Too Sad to Live
Depression

Materials for Learners:

- Handout #1: DSM-IV Criteria for Major Depressive Episode
- Handout #2: Depression in Adolescent
- Handout #3: Suicide Risk Assessment
- Handout #4: Sample Contract for Safety
- Clinical pearls
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Handout #1: Criteria for Major Depressive Episode

DSM-IV criteria:

A. Five or more symptoms present during the same two week period and represent a change from previous functioning. At least one of the symptoms must be either (1) depressed mood or (2) loss of interest or pleasure. Do not include symptoms that are due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) Depressed mood most of the day, almost every day, as indicated by either subjective report (e.g. feels sad) or observation made by others (e.g. appears tearful). **Note:** Irritable mood can substitute for depressed mood in children and adolescents.

(2) Noticeably diminished interest or pleasure in all, or almost all, activities most of the day, almost every day, as indicated by either subjective account or observation made by others.

Plus at least four of the seven remaining symptoms below:

(3) Significant weight loss (when not dieting) or weight gain constituting a change of more than 5% of body weight in a month. Or a decrease or increase in appetite almost every day.

(4) Insomnia or hypersomnia

(5) Psychomotor agitation or retardation nearly every day observable by others

(6) Fatigue or loss of energy

(7) Feelings of worthlessness or excessive/inappropriate guilt

(8) Diminished ability to think or concentrate, or indecisiveness, almost every day as reported either by subjective account or as observed by others.

(9) Recurrent thoughts of death, suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a mixed episode.

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

D. The symptoms are not due to the direct physiological effects of a substance or a general medical condition.

E. The symptoms are not accounted for by bereavement, they persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psycho-motor retardation.

Handout #2: Depression in Adolescents

11% of adolescents have a depressive disorder by age 18 (National Comorbidity Survey – Adolescent supplement; NIMH Depression in Children and Adolescents Fact Sheet)

Questions to Assess Depression in Adolescents:

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)

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?

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 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?

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)

Handout #3: Suicide Risk Assessment

Suicidal Ideation

Suicide is 3rd leading cause of death among 15-24 year olds (National Center for Injury Prevention and Control)

- 15.8% of high school students report having suicidal ideation in past 12 months (2011 Youth Risk Behavior Survey)
- Rates of suicidal ideation are much higher among youth with lifetime history or current diagnosis of Major Depression; however, youth without a history of Major Depression may also report suicidal ideation
- Rates of suicidal ideation are higher among depressed than anxious youth
- Rates of suicidal ideation are higher among girls than boys

Suicide Attempts

- 7.8% of high school students (2011 YRBS) had attempted suicide one or more times during the 12 months preceding the survey
- Intensity and frequency of ideation predicts attempts
- Intensity of ideation predicts lethality of attempt
- Rates of attempts are higher in gay/lesbian/bisexual youth
- Rates of attempts are higher among girls than boys
- Rates of completion are higher among boys than girls (boys tend to use more violent and lethal means, e.g., firearms, hanging)

Predictors of Suicide Attempt

- Previous attempt
- A plan
- Depression
- Suicide attempt by friend or family member
- Unwillingness to use outside resources/lack of perceived support
- History of substance use disorder
- Low social self-competence
- Low social support from friends
- Hopelessness
- Functional impairment due to illness/injury
- Gay/lesbian/bisexual sexual orientation, especially with lack of parental support
- Transgender or gender nonconforming identity, especially with lack of parental support
- Availability of weapons
- Preoccupation with death

Questions:

- *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?*

Handout #4: Sample Contract for Safety

I, (name of patient), promise not to do anything to harm myself in any way. If I have thoughts about harming myself I will talk to (identified adult) about it, and I will agree to do what she/he says I should do about these thoughts. If I feel unsafe in anyway, or I think I might actually do anything to harm or kill myself, I will 1) talk with (identified adult) about it and, 2) call (identified clinician). If (identified adult) is not available, I promise to call (identified clinician).

Telephone number to call: (telephone # of identified clinician)
_____

Signature of patient _____

Signature of clinician _____

I, (name of identified adult), promise to keep (name of patient) safe in the most appropriate manner possible. This includes being available to speak with (name of patient) if he/she is feeling unsafe or thinks he/she will cause harm to him/herself in any way.

_____
Signature of identified adult

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:

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?*
a. 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.
b. Self-harm behaviors are always premeditated while suicide attempts are almost always impulsive.
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.
d. Self-harm behaviors and suicidal gestures are almost never present in the same individual.
e. 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?*
a. Access to methods such as weapons or medications.
b. A friend or family member who has attempted or committed suicide.
c. Severity of depression or other psychiatric illness.
d. Current self-harm behaviors.
e. Prior suicide attempt.

5. *What are the purposes of contracting for safety? (select all that apply)*
a. To ensure a patient will not attempt suicide.
b. The lay out in clear terms the care plan and safety plan for the clinician, patient, and family members (if applicable).
c. To further support the patient in adhering to the care plan..
d. To protect clinicians from medical liability in the care of subsequent suicide attempt.
e. 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 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 it 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 clinicians 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 intervention 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.

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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.ww?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/