Depression Overview

With teen depression and suicide more prevalent in the media, awareness of these issues is increasing. Point prevalence of depression in school-aged children is 1-2% and is 1-7% in adolescents. Up to 9% of youth experience at least one major depressive episode by age 14. Depression can be cyclical in nature and youth with a history of a major depressive episode are at high risk for a depressive recurrence with a cumulative recurrence rate of 40% by two years and 70% by five years after first episode remission.

Considerations in children and youth:

- Prevalence rates reach adult levels between ages 15-18
- Girls experience depression at roughly twice the rate of boys
- Depressed children often present as more irritable than sad or down
- Depression is associated with significantly elevated risk for anxiety, behavior, eating and substance use disorders

Although some sadness and irritability is normal, consider depression if you hear the following:

- Child is spending a lot of time in his/her room and does not want to interact with family or friends
- Child has significant decrease in energy level and is spending more time in bed/sleeping than usual
- Child is very "sensitive" and cries easily
- Child appears to get angry "out of nowhere"
- Child does not want to go to school
- Parent is concerned about child's appetite – suddenly eating significantly more or less

It is also important to rule out other common medical conditions which may be contributing to symptoms such as anemia, hypothyroidism, etc.

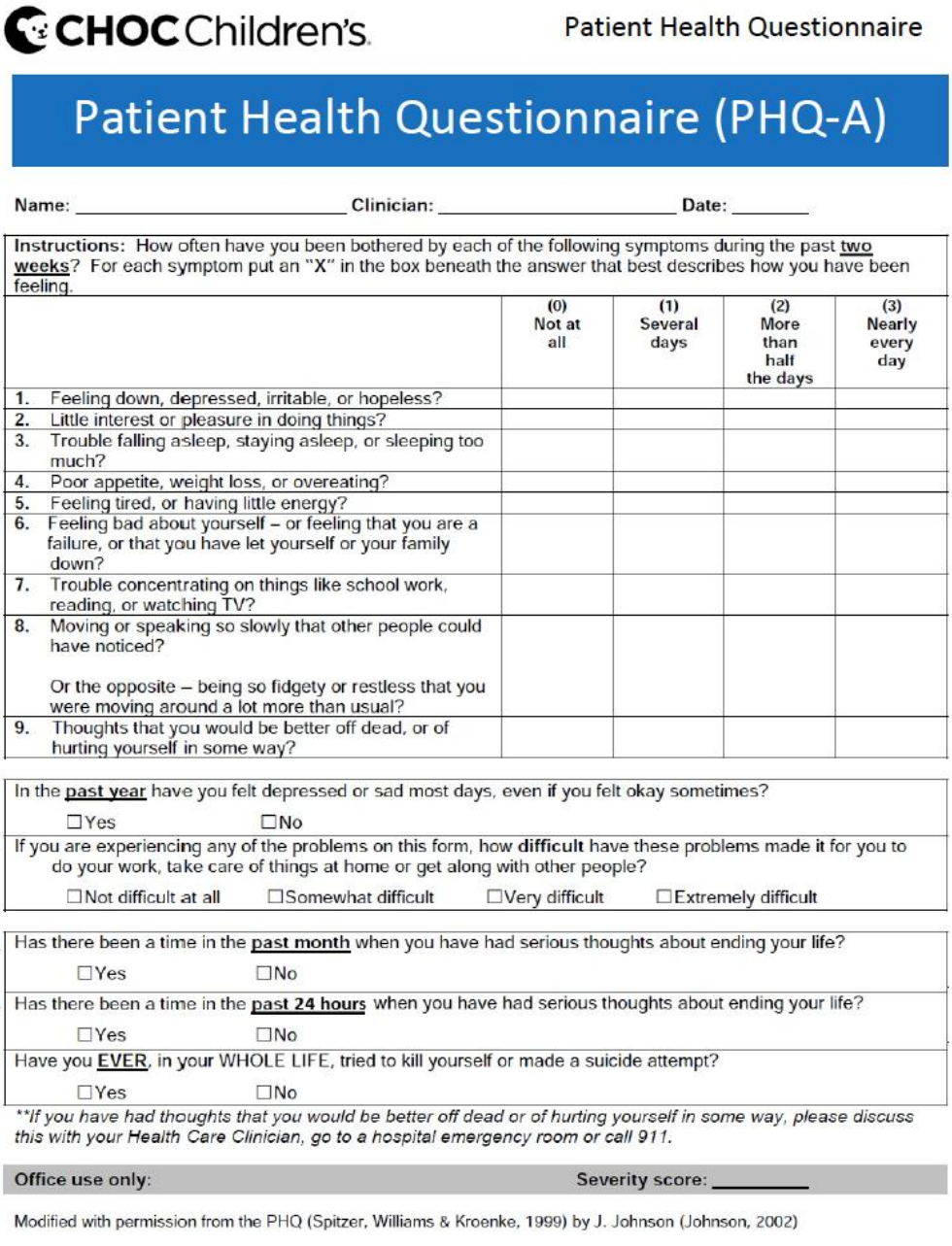
Resources:

Depressed Child: A Parent's Guide for Rescuing Kids, by Douglas A. Riley
Help me, I'm sad: Recognizing, Treating and Preventing Childhood Depression and Adolescent Depression by David G.Fassler and Lynne S Dumas
Lonely, Sad and Angry: How to Help Your Unhappy Child, by Barbara D. Ingersoll
Raising Depression-Free Children: A Parent's Guide to Prevention and Early Intervention, by Kathleen Panula Hockey
The Childhood Depression Sourcebook, by Jeffrey A. Miller

Screening Measures

Diagnostic tools can be a helpful way to screen for depressive disorders as patients and families can fill them out in the waiting room or exam room. They can help parse out the types of symptoms that patients are having to help you target your exam questions in those areas. Some examples are:

- Patient Health Questionnaire (PHQ-9)
- Pediatric Symptom Checklist (PSC)
- Moods and Feelings Questionnaire – Parent and child versions



CHOC Children's Patient Health Questionnaire

Patient Health Questionnaire (PHQ-A)

Name: _____ Clinician: _____ Date: _____

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?				

A. In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
☐Yes ☐No

B. 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

C. Has there been a time in the **past month** when you have had serious thoughts about ending your life?
☐Yes ☐No

D. Has there been a time in the **past 24 hours** when you have had serious thoughts about ending your life?
☐Yes ☐No

E. Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

DSM 5 Criteria for Depressive Disorders[2]

There are many different depressive disorders, each with their own specific criteria for diagnosis. Here are just some common examples but there are more (Ex: Substance/Medication-Induced Depressive Disorder, Depressive Disorder due to Another Medical Condition, Other Specified Depressive Disorder, Unspecified Depressive Disorder).

Major Depressive Disorder

ICD-10: F32 (Single episode), F33 (Recurrent episode)

Five or more of the following symptoms must be present for at least a two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) or (2):

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others (Note: In children and adolescents, can be irritable mood)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation)
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 or increase in appetite nearly every day
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
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

*Note: If patient endorses any suicidal ideation or self-harm, refer to safety assessment to determine the most appropriate level of care

Adjustment Disorder with Depressed Mood

ICD-10: F43.21

The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s). These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:

1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation
2. Significant impairment in social, occupational, or other important areas of functioning

Low mood, tearfulness, or feelings of hopelessness are predominant. The symptoms do not represent normal bereavement. Once the stressor/consequences have terminated, symptoms do not persist for more than an additional 6 months.

Persistent Depressive Disorder (Dysthymia)

ICD-10: F34.1

Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 1 year (2 years in adults). Presence, while depressed, of two (or more) of the following:

- Poor appetite or overeating
- Insomnia or hypersomnia
- Low energy or fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Feelings of hopelessness

During the 1-year period (2-years for adults) of the disturbance, the individual has never been without the symptoms for more than 2 months at a time

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

Premenstrual Dysphoric Disorder (PMDD)

ICD-10: N94.3

In the majority of menstrual cycles in the past year, at least five symptoms must be present in the final week *before* the onset of menses, start to *improve* within a few days after the onset of menses, and become *minimal* or absent in the week postmenses.

One (or more) of the following symptoms must be present (Note: Should be confirmed through prospective daily ratings during at least two symptomatic cycles):

- Marked affective lability (e.g. mood swings; feeling suddenly sad or tearful; or increased sensitivity to rejection)
- Marked irritability or anger or increased interpersonal conflicts
- Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts
- Marked anxiety, tension, and/or feelings of being keyed up or on edge

One (or more) of the following symptoms must additionally be present, to reach a total of five symptoms when combined with symptoms above:

- Decreased interest in usual activities (e.g. work, school, friends, hobbies)
- Subjective difficulty in concentration
- Lethargy, easy fatigability, or marked lack of energy
- Marked change in appetite; overeating; or specific food cravings
- Hypersomnia or insomnia
- A sense of being overwhelmed or out of control
- Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of "bloating" or weight gain

Algorithm for Evaluation and Diagnosis

Routine screening and/or appointment with concern for depression

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Initial Assessment:

1. Assess for any acute safety concerns (see "Assessing for Safety" on next page)
2. It's important to rule out any underlying medical causes of depression or depression-related symptoms (e.g. hypothyroidism, anemia, drug or medication side effect)
3. It's also important to rule out any other psychiatric conditions (e.g. ADHD, pervasive developmental disorders such as Autism/Asperger's, learning disabilities, anxiety, bipolar disorder, or psychotic disorders) with similar or related symptoms (ex: ADHD or learning disabilities may lead to difficulty with school and subsequent increased depression about performance, psychotic disorders may have associated negative symptoms of apathy/anhedonia/isolation, etc)
4. With "sudden onset" change in functioning, also consider screening for psychosocial factors such as bereavement, bullying (including cyberbullying), trauma or substance use

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Some helpful self-report measures (for children 11yrs and older):

- Patient Health Questionnaire (PHQ-9)
- Pediatric Symptom Checklist (PSC)
- Moods and Feelings Questionnaire (Parent and Child versions)

Other helpful information:

- Parent reports (can also have them complete the Parent Version of the Moods and Feelings)
- Difficulties in functioning such as drop in grades, missed extracurricular activities due to anxiety, difficulty with relationships, etc

Assessing for Safety

Some of the more troublesome symptoms of depression include self-harm and suicide. With any patient presenting with depressive symptoms, it's always important to assess for presence of any thoughts or behaviors that may present as an acute safety concern. Patients with imminent risk of harm may need to be hospitalized for their safety. The first step is to always ask both patients and parents separately for any concerns.

Assessments like the Columbia-Suicide Severity Rating Scale (next page) can be helpful in guiding your questioning. Some patients may have chronic thoughts of suicide without any intent or plan to act on them, and can still be managed on an outpatient basis.

- Any "yes" responses in the orange or red categories on the questionnaire should be a flag for further psychiatric assessment
- Other things that may be red flags would be if the patient is responding "no" but appears to be very guarded and you're concerned they're not being completely transparent

"No harm" contracts have not been found to be protective in preventing suicidal behaviors or attempts. If patient is having active intent or plan, it's important to err on the side of caution. Even if the parent does not want the patient to get a mental health assessment, if you have concerns for the patient's safety it is your duty to have them properly evaluated.

If any concerns arise, request a mental health assessment:

- Call an ambulance or police department for the patient to be taken to the closest Emergency Room
- Call the Crisis Assessment Team (CAT team, 866-830-6011 for Orange County) which is a 24-hour mobile response team of behavioral health specialists that can come and assess the patient and make recommendations for most appropriate level of care
- Both police officers and CAT team members can write a 5585 hold, which is an involuntary 72-hour hold stating the patient must be placed in an appropriate mental health facility

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Primary Care *Screen with Triage Points*

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	**Past month**	
Ask questions that are in bold and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan."* ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."* ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to "*I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past 3 months?***	**Lifetime** **Past 3 Months**	

Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Behavioral Health Consultation and Patient Safety Precautions
Item 5 Behavioral Health Consultation and Patient Safety Precautions
Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions

For Trainings on the C-SSRS:
http://cssrs.columbia.edu/training/training-options/

Algorithm for Treatment

Patient diagnosed with depressive disorder appropriate for outpatient treatment (no acute safety concerns)

Initial treatment always includes referral for psychotherapy

- Generally, individual therapy is 1-2 times a week
- If symptoms are significantly affecting school or occupational functioning, consider a Partial Hospitalization Program (five days a week during the day) or Intensive Outpatient Program (3-4 days a week in the evenings) [Note: these are group-based therapies]
- Also consider school involvement for accommodations if the depression is affecting or related to school performance

If symptoms are moderate or severe (affecting social or school functioning), make participation in psychotherapy difficult, or psychotherapy results in only partial response, consider adding treatment with medication

Start treatment with SSRI (selective serotonin reuptake inhibitor):

- Start low and go slow!
- Choice of SSRI is usually based on the side effect profile or if there's been a family member with anxiety who responded to a particular SSRI
- Follow-up at least every 4 weeks to monitor for side effects, but give each dose 4-8 weeks before advancing to next dosage

Consider referral to psychiatry if:

- Very young child (<6yrs old)
- Medically complicated or multiple co-morbid psychiatric conditions
- Medication or comorbid condition contraindicating SSRI (ex: concern for underlying Bipolar Disorder)
- Previous failed medication trials
- Any time you're considering medication or treatment outside of your comfort zone

Commonly Used SSRIs

Medication	Starting dose	Target dose	Pros	Cons
Fluoxetine (Prozac)	10mg	10-40mg	FDA approved for 8yrs and up for MDD Most validated data for treatment of depression in adolescents Oral solution available	Can be somewhat "activating" which can sometimes worsen anxiety short term if they also have anxiety Can cause some appetite suppression initially
Escitalopram (Lexapro)	5mg	10-20mg	FDA approved for 12yrs and up for MDD Low incidence of drug-drug interactions Works well for anxiety also Oral solution available	Some patients have more sleepiness on medication (dose at bedtime if present)
Sertraline (Zoloft)	12.5-25mg	50-200mg	Wide range of dosages available Works well for anxiety also Oral solution available	Higher incidents of patients complaining of GI upset Not FDA approved for pediatric use for MDD (use off label)
Paroxetine (Paxil)	10mg (12.5mg CR)	60mg (75mg CR)	Oral solution available	**Avoid using in children and adolescents** due to high rate of side effects and short half-life with associated withdrawal symptoms Not FDA approved for pediatric use for any diagnosis

A word about the Black-Box Warning:
In 2004, the FDA issued a black-box warning on anti-depressants stating they were associated with increased risk of suicidal thinking in adolescents. This warning was based on a meta-analysis that showed that depressed youth on anti-depressants had a 4% incidence of suicidal thoughts whereas depressed youth not on anti-depressants had a 2% incidence. In the study there was no increase in completed suicides in the anti-depressant group. Since the FDA warning was issued, there was a subsequent decrease in prescribing of anti-depressants by 20% between 2003 and 2005. This actually led to an increase in suicides, as it meant that many patients with depression were not being adequately treated for their symptoms. Suicide and self-harm are two of the most troublesome symptoms associated with depression. When choosing the right treatment for your patient, it's important to weigh the risks and the benefits evenly, including considering the risks involved with not treating their symptoms.