Pediatrics teleECHO

Depression: Assessment and Etiology

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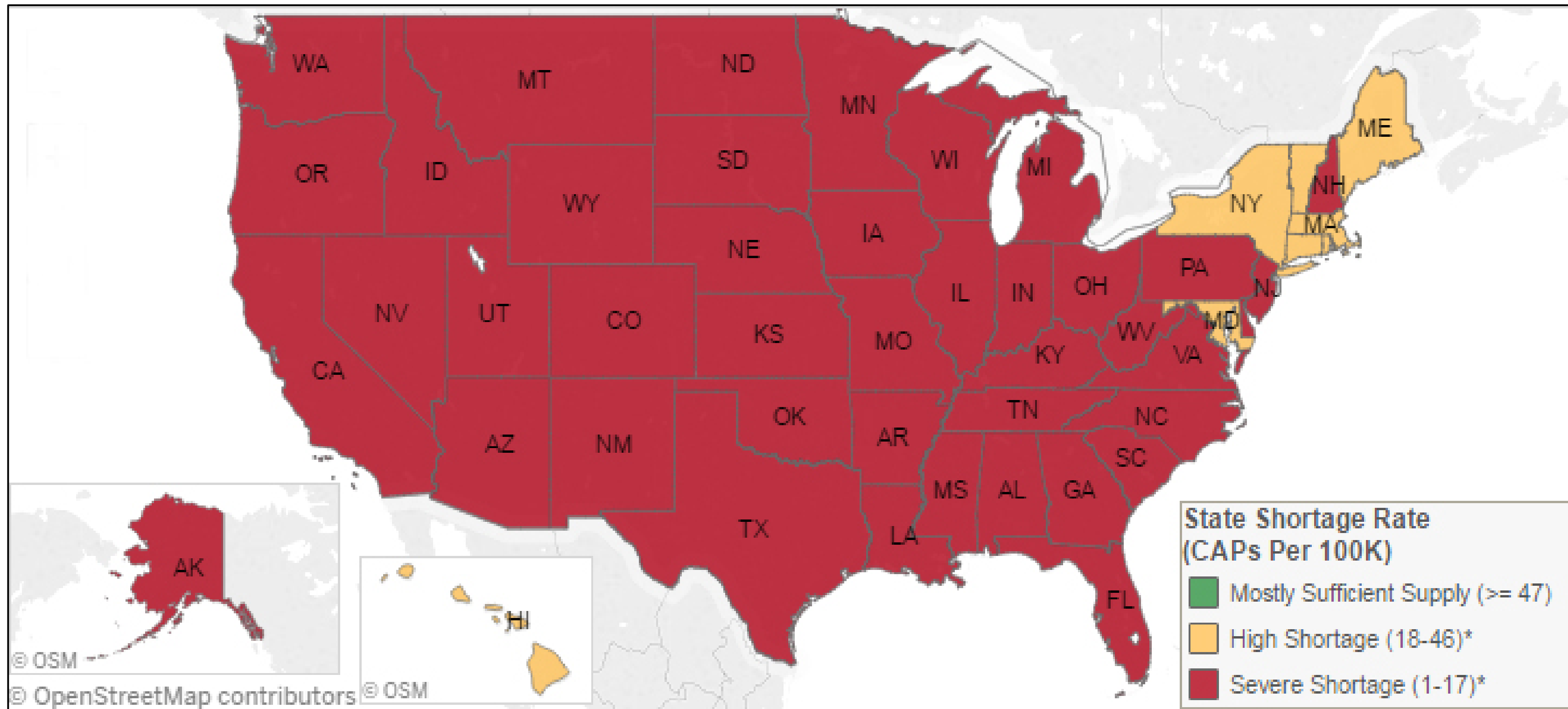
Child & Adolescent Psychiatrist Workforce Map by State (AACAP)



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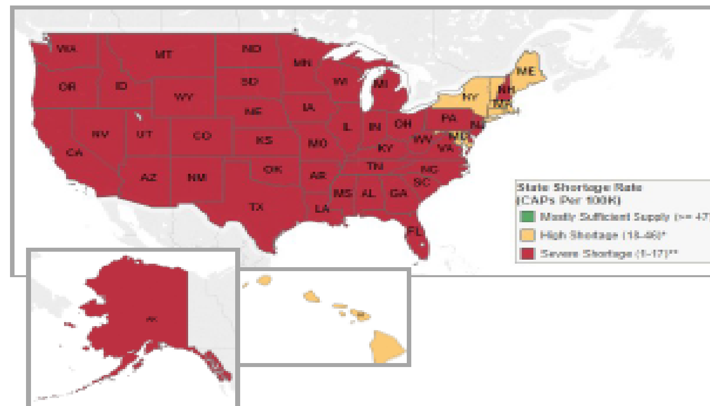
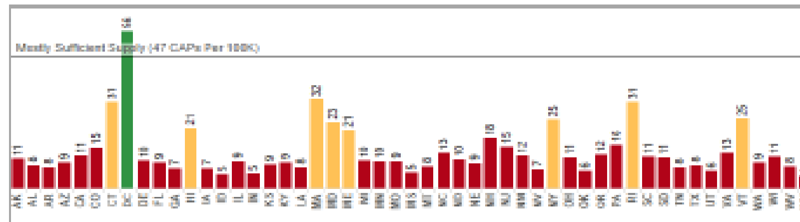
Utah Workforce Distribution (AACAP)

UTAH
Child and Adolescent Psychiatrist (CAP)
Workforce Distribution Map

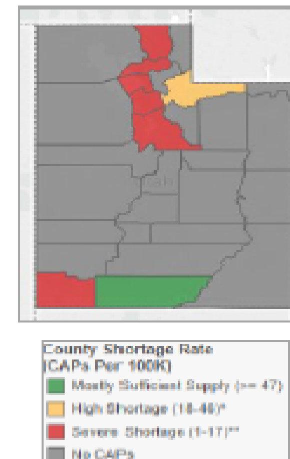
Practicing Child and Adolescent Psychiatrists by State 2015
Rate per 100,000 children age 0-17



State CAPs per 100,000 children age 0-17



Practicing Child and Adolescent Psychiatrists by County 2015
Rate per 100,000 children age 0-17



*Council on Graduate Medical Education. Re-examination of the Academy of Physician Supply made in 1980 by the Graduate Medical Education National Advisory Committee for selected specialties, Bureau of Health Professions in support of activities of the Council on Graduate Medical Education. 1990. Cambridge, ABT Associates.

**Kim WJ, American Academy of Child and Adolescent Psychiatry Task Force on Workforce Needs. Child and adolescent psychiatry workforce: A critical shortage and national challenge. Acad Psychiatry. 2003;27:277–82.

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Pediatric Behavioral Health Issues. . .

- Approximately 1 in 5 children in the U.S. suffer from a mental illness
- Yet 80% never receive treatment
- 75% of the children who do have psychiatric disorders are normally seen in their primary care clinic
- 85% of prescribing is done by the primary care physician
- Pediatricians and primary care doctors are on the front line. . .

Pediatric Depressive Disorders. . .

Pediatric Depressive Disorders – Clinical Description

- DSM V criteria for pediatric depressive disorders are the same for children and adults, though can have different clinical features and presentations
  - Depressed mood in adult can be irritable mood in a child
  - Change in weight or appetite for adult can be failure to make expected weight gain in a child
- New for DSM V
  - Persistent Depressive Disorder encompasses the diagnoses of both dysthymic disorder and chronic major depressive disorder
  - Disruptive Mood Dysregulation Disorder (discuss later)

DSM V Criteria for Major Depressive Disorder

- **NEED 5 or more of the following symptoms, during the same 2 week period AND represents a change from previous functioning; ONE of the symptoms is EITHER Depressed Mood OR Loss of Interest/Pleasure**
- Depressed mood most of the day, nearly every day, either subjectively or objectively (**can be irritable for children)
- Markedly diminished interest or pleasure in all or almost all activities most of the day nearly every day.
- Significant weight loss when not dieting or weight gain (**failure to make expected weight gain in children)
- Inability to sleep or oversleeping nearly every day.
- Psychomotor agitation or retardation nearly every day.
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (may be delusional).
- Diminished ability to think or concentrate, or indecisiveness, nearly every day.
- 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.
  - Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
  - The episode is not due to the effects of a substance or to a medical condition
  - The occurrence is not better explained by an unspecified schizophrenia spectrum or other psychotic disorders
  - There has never been a manic episode or a hypomanic episode

Pediatric Depression Clinical Features

- Children: may see more anxiety, somatic symptoms (headache and stomach aches), missing school, auditory hallucinations, temper tantrums, **irritability** and behavioral problems
- Adolescents: sleep and appetite changes, academic concerns, school refusal, suicidality, irritability, explosive moods and behavioral symptoms, substance use
- Overall Depression in youth can lead to significant functional impairment – school, friends, social and family relationships, and an increase in alcohol/drug related disorders AND is a significant safety issue for children and adolescents

Pediatric Depression Epidemiology

- Prevalence of major depression is estimated at 1%-3% in prepubertal children 6-12 and 3%-9% in adolescents 13-18 years of age
  - Before puberty ratio of F:M is 1:1, then through adolescence increases similar to adult rates, 2:1 for F:M
- Rates can vary with population, diagnostic criteria and methods of assessment
- Lifetime prevalence of at least one episode of major depression by late adolescence is 20%-25%
- Many more youth have subsyndromal depressive symptoms that may go undetected or treated

Pediatric Depression Etiology

- Similar to those seen in adults
- Depression risk increases if one or both parents have a history of depression, both genetically and interpersonal influences
  - Parent modeling, emotional regulation, availability, parenting styles and capacities
- Abuse and neglect can increase risk
- Can be co-morbid with substance use disorders, anxiety disorders, gender dysphoria, chronic medical issues, ADHD and other disruptive behavior disorders

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Pediatric Depression Evaluation/Differential Diagnosis

- During the interview ask the children/teens about their depression, they may have a hard time describing their mood, may use words like "bored" or give short, brief answers . . .build rapport and interview patient and parents individually and together
- Both parent and patient reports are necessary
- May have limited insight into their moods
- Kids/Teens can report their feelings fairly well, parents can report more accurately behaviors and interactions they are witnessing

Pediatric Depression Evaluation/Differential DX

- Rating Scales are an option for assessment . . .
  - Children’s Depression Inventory - self report measure for children
  - Children’s Depression Rating Scale - semi structured interview
  - Hamilton Depression Rating Scale – administered by the clinician
- Assessing safety is paramount for self harm, self injurious behaviors and suicidal ideation, intent or plan
- Assess for previous suicidal and self injurious behaviors, also family history of suicide attempts – following are some significant risk factors to consider
  - Loaded gun increases risk 30x, aggression, hopeless, sexual identity/gender dysphoria, substance use, insomnia, chronic medical issues, family history, trauma, . . .
  - PCH uses the Columbia Suicide Severity Rating Scale (C-SSRS)

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Pediatric Depression Evaluation/Differential DX

- Take a good history and look for co-morbid disorders such as anxiety disorders (separation anxiety disorder can look similar in younger children), substance use, gender dysphoria, sexual identity concerns, abuse, trauma, bullying, disruptive behavior disorders, hallucinations
- Take a good medical history and rule out any potential medical concerns that could be contributing such as thyroid disorder, diabetes, epilepsy
- Assess sleep and insomnia; chronic insomnia for teenagers is rampant with social media use, video games, cell phone use; chronic insomnia and going to sleep past midnight increases suicide risk

Pediatric Depression – Course/Prognosis

- Mood disorders in children are serious and potentially fatal
- National suicide rates are increasing to an all time high and currently suicide is the leading cause of death in Utah for 10-17 year olds
  - 10-14 year old age groups for males and females have increased, suggesting that the population of young early adolescents is now much more vulnerable.
- Earlier age of onset of depression can mean a lengthier and more debilitating course long term
- Age of onset unfortunately is increasing over the past 25 years
- Depression can affect social, emotional, spiritual and academic functioning that can be far reaching in effect for both patient and family
- Depressive episodes can last months and can be frequent and consistent throughout adolescence, can wax and wane throughout lifetime

Disruptive Mood Dysregulation Disorder

New Diagnosis in DSM V in Depression Disorders Section

Still Learning About This Disorder. . .

Disruptive Mood Dysregulation Disorder

- To reduce diagnosis of pediatric bipolar disorder and the resulting exposure to psychotropic medications
- DSM V work group evaluated pediatric patients who exhibited chronic irritability
- Introduced a *new disorder* in the Depressive Disorders Section which features temper outbursts and irritable moods as the predominant feature of the disorder
  - Severe temper tantrums that are disproportionate to the situation and that are not consistent with the child's developmental level
  - The tantrums must be regular, occur at least three times a week
  - Symptoms have been present for 12 months or longer, and the child has not been without symptoms for longer than three consecutive months
  - Persistent angry or irritable mood in between tantrums
  - The child must be over the age of 6, and the behavior must be present in at least two contexts; a child who is angry with an unstable mood only when at school would not qualify for a diagnosis

Disruptive Mood Dysregulation Disorder

- Youth likely to have co-morbid ADHD as well
- Manifests more like a Disruptive Behavior Disorder than a Mood Disorder . . .inconsistent with Mood Disorders which are usually more “episodic”
- Reserve diagnosis for youth with severe irritability that manifests in “multiple” settings and is “impairing” in at least one of them. . .
- DMDD may reduce the diagnosis of bipolar disorder in children and could change prescribing practices for these youth . . .

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Disruptive Mood Dysregulation Disorder

- Potential pharmacologic consequences for adding a new diagnostic category with unknown treatment parameters
- No clear studies yet on most effective treatment
- Differentiating DMDD from other disorders such as Bipolar D/O or Oppositional Defiant Disorder can be confusing
- DMDD diagnosis and symptoms tend to decrease in adolescent years
- Does not show an increased risk for bipolar disorder
- See more anxiety and depression as they move into adulthood
- Important because assumptions about diagnosis leads to treatment. . . SSRI vs. Mood Stabilizer vs. Antipsychotic. . .

Pediatric Depressive Disorders

- Questions or comments?