Depression in Youth

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Depressive disorders are usually inherited and passed down through families

Usually recurrent conditions

Depression has a significant impact on the youngster’s normal development and level of functioning

Early identification and effective treatment is crucial
- Better overall outcome
- Reduce risk of suicide, substance abuse, other disorders

(Dulcan, 2010)
Clinical depression is estimated to occur in about 2% of children (under age 13 years)

Occurs in about 4%-8% in adolescents

Boy-girl ratio approximately 1:1 in childhood

Boy-girl ratio increases to 1:2 in adolescents

Sub-clinical depression in youth may be present in 5%-10% of youngsters

- VERY IMPORTANT GROUP OF YOUNGSTERS
- Significant impairment in functioning and usually have family members with depressive disorders
- Increased risk for suicide and developing clinical depression

(Dulcan, 2010)
Symptomology

- Clinical picture of depression in children & adolescents similar to depression in adults
  - Depressed mood, decreased interest/pleasure in activities, change in weight (may increase or decrease), sleep disturbance, guilt, suicidal ideations
- However, due to developmental influences there are differences:
  - In children: more irritable, lower frustration tolerance, temper tantrums, physical complaints (tummy ache), isolate more, hallucinations
  - In adolescents: increased level of depression, anhedonia, significant guilt, feelings that life may not be worthwhile or lack of sense of purpose in life, increase in suicide attempts

(Dulcan, 2010)
Different types of depression lead to different treatment approaches and outcomes

Psychotic depression
- Family history of psychotic depression and bipolar disorder
- More severe form of depression
- Usually lasts longer than non-psychotic depression
- Frequently requires more than 1 antidepressant

“Atypical” depression
- Increased sensitivity to rejection
- Very poor energy level
- Increased appetite (particularly for sweets)
- Increased sleep

(Dulcan, 2010)
The presence of other conditions in youth with depression is more the rule than the exception.
Frequently associated with anxiety disorders, disruptive/behavioral disorders, attention-deficit/hyperactivity disorder.
In adolescents, associated with substance use disorders.

(Dulcan, 2010)
Depression is a condition that is highly heritable, so family history of depression is the most influential risk factor.

But, ultimately, depression is multifactorial and a combination of biology and environment.

Environmental precipitating factors:
- Losses
- Abuse (physical, sexual, emotional)
- Neglect
- Exposure to violence
- Ongoing family conflicts

Other risk factors:
- Family history of anxiety disorder and substance abuse
- Prior history of depression, other psychiatric disorders (e.g., anxiety, substance abuse, ADHD, eating disorders), medical (e.g., diabetes), medications (e.g., corticosteroids)

(Dulcan, 2010)
Clinical Course

- Average length of clinical depressive episode in youth is about 8 months (similar to adults)
- Likelihood of recurrence is high:
  - 20%-60% after 1-2 years
  - Up to 70% after 5 years
  - Many youth will have clinical depressive episodes as adults
- Factors influencing poorer outcome:
  - Severity, chronicity, multiple recurrent episodes
  - Comorbid conditions
  - Family problems
  - Low socioeconomic status
  - Ongoing exposure to abuse, family conflict, etc.
  - Youngster who has natural tendency to think negatively
  
(Dulcan, 2010)
Perhaps as much as 20% - 40% depressed youth develop bipolar disorder
  • Greater tendency for psychotic depression
  • More likely to have family history of depression
  • May be more susceptible to antidepressant-induced mania or hypomania

Significant negative effects on development if untreated

Increased risk for suicide
  • History of suicide attempts
  • Comorbid psychiatric disorders (e.g., disruptive, substance abuse)
  • Impulsivity and aggression
  • Availability of lethal means (e.g., firearms)
  • Exposure to physical or sexual abuse, violence
  • Family history of suicidal behavior

(Dulcan, 2010)
Youth with depression at higher risk for
  • Substance abuse
  • Legal problems
  • Physical illness
  • Early pregnancy
  • Poor work, academic, psychosocial functioning

Sub-clinical depression may persist after discreet depressive episode

(Dulcan, 2010)
The best way to assess depression in youth is a comprehensive diagnostic evaluation
  • Always think developmental stage!!
  • No blood tests or imaging studies have yet been developed to assess for depression in youth
Multiple, reliable informants always helpful
Keep in mind possible bipolar depression versus unipolar depression
  • Strong family history of bipolar disorder
  • Psychosis
  • History of medication-induced mania or hypomania

(Dulcan, 2010)
Assessment (cont.)

- Differential diagnosis
  - Psychiatric
    - Anxiety disorder
    - ADHD
    - Oppositional defiant disorder (ODD)
    - Autism spectrum disorder (ASD)
    - Substance abuse
  - Medical
    - Hypothyroidism
    - Mono
    - Anemia
    - Cancer
    - Premenstrual depression
  - Bereavement
  - Adjustment disorder (reaction to stressors)
  - Suicidal ideations/homicidal ideations
  - Appropriate treatment level of care

(Dulcan, 2010)
Treatment

- Goal is *complete* resolution of depressive symptoms
- Adequate frequency of follow-up sessions
- Think in terms of *functional* improvement rather than just *symptom* improvement
- Remember to monitor medication compliance (it won’t work if you don’t take it), side effects, and elicit perceived benefit from BOTH youngster and parent(s)

(Dulcan, 2010)
Psychoeducation and Supportive Management

- Youngster
- Family
- Don’t forget the school!

Educate about causes, symptoms, course, treatment and risks of depression

- Written material
- Reliable Web sites

School accommodations may be needed

- Good reason why it’s always good to keep school in the loop when appropriate

Many youngsters with mild or brief depression respond with supportive treatment alone

- 50%-60% of youngsters respond to “placebo” in RCTs

(Dulcan, 2010)
Psychotherapy

- Variety of types of psychotherapy utilized for the treatment of depression in youth
- Only cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT) are evidence-based for the treatment of depression in youth, especially for adolescents
- Perhaps surprisingly, few studies have examined the efficacy of family therapy in RCTs
- Probably more effective for ongoing treatment rather than for acute symptoms

(Dulcan, 2010)
Cognitive behavioral therapy (CBT)

- Most studied therapy for depression in youth
- May be a treatment option in primary care settings for depressed children and adolescents
- May be helpful for younger children as well
- Helpful when comorbid conditions such as anxiety disorder is present

Interpersonal psychotherapy (IPT)

- Most studies done for adolescent depression
- May be particularly helpful in moderately to severely depressed adolescents and in older teens
- Therapists in school-based health clinics with brief training and supervision showed improvement in depressed youth

(Dulcan, 2010)
Pharmacological Treatment

- Involves parent and patient education, restoration of hope, and, when indicated, individual and family psychotherapy
- Education of patient and family enhances engagement and improves compliance
- Family conflict and parental depression are barriers to optimal treatment with medication
- Treatment of parental depression prevents onset of depressive disorders in children and optimizes treatment outcome in depressed youth

(Martin, Scahill, & Kratochvil, 2011)
Selective Serotonin Reuptake Inhibitors (SSRIs)

- Response rate between 40%-60% for the SSRIs
- Response rate between 30%-50% for placebo!
- Children have shown less responsiveness to antidepressants than adolescents
  - One exception is fluoxetine (Prozac)-equally effective for both age groups
- FDA-approved for treatment of pediatric depression
  - Fluoxetine (Prozac) for both children and adolescents
  - Escitalopram (Lexapro) for adolescent depression

(Martin et al., 2011)
Few studies support the effectiveness of other types of antidepressants in the treatment of pediatric depression.

There is significant evidence that tricyclic antidepressants (TCAs) are no better than placebo in the treatment of children and adolescents with depression.

- One possible exception is clomipramine (Anafranil) - effective for treatment of OCD.

(Martin et al., 2011)
Side effects of SSRIs
- Well-tolerated in children and adolescents
- Long-term effects are not known
- Onset or worsening of suicidal ideation and, more rarely, suicide attempts
  - Small, but statistically significant, risk
  - No association with completed suicides in studies
  - Apparent dramatic decline in adolescent suicide associated with increase in usage of SSRIs

Practice guideline
- Supportive treatment and education first-line treatment
- Reserve antidepressant treatment for those with moderate to severe depression

(Martin et al., 2011)
Prevention

- Strategies include treatment of sub-clinical depression, underlying psychiatric disorders (e.g., anxiety disorders), parental psychopathology, and removing chronic toxic stressors
- Early identification and treatment of childhood depression
- Treatment of mothers with depression
- Lifestyle modifications
  - Good sleep hygiene, exercise, diet, improve coping skills for stress, etc.

(Dulcan, 2010)
References

Questions?

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