# CHILD / ADOLESCENT MENTAL HEALTH ECHO

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:
  - **S**leep disturbance
  - (**I**nterests decreased)
  - **G**uilt
  - **E**nergy decreased
  - **C**oncentration decreased
  - **A**ppetite changes
  - **P**sychomotor agitation or retardation
  - **S**uicidal 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!

# EXAMINATION

## 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

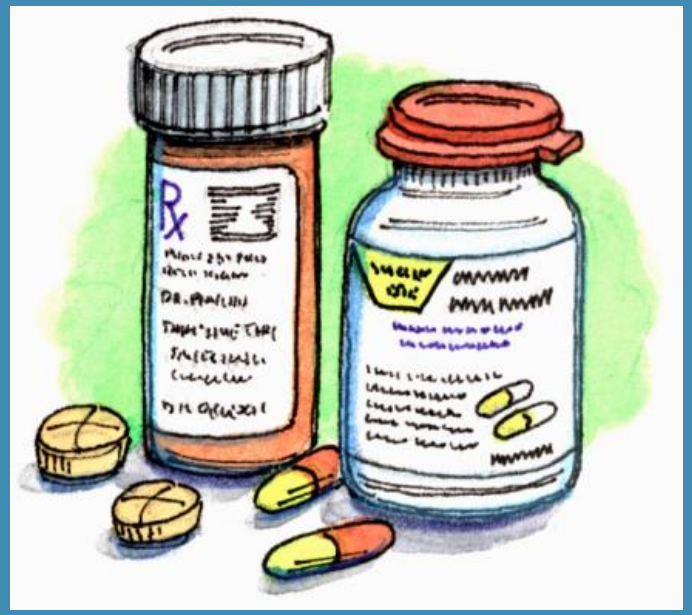

- Use combination care: medication & therapy
- Utilize the care continuum appropriately
  - Traditional outpatient
  - Intensive outpatient
  - Home-based / Wrap around
  - Partial hospitalization
  - Inpatient
  - Residential
- Assess suicide risk regularly
- Monitor for comorbidity
- Involve family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

# PSYCHOTHERAPY

- 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

# PSYCHOTROPIC MEDICATIONS

***Start low, go slow***




- 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

# THE BLACK BOX WARNING

## 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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