Pediatric Depression in a Primary Care Setting

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Learning Objectives

• Understand basics of pediatric depression and how it results from a combination of biological, psychological, and social factors

• Learn about commonly-used approaches to treating depression

• Review models of psychological treatment in primary care setting

• Complications to treatment in primary care setting
Types of Mood Disorders

Includes the following within the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, edition 5):

- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)
- Disruptive Mood Dysregulation Disorder (diagnosed in children/adolescents only)

Also consider:
- Bipolar Disorders (Bipolar I, Bipolar II, Cyclothymia)
- Adjustment Disorder with Depressed Mood

- Depression may exist on a continuum with normal experience rather than being considered a discrete category (Hankin et al., 2005)
Symptoms of Major Depressive Disorder

- 5 or more symptoms are present nearly every day, most of the day, for at least 2 weeks with one of the symptoms either of the following:

  - Depressed (sad, empty, hopeless) mood
    – Note: can be irritable mood in children/adolescents
  
  - OR diminished or loss of pleasure in all or almost all activities (anhedonia)

  - PLUS four of the following symptoms:
    - Significant changes in weight or appetite (in children, can be failure to make expected weight gain)
    - Insomnia or hypersomnia
    - Psychomotor retardation or agitation (must be observable to others)
    - Fatigue or loss of energy
    - Feelings of worthlessness or excessive or inappropriate guilt
    - Difficulty concentrating, thinking, or making decisions
    - Recurrent thoughts of death or suicide, suicidal plan, or suicide attempt

  Must have clinically significant distress or impairment!
Symptoms of Persistent Depressive Disorder (Dysthymia)

- Depressed mood most of the day for more days than not for at least 2 years *(can be irritable mood in children/adolescents and minimal duration is at least 1 year; cannot have period without symptoms for more than 2 months at a time)*

- PLUS 2 of the following symptoms:
  - Poor appetite or overeating
  - Insomnia or hypersomnia
  - Psychomotor retardation or agitation *(must be observable to others)*
  - Fatigue or loss of energy
  - Feelings of worthlessness or excessive guilt *(Low self-esteem)*
  - Poor concentration or difficulty making decisions
  - Recurrent thoughts of death or suicide *(Feelings of hopelessness)*

Must have clinically significant distress or impairment!

DSM-5 does not distinguish between chronic MDD and dysthymia
Symptoms of Disruptive Mood Dysregulation Disorder

- Following symptoms present for 12 or more months (with no consecutive period of 3 months without all symptoms), present in multiple settings, and severe in at least 1:
  - Severe recurrent temper outbursts manifested verbally or behaviorally that are out of proportion in intensity or duration to the situation or provocation
  - Temper outbursts inconsistent with developmental level
  - Temper outbursts occur 3 or more times a week on average
  - Persistently negative or irritable mood between temper outbursts most days nearly every day and observable to others
  - Diagnoses made between age 6 and 18, onset of symptoms before age 10
  - Cannot occur in context of other disorders (including ODD), although can coexist with MDD, ADHD, conduct disorder, and substance use disorders
Symptoms of Bipolar Disorders (Bipolar I, II; Cyclothymia)

Depressive episode may or may **not** be present (Bipolar I requires only episode of mania)

- Mania or hypomania always required

  **Symptoms of mania:**
  - Distinctly elevated, expansive, or irritable mood for most of the day nearly every day (mania: symptoms for 1 week or require hospitalization; hypomania: symptoms for at least 4 days, functioning changes observable to others but not marked impairment, no psychotic symptoms present)
  - Abnormally and persistently increased activity or energy
  - At least 3 of the following are *noticeably changed from baseline* (4 if mood is irritable):
    - Increased self-esteem; belief that one has special talents, powers, or abilities
    - Decreased need for sleep
    - Unusual talkativeness; pressured speech
    - Flight of ideas or subjective impression that thoughts are racing
    - Distractibility
    - Increase in goal-directed activity or psychomotor agitation
    - Excessive involvement in activities with high potential for painful consequences, such as reckless spending, promiscuity
Symptoms of Adjustment Disorder with Depressed Mood

• Development of emotional or behavioral symptoms in response to identifiable stressor occurring within 3 months of onset of stressor

• PLUS one or both of the following:
  • Marked distress out of proportion to severity or intensity of stressor, accounting for external context and cultural factors influencing symptoms severity and presentation
  • Significant impairment in functioning

For adjustment disorder with depressed mood:
— Low mood, tearfulness, or feelings of hopelessness are predominant
Mood Disorders: Suicide

Will be addressed later in symposium.
Epidemiology and Consequences

• Depression is not particularly common in children (1 year prevalence rate: 1-3%)
  – Rates rise significantly in adolescence
  • 1 year prevalence rate: 5% to 6% in community samples (Garber & Horowitz, 2002; Lewinsohn & Essau, 2002)

• Lifetime prevalence rate (up to age 18): 18% (Merikangas et al., 2010)

• Episode before age 18 increases risk for depression in adulthood (Lewinsohn et al., 1999)
Mood Disorders: Comorbidity, Sex Differences

Comorbidity: 40-70% of youth with MDD have at least one other disorder, and 20-50% have two or more comorbid diagnoses (Angold et al., 1999)

- Common comorbidities include:
  - Anxiety disorder (30-80%)
  - Disruptive behavior disorders (10-80%)
  - Substance use disorders (20-30%)

Sex differences: Roughly equal rates in boys/girls in childhood; greater percentage girls vs. boys in adolescence (Costello et al., 2006)
Primary, Secondary, and Tertiary Prevention Model of Care

Primary prevention – avoids development of disease in general population

E.g., assessing for psychosocial factors that may contribute to future depression, providing appropriate medical/psychosocial supports and services

Secondary prevention: avoids development of disease in at-risk population

E.g., using screeners for depression and monitoring patients with elevated (but not clinical) levels of symptoms, providing interventions within primary care setting through education/brief interventions, offering additional psychosocial support

Tertiary prevention: reduces negative impact of already established disease through treatment

E.g., referring patient with clinical levels of depressive symptoms to psychologist
Screening Tools for Depression

**Patient Health Questionnaire for Adolescents (PHQ-A)**
Ages 13-18, 83 items, self-report, freely accessible

**Beck Depression Inventory – FastScreen (BDI-FS)**
Ages 13+, 7 items, self-report, proprietary ($114 per 50 forms w/ manual)

**Child Depression Inventory**
Ages 7-17, 17-27 items, self/parent/teacher report available, proprietary ($303 per 100 forms w/ manual)

**Short Mood and Feelings Questionnaire**
Ages 8-16, 17-27 items, self/parent report available, free with permission
Integrated Health Care: Psychologist in Primary Care

• Movement toward including psychologists as integral team members in primary care setting
  — Associated with improved outcomes for health and mental health issues (Butler et al., 2008; Unutzer et al., 2006)

• Increased training in graduate schools to prepare psychologists for primary care setting (Inter-Organizational Work Group for Primary Care Psychology Practice, American Psychological Association, 2015)

• Psychologists provide behavioral health services including prevention, diagnosis, evaluation, assessment, treatment, and management
Integrated Health Care: Psychologist in Primary Care

Common targets for treatment:
Addressing depression and/or anxiety symptoms, ADHD management, toileting, feeding concerns, behavioral aspects of managing chronic illness (e.g., addressing adherence to treatment for obesity, diabetes, etc.)

Advantages:
• Easy access to patients
• Less stigmatizing (Kelleher et al., 2006)

Disadvantages:
• Less cost-effective in short-term for clinics (may be beneficial long-term by reducing costs associated with chronic illnesses and comorbid mental health conditions)
Outside Referrals to Psychologists

Primary care provider gives referral to psychologist within community (outside of primary health care system)

**Advantages:**
- May be more equipped to address complex conditions (less limitations on schedule, can provide longer, more in-depth treatment than psychologists embedded in primary care)

**Disadvantages:**
- Poor follow up with mental health referrals (Glied & Cuellar, 2003)
- Communication may be more limited with medical providers
- May be less familiarity with quality of referrals
Cognitive-Behavioral Therapy (CBT)

- Assumes that thoughts, feelings and behaviors are connected
- Negative cognitions are identified, challenged, and modified through cognitive restructuring (Beck, 2011)
- Teaches coping skills and structured problem-solving
- Addresses problematic behaviors through behavioral activation
- Addresses other symptoms that may be interfering with functioning
  - Sleep and eating issues
Summary – what can you do?

**General suggestions:**

- Screen for mental health symptoms (both child and parent report)

- Ensure child has overall healthy lifestyle
  - For example, sleeping habits may influence risk for mental health difficulties

- Offer psychosocial supports to family

- Provide referral for mental health provider if appropriate
Summary – what can you do?

**Parental suggestions:**

- Check in repeatedly about whether parents have followed through with referrals for psychology.

- Encourage parents to look for warning signs of depression and to take symptoms seriously, particularly suicidal ideation or self-harm, and follow up with treatment.

- Encourage parents to receive treatment for their own mental health disorders!
  - Having a depressed parent is one of the strongest predictors of depression in youth (2x rates for children of depressed vs. nondepressed mothers (Hammen et al., 2003))
Questions?
Thank you!