed by the American Psychiatric Association and is also widely used to define depression. It has similar criteria to the ICD 10 but additionally includes the presence of the symptoms for more than two weeks in the criteria for major depressive disorder [11].

There is a strong body of evidence that the interplay of individual, family, social, economic and environmental risk and protective factors are associated with susceptibility to mental health disease. Examples of risk factors include: genetic predisposition, medical illness, academic failure, poor working skills, learning disabilities, social incompetence, child

abuse or neglect, exposure to violence or trauma, family conflict, stressful life events, low social class, and bereavement. Examples of protective factors include: good coping strategies, adaptability, sense of security, problem solving skills, literacy, good self-esteem, good parenting and social support, economic security, and mental health promotion in schools and communities [12].

Depression in Adolescents in Sub-Saharan Africa:

Mental health problems are prevalent in adolescents in Sub-Saharan Africa. In a study by Cortina *et al*, considerable levels of mental health problems were found to exist among children and adolescents in sub-Saharan Africa. One in 7 children and adolescents had significant difficulties, with 1 in 10 (9.5%) having a specific psychiatric disorder [13].

The Ugandan Global School Based Health Survey showed that 11.2% girls and 10.1% of boys aged 13-15 reported feeling lonely most of the time and that 22.8% of girls and 14.5% of boys reported seriously considering attempting suicide within 12 months prior to the survey [14].

Another study in Uganda found that disadvantaged children living in northeastern Uganda had a high prevalence of depressive disorders. Ecological factors, markers of the quality of the child-principal caregiver relationship and the presence of psychiatric co-morbidities or psychiatric problems were found to be the important independent determinants of childhood depression [15].

During the war in Northern Uganda (roughly 1986-2008), many individuals were exposed to extreme trauma and harsh conditions and thousands had been abducted into the rebel army. Former abductees continue to suffer from severe mental health problems [16].

For Ugandan families where HIV/AIDS was an issue, one study revealed that most children felt hopeless or angry when their parents became sick with HIV/AIDS and scared that their parents would die. Most children who had become orphaned were found to be depressed [17].

A study in HIV-infected adolescents in Malawi, conducted by Baylor's Children's foundation, demonstrated that the prevalence of depression in adolescents infected with HIV was high (20%) and was greater among females than males (25.6% VS 12.6%); the WHO Stage and change in caregivers or guardians were significantly associated with depression [18].

Suicide:

According to the WHO, suicide accounted for 6% of all adolescent deaths worldwide in 2004. Almost two thirds of these deaths were in sub-Saharan Africa and Southeast Asia. Pronounced rises in mortality rates were seen from early adolescence (10-14 years) to young adulthood (20-24 years) [19].

Worldwide, girls and women have higher rates of suicidal ideation and suicidal behavior but lower rates of suicide mortality than boys and men [20]. Males also suffer from depression and are more likely to complete suicide compared to females. On average, there are three completed male suicides for every female suicide [21].

One study in Kampala, Uganda found the male to female ratio of completed suicide was 3.4:1 for those aged 15 years and above, with a peak age of suicide in the 20-39 years age group. The main methods of completed suicide in this study were hanging and ingestion of poison (mostly organophosphates), similar to that seen in other developing countries. Loneliness, problems with

making or maintaining friends, unemployment, poverty, feelings of shame and higher psychological distress scores were risk factors found to be associated with completed suicide [22].

An analysis of the Global School-Based Student Health Surveys (GSHS) conducted on students aged 13-16 years of age in Botswana, Kenya, Tanzania, Uganda and Zambia revealed that sadness and feeling lonely were most commonly associated with suicidal ideation. Reported rates of suicidal ideation varied by country: Zambia (31.9%), Kenya (27.9%), Botswana (23.1%), Uganda (19.6%), and Tanzania (11.2%) [23].

In many parts of the world, suicide is a taboo, carries social stigmata, and those who attempt suicide may be condemned for religious or cultural reasons. As a result, suicidal thoughts and attempts may be kept private and therefore may be underreported [21]. In many parts of the world suicide is a crime. Ugandan penal code denotes suicide as a misdemeanor and anyone who attempts suicide can end up in jail [24]. Additionally, those who die by suicide may not given a decent or proper burial and their families are often shunned [25].

Assessment Tools:

How depression is manifested can vary based on cultural setting. For example, in Western cultures mood change is one of the primary features of depression. This may not be a core feature of depression in culturally different communities [8]. To identify and monitor mental health disorders including depression, the cultural context of mental illness needs to be considered. Local adaptation and validation of screening instruments can most successfully measure the prevalence and incidence of mental health problems [26,27].

There are few psychological tools developed and standardized for use in

sub-Saharan Africa. One review article found that consulting with local communities was a successful way to both develop and adapt measures for use [28]. Another study revised the Response Inventory for Stressful Life Events tool and showed that it could be successfully used along with a clinical interview to detect and confirm the presence of mental health illness and suicidal feelings in students from Makerere University and the general population in the Adjumani and Bugiri districts in Uganda. Interestingly individuals in the Adjumani and Bugiri district did not have specific words for depression and suicide but the concept was well understood. The expressions for depressed mood were "heavy pain in the heart" or "thinking too much" compared to words such as disappointment and sadness [25].

Delivery of Mental Health Care:

There are many challenges to delivering mental health care worldwide and the challenges are greatest in developing countries. In these settings, individuals seek help from any available sources including traditional healers, physicians, nurses, mental health providers, family members and community or religious leaders. In addition to inadequate access to validated treatment in many developing countries, there is stigma associated with mental health disease, poor recognition of mental health problems and lack of trained mental health personnel [8]. Despite these challenges, developing (low income) countries have been effective in implementing strategies to both prevent and treat mental health problems in a variety of settings. Depression has been shown to be effectively managed by improving community responsibility, providing social support, increasing the types of providers who administer mental

health care and training lay providers [29,30]. In many developed countries care for depression is poorly coordinated and managed by primary care doctors who may not be very interested or skilled in dealing with mental health disease. Perhaps developed countries can learn from these strategies employed in the developing world [30].

One study trained lay and community health workers to deliver culturally adapted and accepted mental health treatments to depressed individuals over the age of 16 living in three resource-poor countries, including rural Uganda. This approach resulted in practical and effective interventions for depression [29]. One recent study done in Uganda interviewed 246 Ugandan lay and professional adults to determine the personal, social, and cultural beliefs about the nature and cause of depression. Although depression in Uganda was found to share much in common with the Western psychologically based perception of depression, important cultural features specific to Uganda were identified such as the role of poverty and illnesses like HIV/AIDS, the social stigma associated with depression, and the reliance on social support. Additionally, findings indicated that concepts of depression differed between the lay community and Ugandan caregivers including traditional healers (who play a major role in care giving in Uganda), primary care professionals, and mental health providers. For example, the lay population and mental health professionals held the same belief as to the

cause of depression, but the lay population agreed more with traditional healers about the impact of depression. This study also noted that many primary care staff could not reliably identify depression thus highlighting the need for education and training in this area [31].

In Uganda, there are few treatment centers specifically targeting children and adolescents. There is only one children's ward at the National Referral Psychiatric Hospital (Butabika) offering both inpatient and outpatient care. Mulago National Referral Hospital has now established one Psychiatric Clinic for children and adolescents and one General Adolescent Clinic to meet the mental health needs of young people. Mbarara and Gulu Regional Referral Hospitals have also established clinics for children and adolescents. Other clinics are being developed at Arua, Jinja, Masaka and Kabale Regional Referral Hospitals.

Conclusion:

Depression is one of the common problems experienced by all children and adolescents worldwide, including those living in developing countries like Uganda. Depression among adolescents has many negative consequences. These may include low self-esteem, poor academic achievements, risky sexual behaviors and suicidal behavior. More services specifically for young people need to be established. Resources need to be appropriately distributed to meet the mental health needs of the young people.

Take Home Points about Depression in Adolescents

- Worldwide, mental health problems, specifically depression, are prevalent problems in adolescents.
- It is important to understand and respect how culture impacts on the manifestations of depression.
- Evidence based studies on depression in Sub-Saharan Africa adolescents are scarce and are urgently needed. Local validation of appropriate screening tools will help identify the prevalence/incidence of depression in adolescents living in different cultural settings and monitor the efficacy of designed interventions.
- Programs that have expanded the types of health care providers who deliver mental health, trained lay personal and involved community support have shown to be effective interventions for prevention and treatment of depression in several low resource settings.
- *“Addressing young people's mental-health needs is crucial if they are to fulfill their potential and contribute fully to the development of their communities”* [32].



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