Adolescent Mood Disorders

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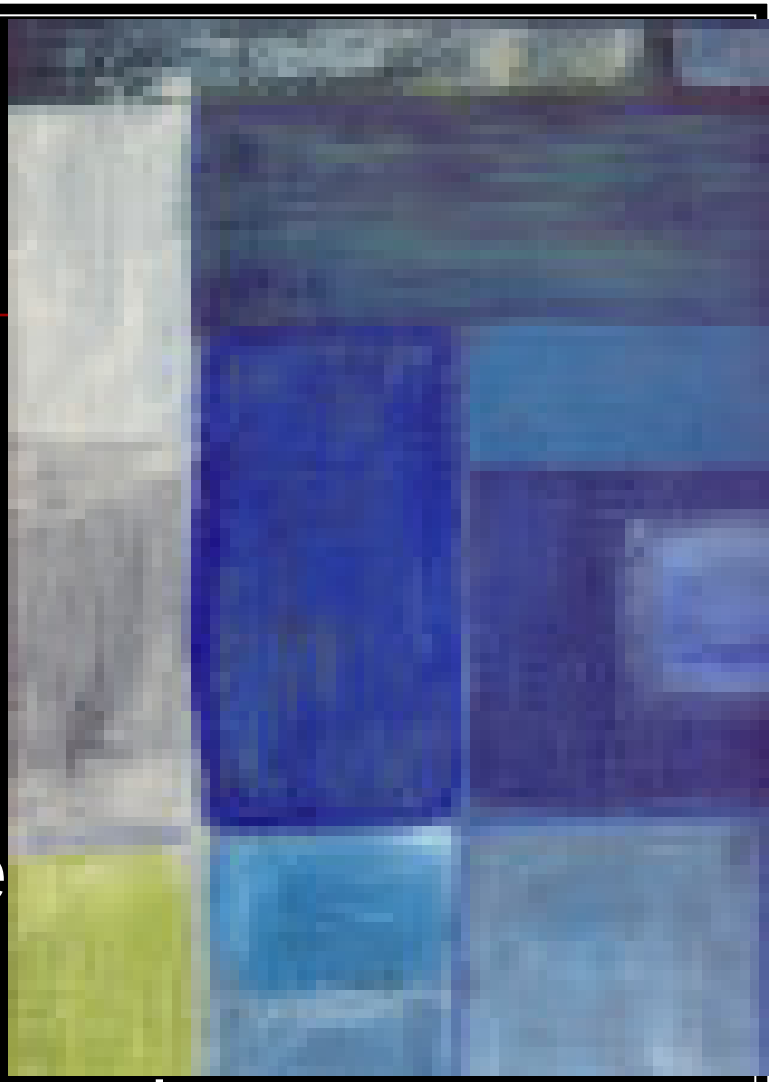
Adolescent Mood Disorders

- 10-20% of Canadian youth are affected by a mental illness or disorder
- Total number of 12-19 year olds in Canada at risk for developing depression is 3.2 million.
  Major depressive disorder affects over 200,000 adolescents in Canada, (Burke et al., 1991).

Outline

- Clinical picture
- Epidemiology
- Risk Factors
- Course
- Management
- Recommendations for Current Best Practice Treatment

Clinical Picture



Core symptoms

- Sadness/irritability
- Anhedonia
- Boredom
- Persistent and pervasive
- Functionally impairing
- Unresponsive to usual experiences

How to distinguish b/w depression and “normal ups and downs”?

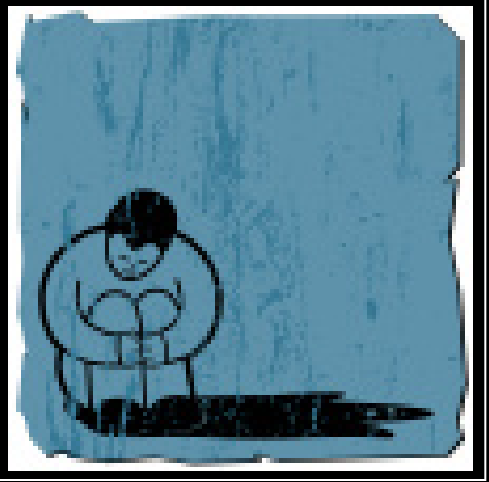
Functional impairment

- Intensity
- Duration

- Lack of responsiveness of depressed mood and associated symptoms

Depressive Disorders

- Exist on a continuum
- Severity
- Pervasiveness
- Presence or absence of mania



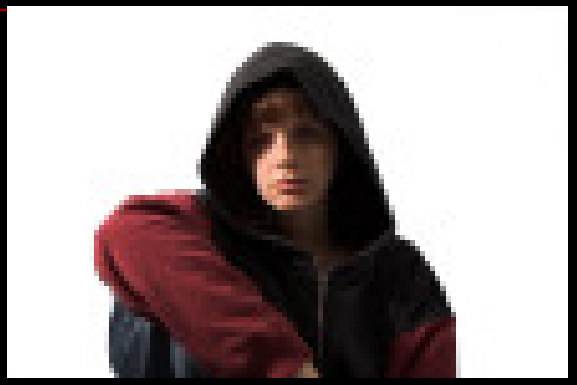
Adjustment Disorders

- Mildest end of the spectrum
- Self-limited
- Response to a clear stressor

Depression NOS

- “minor” or subsyndromal
- depressed mood
- anhedonia
- irritability
- up to 3 symptoms of major depression

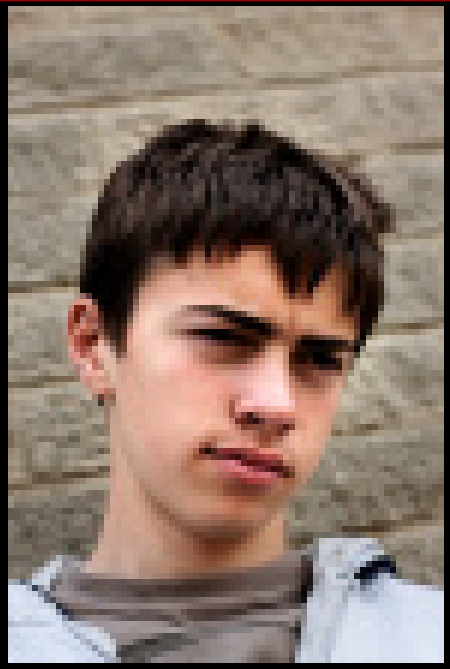
Dysthymic Disorder



- chronic condition
- fewer symptoms
- lasts a minimum of one year
- minor depression and dysthymic d/o functionally impairing and precursors
- “double depression”

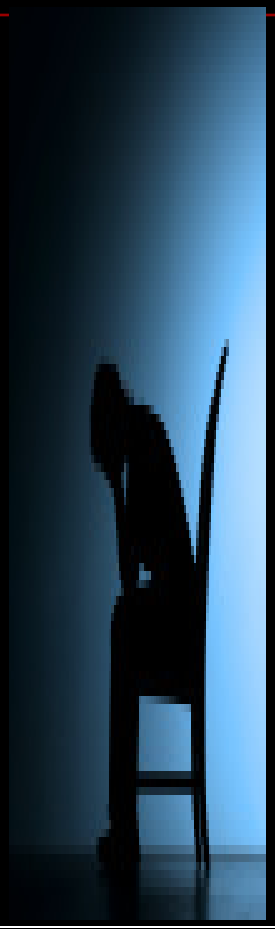
Major Depression

- most severe
- either sad / irritable mood
- or anhedonia
- at least 5 of the following:



Major Depression

- social withdrawal,
- worthlessness,
- guilt
- suicidal thoughts or behavior
- sleep ↑ or ↓
- ↓ motivation ↓concentration
- appetite ↑ or ↓



Screen for presence of mania

- > 50% bipolar youth have a prior episode of depression
- Major depression may precede the onset of mania
- Depression may be the initial presentation of their bipolar d/o
- Important to probe for a history of mania in adolescents presenting with depression

Symptoms of Mania

- Mood elevated, expansive, irritable
- Grandiosity
- ↓Need for sleep
- ↑Talkativeness
- Racing thoughts
- Distractibility
- ↑goal directed activity; agitation
- ↑involvement in risk-taking activities

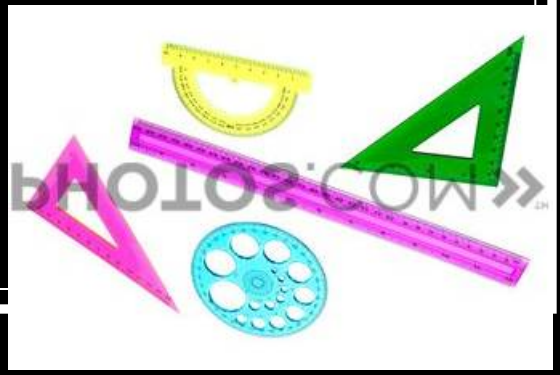
Symptoms of mania from metaanalysis of pediatric studies

Symptom	Weighted Rate	95% Confidence Interval
Increased energy	89%	76–96%
Distractibility	84%	71–92%
Pressured speech	82%	69–90%
Irritability	81%	55–94%
Grandiosity	78%	67–85%
Racing thoughts	74%	51–88%
Decreased need for sleep	72%	53–86%
Euphoria/elation	70%	45–87%
Poor judgment	69%	38–89%
Flight of ideas	56%	46–66%
Hypersexuality	38%	31–45%

[From Kowatch et al. (4)].

Standardized Assessment Tools

- Beck Depression Inventory
- Columbia depression scale – teen version
- Columbia dep scale- parent version
- Kutcher Adolescent Depression scale
- PHQ-9; modified for teens; parents
- Children's Global Assessment (CGAS)



Comorbidity

- Anxiety
- ADHD
- Alcohol, drug and tobacco use: (bidirectional causality)
- Conduct disorder (sharing of risk factors)

Epidemiology

3:1 female to male ratio due to

- Increases in hormones
- Higher rates of anxiety
- Increased interpersonal conflict

Age and Developmental Factors

Risk factors:

- early onset of puberty
- experimenting with drugs, ETOH, tobacco
- ↓ adult supervision and contact
- > need for sleep
- tendency to get ↓ sleep

Risk Factors for onset and recurrence

- Genetic
- Cognitive Factors
- Familial/Environmental Risk Factors
- Neuroendocrine
- Sleep
- Neuroimaging Studies

Protective Factors

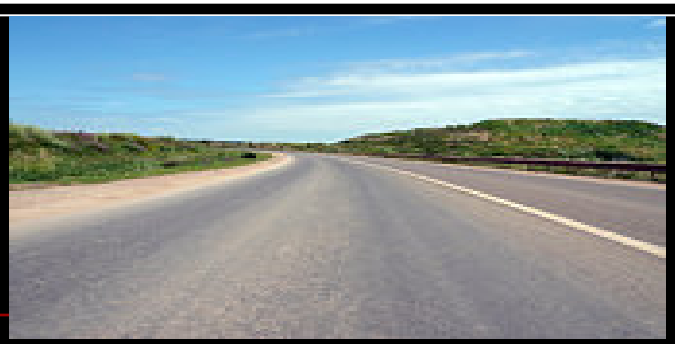
- Connection to family and school
- Parental expectations for behavior and academics
- Non deviant peer group

Course

Episode Length and Recovery

- 3-6 months
- 5-8 months
- 20% have persistent depression for 2 years or more

Course



Longer episodes are due to:

- comorbid disorders
- > initial severity
- suicidal ideation (current or past)
- parental depression
- family discord

Risk for Recurrence

- Range b/w 30-70% in 1-2 years
- parental depression
- incomplete recovery
- preexisting social dysfunction
- history of sexual abuse
- family discord

Risk for Bipolar Disorder

- 10 - 20%
- ↑risk in hypomania on antidepressants
- psychotic features
- hypersomnia
- family history of bipolar disorder
- adolescents exposed to antidepressants

Other Sequelae

↑risk for:

- Conduct disorder
- Personality disorders
- Substance abuse
- Educational and occupational ↓achievement
- Unfulfilling social relationships
- Family discord

Clinical Management

Currently 3 treatments:

- Antidepressant medications
- Cognitive behavioral therapy (CBT)
- Interpersonal therapy (IPT)

Antidepressant Medication

- Tricyclic antidepressants (TCAs):

  no difference b/w medication and placebo
- Selective serotonin reuptake inhibitors (SSRIs)

  several studies with efficacy of fluoxetine (Prozac)

Antidepressants

TADS (Treatment of Adolescents with Depression Study)

- Fluoxetine was more efficacious than both placebo and CBT
- However, combined treatment resulted in the highest rate of remission

Other antidepressants

Demonstrated efficacy studies for:

- Esitalopram
- Citalopram
- Paroxetine
- Sertraline
- (FDA approval for fluoxetine and escitalopram)

Adverse Events

- FDA found a higher rate of suicide related on med than on placebo (4% vs 2%)
- Another study found rate 2.5% vs 1.7%
- The number who benefit from SSRIs is 14 times higher than those who become suicidal (acceptable risk benefit ratio)

Predictors of Antidepressant Response

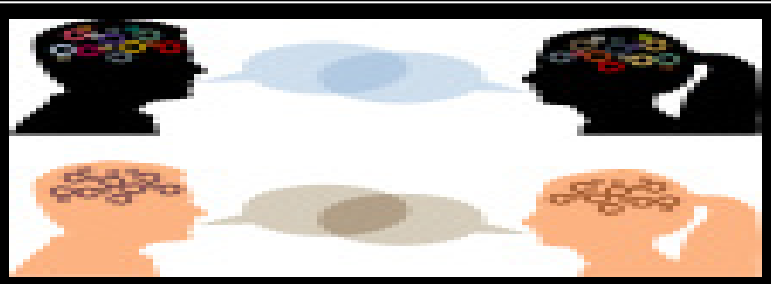
Poorer outcome predicted by:

- Family discord
- Comorbidity
- > severity and impairment
- > levels of hopelessness
- Melancholic features
- Metabolize meds faster; need ↑doses

Continuation, Maintenance and Prevention

- If started with fluoxetine, continuation treatment with fluoxetine much lower rate of relapse than placebo
- Successful treatment of anxiety disorders may reduce risk for subsequent depression

CBT



- one’s thoughts feelings and behaviors affect one another
- negative thoughts evoke negative feelings and exacerbate depression
- goal is to modify negative thoughts and behavior to break depression cycle

Cognitive Behavior Therapy

5 studies :

- 6 sessions over 1-5 months
- 5-8 sessions over 12 weeks
- 12-16 sessions
- TADS: CBT; fluox; placebo; CBT+fluox

TADS

Results:

- CBT was not superior to placebo (43% to 35%)
- Combo treatment (71%) and fluox alone (61%) markedly superior to both CBT and placebo
- Combo Rx: faster recovery and superior to fluox alone for remission (37 vs 20%)

IPT

- Interpersonal problems may exacerbate depression
- Depression in turn exacerbates interpersonal problems
- Treatment targets interpersonal problems to improve interpersonal functioning and mood

Current Best Practice Treatment

Mild Depression

- family education
- supportive counseling
- case management
- problemsolving

Current Best Practice Treatment

Moderate Depression

Initial treatment with either one of the following:

- Antidepressants
- CBT
- IPT

Patient preference; local expertise availability

Current Best Practice Treatment

- Assess response in 6-8 weeks
- Nonresponse:

  -combination of med and therapy

  -switch in medication

  -augmentation strategy

Treatment

- If no clinicians trained in CBT or IPT,

  more generic psychotherapies are not shown to be helpful

- In such cases, antidepressant becomes a first-line of treatment

Treatment

- Severe depression: ↓motivation, concentration, sleep and appetite
- Meds are first line of treatment

  (fluoxetine, escitalopram)

Treatment

- For mod to severe depression, make a **safety plan** with patient and family, an emergency communication mechanism if patient deteriorates

Treatment

- Start at half the initial target dose (10mg fluoxetine, 5 mg escitalopram)
- Follow up in 1 week and increase dose for next 3 weeks
- ↑ dose every 4 weeks

Treatment

- If fails to respond to adequate dose and duration, rule out reasons for nonresponse
- If partial response: augment
- If no response: switch med or add therapy
- If 2nd SSRI has no response: switch to a different class of med (venlafaxine, buproprion)

Treatment of Bipolar disorder

Mania

- first line: monotherapy with atypical antipsychotic, lithium, valproate, CBZ
- Combination of lithium + valproate or

  mood stabilizer + atypical antipsychotic

Treatment of Bipolar Disorder

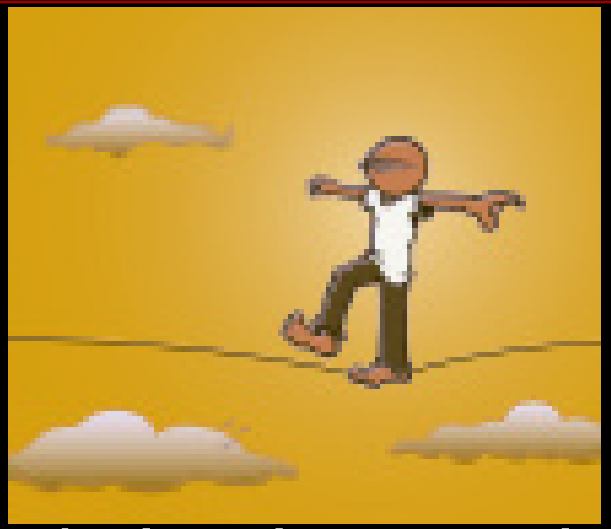
Bipolar depression

- SSRI after stabilization of manic symptoms with mood stabilizer or antipsychotic
- Quetiapine, Aripiprazole,
- Risperidone, Olanzepine

FDA approved for manic/mixed states in adolescents

Treatment of Bipolar disorder

- Quetiapine
- Aripiprazole
- Risperidone
- Olanzepine



FDA approved for manic/mixed states in adolescents

Summary

- Adolescent depression common
- Prevalence 8%
- Significant illness burden
- GLAD-PC guidelines developed (Cheung et al)

  -ID at risk pts and monitor

  -Use standardized tools

  -Direct interviews

Summary

GLAD-PC

- functional impairment

-educate and counsel

-discuss confidentiality

-develop Rx plan: set goals

-make safety plan

Summary management

GLAD-PC

-Mild dep: active support and monitoring

-Mod-severe depression or psychosis and sub abuse: consult w. MHC

- evidence based Rx

- adverse events for SSRIs

Summary ongoing management

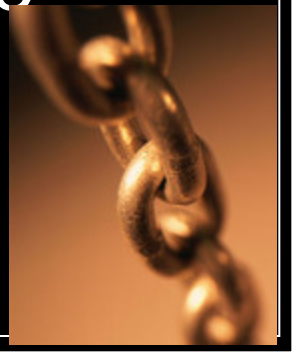
GLAD-PC

-track goals & Rx outcomes in all domains

-if no Δ 6-8 wks, reassess

-if partial Δ and above, get MHC

-active support of referred pt. to MHC to ensure adequate management



Resources

- Guidelines for Adolescent Depression for Primary Care Physicianswww.glad-pc.org
- Canadian Mental Health Association,, www.cmha.org
- American Academy of Child and Adolescent Psychiatry, www.aacap.org
- American Psychiatric Association, www.psych.org
- Child and Adolescent Bipolar Foundation, www.bpkids.org
- Federation of Families for Children's Mental Health, www.ffcmh.org
- Knowledge Exchange Network, www.mentalhealth.org
- Depression and Bipolar Support Alliance www.ndmda.org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