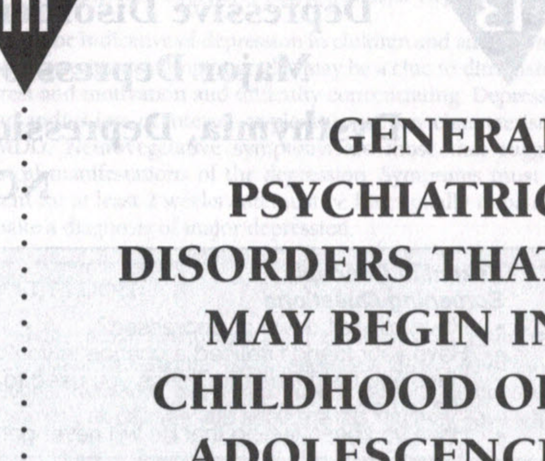


III GENERAL PSYCHIATRIC DISORDERS THAT MAY BEGIN IN CHILDHOOD OR ADOLESCENCE

13 Depressive Disorders: Major Depression, Dysthymia, Depression NOS

Essential Concepts
Screening Questions
- Have you felt down or depressed?
- Have your friends noticed a change in you?
- Have you lost interest in things you used to like to do?
- Have you been feeling that life will never get better?

Mnemonic: SIG: E-CAPS

Our generation has had no Great War, no Great Depression. Our war is spiritual. Our depression is our lives.

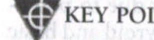
—Chuck Palahniuk

CLINICAL DESCRIPTION

Rates of depression have increased over the past five decades, with younger age of onset. Many adolescents suffer from brief periods of depression when they are faced with an upsetting event or disappointment (breakup with girlfriend or boyfriend, for example). With increased rates of depressive disorders has come an increased rate of suicide attempts. However, after a marked increase, the rates of completed suicides for youth have declined since 1990, possibly due to improved detection and intervention of depression. Substance use, concomitant conduct problems, and impulsivity increase risk.

Major depressive disorder (MDD) and dysthymic disorder (DD) in children and adolescents are diagnosed in the same manner as those of adults. However, children and adolescents may present differently. Irritability, the new onset of oppositionality and angry outbursts, and failure to make expected weight

gain may be indicative of depression in children and adolescents. A rather precipitous drop in grades may be a clue to diminished interest and motivation and difficulty concentrating. Depressed mood and/or loss of interest or pleasure are key characteristics of MDD. Neurovegetative symptoms are those that suggest physical manifestations of the depression. Symptoms must be present for at least 2 weeks and must be functionally impairing to make a diagnosis of major depression.


KEY POINT

One of the most difficult parts of psychiatry is asking the uncomfortable questions. Asking about suicide is one of those questions. However, put it into your repertoire of questions that you ask all children and adolescents. You may save a life.

MAJOR DEPRESSIVE EPISODE (MDD)

Mnemonic: SIG E CAPS

When checking for neurovegetative symptoms of depression, think of the mnemonic devised by Dr. Carey Gross at MGH which refers to what one might write on a prescription sheet for a depressed patient: **SIG**: **E**nergy **CAPS**ules

Sleep disorder (either increased or decreased)*
Interest deficit (anhedonia)
Guilt (worthlessness,* hopelessness,* regret)
Energy deficit*
Concentration deficit*
Appetite disorder (either decreased or increased)*
Psychomotor retardation or agitation
Suicidality

*For dysthymia, two of the six starred symptoms must be present for a 1-year duration.

CLINICAL VIGNETTE

A 15-year-old adolescent girl presented for her first office visit because her parents are concerned that she is depressed. You ask about sad mood and find out that she has been crying every day since she broke up with her boyfriend over 2 weeks ago. She has not wanted to get out of bed, and her friends have

complained that she doesn't want to go out with them anymore. She has typically been an A–B student and failed her first math test last week. You ask if she has felt as though life was no longer worth living, and she replies, "Sure, but it doesn't do any good. I took 10 Tylenols last week and I'm still here." You assess for acute suicidality and ask her mother to join the session. The girl tells her mother, who responds with appropriate concern. You determine the patient is safe to go home, but her mother will secure all medications. You send her to get blood drawn for liver function tests due to potential hepatoxicity of acetaminophen, and add thyroid and basic screening labs to the panel. You call her pediatrician to inform her of the patient's depression and overdose. You set up the patient for a partial hospital program the next day.

Epidemiology

The prevalence of MDD is approximately 2% in preadolescent children, with a roughly equal prevalence of boys and girls. In adolescents, the prevalence is approximately 6%, with a female-to-male ratio of 2:1, similar to the adult population. Population-based studies estimate lifetime prevalence rates of MDD by age 19 to be 28% (35% in young women and 19% in young men). The average duration of an untreated major depressive episode in a child or adolescent is 7 to 9 months. Unfortunately, 50% of youth relapse. About 10% will have a chronic course. Prevalence rates for DD are similar to MDD: 0.6 to 1.7% in children and 1.6 to 8.0% in adolescents.

It is increasingly clear that depression is often a chronic, recurrent disorder likely to continue into adulthood. Comorbid psychiatric disorders (especially conduct disorder), exposure to negative life events, family history of MDD, and conflict within the youth's family all lead to a worse prognosis. Additionally, 20 to 40% of those with childhood-onset MDD with psychotic features, family history of bipolar disorder, or a hypomanic episode as a result of antidepressant medications will develop bipolar disorder.

CLINICAL VIGNETTE

A resident was interviewing a 17-year-old twelfth-grade adolescent and asked, "How have you been sleeping?" The youth

answered, "Terribly. I never get to sleep until 1:00 or 2:00 and then I can't get out of bed in the morning." The resident considered this statement sufficient to meet the criteria for the insomnia of depression, until the girl mentioned that she has been a "night owl" since ninth grade, preferring to stay up at night Instant-Messaging with friends. It turned out that she had a sleep cycle disorder (common in adolescents).

Etiology

The etiology of depression is not completely understood. We know that the following factors play a role: genetic heritability, dysregulation of central serotonergic or noradrenergic systems, hypothalamic-pituitary-adrenal (HPA) axis dysfunction, and the influence of pubertal sex hormones. Personality factors such as a negative cognitive style have been implicated. Individuals with negative cognitive styles tend to see the "glass half empty" in all situations and see little positive in their lives. The stress-diathesis model suggests that a negative cognitive style combined with negative life events and environmental adversity is contributory to MDD.

Assessment

When assessing the child or adolescent who may be depressed, it is important to perform a comprehensive psychiatric evaluation that considers all possible psychiatric disorders, as symptoms of depression overlap with other disorders (Table 13.1). One should also be alert to the possibility of mania, as juvenile bipolar disorder frequently presents with a mixed state of depressive and manic symptoms.

TIP

Contracting for safety is a good way to engage children and adolescents around their responsibility for safety. However, don't put too much faith in them. There is no evidence that "safety contracts" protect against suicide. Listen to the patient's behavior as much as the words.

TABLE 13.1. Assessment Essentials for Depression

1. The clinical interview remains the most accurate method for assessing the presence of depression.
2. Interview the child or adolescent separately to obtain accurate information about depressive symptoms.
3. Rating scales may be used as adjunctive measures to elicit more information about symptoms (such as the Beck Depression Inventory [DBI] or the Childhood Depression Inventory [CDI]).
4. Assessment of suicidality is an essential component of the assessment of depression.
5. Both the parents and the youth should be asked about the presence of suicide risk factors, including the availability of guns, large quantities of medications, or other potential methods of suicide.
6. Comorbid conditions such as anxiety disorders, substance abuse, and disruptive behavior disorders should be evaluated.
7. Physical examination, review of systems, and laboratory testing should be done to rule out medical causes (e.g., anemia, infectious illness, hypothyroidism, effects of illicit substances or medications).

KEY POINT

Successful intervention for suicidal behavior in youths targets three domains: 1) treatment of current psychopathology; 2) remediation of social, problem-solving, and affective regulation deficits; and 3) family psychoeducation and intervention.

Treatment

Treatment is multimodal and requires a thoughtful, stepwise intensive treatment of the child and adolescent. Table 13.2 gives the essentials of treatment, elaborating on the types of psychosocial and medication treatment options available. Figure 13.1 suggests an algorithm for acute treatment of major depression.

There has been much recent controversy about the use of SSRIs and other antidepressants in children and adolescents. The data suggest that antidepressants pose a 4% risk, versus a 2% risk in placebo, of suicidal thinking or behavior. This prompted the FDA to issue a "black box" warning for

TABLE 13.2. Essentials of Multimodal Treatment of Depression

Ensuring Safety

Parent and child psychoeducation—about depression as a disease, treatments, and what the patient and family can do to decrease depression. Education around safety—need to secure medications. Always ask about guns and be sure there are none or they are locked.

Hospitalization—If the youth is suicidal or engaging in self-destructive behaviors, hospitalization needs to be considered.

Partial hospital and therapeutic after-school programs—If the risk is not imminent, but safety and severity of depression is of concern, Partial Hospital and Therapeutic After-School Programs may be considered.

Environmental stress—Identify and minimize stressors. Refer parents with their own depression or other mental health issues for treatment as well.

Collaboration with primary care physician—Monitor and collaborate in ensuring overall health (mental and physical) of the child is being treated.

School psychoeducation—with consent, close collaboration between outside treaters and school personnel is advised. School counseling and outpatient therapy should be coordinated with a unified treatment approach.

Psychosocial Treaments

Cognitive-behavioral treatment (CBT)—strongest evidence of effectiveness. Identifies patient's cognitive distortions and promotes more realistic and positive cognitions.

Interpersonal therapy (ITP)—focuses on problematic styles of interaction that may be a symptom of or a contributor to depression.

Supportive psychotherapy—helps the child reconnect with prior coping skills and restore a sense of hopefulness.

Behavior therapy—focuses on changing behaviors that may fuel depression. A focus on lifestyle (exercise, getting out, etc.) may be particularly helpful.

Family therapy—engaging families and working directly with family relationship and communication difficulties are critical to treating depressed youth.

Psychodynamic psychotherapy—talking (or play therapy for younger children). Most helpful for chronic dysthymia and highly motivated patients (and their families) who are capable of insight.

(Continued)

TABLE 13.2. Essentials of Multimodal Treatment of Depression (*continued*)

Group therapy—many children and adolescents prefer a group experience. Can be helpful for support, psychoeducation. Beware of discussions about self-destructive behavior and "copycat" behaviors.	
Medication Treatment for Depression	
Selective serotonin reuptake Inhibitors (SSRIs)	
Fluoxetine (Prozac)	8 and older (for MDD, OCD)
Sertraline (Zoloft)	6 and older (for OCD)
Fluvoxamine (Luvox)	8 and older (for OCD)
Citalopram (Celexa)	18 and older
Escitalopram (Lexapro)	18 and older
Paroxetine (Paxil)	18 and older
Other antidepressants	
Clomipramine (Anafranil)	8 and older (for OCD)
Bupropion (Wellbutrin)	18 and
Mirtazepine (Remeron)	18 and older
Nefazadone (Serzone)	18 and older
Trazodone (Desyrel)	18 and older
Venlafaxine (Effexor)	18 and older
All antidepressants have a "black box" warning for potential increases in suicidality. Only fluoxetine is FDA approved for use in children for major depression.	

suicidality for all of the antidepressants. Notably, there were no completed suicides in the study samples. Fluoxetine, the best studied of the medications, is the only one to show a significant advantage over placebo in terms of efficacy for major depression in children and adolescents (although citalopram has some positive studies, as well).

Although we do not entirely understand the finding of increased "suicidality," activation is a noted side effect of the selective serotonin reuptake inhibitors (SSRIs), and may result in more acting-out behavior. The increased energy that is noted as depression lifts, but before the patient experiences significant emotional relief, may also increase the potential of self-harm behavior. The risk of "switching" of children who are predisposed, from depression to mania, must always be considered.

In an effort to improve safety and ensure that patients with major depression receive effective treatment, the following is recommended for monitoring:

Acute Treatment of MDD
Mild-Moderate Episode
(few if any symptoms in excess to make diagnosis, mild to moderate functional impairment)

1. Start with psychoeducation and psychotherapy (for 4–6 weeks).
2. If only partial or no response, continue psychoeducation, psychotherapy, and start SSRI (continue for 6–12 weeks).
3. If no response after 6–12 weeks, switch to another SSRI (continue for 6–12 weeks).
4. If no response after 6–12 weeks of second SSRI, recheck diagnosis/comorbidities (especially ADHD and anxiety), adherence/compliance, medical illnesses, family functioning, negative life events, parent/sibling illness. Consider referral to specialist. May switch to a second-line antidepressant (buproprion, venlafaxine, nefazodone, mirtazapine).
5. Continue medication for 6–12 months after a response, then, if no relapse, progressively discontinue treatment.
6. If a second uncomplicated episode, then continue medication for 1–3 years.

Acute Treatment of MDD
Severe Episode
(several symptoms in excess of those to make diagnosis and symptoms markedly interfere with functioning, suicidality, psychotic features, bipolar, and/or recurrent)

1. Start with psychoeducation, psychotherapy, and an SSRI (for 4–6 weeks). If suicidality is present, consider safety issues and level of care.
2. If no response after 6–12 weeks, switch to another SSRI (continue for 6–12 weeks).
3. If no response after 6–12 weeks, consider referral to specialist or switch to a second-line antidepressant (buproprion, venlafaxine, nefazodone, mirtazepine).
4. Continue medication for 1–3 years.
5. If two or more complicated depressive episodes, three or more uncomplicated episodes, or chronic depression, then continue medication for 3 years to lifelong.

FIG. 13.1. Suggested algorithm for acute treatment of major depression. (Reprinted with permission from Cheng K, Myers KM. *Child and Adolescent Psychiatry: The Essentials*. Philadelphia, PA, Lippincott Williams & Wilkins, 2005.)

1. Discuss risks (including suicidal and self-destructive behavior) with parents, guardians, and patients. Advise parents what symptoms (increased agitation, thoughts of suicide, or anxiety and restlessness) to look for and to call right away if these new symptoms occur.
2. Set up weekly monitoring visits for the first month, then twice monthly for a month, and at least monthly thereafter.

The most important aspect of treating depressed children and youth is engaging them and their families actively in treatment, and providing the intensive, closely supervised treatment necessary to decrease suffering and improve prognosis.