

Facilitator Preparation: Facilitators should thoroughly review this module. They should review the clinical presentations, diagnostic criteria, and typical management of the psychiatric illnesses presenting in this case (Major Depressive Disorder, Post-Traumatic Stress Disorder). They should also prepare or photocopy handouts to distribute during the course of the case presentation and the “Materials for Learners” packet.

Open the Discussion: Introduce the case title and the objectives of the session. Explain that this will be an interactive case discussion prompted by a series of multiple choice questions and not a lecture. Distribute Part I of the case and ask one or more of the participants to read it aloud.

Too Sad to Live

Depression

Case Authors:

Richard Chung MD
Duke University School of Medicine
Duke University Medical Center

Expert Content Reviewer:

Lydia Shrier MD MPH
Harvard Medical School
Boston Children’s Hospital

Scott Leibowitz MD
Harvard Medical School
Boston Children’s Hospital

Objectives:

- Describe the general symptoms and varied presentations of depression in adolescents.
- Formulate a series of questions for the assessment of depression and suicidality.
- Describe a plan of action for the management of the depressed or suicidal adolescent.

Part I

Introduction

Chantel is a 17 year old young woman who comes to your office with a chief complaint of abdominal pain. You begin the visit by welcoming her to your office and review general confidentiality provisions as well as the limits of those provisions, highlighting the utmost importance of her safety. She verbalizes understanding of those provisions and you begin asking her about her situation. She stares down at the floor while she speaks to you quietly. She reports a three-month history of mild diffuse abdominal pain. She denies vomiting, diarrhea, constipation, vaginal discharge or dysuria. She reports normal menstrual cycles with mild dysmenorrhea; her last menstrual period was 2 weeks ago. She discloses tearfully to you that she was raped 2 months ago by an ex-boyfriend. She currently has no contact with him and does not feel in danger. She has been postponing this visit because she is anxious about having a pelvic exam.

She describes significant fatigue and difficulty sleeping. She also tells you that she does not like school as much as she used to and that her grades are dropping. When you ask about her friends,

she tells you that she does not have any close friends anymore. She is not involved in any social or recreational activities and cannot remember why she stopped hanging out with her friends.

Following this reading, ask all participants “So what do you think about this case? What would you like to focus on during our discussion today?” List agenda items on a blackboard or flipchart. Then use the questions below to start the discussion. Remember that the key to successfully leading a small group is facilitating the discussion rather than lecturing. Draw as many participants as possible into the discussion. Allow for moments of silence while group members think about questions.

Potential Discussion Questions:

How would you explain the protections and limitations of confidentiality provisions in the medical setting to Chantel?

Confidentiality is a critical element in caring for adolescents, and it is important to review this at the beginning of the visit so that the adolescent may feel more comfortable during the clinical interview. If a parent or guardian is present, it is also important to inform them of this framework so that they understand the dynamics of the visit and will be able to partner with you in ensuring their adolescent’s privacy. One way to explain confidentiality is the following: “During this visit I’ll spend some time alone with you (patient) so that I can hear more about your life. The conversation we have alone will be private, meaning that, in general, nothing will be shared with anyone else. This is to make it easier for you to talk freely about your life. However, if your life or someone else’s is in danger, we will involve your parents (or guardian) after first discussing how to tell them about it.”

What else would you like to know about Chantel?

Clinicians should take a complete psychosocial history. Suggest using the HEADDSSS format (Home, Education, Activities, Drugs, Diet, Sex, Suicide/Emotional health, Safety) to guide such conversations. Starting with a discussion of the adolescent’s strengths may facilitate conversation about more sensitive topics.

What are the key portions of Chantel’s presentation that make you suspicious of emotional distress?

Factors suggesting distress include:

- history of sexual trauma
- school failure
- tearfulness
- increasing isolation
- lack of eye contact
- extreme anxiety about pelvic exam
- sleep disturbance
- history of chronic pain
- anhedonia (e.g., lack of motivation in school)

How would you assess Chantel for Major Depression?

Explain that it is always better to start with open-ended questions and then get increasingly specific.

Ask learners to refer to Handout #1 (DSM IV Criteria for Major Depressive Episode) and allow learners a few minutes to review the contents. Write out the headings below (Depressed mood, Anhedonia, etc.) and ask participants to come up with specific questions that assess each area.

Assessing DSM criteria for a Major Depressive Episode:

Depressed Mood:

How has your mood been in general lately? (Wait for answer, then ask directly. Follow this format for each question-group below.)

Do you feel like you're depressed?

How much of each day do you feel depressed?

What is the longest period of time you have felt depressed without being able to feel better?

Do you think you are more depressed in the winter than the summer, or only in one season?

When you get sad or down, how long does it last?

Have you ever felt hopeless?

Have you experienced any personal losses recently?

How do you feel about (specific event/life in general)?

Do you feel your mood changes according to your menstrual cycle? (for females)

Do you often feel irritable?

Anhedonia:

Do you ever not feel depressed?

Is there anything you do that can take your mind off of being depressed?

What do you do to enjoy yourself/have a good time/for fun?

Has your interest in this/these things changed?

Are you able to enjoy any of the things you used to enjoy?

Have you been feeling bored all the time?

Neurovegetative Symptoms:

How is your appetite? Is this different than usual?

How have you been sleeping? When do you have difficulty?

When you can't fall asleep, what is keeping you awake?

Is it that you just can't sleep, or is your mind racing or having upsetting thoughts?

Do you wake in the middle of the night other than to go to the bathroom, and then can't get back to sleep?

Do you ever wake up early and then have trouble falling asleep again?

How is your daytime energy level?

Is it hard to get going/hard to sit still? Do you feel more restless than usual?

Has your concentration gotten worse since feeling more down or sad?

Is it hard for you to focus on things you used to be able to, like watching TV, reading a book or magazine?

Have you recently gained or lost weight while feeling depressed?

Feelings of Guilt or Worthlessness:

How have you been feeling about yourself lately? What are some aspects about yourself that you wish you could change?

What are the things about yourself that you appreciate?

Are you feeling like you've done something wrong/like everything you do is bad/your fault?

Are you hard on yourself? Are there times when you call yourself names?

Have you been harder on yourself lately?

Do you feel guilty for anything specific?

How often do those thoughts come into your mind?

Do you find yourself continuing to remember or think about an unpleasant experience that happened in the past?

Manic Symptomatology:

Has there been any distinct period of time where you felt the opposite of depressed, in other words, extremely happy for no reason?

During that period, did your friends and family members notice that you weren't acting as your usual self?

How long did that period last?

During that time, did you notice that you didn't need to sleep and still felt energetic the next day?

Did anyone say that you were speaking faster than usual or didn't make sense?

Did you feel your thoughts were so fast that you couldn't finish one idea before the next idea entered into your head?

Did you do anything more risky than usual that you wouldn't have done otherwise (e.g. spend money you didn't have, impulsively act on a thought that wasn't in your best interest)?

Shame, humiliation, and self-blame are central experiences/symptoms of survivors of sexual assault (and sexual abuse). Therefore, *how* questions are asked is critical. Taking an empathic approach, while avoiding questions that could be misinterpreted by Chantel as blaming her in any way for her experience, are essential. Close observation of Chantel's behavior and affect as you interact with her is also important. What is her response to questioning about depression and suicidal thoughts? She may decompensate, become belligerent or silly, avoid questions by changing the subject or not responding, or respond in any number of other ways. Her response reflects her "coping style" and can signal if she feels overwhelmed, uncomfortable, and/or avoidant.

Finally, assessment of psychotic features will also be necessary:

- Are there perceptual disturbances? That is, Chantel might be experiencing auditory, visual, or tactile hallucinations. One way to ask this question is to say: "*Many others who have felt the way you do have experienced hearing or seeing something that wasn't there. Have you ever heard or seen something that wasn't there? Did you realize your mind was playing tricks on you?*"

- Are there delusions? If so, are the delusions bizarre (not possible) or non-bizarre (possible, but not true for this patient). Understanding the patient's beliefs would help to differentiate reality-based thought patterns from those that are not based in reality and might affect your assessment, treatment plan, and disposition.
- If hallucinations and/or delusions are present, are they experienced in the context of a mood episode or are they independent of mood symptoms? That is, if Chantel is experiencing auditory hallucinations that seem consistent with her depressed mood (i.e. hurtful statements), and only experiences them while depressed, then the diagnosis and treatment recommendation might be different from a situation where the psychotic features are experienced independent from her depression.

After the group has generated questions in each area, note that Handout #2 (Depression in Adolescents) is a summary of above for learners to use for future reference.

In addition to the categories above, the acronym SIG E CAPS is often useful as a mnemonic to guide assessments. The elements represented include sleep, interest (anhedonia), guilt, energy, concentration, appetite, psychomotor retardation or agitation, and suicidality or other safety concerns. Please note that the acronym does not include the core feature of sadness which typically is assessed before exploring these additional complementary areas.

Does Chantel meet criteria for a Major Depressive Episode (DSM-IV)?

Review the DSM-IV criteria and decision rules for a Major Depressive Episode. Explain that: **1) Chantel must meet criteria for depressed mood or anhedonia (criteria 1 and 2, respectively), and experience any other 4 of the remaining 7 symptoms listed within the same 2-week period; and 2) irritable mood can substitute for depressed mood in the case of children and adolescents.** You may also wish to explain that a Major Depressive Episode is not necessarily the same as a Major Depressive Disorder, which is diagnosed on the basis of one or more major depressive episodes, but NO experience of any manic, mixed, or hypomanic episodes. Chantel denies any kind of manic symptoms.

How would you assess Chantel for risk of suicide? What are potential questions to ask?

Suicidal ideation and/or intent are symptoms of depression. Once acknowledged by the patient, it is important to get an impression of the frequency and seriousness of the ideation, as these are related to the likelihood of an actual attempt. Also, the presence of intent, seriousness of intent, and access to methods of carrying out such intent are critical issues in the assessment of a patient's risk of attempting and completing suicide. Finally, remember that predictors of future attempts include: 1) a previous suicide attempt, 2) concurrent presence of depression, 3) the experience of having a friend or relative commit suicide, and 4) the presence of a co-occurring substance use disorder.

Many people fear that asking questions about suicidal thoughts will “put ideas in someone's head” and perhaps precipitate behaviors that would not have otherwise occurred. Although adolescents are influenced by peers who commit suicide, there are no data suggesting that assessment of suicidality by a health or mental health clinician is “suggestive” in this way. The

risk/benefit balance in this regard is clearly in favor of assessing and preventing suicide rather than avoiding the subject altogether. Taking an empathic approach and normalizing an adolescent's experience are interview strategies that are more likely to lead to an accurate response.

Suicide:

- *Sometimes adolescents who feel depressed or irritable wish they didn't have to continue on living. Have you ever felt this way?*
- *Sometimes adolescents who feel depressed or irritable have thoughts of hurting themselves. Have you ever had thoughts of hurting yourself in any way?*
- *Have you done something to hurt yourself even without the intention of killing yourself?*
- *Sometimes adolescents who feel the way you do think about killing themselves. Do you ever think about killing yourself?*
- *What thoughts come into your mind when you think about hurting/killing yourself?*
- *How often do you think about these things?*
- *Do you have any thoughts that prevent you from following through on this?*
- *What might be some reasons to not kill yourself?*
- *Have you thought through or researched ways to actually go through with killing yourself?*
- *When you think about hurting or killing yourself, how do you imagine you might do it?*
- *How close to actually following through on these plans have you come? Do you still feel this way?*
- *Are you able to get the things to enact this plan (e.g., pills, knives, guns)?*
- *What do you think it would be like for your loved ones if you were able to kill yourself?*
- *What would it mean to be dead (assess realistic thinking about death)?*
- *Have you ever tried to hurt yourself or kill yourself before? If so, did you tell anyone?*
- *Have you ever known or heard of anyone who killed themselves? How close were you to this person? How did it affect their loved ones?*

Additional questions surrounding gun/weapon/item safety are also important to consider, as such counseling has been shown to be effective:

- *Are there any items in your home that might be considered unsafe weapons?*
- *Are there any medications that are not yours that you have thought about taking?*
- *Are there any over-the-counter medications that you have thought about taking inappropriately (too much, too frequently, without need)?*
- *Is there a gun in your house?*
- *Is it locked and is the ammunition locked and stored separately?*
- *Are there any guns in the homes where you visit, such as the homes of grandparents, other relatives, or friends?*

Ask learners to turn to Handout #3 (Suicide Risk Assessment) and allow a few moments to review it.

What other factors may affect Chantel's situation?

Other possible factors that should be assessed include stressful events or ongoing stressors, sources of support, past psychiatric history, familial psychiatric history, and comorbid conditions.

A. Stress and Support.

Chantel has already disclosed the most likely precipitant for her current distress (a sexual assault), however, it is important to get a sense of other areas of stress and support in her life, as these can potentiate current stressful events or provide a buffer. A support system includes people (family and friends), institutions (school, clubs), and activities which make her feel good about herself (good academic functioning, sports, extracurricular activities, etc.).

B. Psychiatric History (Patient and Family)

Past psychiatric history is important. Depression is a recurrent and sometimes chronic disorder, and if Chantel has a history of depression, she is at greater risk for current depression. If Chantel has a history of treatment for depression, this will provide information regarding the level of intervention that has been necessary in the past (e.g. hospitalization vs. partial day program vs. outpatient psychotherapy and/or medication management), what has worked, and past treatment providers. In addition, depression runs in families, and it is more likely to occur in children and youth with family histories of other psychopathology as well.

C. Comorbid Conditions.

Comorbidity of psychological problems and psychiatric diagnoses is common in adolescents. Comorbidity often suggests a more serious disturbance, with a more adverse course and worse outcomes, including increased risk for suicide. It is important to assess for potential comorbid psychiatric or behavioral problems that may require further assessment and treatment. In this case, Post Traumatic Stress Disorder (PTSD) is the most salient comorbid condition, and is important because of the increased risk it suggests for serious disturbance and suicidality and its relevance to treatment choices. Other possible comorbidities that should be considered include substance-related disorders and other anxiety disorders, among others. Criteria for these disorders can be found in the DSM-IV.

Possible questions to ask Chantel in order to assess for PTSD include:

- *How often do you find yourself thinking about the assault?*
- *Are you able to stop thinking about it if you want?*
- *Does it feel like the thoughts just come into your mind unexpectedly and you can't do anything about it (intrusive thoughts)?*
- *Does it ever feel like the whole thing is happening again in the present even though it's not (flashbacks)?*
- *Are there any specific triggers in your environment that might lead to a flashback or re-experiencing of the assault?*
- *Do you avoid talking about the assault?*
- *Do you avoid any activities, places, or people who might remind you of this memory?*
- *Are you having any nightmares?*
- *Does your body have any specific reactions when you think about or are reminded of the memory (hyperarousal: palpitations, sweating, shortness of breath)?*

- *How long have these experiences occurred? A week? Here and there? A month? Longer?*

Possible questions to ask Chantel in order to assess/screen for other anxiety disorders include:

- *Do you feel restless or tense more often than not without any specific reason?*
- *Have you experienced any specific instances where your body felt out of control, like you were having a heart attack or feared you would die, without any specific reason? How long did that last and how frequent has it happened?*
- *Has your body ever physically reacted when you feel tense with experiences like palpitations, shortness of breath, sweating, dizziness, nausea, or chest pain?*
- *Do you find you have certain thoughts that enter your mind and you cannot get them out until you do something specific to release the tension? (Give an example if asked)*

Assessment for substance-related disorders is discussed in the related case *The Crafty Pupil*.

Distribute Part II of the case and have participant(s) read it aloud.

Part II

Next Steps

Further questioning reveals that Chantel lives with her mother and 14 year-old sister. Her father “disappeared” 2 years ago. She is in the 11th grade. She has a history of alcohol abuse but has been sober since last year. She smokes 1 to 3 cigarettes a day. When asked about her mood, she states, *It isn’t anything.* She cannot name anything she has done lately that she has enjoyed. She reports feeling too tired to go out with her friends. She also says she feels like no one likes her because she is *“stupid and can’t do anything right.”* She says she lies in bed for hours trying to fall asleep and wakes up early because she cannot stop thinking about *“things.”* When you ask her to describe these *things*, she reports feelings of guilt about what happened (i.e., the sexual assault and the disappearance of her father), and her belief that it is all her fault. She also reports no appetite lately and that others tell her she looks like she is losing weight. She then tells you that, *“I tried to cut my wrists in the bathroom at school yesterday just like this other girl I know did a few months ago.”*

Pause and begin next set of discussion questions.

Potential discussion questions:

What are you most concerned about now? What is her level of risk for self-destructive behavior/suicide?

Chantel’s admission that she cut her wrists should raise concern for suicidal potential. However, it is important to keep in mind that an expressed desire or actual behavior can be consistent with self-injury in itself rather than suicidal ideation or attempt. Self-injurious behaviors are typically a means of relieving psychological pain, not ending one’s life. However, it can be difficult to distinguish between the two and thus vigilance is critical. Asking a clarifying question such as *“When you cut your wrists, what would you hope would happen?”* can be helpful. If the patient acknowledges a hope that such injury would lead to death or is noncommittal or unclear, further clarification should be sought. Although self-injurious behaviors may not always constitute a

true risk to life, there is the potential for severe injury and thus, these behaviors should be addressed proactively.

True suicidal intent and the presence of a plan indicate serious risk. Chantel's risk is also increased because she knows someone or knows of someone who has attempted or committed suicide.

What is your plan of action?

In addition to determining whether any acute medical treatment is needed for the wrist lacerations, it is most important to decide whether referral for emergency psychiatric evaluation or referral for outpatient therapy is most appropriate. Hospitalization can be stigmatizing and should be avoided if it is possible to devise an outpatient plan. Central to this decision is the determination of whether Chantel can keep herself safe and contract for safety. If safety can be maintained, yet your assessment yields a distinct period of poor functioning in the presence of outpatient supports, it may be worth considering an intermediate level of care such as a day program. Primary care clinicians should be knowledgeable about contracts but should also work in collaboration/consultation with mental health clinicians to devise an appropriate management plan. It is also critical to ascertain whether Chantel has access to weapons or other objects that she might use to harm herself, including medications. The lack of such items does not eliminate risk, but knowing about any such items that she actually does have access to can be helpful for risk assessment and safety planning.

****Optional Exercise on Safety Contracts: What might be important to include in a contract for safety?**

Written contracts for safety are preferred to verbal contracts, unless the patient's risk is thought to be very low (e.g., low intent/no plan). Emphasize that the more specific the contract is, the better. An explicit, concrete plan for what Chantel will do if she should feel unsafe in any way should be included in the *written* contract.

Ask learners to turn to Handout #4 (Sample Contract for Safety) and allow a few minutes to review the contents.

If Chantel is able to contract for safety, contact should be made with her mother (legal guardian) who will be responsible for supervision and will be available for Chantel any time she is feeling at risk. The contract should be shared with the adult and the adult should be responsible for enforcing its terms. All should sign, and copies should be made. If the parent or guardian is not available to provide this degree of supervision and support, or if there is concern that disclosure of this safety issue to the parent or guardian will not be in the best interest of the patient due to dysfunctional relational dynamics, then immediate psychiatric assessment (and possibly hospitalization or a referral to a day program) through emergency services is necessary. In this situation, Chantel admits that she cut her wrists yesterday because she thinks she would be better off dead; she had to stop when a teacher walked into the bathroom and sent her back to class. She cannot contract for safety. Chantel should be escorted directly to the emergency room, or emergency medical services should be involved in making that transition of care.

****Keep in mind that "contracting for safety" is not sufficient to truly ensure a patient's safety. Clinical assessment, careful decision-making, and establishing a clear safety plan are the crux of**

maximizing a patient's safety. Contracting is helpful for clarifying the patient's safety plan and current intent to remain safe, and for providing the patient's legal guardian with a framework for supporting the adolescent at home, but should not be seen as a full assurance of safety and should never take the place of standard assessment and treatment. Many suicide attempts are impulsive, and as such supersede any contracts or verbal "promises" that may have been made previously.

Distribute the Epilogue. Ask someone to read the Epilogue aloud.

Part III

Epilogue

Chantel is escorted to the emergency room for immediate psychiatric consultation. She is admitted to a psychiatric inpatient facility. She is diagnosed with major depressive disorder and PTSD. She remains an inpatient for one week and is started on an antidepressant. On follow-up, her mood is remarkably improved and she is no longer suicidal.

Pause and begin final set of discussion questions.

Potential questions include:

What are your responsibilities for Chantel now?

Facilitate a discussion about the primary care physician's follow-up role in managing psychopharmacologic therapy and arranging outpatient psychotherapy. Discuss why adolescents might be more or less likely than children or adults to present to a medical office with emotional issues, rather than to a parent or counselor (e.g., developmental needs for autonomy from adults, peer pressure to be cool, stigma associated with mental health services in conjunction with acute social pressure during adolescence, inability to recognize emotional issues when they arise and how they might be connected to somatic symptoms). Chantel is presenting to a medical clinic ostensibly with a medical complaint, but her complaint appears to be more related to critical emotional/psychological issues. The physician is therefore her link to the services she needs.

What may be difficult for medical providers in dealing with issues of depression and suicidality in a medical setting?

Discuss how the learners felt while hearing about this case. How do you feel when confronted with a 17 year-old girl who has been raped, may be suicidal, and is in your primary care office at the moment? You may want to share that the clinician who actually saw this case described it as "overwhelming." Psychiatric issues may be uncomfortable/unsettling and clinicians must be aware of personal discomfort and the possibility of avoidance as a result (e.g., choosing to focus on medical issues with which you are probably more comfortable). In general, if it is making you anxious, it is worthy of attention. Validating that even the most experienced of medical providers are allowed to feel uncomfortable is important, yet being aware of that comfort level and addressing it is the key to providing effective clinical care. Adolescents often feel more comfortable when their provider exudes a compassionate, yet confident approach to an emotional issue they disclose.

What are some community prevention strategies?

Primary prevention efforts have included restricting access to methods used to commit suicide, school-based programs, educating health care providers to recognize potentially at-risk teens,

and programs that target youth in high-risk groups. Reducing the availability of lethal means (e.g., restrictive gun control laws, regulation of the number of potentially lethal pills dispensed per prescription) has been shown to reduce suicide rates. School-based programs tend to be directed at a general school population, and thus, may not be effective in changing the attitudes of at-risk youth. Secondary prevention programs include hotlines, crisis centers, and peer support groups that tend to target suicidal youth.

Refer back to group's learning agenda and summarize the key teaching points that were made. This will give the group a sense of accomplishment, and emphasize the important messages. Suggest further sources of reading or other information if there are agenda items that were not covered in the discussion.

Clinical Pearls:

- Although typical symptoms and signs of depression are prevalent among adolescents suffering from Major Depression, atypical features, including irritability or muted presentations, are common and may be difficult to discern.
- Trauma is a common source of distress resulting in depression and can complicate initial assessment and treatment planning.
- Well-established categories of focused questioning can elucidate whether or not a patient's clinical presentation is truly consistent with a Major Depressive episode versus other presenting scenarios such as a subclinical depressive presentation or manic symptomatology.
- Initial treatment planning is guided by the patient's clinical characteristics including severity of symptoms, safety profile, and resources available in the particular situation.

Knowledge questions:

Ask learners to complete the knowledge questions in their packet. If time allows, questions and answers can be discussed as a group, or learners can complete and review answers on their own.

1. *What clinical characteristics must a patient have to meet criteria for Major Depressive Disorder? (select one)*

- a. Disordered sleep
- b. Safety concerns
- c. Sadness
- d. Sadness and/or irritability and/or anhedonia
- e. Depressive symptoms for at least one month

2. *Which of the following is not a typical symptom of depression? (select one)*

- a. Guilt
- b. Fatigue or low energy
- c. Poor concentration
- d. Hallucinations
- e. Sluggishness

3. Which of the following statements about distinguishing self-harm and suicidal gestures is *true*?
- Self-harm behaviors are typically mild and rarely pose a true risk to safety while suicide attempts are almost always dramatic and require significant medical care.
 - Self-harm behaviors are always premeditated while suicide attempts are almost always impulsive.
 - Self-harm behaviors are means of coping with emotional distress without a desire to die, whereas suicide attempts are means of coping with emotional distress in hopes of ending one's life.
 - Self-harm behaviors and suicidal gestures are almost never present in the same individual.
 - Self-harm behaviors and suicide attempts fall along the same spectrum. If a patient is demonstrating self-harm behaviors it is only a matter of time until a suicide attempt will happen.
4. Which of the following is the greatest predictor of future suicide attempt?
- Access to methods such as weapons or medications.
 - A friend or family member who has attempted or committed suicide.
 - Severity of depression or other psychiatric illness.
 - Current self-harm behaviors.
 - Prior suicide attempt.
5. What are the purposes of contracting for safety? (select all that apply)
- To ensure a patient will not attempt suicide.
 - The lay out in clear terms the care plan and safety plan for the clinician, patient, and family members (if applicable).
 - To further support the patient in adhering to the care plan..
 - To protect clinicians from medical liability in the care of subsequent suicide attempt.
 - To determine the level of care a patient needs.

Answers to Knowledge Questions:

1. What clinical characteristics must a patient have to meet criteria for Major Depressive Disorder? (select one)

Preferred response: D "Sadness and/or irritability and/or anhedonia"

A required component of the DSM diagnosis of Major Depression is at least one of these three components in conjunction with at least 4 additional elements.

Although sleep difficulties are common in Major Depression, they are not required to make a diagnosis of Major Depression. Similarly, although self-harm and suicidality are often linked with Depression, they are also not required to make the clinical diagnosis. While sadness is the more common component of Major Depressive disorder, irritability may substitute for sadness in making this diagnosis in children and adolescents. Finally, while it is possible to suffer from a depressive episode for a month or longer, the diagnostic criteria highlight two weeks as the key threshold for diagnosis.

2. Which of the following is not a typical symptom of depression? (select one)

Preferred response: D "Hallucinations"

Although it is possible to have Depression with psychotic feature, this is not typical. Other psychotic features may suggest an alternate diagnosis such as a Bipolar Disorder or Schizophrenia.

Although not a required element of diagnosing Major Depression, guilt regarding prior experiences is often present and can be a debilitating feature. Similarly, fatigue is a common subjective aspect of a Major Depressive Episode and can exacerbate the distress of anhedonia and hopelessness. Concentration is also commonly perturbed and may even be the presenting symptom of depression in adolescents who attend school and begin to struggle. Although Depression and Attention Deficit Hyperactivity Disorder can coexist, it can be hard to distinguish the two from each other. Finally, psychomotor agitation or retardation is also a common component of Depression. Sluggishness may present in the form of difficulty getting started in the morning or initiating any sort of physical activity.

3. *Which of the following statements about distinguishing self-harm and suicidal gestures is true?*

Preferred response: C “Self-harm behaviors are means of coping with emotional distress without a desire to die, whereas suicide attempts are means of coping with emotional distress in hopes of ending one’s life.”

Self-harm behaviors are typically distinct from suicidality and are often described as a means of coping with severe emotional distress without hopes of ending one’s life.

Self-harm behaviors such as cutting can pose significant risk to safety depending on the location and depth of the lesions sustained. Also, suicidal gestures vary significantly in their lethality from overdosing on a fairly safe medication such as an SSRI to overdosing on something more readily lethal such as a TCA or Acetaminophen. Although suicide attempts are often impulsive, self-harm behaviors can also be impulsive, in the context of an emotional outburst and acute emotional distress. It is possible for the same individual to utilize self-harm as a coping mechanism while also experiencing suicidality and perhaps demonstrating suicidal gestures distinct from the self-harm experience. Finally, although both behaviors may stem from a similar source of distress, and although self-harm behaviors may be present prior to overt suicidality, self-harm behaviors do not always lead to suicidality. When self-harm is present, suicidality should be screened for, but a direct connection cannot always be assumed.

4. *Which of the following is the greatest predictor of future suicide attempt?*

Preferred response: E “Prior suicide attempt”

A prior suicide attempt is the greatest predictor of future suicide attempt. Asking about prior behaviors is critical when assessing suicidality.

Although access to methods is essential for making a suicide attempt, it is not the greatest predictor of actually making an attempt. Having a history of suicidality in one’s family or friend network is a risk factor for future suicide attempt, but it is also not the greatest risk factor. Severity of psychiatric illness and self-harm behaviors may also contribute to potential for suicide attempt, but likewise are not considered the greatest predictors.

5. *What are the purposes of contracting for safety? (select all that apply)*

Preferred response: B and C “To lay out in clear terms the care plan and safety plan for the clinician, patient, and family members (if applicable)” and “To further support the patient in adhering to the care plan.”

The care and safety plans for patients with psychiatric distress can be complex. It is often very helpful to write out in clear terms the mutually agreed upon plan. Safety planning is critical so that patients will know how to respond when faced with severe distress without having to make critical judgments and decisions while in that compromised state. Additionally, contracting is an important behavioral change tool and is thought to be somewhat effective in encouraging adherence to established plans when genuinely agreed upon. Contracts should never be used to coerce patients into certain behaviors when the patient truly does not agree to those behaviors. Used in that way, contracts can actually be harmful to the clinician-patient relationship.

Although contracts are often used to ensure that a patient will not attempt suicide, they have not been shown to guarantee safety. Although some patients may be less prone to attempt suicide after having contracted for safety, this should not be assumed and is not a guarantee of safety nor a substitute for other means of safeguarding patients. Contracting also does not protect clinicians from liability. In fact, when contracts are used in isolation and other elements of standard practice are neglected, contracting can increase a clinician's potential liability in the face of a poor outcome. Contracts, in this sense, are not legal documents. They are simply a clinical tool to help the patient adhere to treatment plans. Contracts are only helpful if the remainder of standard practices, such as appropriate screening, counseling, and other interventions are employed. Even if a patient contracts for safety, if their psychological distress is severe enough, they may still warrant admission or other escalation of care. Safety considerations are only one consideration in making decisions related to levels of care.

References

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Additional Resources (annotated)

1. *American Academy of Child and Adolescent Psychiatry-Facts for Families*. This site offers access to the AACAP's award winning "Facts for Families" pamphlet series on various developmental topics. The information sheet entitled "The Depressed Child" is linked below.
<http://www.aacap.org/page.wv?section=Facts%20for%20Families&name=The%20Depressed%20Child>
2. *ParentsMedGuide*. Although not addressed in this case, pharmacotherapy is a cornerstone of effective management of depression. Safety and effective use of antidepressants often relies on the support of parents or guardians. The ParentsMedGuide is a key resource of empowering adults to care for their children well.
http://www.parentsmedguide.org/pmg_depression.html
3. *Improving early identification & treatment of adolescent depression: Considerations & strategies for health plans*. A 2010 National Institute for Health Care Management brief that outlines the scope of adolescent depression, current guidelines and recommendations, possible barriers to effective diagnosis and treatment, and opportunities for improvement of care as well as research.
http://nihcm.org/pdf/Adol_MH_Issue_Brief_FINAL.pdf
4. *Teen Screen*. A nationally recognized organization that seeks to equip clinics and other school and community-based outlets to effectively screen adolescents for psychological distress. The website contains a wealth of useful resources including screening instruments and patients education materials.
<http://www.teenscreen.org/resources/providers/>
5. *Guidelines for Adolescent Depression – Primary Care (GLAD-PC) toolkit*. Sponsored by The REACH Institute, the GLAD-PC toolkit offers useful guidance in managing adolescent depression in the primary care setting.
<http://www.glad-pc.org/>

Materials for Learners :

- Handout #1: DSM-IV Criteria for Major Depressive Episode
- Handout #2: Depression in Adolescents
- Handout #3: Suicide Risk Assessment
- Handout #4: Sample Contract for Safety
- Clinical pearls
- Knowledge questions and answers
- References

Too Sad to Live

Depression

Part I

Introduction

Chantel is a 17 year old young woman who comes to your office with a chief complaint of abdominal pain. You begin the visit by welcoming her to your office and review general confidentiality provisions as well as the limits of those provisions, highlighting the utmost importance of her safety. She verbalizes understanding of those provisions and you begin asking her about her situation. She stares down at the floor while she speaks to you quietly. She reports a three-month history of mild diffuse abdominal pain. She denies vomiting, diarrhea, constipation, vaginal discharge or dysuria. She reports normal menstrual cycles with mild dysmenorrhea; her last menstrual period was 2 weeks ago. She discloses tearfully to you that she was raped 2 months ago by an ex-boyfriend. She currently has no contact with him and does not feel in danger. She has been postponing this visit because she is anxious about having a pelvic exam.

She describes significant fatigue and difficulty sleeping. She also tells you that she does not like school as much as she used to and that her grades are dropping. When you ask about her friends, she tells you that she does not have any close friends anymore. She is not involved in any social or recreational activities and cannot remember why she stopped hanging out with her friends.

Too Sad to Live

Depression

Part II

Next Steps

Further questioning reveals that Chantel lives with her mother and 14 year-old sister. Her father “disappeared” 2 years ago. She is in the 11th grade. She has a history of alcohol abuse but has been sober since last year. She smokes 1 to 3 cigarettes a day. When asked about her mood, she states, *It isn't anything.*” She cannot name anything she has done lately that she has enjoyed. She reports feeling too tired to go out with her friends. She also says she feels like no one likes her because she is *“stupid and can't do anything right.”* She says she lies in bed for hours trying to fall asleep and wakes up early because she cannot stop thinking about *“things.”* When you ask her to describe these *things*, she reports feelings of guilt about what happened (i.e., the sexual assault and the disappearance of her father), and her belief that it is all her fault. She also reports no appetite lately and that others tell her she looks like she is losing weight. She then tells you that, *“I tried to cut my wrists in the bathroom at school yesterday just like this other girl I know did a few months ago.”*

Too Sad to Live

Depression

Part III

Epilogue

Chantel is escorted to the emergency room for immediate psychiatric consultation. She is admitted to a psychiatric inpatient facility. She is diagnosed with major depressive disorder and PTSD. She remains an inpatient for one week and is started on an antidepressant. On follow-up, her mood is remarkably improved and she is no longer suicidal.