Medication Management of Major Depressive Disorder

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ASSESSING DEPRESSION
DIAGNOSTIC CRITERIA

• Pervasive change in mood for 2 weeks: depressed or irritable and/or lack of interest or pleasure, plus 4 of the below:
  • Sleep disturbance
  • (Interests decreased)
  • Guilt
  • Energy decreased
  • Concentration decreased
  • Appetite changes
  • Psychomotor agitation or retardation
  • Suicidal thought
• Symptoms cause marked distress and/or interfere with functioning
• There is no other medical or psychiatric explanation for symptoms
DEVELOPMENTAL CONSIDERATIONS

Children

• Often externalize
  • somatic complaints (headache, abdominal pain)
  • temper tantrums / oppositional behavior
• Psychotic features more likely to be hallucinations (usually auditory)
• Preoccupations with death, rarely suicidal ideation or attempt

Adolescents

• Often internalize
  • negative cognitions (low mood – sad or irritable, guilt, hopelessness)
  • sleep & appetite disturbances
• Psychotic features more likely to be delusions
• Suicidal ideation & attempts present

Both: lowered self-esteem, social withdrawal / rejection, & poor school performance
INTERVIEW

- Provide confidentiality
- Focus on:
  - symptoms
  - psychosocial stressors
  - family history
  - comorbidity – medical and psychiatric
- Use a written screening / severity tool
- Get collateral
- Observe kids and parents together
- Ask about safety!
Goal # 1: Assess Mental Status

- Appearance
- Behavior / Attitude
- Orientation & Consciousness
- Mood & Affect
- Speech, Language
- Motor / Abnormal Movements
- Memory
- Attention
- Intellectual Functioning
- Insight & Judgement
- Thought Content
- Thought Process
- SI/HI

Goal # 2: Identify Medical Masquerades

- Hypothyroidism
- Hypercalcemia
- Vitamin D deficiency
- Diabetes
- Sleep disturbance
- Chronic pain / fibromyalgia
- Substance Use
- CNS Disease
- Infection
CLINICAL COURSE
• 90% of MDD episodes remit in 1-2 years
• 10% of cases will be protracted / chronic
• 40-60% relapse within the episode
• 70% have recurrence by five years
• 40%-90% develop comorbidity
• 50% have two or more comorbid disorders
• Increases risk for substance abuse, physical illness, and poor academic functioning
• Major cause of suicide attempts & completion
• Affects social, emotional, and cognitive development; interpersonal skills; & the attachment bond between parent and child
TREATMENT
GENERAL PRINCIPLES

- Use combination care: medication & therapy
- Utilize the care continuum appropriately
  - Traditional outpatient
  - Intensive outpatient
  - Home-based / Wrap around
  - Partial hospitalization
  - Inpatient
  - Residential
- Assess suicide risk regularly
- Monitor for comorbidity
- Involve family
- Consider DCS involvement as needed
Psycho-education

“Is it adolescence or is it depression?”

Cognitive-Behavioral Treatment (CBT)

- Cognitive distortions, generalization, over- attribution, catastrophizing

Interpersonal Psychotherapy (IPT)

- Areas of loss and grief, interpersonal roles and disputes, role transitions

Play Therapy

- Expression of distress & modeling of coping through play

Family Therapy

- Family systems issues
Consider medication when:

- Symptoms prevent participation in psychotherapy
- Adequate psychotherapy trial has been ineffective
- Depression is chronic or recurrent
- There are severe symptoms or suicide risk
- Use one agent at a time
- Monitor response closely
- Allow time for adequate trials
- Maximize dose before adding / changing
- Do not stop medication abruptly
- Treat for a minimum of 6-12 months
- Set expectations: not all symptoms will go away – that’s why they still need therapy

Start low, go slow
Why warn?

• 2004: FDA pooled analyses of 24 short-term (4 - 16 week) placebo-controlled trials of over 4,400 patients on 9 different antidepressants

• Greater risk for suicidal thinking or behavior during the first few months of treatment in those receiving antidepressants compared to placebo (4% vs 2%)

• 78 of 4,400 patients had suicidal thinking or behavior, but NO suicides occurred in these trials

• Warning extends up to age 25

Why treat?

• Suicide occurs most often in untreated depression

• Several SSRI trials show efficacy in treating depression

• SSRI's did not increase risk of suicide or suicidal thinking in youths based upon strong evidence from other clinical trials, epidemiology, and autopsy studies

• Increased use of SSRI's worldwide led to 33% decline in youth suicide over the 15 years prior

American College of Neuropsychopharmacolgy Task Force Report, January 2004
SELECTIVE SEROTONIN REUPTAKE INHIBITORS

• Stick with Fluoxetine, Sertraline, Citalopram/ Escitalopram
• Common side effects are usually mild and short term
  • GI, headache, increased motor activity, insomnia, sexual dysfunction
• Less common side effects can be managed by reducing or changing SSRI
  • disinhibition, agitation / aggression
OTHER OPTIONS

• Trial these after 2-3 SSRIs fail or if there is contraindication to SSRI
• Bupropion
  • Watch for increases in anxiety
  • Beware of lowering seizure threshold
• Serotonin / Norepinephrine Reuptake Inhibitors
  • Duloxetine has FDA approval for kids and may help with pain
• Mirtazapine
  • Great if you want to increase appetite / sleep
QUESTIONS / COMMENTS

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