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

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

[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 scale (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
- problem solving
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, antidepressants become 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 2\textsuperscript{nd} SSRI has no response: switch to a different class of med (venlafaxine, bupropion)
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 $\Delta$ 6-8 wks, reassess
- if partial $\Delta$ and above, get MHC
- active support of referred pt. to MHC to ensure adequate management
Resources

- Guidelines for Adolescent Depression for Primary Care Physicians [www.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]