Pediatric Mental Health Care Access Grant

PEDIATRIC PERSISTENT DEPRESSIVE DISORDER (P-DD)

Diagnostics, Prevalence, and Treatment

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SANFORD RESEARCH

OBJECTIVES

1. Identify diagnostic criteria, and observable presentation, of Persistent Depressive Disorder
2. Recognize differences between Major Depressive Disorder and Persistent Depressive Disorder
3. Identify best-practice treatment approaches for Persistent Depressive Disorder

REVIEW OF MAJOR DEPRESSIVE DISORDER

DSM-5 Diagnostic Criteria

AT LEAST ONE OF THESE TWO SYMPTOMS MUST BE PRESENT:

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

REVIEW OF MAJOR DEPRESSIVE DISORDER

DSM-5 Diagnostic Criteria (must be at least FIVE total signs/symptoms)

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.

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive guilt nearly every day

8. Diminished ability to think or concentrate (indecisiveness)

9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

PERSISTENT DEPRESSIVE DISORDER

- New category in the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5)
  - Combines the DSM-IV categories of Dysthymic Disorder and Major Depressive Disorder – Chronic
- "Dysthymic Disorder"
- "Dysthymia"

PERSISTENT DEPRESSIVE DISORDER

DSM-5 Diagnostic Criteria

A. Depressed (or irritable) mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least ONE YEAR

B. Presence, while depressed, of TWO (or more) of the following:

1. **Poor appetite or overeating**
2. **Insomnia or hypersomnia**
3. **Low energy or fatigue**
4. **Low self-esteem**
5. **Poor concentration or difficulty making decisions**
6. **Feelings of hopelessness**

PERSISTENT DEPRESSIVE DISORDER

DSM-5 Diagnostic Criteria

During the 1-year period, the child has never been without the symptoms in criterion A and B for more than two months at a time

Criteria for Major Depressive Disorder may be continuously present for TWO years

There has never been a manic episode or a hypomanic episode, and criteria have never been met for Cyclothymic Disorder

The disturbance is not better explained by Schizophrenia or a psychotic disorder

The symptoms are not attributable to the physiological effects of a substance or another medical condition

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

"And how are you?" said Winnie the Pooh. Eeyore shook his head from side to side. "Not very 'how,'" he said, "I don't seem to have felt at all 'how' for a long time."

- If we think of Major Depressive Disorder (MDD) as a severe and chronic bout of the flu…
- We may liken most cases of Pervasive Depressive Disorder (P-DD) to chronic problems with allergies
  - These are not as severe but they *DO* persist and they affect nearly every aspect of a child's life
  - Some individuals experience P-DD for so long that they normalize it and think that they have just "always been this way" and that there is no problem

DIFFERENCES BETWEEN MDD AND P-DD

- P-DD can be differentiated from MDD by:
  - Onset
    - P-DD usually begins gradually and is a long-term condition
      - 2-5 years
    - MDD usually begins more rapidly and usually only lasts a few months
      - 8 months on average
  - Severity
    - MDD is more severe and requires more signs/symptoms to meet diagnostic criteria

ONSET, COURSE, AND OUTCOME

- P-DD is characterized by symptoms of depressed mood that occur on most days, and persist for at least one year
  - Children with P-DD may also display at least two somatic (physical) or cognitive symptoms
- Symptoms are less severe, but more chronic than those of MDD
- Children with P-DD have:
  - Poorer response to treatment
  - Greater long-term morbidity at follow-up
  - Higher prevalence rate of genetic history of mood (affective)

SUBJECTIVE SIGNS/SYMPTOMS

- Children/adolescents with P-DD are described by *OTHERS*:
  - "Uninteresting"
  - "Unlikable"
  - "Ineffective"
- Children/adolescents with P-DD often regard *themselves*:
  - "Moody"
  - "Sluggish"
  - "Down"
  - "Cranky"

PREVALENCE AND COMORBIDITY

- Rates of P-DD are lower than those of MDD
  - Pervasive Depressive Disorder
    - 1% of children
    - 5% of adolescents
  - Major Depressive Disorder
    - Between 2-8% of children age 4-18 experience MDD
    - Depression is rare among preschool and school-age children (1-2%)
- As many as 70% of children with P-DD will have a comorbid episode of MDD at some point

ONSET, COURSE, AND OUTCOME

- P-DD develops approximately 3 years earlier than MDD
- Most common first presentation around 11-12 years old
- Average episode of P-DD lasts 2-5 years
- About 50% of children with P-DD may have comorbid:
  - Anxiety disorders
  - Conduct disorder
  - ADHD

ONSET, COURSE, AND OUTCOME

- Characterized by poor emotion regulation
  - Constant feelings of sadness, being unloved and forlorn, self-deprecation, low self-esteem, anxiety, irritability, anger, and temper tantrums
  - Children with both MDD and P-DD are more severely impaired than children with just one disorder

ONSET, COURSE, AND OUTCOME

- Intellectual and academic functioning
  - Difficulty concentrating, loss of interest, and slowness of thought and movement may have a harmful effect on intellectual and academic functioning
    - Lower scores on tests, poor teacher ratings, and lower levels of grade attainment
  - Interference with academic performance, but not necessarily related to intellectual deficits
    - May have problems on tasks requiring attention, coordination, and speed

ONSET, COURSE, AND OUTCOME

- Social and peer problems:
  - Few close friendships, feelings of loneliness, and isolation
  - Social withdrawal and ineffective styles of coping in social situations
- Family problems:
  - Has less supportive and more conflicted relationships with parents and siblings
  - Feels socially isolated from families and prefers to be alone

DEATH BY SUICIDE

- Approximately 12% of adolescents experience suicidal thoughts
- 4% report a suicidal plan or past attempt
- 5,000 youths die by suicide annually
  - 2.1 in 100,000 children between 10-14
  - 14.5 in 100,00 adolescents between 15-24
- Over the past 15 years, death by suicide rates have increased 24% in the United Stated
- The prevalence of death by suicide in females 10-14 has nearly doubled

THEORIES OF DEPRESSION

- **Neurobiological**
  - Neurochemical and receptor abnormalities
  - Hypothalamus-Pituitary-Adrenal (HPA) Axis over-excitement
    - Cortisol is released – stress hormone (fight-or-flight; alertness; apprehension)
    - Individuals with depression may have difficulty shutting down HPA excitement
- **Cognitive**
  - Negative view of self, world, and future
  - Hopelessness
  - Poor problem-solving ability

THEORIES OF DEPRESSION

- **Behavioral**
  - Lack or loss of positive reinforcement
- **Attachment**
  - Insecure early attachments leading to distortion of self and others
- **Interpersonal**
  - Interpersonal deficits
  - Social withdrawal
  - Single parenting

THEORIES OF DEPRESSION

- Socio-Environmental
  - Lack of social support
  - Stressful life circumstances and lack of ability to cope
- Psychodynamic
  - Loss of self-esteem
  - May be due to loss (loved one) which is turned inward
- Self-Control
  - Problems in organizing behavior toward long-term goals
  - Deficits in self-monitoring

IDENTIFYING/TESTING DEPRESSION

- Standardized measures
  - Child Behavior Checklist (CBCL)
  - Behavior Assessment System for Children – Third Edition (BASC-3)
  - Minnesota Multiphasic Personality Inventory- Adolescent (MMPI-A)
- Public Domain screening measures – face valid, reliable, and cost-effective psychological screening instruments for depression
  - Patient Health Questionnaire – 9 (PHQ-9)
  - Beck Depression Inventory – Second Edition (BDI-II)

NATURAL "TREATMENT" APPROACHES

- 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
  - Cyber Bullying
- School Support
- Social Support

TREATMENT

- Cognitive-Behavioral Therapy (CBT)
  - Cognitive Therapy
    - Focuses on becoming more aware of negative thoughts and causal attributions. Once these self-defeating thought patterns are recognized, the child is taught to change from a negative view to a more positive view.
  - Behavior Therapy
    - Increase behaviors that elicit positive reinforcement. May involve teaching social and other coping skills and using anxiety management and relaxation training.

TREATMENT

- Medication
  - Consult with pediatrician and/or child psychiatrist
    - Fluoxetine (Prozac; SSRI) is the only FDA approved medication for children (8y/o and older)
    - Paxil, Lexapro, and Effexor have empirical research showing no evidence of effectiveness over placebo
- Inpatient psychiatric treatment if there is suicidal/homicidal ideation/plan/intent, self-injurious behavior, and/or behavior threatening to others
- Intensive outpatient treatment to learn new coping skills