Chapter 13. Depressive Disorders and Suicide

# 13.1 Disruptive Mood Dysregulation Disorder

## What is Disruptive Mood Dysregulation Disorder?

* DMDD is a mood disorder characterized by severe, recurrent temper outbursts and persistently irritable or angry mood. It is diagnosed in children between 6 and18 years of age who show problems for at least 12 months in two or more settings.
* Approximately 2-3% of school-age children have DMDD. Prevalence is much higher among children receiving mental health treatment.

## How is DMDD different from other childhood disorders?

* Children with DMDD always display mood problems; in contrast, children with ADHD typically do not display chronic anger or irritability.
* Children with DMDD typically direct their angry outbursts at people and objects; in contrast, children with ODD usually are oppositional toward specific people.
* Children with DMDD are at risk for anxiety and depression later in life; relatively few children with DMDD develop Bipolar Disorders.

## What causes DMDD?

* Youths with DMDD often selectively attend to negative social cues, making them more susceptible to negative emotions.
* Youths with DMDD often show deficits in recognizing and interpreting emotional expressions in others, causing them to become misperceive others’ actions as hostile.
* Youths with DMDD often have difficulty regulating their own emotions. Overactivity of the medial frontal gyrus and anterior cingulate is associated with these emotion-regulation problems.

## What Evidence-Based Treatments are Available for DMDD?

* Traditional parent training has not been effective for youths with DMDD, because it does not specifically target children’s angry outbursts and mood problems.
* Comprehensive Family Therapy, in which children and parents learn to manage children’s tantrums and outbursts, is effective in improving children’s behavior and mood and the quality of parent–child interactions.
* Improving the quality of sleep may also help reduce DMDD symptoms although additional research is necessary.

# 13.2 Major Depressive Disorder & Dysthymia

## What is Major Depressive Disorder?

* Children with MDD experience at least five symptoms of depression, including depressed mood or anhedonia, for at least two weeks. These symptoms cause distress or impair the child’s functioning at home, school, or with friends.
* “After his ship was demasted by the enemy, the captain felt guilty.” You can remember the symptoms of depression using the acronym DEMASTED + Guilt. D = depressed mood; E = eating problems; M = movement problems; A = anhednia; S = sleep problems; T = thought/concentration problems; E = energy low; D = death/suicide + Guilt

## What is Persistent Depressive Disorder?

* Children with Persistent Depressive Disorder experience chronically depressed or irritable mood for at least one year. They often regard themselves as unlikable and ineffective, are plagued by self-doubts and self-criticism, and are pessimistic about the future.
* Compared to MDD, Persistent Depressive Disorder usually has a more gradual onset, longer duration, and lesser severity.

## How Common Is Depression in Children and Adolescents?

* Approximately 1-2% of prepubescent children experience a depressive disorder. Prevalence increases markedly in adolescence, especially for girls; as many as 14% of adolescent boys and 28% of adolescent girls experience depression.
* Youths who experience a depressive episode are at risk for another depressive episode in the future, a phenomenon known as “kindling.”
* Approximately 20% of youths experience high susceptibility for depression in adolescence and recurrent mood problems into adulthood.

## What Genetic and Biological Factors Contribute to Childhood Depression?

* Depression is highly heritable; twin concordance is approximately 70-85%.
* The neurotransmitters most often implicated in childhood depression are the monoamines: serotonin and norepinephrine. Antidepressant medications tend to affect these neurotransmitters.
* Young children who inherit difficult temperaments are at risk for depression later in life, either directly (by increasing negative emotions) or indirectly (by affecting parent–child interactions or the child’s coping skills).
* Some youths with depression show dysregulation of the HPA axis, the body’s stress response system.

## What behavioral and cognitive factors contribute to childhood depression?

* Stressful life events are directly correlated with children’s depressive symptoms.
* According to Beck’s cognitive theory of depression, cognitive biases and distortions contribute to a negative view of self, world, and the future.
* The reformulated learned helplessness model posits that depression occurs when we attribute negative events to internal, stable, and global causes.

## How might parents and peers contribute to childhood depression?

* Children who develop insecure attachment relationships with their caregivers, or whose caregivers are depressed themselves, are at risk for depression.
* Peer rejection can place youths at risk for depression.
* Children at-risk for depression often show social information-processing biases; they may view others’ actions as hostile and blame themselves for their own victimization.

## Is medication effective and safe for treating children with depression?

* On average, 60% of youths with depression respond to SSRIs whereas only 49% respond to placebo. However, only fluoxetine (Prozac) is FDA approved for treating childhood depression.
* SSRIs are associated with a slightly higher risk for increased suicidal thoughts (4%) than placebo (2%), but not increased risk for suicide attempts.

## What evidence-based psychotherapies are available for youths with depression?

* Stark’s cognitive-behavior therapy is effective in reducing depression in children. Children learn to (1) recognize negative emotions, (2) solve social problems, (3) cope with negative feelings, and (4) challenge cognitive biases and distortions.
* Coping with Depression is a group therapy that is effective for adolescents. First, adolescents learn emotion recognition skills and techniques to increase positive affect. Second, adolescents learn relaxation skills and strategies to manage negative emotions and avoid conflicts.
* In interpersonal therapy, adolescents target one of the following triggers for depressed mood: grief, interpersonal role disputes, interpersonal role transitions, or interpersonal deficits.

## Should medication and psychotherapy be combined to treat depression?

* In the TADS study, depressed adolescents who received medication and therapy showed the greatest improvement.
* In the TORDIA study, depressed adolescents with a history of suicidal behavior showed the greatest improvement when receiving both medication and therapy.

# 13.3 Suicide

## How Common is Child and Adolescent Suicide?

* In the United States, approximately 5,000 youths die by suicide each year.
* Suicide death is higher in adolescents (14.5/100,000youths) than older children (2.1/100,000 youths).
* Approximately 12% of adolescents experience suicidal thoughts and 4% report a suicide plan or past attempt.

## How Does Suicide Vary as a Function of Gender, Age, and Ethnicity?

* Girls are three times more likely than boys to attempt suicide, but boys are 3-4 times more likely than girls to die by suicide, perhaps because boys use more lethal means.
* The prevalence of suicidal thoughts and actions increases markedly after puberty.
* Latinas and American Indian boys and girls show the highest rates of suicide. African-American youths show the lowest rates.

## What Factors Predict Suicide in Children And Adolescents?

* Approximately 90% of youths who commit suicide have a history of a mental disorder, including Major Depressive Disorder, Bipolar Disorder, Substance Use Disorders, and ADHD.
* Many youths who attempt suicide have a history of maltreatment in their families. Youths who feel that they are a burden on their families are at particular risk.
* Youths who are bullied, or you identify as LGBT, are at particular risk for suicide. Youths who feel like they do not belong in their family or peer group are at particular risk.

## What Theories Help Explain Suicide in Children and Adolescents?

* According to hopelessness theory, youths are at risk for suicide when they (1) attribute negative events to stable and global causes, (2) believe the consequences of the negative events are important, and (3) see themselves as worthless because of the event.
* According to interpersonal-psychological theory, youths are at risk for suicide when they (1) view themselves as a burden to others, (2) feel like they do not belong to their family or peer group, and (3) feel capable of self-harm.

## How Do Clinicians Assess Suicide Risk?

* Suicide risk is determined by the youth’s general thoughts about death, specific suicidal ideation, whether he or she has made a plan, how feasible and lethal the plan is, and whether the youth has made an attempt in the past.

## How Can Clinicians Help Youths Who Attempt Suicide?

* Safety planning includes means restriction; identifying thoughts, feelings, and situations that might trigger a future suicide attempt; and finding sources of support in case of future crises.
* Results of the TASA study indicate that medication, especially SSRIs, are effective in preventing future suicide attempts among adolescents with a history of suicide attempts.
* In family-focused treatment, families learn how to (1) restrict youths’ access to firearms, pills, or other means of suicide; (2) improve communication and connectedness in the family; (3) identify and cope effectively with negative events, thoughts, and feelings. Examples of the SAFETY and RAP-P programs.

## Can We Prevent Suicide in Children and Adolescents?

* Gatekeeper training, educational awareness programs, and school climate/peer support programs have demonstrated modest effectiveness in preventing suicide.