PEDIATRIC MAJOR DEPRESSIVE DISORDER

Diagnostics, Prevalence, and Treatment

Presented By:
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OBJECTIVES

1. Recognize main signs/symptoms of depression
2. Identify consequences behaviorally, academically, and socially
3. Identify diagnostic criteria and best-practice treatment approaches

HISTORICAL PERSPECTIVE

- Historically, it was believed that depression did not exist in children
- We now know that:
  - Children do experience depression to a significant degree comparable to that of adults
- Depression in children may be masked, and thus overlooked
  - Likely due to signs/symptoms that are different from adults

DEPRESSION AND DEVELOPMENT

- Almost all young people experience some symptoms of depression
- Depression in children may be most easily recognized (although often overlooked) as:
  - Chronic depressed mood
  - Disturbances in thinking
  - Disturbances in physical functioning
  - Disturbances in socialization
- 90% of young people with depression show impairment in daily functioning due to these signs/symptoms

DEPRESSION AND DEVELOPMENT

- Preschoolers
  - May appear overly somber and tearful
  - May display excessive clinging and immature behavior around mothers
- School-age children
  - Increased irritability, disruptive behavior, and behavioral outbursts (tantrums)
    - Tantrums not to the degree of that seen in children with Disruptive Mood Dysregulation Disorder
- Teenagers
  - The above criteria for school-age children, plus:
    - Self-blame
    - Low self-esteem
    - Social withdrawal

DEPRESSION AND DEVELOPMENT

- Features in children
  - Some features (i.e., irritability) are more common in children and adolescents with depression than in adults
  - Depression may be overlooked because other comorbid (externalizing) behaviors attract more attention
    - Anxiety
    - ADHD
    - Oppositional behavior

DEPRESSION AND DEVELOPMENT

- Academic presentation
  - Preschool and Grade School:
    - Anxiety
    - Avoidance
    - Withdrawal
  - Grade School and High School:
    - Comorbid symptomatology
      - Poor attention
      - Lowered processing speed
      - May have a (sudden) history of academic/social/behavioral struggles
      - May have an IEP
      - May appear defiant
      - Withdrawn

PREVALENCE

- Between 2-8% of children age 4-18 experience MDD
- Depression is rare among preschool and school-age children (1-2%)
- The increase in adolescence may result from biological maturation at puberty interacting with environmental demands (school, social, home)
  - Interaction between genetics and epigenetics (nature vs. nature)

COMORBIDITY

- **As many as 90% of young people with depression have one or more other disorders; 50% have two or more**
- **Most common comorbid disorders include:**
  - **Anxiety disorders (especially GAD)**
  - **ADHD**
  - **Conduct problems**
  - **Substance Use Disorder**

ONSET, COURSE, AND OUTCOME

- **Onset may be gradual or sudden**
  - **Usually a history of milder episodes that do not meet diagnostic criteria**
- **Age of onset usually between 13 and 15 years**
- **Average episode lasts eight months**
  - **Longer duration if a parent has a history of depression**

ONSET, COURSE, AND OUTCOME

- Most children eventually recover from initial episode
  - Chance of recurrence is 25% within one year, 40% within two years, and 70% within five years
  - About one-third develop bipolar disorder within five years after onset of depression (bipolar switch)

GENDER, ETHNICITY, AND CULTURE

- No gender differences until puberty
  - After puberty, females are two to three times more likely to suffer from depression
- Symptom presentation is similar for both sexes, although the reasons for depression differ by gender

DSM-5 DIAGNOSTIC CRITERIA

DSM-5 Diagnostic Criteria for Major Depressive Disorder

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning

AT LEAST ONE OF THESE TWO SYMPTOMS MUST BE PRESENT FOR DIAGNOSIS:

1. **Depressed mood**
   - **Excessive unhappiness ("dysphoria")**
2. **Loss of interest or pleasure**
   - **In once enjoyable activities ("anhedonia)**

DSM-5 DIAGNOSTIC CRITERIA

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month) or decrease/increase in appetite nearly every day.

DSM-5 DIAGNOSTIC CRITERIA

4. Insomnia or hypersomnia nearly every day.

DSM-5 DIAGNOSTIC CRITERIA

5. Psychomotor agitation or retardation nearly every day

Observable by others, not merely subjective feelings of restlessness or being slowed down

DSM-5 DIAGNOSTIC CRITERIA

6. Fatigue or loss of energy nearly every day.

DSM-5 DIAGNOSTIC CRITERIA

7. Feelings of worthlessness or excessive guilt (unsubstantiated) nearly every day

Not merely self-reproach or guilt about being sick

DSM-5 DIAGNOSTIC CRITERIA

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day

Either by subjective account or as observed by others)

DSM-5 DIAGNOSTIC CRITERIA

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Many young people with depression think about suicide, and as many as one-third will attempt suicide

- **Most common methods for those who complete suicide are firearms, hanging, suffocation, poisoning, and overdose**
- **Worldwide, the strongest risk factors are having a mood disorder and being a young female**
- **Ages 13-14 are peak periods for a first suicide attempt by those with depression**

DSM-5 DIAGNOSTIC CRITERIA

- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The episode is not attributable to the physiological effects of a substance or to another medical condition
- The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders
- There has never been a manic or hypomanic episode

DSM-5 DIAGNOSTIC CRITERIA

- Mild, Moderate, or Severe
- With or without psychotic features
- In partial remission
- In full remission
- Unspecified

DSM-5 DIAGNOSTIC CRITERIA

- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With seasonal pattern

TREATMENT

- Sleep
  - CDC Guidelines (https://www.cdc.gov/sleep/about_sleep/how_much_sleep.html)
- Physical activity
  - 60 minutes per day of Moderate-to-Vigorous
- Nutritious Food
- Screen Time and Social Media
- School Support
- Social Support

TREATMENT

- **Cognitive-Behavioral Therapy (CBT)**
  - **The most common form of psychosocial intervention.**
- **Behavior Therapy**
  - **Aims to increase behaviors that elicit positive reinforcement and to reduce punishment from the environment. May involve teaching social and other coping skills and using anxiety management and relaxation training.**
- **Cognitive Therapy**
  - **Focuses on becoming more aware of pessimistic and negative thoughts, beliefs and biases, and causal attributions of self-blame. Once these self-defeating thought patterns are recognized, the child is taught to change from a negative, pessimistic view to a more positive, optimistic one.**

TREATMENT

- **Medication**
  - **Consult with pediatrician and/or child psychiatrist**