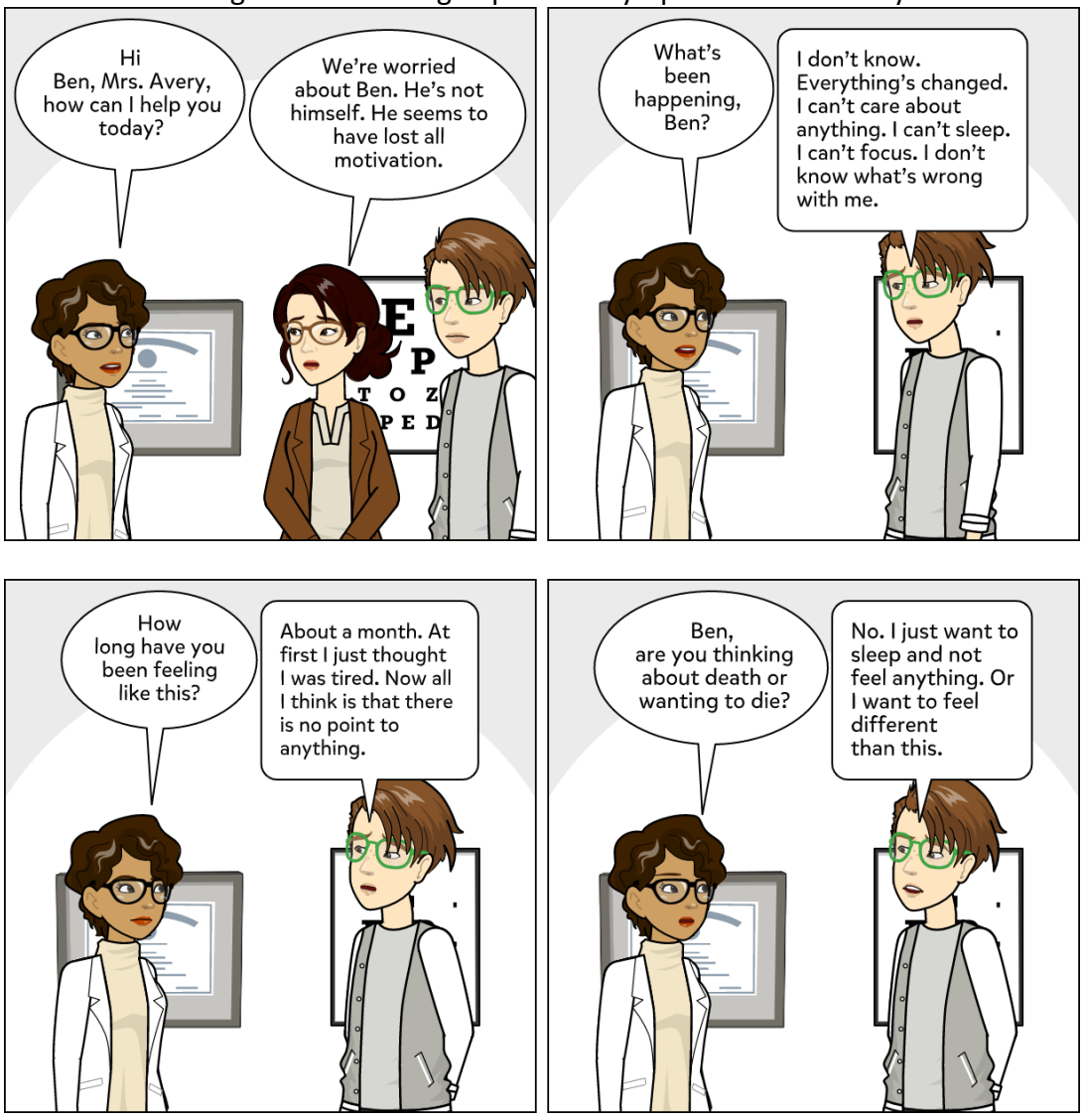
Mental Health Care in the Pediatric Clinic

The Depressive Disorders

Objectives

By the end of this chapter, you will be able to:

- Recognize the various depressive disorders
- Outline strategies for assessing depression symptoms and severity



Major Depressive Disorder (MDD)

At least 2 weeks of persistent depressed mood (or irritable mood in children) and/or decreased interest or pleasure in activities

And 4 of the following (or 3, if both of the above are present:

- Sleep: insomnia or hypersomnia nearly every day
- Interest: decreased interest in or enjoyment in activities
- Guilt: feeling worthless or excessive guilt
- Energy: Fatigue or loss of energy
- Concentration: Decreased concentration/indecisiveness
- Appetite: decreased appetite or overeating
- Psychomotor retardation or agitation (observable)
- Suicidal ideation or recurrent thoughts of death

Ben's symptoms are consistent with an episode of Major Depression. He has had both depressed mood and decreased interest in typical activities for about a month. He has trouble focusing and poor sleep. On further questioning he reports low energy and feeling guilty about not being a good person. He appears slowed down and makes poor eye contact. This is a big change from the energetic, friendly kid you have known for several years.

Major depression in children and adolescents is characterized by at least 2 weeks of either persistent depressed or irritable mood and/or decreased interest or pleasure in activities, which we sometimes call anhedonia. Either symptom or both must be accompanied by neurovegetative symptoms affecting sleep, energy, concentration, appetite, psychomotor changes, and guilt or sense of worthlessness, or suicidal thoughts or recurrent thoughts of death. At least 5 symptoms must be present, and they must include depressed moor or anhedonia.

Ask about psychotic symptoms

Children and teens with MDD will sometimes have hallucinations, most commonly auditory hallucinations that essentially broadcast the negative cognitions that are part of depression. These can greatly intensify the severity of depressive symptoms. These voices can feel very real and compelling, and kids don't always volunteer that they hear them. Command auditory hallucinations are particularly important to recognize because they represent a significant risk for suicidal behavior or harm to others.

Derogatory, cruel statements: you're no good, nobody loves you, you are a waste of space

Suggestions or commands: you should die, you should kill yourself, you should punch your brother

ASK: "do you ever feel like you are hearing things that others can't hear? or seeing things that others can't see? What is that like? What do you hear? (If voices) What do they say? Do they ever tell you to do things? When you hear that, do you feel that you have to do what they say?"

Visual hallucination in MDD are less common. They are often brief glimpses of scary images representing danger or death. Hallucinations in MDD will generally resolve as mood improves, and do not indicate that the child has schizophrenia or other psychotic disorder.

Ask about mania

Mania is a period of at least 7 days with expansive, high, or irritable mood and increased activity and >=3 of the following (or >=4 if mood is irritable only):

- Distractibility and easy frustration
- Irresponsibility and erratic uninhibited behavior
- Grandiosity
- Flight of ideas.
- Activity: increased goal directed activity
- Sleep: decreased need for sleep
- Talkativeness: talking excessively, out of character

When assessing for MDD, one should check for a history of manic symptoms. These are more likely to be present if there is a family history of bipolar disorder, or if the child has a long history of depressed mood that has been poorly responsive to treatment. Few children or adolescents will have had a full manic episode, the symptoms of which are listed here. But hypomania, or lower duration, number or intensity of symptoms may indicate risk for emerging bipolar disorder and poor response to an SSRI. These patients should be monitored closely for emergence of mania.

Asking about mania

Asking about mania can be tricky. It may work well to describe it, and ask if the child or adolescent has felt that way. If they say yes, always ask about the circumstances. They will often describe feeling very happy and excited around a particular event or situation, such as "when I'm with my girlfriend" or "when my team won the game", and they are referring to a normative response to a happy event, which is not mania.

> "*It sounds like your mood has been pretty low lately. Has there ever been a time when your mood was up, not just ok or happy, but weirdly happy, and you had a lot more energy than usual, and felt like you could do anything, or that you didn't need to sleep, or that your thoughts were going super fast*?"
>
> If yes, "*Tell me about that time. What was going on*?"

Ask about non-suicidal self injury (NSSI)

- In clinical samples of adolescents, single incident history of NSSI up to 60%, recurrent NSSI up to 50%
- Co-occurs with all major affective, anxiety, substance and trauma-related disorders
- Also occurs in the absence of other psychiatric disorders
- Peaks around age 15-16 years
- NSSI is a risk factor for suicide and suicide attempts
- NSSI is a risk factor substance abuse, even after NSSI stops

In the example above, you asked Ben if he was having thoughts of death or suicide. He said he just wanted to sleep and not feeling anything, or feel differently. We will discuss safety assessment in another module, but you would want to ask a few follow-up questions. Kids who just want to sleep and not feel anything may take excessive doses of medications in an attempt not to die to but sleep for a long time, and can be at risk for a dangerous overdose. Even if Ben is not thinking about killing himself or taking an overdose, you want to ask

about other types of self-harm. In clinical samples of adolescents, single incident history of NSSI up to 60%, recurrent NSSI up to 50%

Differential diagnosis

All of the psychological and medical diagnoses on this list should be considered in the differential diagnosis for major depression, but they also may all co-occur with depression**.**

Dysthymia – see below
Drugs or alcohol – along with MDD, or instead of
ADHD – especially untreated
Autism spectrum disorders – mild, undiagnosed
Adjustment reaction, bereavement
Anxiety- along with, or instead of
Hypothyroidism
Anemia
Mononucleosis
Autoimmune syndromes (lupus)
Chronic fatigue syndrome

Ben's symptoms are consistent with an episode of MDD, but you want to think through your differential diagnosis. The differential diagnosis for MDD includes other psychiatric disorders, listed in purple and non-psychiatric disorders shown in orange. We will talk about dysthymia in a minute. Substance abuse, including drugs and alcohol, can look like depression, and teens with depression are at high risk for substance abuse. We have mentioned bipolar disorder. The difference between an adjustment disorder and Major depression is that an adjustment disorder is triggered by a specific difficult event, tends to have only mild impact on functioning, and tends to improve the further out in time you get from the stressor. Adjustment disorders in kids are commonly triggered by difficult life changes such as parental divorce or separation, an unwelcome move to a new school, or a medical diagnosis that affects lifestyle.
Medical disorders in the differential diagnosis for MDD are essentially any condition with relatively gradual onset that saps energy and leaves the patient feeling drained.

Epidemiology of MDD

Depression is common, especially in adolescence. In community samples, duration of an episode tends to be fairly brief, but has a very high rate of recurrence.

Prevalence

children: 2%, with 1:1 M:F ratio
adolescents: 4-8% with 1:2 M:F ratio

Cumulative **incidence** 20% by age 18 in community samples
Median **duration**:

community samples: 1-2 months
referred samples: 8 months

Recurrence:

in 1-2 years: 20-60%
in 5 years: 70%

Risk factors for depression

Genetics + stress

Heritability of MDD is about 40-60%.
Genetic predisposition interacts with stressful life events to lead to depressive symptoms.
Negative cognitive styles (glass half empty), losses, abuse, neglect, ongoing conflict, exposure to violence, substance use disorders (in parent or patient), untreated ADHD, anxiety disorders, medical illness, and some medications increase risk. But remember – there does not have to be a clear trigger.

Prevention of depression

- Treat maternal depression
- Treat pediatric anxiety
- Address bullying, abuse and neglect
- Encourage regular exercise, sleep and coping strategies for stress
- Encourage avoiding unnecessary stressful, unproductive activities (consider social media)
- Encourage pursuit of meaningful activities

Adolescent MDD increases risk for:

- Future depression
- Suicide and self-harm
- Substance abuse
- School drop-out
- Unplanned pregnancy
- Strained relationships

Persistent Depressive Disorder (Dysthymia)

Depressed mood most of the day, more days than not, for 2 years (1 year in children and adolescents), with no more than 2 months of euthymia

- With 2 or more of these:
- Poor appetite or overeating
- Insomnia or hypersomnia
- Low energy or fatigue
- Low self-esteem
- Poor concentration/indecisiveness
- Feelings of hopelessness

Dysthymia is low-grade, long-lasting depression that takes a toll on kids, although they are often functioning adequately. When asking about time frame, it may help to ask, "*Can you tell me about the last time you felt ok, not depressed, and stayed that way for a couple of weeks? When was that? What grade were you in*?"

Screening for depression

The US Preventive Services Task Force recommends routine screening for depression in persons aged 12-18 years using a validated instrument. Listed below are several freely available screening tools for depression in children and adolescents. Note also that all of the screening instruments listed here can be used to track progress and response to treatment for depression.

Instrument	Age range	Parent/child	# items
Patient Health Questionnaire- Adolescent (PHQ-A)	**11+**	**child**	**2 or 9**
Patient-Reported Outcomes Measurement Information System (PROMIS) – Child Depression	**11-17**	**child**	**14**
PROMIS- Parent on Child- Depression	**6-17**	**parent**	**11**
Mood and Feeling Questionnaire (MFQ)	**8-18**	**both**	**11 or 33**

Patient Health Questionnaire-Adolescent

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

The PHQ-A differs only from the adult version of the PHQ -9 in the question about being able to concentrate where "while doing homework" is substituted for "reading the newspaper." Note also that question number 9 is tricky. It was not designed to be a suicide risk screen, but rather to assess depression severity. It does not actually ask if the patient is having thoughts of killing themselves. Any non-zero answer for question 9 should prompt gentle clarification.

Mood and Feelings Questionnaire

- Long version: 33 questions, short version 13 questions
- Parent and child versions of each
- Validated ages 8-18
- May be better option for children up to 14 than PHQ9
- The long version has a nuanced series of suicidality questions.
- https://devepi.duhs.duke.edu/measures/the-mood-and-feelings-questionnaire-mfq/

To code, please use a checkmark (✓) for each statement.	NOT TRUE	SOME TIMES	TRUE
1. I felt miserable or unhappy.			
2. I didn't enjoy anything at all.			
3. I felt so tired I just sat around and did nothing.			
4. I was very restless.			
5. I felt I was no good anymore.			
6. I cried a lot.			
7. I found it hard to think properly or concentrate.			
8. I hated myself.			
9. I was a bad person.			
10. I felt lonely.			
11. I thought nobody really loved me.			
12. I thought I could never be as good as other kids.			
13. I did everything wrong.			

The Mood and Feelings Questionnaire, developed at Duke University and freely available, for children and younger teens. It comes in a patient and parent version so you can compare perspectives. It comes in a short form shown here, which is a good screening instrument. If you know from your interview

that the child is likely depressed, you may choose to use the longer 33-item version which includes a number of questions about thoughts of not wanting to live and of wanting to kill oneself**.**

Depression severity and functional impairment
We can think about depression, like anxiety disorders, in terms of symptom burden and functional impairment.
Mild depression: moderate symptom burden, still able to function in most areas
Moderate depression: moderate to high symptom burden, impaired social, academic, or other functioning. A teen may be going to school, but grades are slipping, and they are limiting social interactions
Severe depression: high symptom burden, impairment in nearly all areas of functioning. Here a teen may be missing school, be unable to participate in previous extra-curricular activities, and cutting themselves off from friends.

Disruptive Mood Dysregulation Disorder (DMDD)

DMDD was introduced in DSM-5. It describes children who have severe recurrent temper outbursts on top of persistent irritable mood. These are not kids who can be sunny and pleasant when things are going well but who blow up when frustrated, redirected, or disappointed. These are kids who are almost never happy, and then are incredibly reactive to negative stimuli.
DMDD: Severe recurrent temper outbursts manifested verbally and/or behaviorally that are grossly out of proportion in intensity or duration to the situation or provocation.
The temper outbursts are **inconsistent with developmental level.**
They occur on average **3 or more times weekly**.
Mood between outbursts is **persistently irritable or angry most of the day**, nearly every day, as observed by others.

The time criteria are complicated, but DMDD emerges between ages 6 and 10 years, and can be initially diagnosed only up to age 18. Emerging between ages 6 and 10 years, it excludes the early temper tantrum years, and cannot have onset after age 10, when adolescent moodiness may emerge. The symptoms must be present for at least a year, and not just at home or just at school but in more than 1 setting.

DMDD arose out of the long controversy about how to treat persistently irritable, explosive kids. Many of these children were diagnosed with "pediatric bipolar disorder" in part because the atypical antipsychotics, which are indicated for bipolar disorder, relieved some of the irritability and explosiveness. Longitudinal studies, however, suggest that these children do not go on to meet criteria for bipolar disorder. Instead, they are more likely to develop depression as adults. Because it is a relatively new diagnostic classification, epidemiology and treatment are not well established. Best recommendations are to treat comorbidities, most commonly ADHD or depression and use therapy and parent-management training.

Summary

- Depressive disorders may begin in childhood but are more common in adolescence.
- Depressive disorders run in families. Their etiology appears to be an interaction between genetic predisposition and stressful experiences.
- Depressive episodes often remit but are associated with high rates of recurrence.