Facade of Behavioral Problems in Chronic Medically Sick Children and Adolescents with Underlying Depression: A Report of Three Cases from India

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ABSTRACT

Depression in children and adolescents with chronic medical conditions is an important area of clinical interest and research. There is sparse literature from developing countries such as India on the interface areas of pediatric mood disorders and chronic medical conditions. Clinical manifestations of depression in children and adolescents with chronic medical conditions can be different as compared to adult depression. Behavioral overlays can be present in child and adolescent depression which can add on to the complexities of diagnosis and treatment. We present three sick children with behavioral problems, who were suffering from α-thalassemia, systemic lupus erythematosus (SLE), and xeroderma pigmentosum. Relevant literature on clinical manifestations, atypical behavioral presentations, challenges faced in clinical assessments, diagnosis, and management of depression in chronic medically sick children and adolescents are discussed.

Keywords: Behavioral problems, Chronic medically sick children and adolescents, Depression α-thalassemia, Systemic lupus erythematosus, xeroderma pigmentosum.


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INTRODUCTION

Chronic illnesses in children are significantly associated with early-onset depressive symptoms, impairment in social functioning, learning problems, and challenging behaviors.1,2 We describe three cases of depression presenting as behavioral problems in medically sick children and adolescents referred for consultation-liaison psychiatric evaluation and the challenges in assessment, diagnosis, and management of depression.

CASE REPORTS

Case 1

Master ABC, a 14-year-old boy, a known case of α-thalassemia was referred for withdrawn behavior, not eating food, agitated and getting angry easily. History elicited from parents revealed that since the past 6 months, the boy had been looking sad and was not going to school regularly. He was also crying excessively and expressing ideas of hopelessness. The child stated that he was very depressed and did not like to interact with others and felt very low all the time throughout the day. He felt that with his kind of illness and frequent hospitalizations, there was no future for him. His mental status examination (MSE) showed psychomotor retardation, the cognitive triad of hopelessness, helplessness, and worthlessness. His primary mental functions were intact and there were no delusions nor hallucinations.

Case 2

Miss PQR, the 11-year-old girl, diagnosed with SLE, was referred in view of behavioral problems of irritability, getting angry, refusing to eat food and quarreling with siblings. The referring team had requested for behavior therapy in their reference notes. Clinical evaluation and MSE showed that the patient was having symptoms of depression for past 1 year with low mood, crying spells, anhedonia (not getting pleasure in normally pleasurable activities), negative thoughts about self, others and future, hopelessness and helplessness, loss of appetite and weight gain. Her treatment history revealed treatment with immune modulators and steroids for SLE. There was no history of any substance use, psychosis, mania, obsessive–compulsive disorder (OCD) or anxiety disorder. MSE revealed depressive mood subjectively, and the effect was depressed with reduced range and reactivity of mood. She also had depressive cognitions and schemata of loneliness and helplessness.

Case 3

Miss XYZ, 8-year-old girl, a case of xeroderma pigmentosum was referred for behavioral disturbances in the ward like pushing other children, throwing things and temper tantrums. Reason for referral was behavioral issues in the
child. We found, after clinically interviewing the child and her parents, that the child had features of depression. She was not going to school nor going to play with other children. She preferred to be at home and would not talk much with her parents for the past 1 year. She appeared sad and would cry frequently. She would get angry, start shouting if her demands were not fulfilled and would be very irritable. On the clinical interview, the child reported that she was very sad about her skin condition and other children bullied her, and she did not like to have friends. She mentioned that she felt sad all the time during the day and parents also reported that her sadness appeared pervasive. She felt very hopeless and felt that there was no future for her due to her skin problems. On mental status examination, she was depressed with psychomotor retardation with depressive cognitions of hopelessness and helplessness.

All three cases when evaluated had certain common factors. They were admitted in the pediatric ward for inpatient management of their medical conditions. They were referred to the psychiatry department for consultation-liaison psychiatry, and the reason for reference as documented was behavioral problems and therefore were referred for behavior therapy. Some of the behavioral problems mentioned were: throwing temper tantrums, irritability, not fully cooperating to medical treatment, refusing to eat food, throwing things, hitting other children, withdrawn, etc. All three cases had pervasive low mood present throughout the day affecting their areas of educational and social functioning significantly. There was no history of substance abuse, psychosis, mania, OCD or anxiety disorder. There was no significant history of premorbid developmental delays nor any family history or past history of psychiatric disorders. They were not fully cooperative for a formal mental status examination initially. During the initial part of the clinical interview, they were appearing withdrawn. The poverty of speech and psychomotor retardation was present. Subjectively mood was depressed as well as Affect was depressed with reduced range and reactivity. However, towards the end of the clinical interview, they did open up and reported feeling low and depressed, perceived themselves as a burden on their families, felt guilty and hopeless of the situation. They also reported that they missed their school and were not going regularly to school because of their illness and they missed their friends and outdoor play activities tremendously. All three had not shared their feelings with anyone since their admission and were very sad and angry internally at why the almighty had chosen them for such an illness. They were diagnosed as severe depression without psychotic symptoms, comorbid with their respective medical sickness. They were started on serotonin selective reuptake inhibitor (SSRI) medication (Tablet fluoxetine 5 mg daily titrated upward gradually to 10 mg, based on response). Psychotherapy techniques combining cognitive, behavioral, play and supportive therapy were done in a holistic manner focused on individual needs and developmental age of the child, on a regular basis. Child apperception test revealed features of depression in all three of them with themes depicting helplessness, hopelessness, guilt, anger, low, and inferiority complex. Centre for epidemiological studies depression scale for children (CES-DC) score was used to assess all three children. These scores were over 15, which is suggestive of significant depression. All of them showed considerable improvement in mood symptoms and behavioral problems throughout 2–4 weeks. They continue to be on regular monthly outpatient follow-up and improvement is maintained.

**DISCUSSION**

Depression in children suffering from chronic medical conditions can be explained by various factors, such as social and physical restrictions, lifestyle changes due to illness and treatment protocols involving painful and distressing procedures. Besides, biopathological changes that occur in most chronic medical conditions that can also mitigate the development of childhood depression. Children with Thalassemia major can have depression and behavioral problems more frequently than healthy subjects and complicated and burdensome medical regimen in Thalassemia can potentially impact the emotional functioning of patients. Depression and anxiety were found to be high and undertreated in children with SLE and mixed connective tissue disorders. Cutaneous and ocular photosensitivity and an increased risk of developing cutaneous neoplasms with associated features of microcephaly, hypogonadism, neurological disorders, mental and growth retardation exist in De Sanctis–Cacchione syndrome, a rare form of Xeroderma pigmentosum. Sparse literature is available on neuropsychiatric co-morbidities in xeroderma pigmentosum. Despite advancements in medical care for chronic illnesses, these children experience significant psychosocial morbidities, such as depression and anxiety. Management of childhood depression in chronic medical conditions should be comprehensive and needs a multidisciplinary approach. Evidence and expert clinical consensus support the use of selected antidepressants in the treatment of depression in youths. The use of the recommended antidepressant medications requires appropriate monitoring of potential adverse effects. Other evidence-based treatment modalities include cognitive behavioral therapies. Attention to psychiatric co-morbidities will not only result in enhanced quality of life but will also promote better adherence to medical recommendations. Depression can
exist in children with chronic medical conditions and has the potential to impact developmental and mental health outcomes. Primary care physicians should be attentive to depressive symptoms in this special patient population.²

**CONCLUSION**

Symptoms of depression in children may differ from those of adults in terms of its nature and intensity.⁹ Pediatricians should be attentive to depressive symptoms which can have behavioral overlays. Chronic medically sick children should be screened for depression and provided appropriate consultation-liaison psychopharmacological and psychotherapeutic treatment. A multidisciplinary approach that takes into account the individual variability of the chronic medical condition and its clinical manifestations helps to improve early detection of depression.¹⁰

**REFERENCES**