Mood Disorders in Children & Adolescents

Depression

Major Depressive Disorder • Dysthmia • Biploar

Depressive Disorders

- A mood disorder (also called affective disorder) describes a disturbance in mood
- Children with mood disorders suffer from
  - extreme,
  - persistent, or
  - poorly regulated emotional states

History of Depressive Disorders

- In the past, it was mistakenly believed that depression did not exist in children in a form comparable to that in adults
- We now know that children do experience depression, and that depression in children is not masked, but rather may be overlooked because it frequently co-occurs with other more visible disorders

Depression in Young People

- One of the most disabling childhood disorders
- Prevalence in children is increasing
- Age of onset is decreasing
- The way in which depression is experienced and expressed changes with age
- Depression in children under age 7 tends to be diffuse and less easily identified

Major Depressive Disorder (MDD)

- DSM-IV clinical diagnosis requires presence of a *major depressive episode*, which is suggested by:
  - depressed mood/sadness most of the day, most days (in children and adolescents, may be irritable mood)
  - diminished interest or pleasure in activities
  - changes in appetite or weight
  - sleep disturbances
  - psychomotor retardation or agitation
  - fatigue or loss of energy
  - feelings of worthlessness or inappropriate guilt
  - difficulty thinking or concentrating
  - thoughts of death or suicidal ideation

Prevalence & Comorbidity of MDD

- Prevalence:
  - 2-8% of children ages 4-18
  - more rare among preschool and school-age children
  - increases into adolescence and adulthood
- Most common comorbid disorders are:
  - anxiety disorders
  - dysthymia
  - conduct problems
  - ADHD
  - substance use disorder

Developmental Course of MDD

- Age of onset usually between 13-15 years
- Average episode lasts 8 months
  - almost all children eventually recover
  - majority of children experience recurrences
- Even after recovery: adjustment and health problems and chronic stress continue
- No gender differences until puberty; after puberty, the ratio of girls to boys is about 2:1 to 3:1

Developmental Course of MDD (cont.)

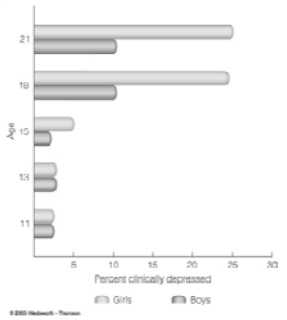

Figure 8.1 The overall rate of depression and the proportion of females with depression increases dramatically during adolescence. Adapted from "Development of Depression from Preadolescence to Young Adulthood: Emerging Gender Differences in a 10-year-Longitudinal Study," by B. L. Hankin, L. Y. Abramson, T. E. Moffitt, P. A. Silva, R. McGee & K. E. Andell, 1998, Journal of Abnormal Psychology, 107, 128-140. Copyright (c) 1998 by the American Psychological Association. Reprinted by permission of the author.

Dysthymic Disorder

- Features:
  - less severe but more chronic (depressed mood most of the day, most days, for at least 1 year) than MDD
  - children with both MDD and DD have "double depression"

Compared with MDD, Dysthmic Disorder has:

LESS
- anhedonia
- social withdrawal
- impaired concentration
- death thoughts
- physical complaints

MORE
- constant sadness
- self-depreciation
- low self-esteem
- anxiety
- Irritability
- Anger
- temper tantrums

Prevalence & Comorbidity of Dysthmia

- Rates of DD are lower than MDD
- Approximately 1% of children and 5% of adolescents
- Most common comorbid disorder is MDD

Developmental Course of Dysthmia

- Most common age of onset 11-12 years (earlier than for MDD)
- May be a precursor to MDD for some children
- Average episode length 2-5 years
- Most recover, but are at high risk for developing other disorders, especially MDD, anxiety disorders, and conduct disorder

Bipolar Disorder (BD)
formerly called Manic Depressive Disorder

- Features
  - Periods of abnormally and persistently elevated, expansive, or irritable mood ←→ Periods marked by major depressive episodes
  - Rapid cycling characteristic of child cases
  - Extremely rare in childhood
  - Onset peak late adolescence to early adulthood.
  - Probably genetic vulnerability paired with environmental stressors
  - Treatment multimodal, including medication
  - Poor long-term prognosis
  - We will NOT cover in depth

Associated Characteristics of Depressive Disorders

1. Interference with academic performance
   - Not necessarily related to intellectual deficits
   - Problems *on* tasks requiring attention, coordination, and speed

Associated Characteristics, cont'd

2. Cognitive disturbances:
   - Feelings of worthlessness
   - Attributions of failure
     - Failure due to character flaw, worthlessness, not just making a mistake
   - Self-critical automatic thoughts
   - Depressive ruminative style
   - Pessimistic outlook & hopelessness
   - Suicidal ideation

Associated Characteristics, cont'd

3. Low or unstable self-esteem
4. Social difficulties
   - few close friendships
   - feelings of loneliness and isolation
   - social withdrawal
   - ineffective coping in social situations
5. Poor relations with parents and siblings

Suicide risk factors

Jacobs: Intensive, multimethod investigation

Five risk factors for *adolescent* suicide attempts:

- longstanding childhood history of problems
- acceleration of problems in adolescence
- progressive failures to cope, and isolation
- dissolution of social relationships
- justification of the suicidal act

Theories of Depression

- Psychodynamic theory: depression results from the actual or symbolic loss of a love object
  - Parent withdraws and witholds affection
- Attachment theory: parental separation and disruption of a secure attachment bond are predisposing factors for depression
  - Separation by war for example
- Behavioral theories: emphasis on importance of learning, environmental consequences, and skills and deficits in the onset and maintenance of depression
  - Learned helplessness for example

Theories of Depression (cont.)

- Cognitive theories: focus on "depressogenic" cognitions
  - depression-prone individuals tend to make internal, stable, and global attributions for the cause of negative events
  - Beck's cognitive model proposes that depressed individuals have:
    - negative automatic thoughts
    - negative outlook regarding oneself, the world, and the future ("cognitive triad")
    - negative cognitive schemata

Theories of Depression (cont.)

- Self-control theories: view depression as associated with difficulties in organizing behavior in relation to long-term goals
- Interpersonal theories: view disruptions in relationships as the basis for the onset and maintenance of depression
- Neurobiological models: emphasize the role of genetic vulnerabilities and neurobiological abnormalities **Serotonin**
- Socioenvironmental theories: focus on the relationship between stressful life events and depression

Causes of Depression

- Genetic and family risk
  - heritability estimates ranging from .35 to .75
  - what is inherited is likely a vulnerability to depression and anxiety, with certain environmental stressors needed for these disorders to be expressed

Causes, cont'd

- Neurobiological influences
  - may involve heightened stress reactions
  - amygdala and hippocampus, HPA axis, sleep architecture, growth hormone, and neurotransmitters (**serotonin,** dopamine, and norepinephrine) have been implicated

What is serotonin?

Serotonin, or 5-hydroxytryptamine (5-HT)

Peptide that is found throughout the body

96% of serotonin is located in the gastrointestinal tract, 2% in platelets, and 2% in the CNS

More than 20 types of serotonin receptors at various locations in the human body have been described

Because structure of receptor determines function of peptide, serotonin has slightly different functions when paired with each different receptor

E.G., GI receptors involved in controlling the motility of & secretions in gut & perception abdominal pain.

Insufficient Serotonin?

- Rats: Increased fearfulness
- Monkeys: Decreased dominance
- Humans: Depression (presumptive)
  - SSRI's
  - Selective Serotonin Reuptake Inhibitors
  - Prevent Serotonin in synapse from being "vaccuumed" away or re-absorbed
  - Keep it functioning longer and increase functional levels of serotonin at brain receptor sites
- Increase Positives or Decrease Negatives?

Causes, cont'd.

- Family influences
  - Families of children with depression display
    - more anger and conflict,
    - greater use of control
    - poorer communication
    - over-involvement
    - less warmth and support
    - more disorganization
    - higher levels of stress
    - lack of social support

Causes, cont'd

- Stressful life events
  - depression is associated with severe stressful life events
  - triggers for depression often involve interpersonal stress or **actual or perceived personal losses**
    - Loss of status, for example, can be as perceived by the child even if it doesn't exist in other people's perceptions—a very individually defined phenomenon

Causes, cont'd

- Emotion regulation
  - difficulty regulating negative emotions may lead a child to be prone to depression
  - avoidance or negative behavior may be used to regulate distress, rather than problem-focused and adaptive coping strategies

Causes of Depression (cont.)

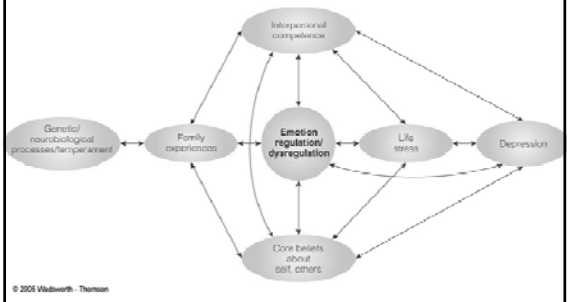

Figure 8.3 A developmental framework for depression in young people.

Treatment of Depressive Disorders

- Psychosocial Interventions
  - Cognitive therapy
    - teaches to identify, challenge, and modify these negative thought processes
      - misattributions
      - negative self-monitoring
      - short-term focus
      - excessively high performance standards
      - failure to self-reinforce

Treatment of Depressive Disorders

- Psychosocial Interventions, cont.
  - Behavior therapy
    - Increase pleasurable activities and events
    - Provide child with the skills necessary to obtain more reinforcement
  - Cognitive-behavioral therapy (CBT)
    - Integration of cognitive and behavioral therapies
    - **Most successful approach to treating depression in young people**

Treatment, cont'd

- Medications with children and adolescents??
  - Tricyclic Antidepressant
    - **Fails to demonstrate any advantage** over placebo in treating depression in youth
  - SSRIs:
    - Fluoxetine (Prozac) only FDA approved
    - Use has increased dramatically past few years
    - 3-4 weeks until takes effect
    - Latency suggests mechanism to repair cellular damage in hippocampus via neurogenesis
    - Increased suicide risk? **Not recommended**

Treatment, cont'd

- Prevention
  - CBT is most effective at lowering risk for depression, as well as preventing recurrences
  - Secondary prevention: At risk children and youth.
    - Family history
    - Stressors or trauma
    - Loss