

ASK THE EXPERTS

How should we treat adolescent depression?



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Q How common is adolescent depression & what are the causes?

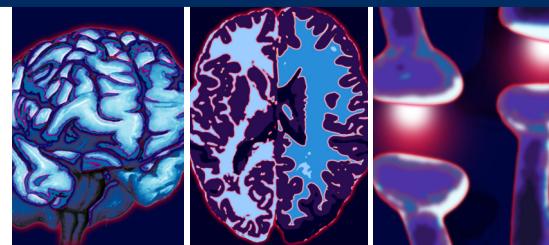
Major depressive disorder occurs in approximately 5% of all adolescents, with girls outnumbering boys in a ratio of 2:1. Dysthymia,

a lesser form of depression where mood is chronically low but overall symptoms are less severe, occurs in 8% of the adolescent population. Owing to comorbidity, some of the same children account for both statistics [1].

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“The cause of depression is complex and not fully understood. It is likely a combination of a fundamental biological vulnerability to the mood state that is then reactive to the environment of the adolescent.”

The cause of depression is complex and not fully understood. It is likely a combination of a fundamental biological vulnerability to the mood state that is then reactive to the environment of the adolescent. For some, the biological predisposition is so strong that depression will likely occur regardless of how ideal a family and social environment is. For others, the environment can be so toxic that even the most favorable combination of biological markers may nonetheless succumb to depression. There is no ‘one cause’ for depression, and efforts to establish such a cause typically leave large populations of depressed adolescents without a suitable explanation for their suffering. The final common manifestation of depression likely represents a host of varying biological vulnerabilities whose expression may have origins in, or implications for, the nervous, endocrine or immune systems.

Q How do adolescent & adult depression differ?

Adolescent depression is similar to adult depression in many respects. Disturbances in sleep, appetite, energy and concentration, in addition to depressed mood, is the norm. Like adults, adolescents may experience a melancholic depression, where sleep and appetite are decreased, or more commonly, an ‘atypical’ depression, marked by hypersomnia and hyperphagia [2]. Where adolescents and adults most differ is the way that they express their depression. While adults will more commonly express sadness or despair, adolescents tend to express irritability, an exaggerated sensitivity to criticism and problems with attention and concentration. Adolescents are also more likely than adults to have significant comorbidities to their depression, including dysthymic disorder, anxiety disorders, substance abuse and conduct disorder [3]. Adolescents presenting with their first depression also have a higher likelihood than adults to be displaying a depressed phase of a bipolar affective disorder [4].

Q What psychotherapeutic options are available for the treatment of adolescent depression? What are the advantages & disadvantages of these approaches?

Cognitive behavioral therapy has the most empirical support among the psychotherapies

available for the treatment of adolescent depression. Interpersonal therapy has also shown efficacy for addressing the symptoms of depression and the associated impairments in functioning for adolescents. In addition, family therapy and psychodynamic therapy are likely to be helpful in individual cases; however, to date, there are few controlled studies of these treatments in adolescents.

Successful psychotherapies give adolescents a ‘toolkit’ of adaptive ways of thinking and behaving. These techniques can be used to effectively improve a depressed mood, as well as to prevent relapse of depression. Psychotherapies offer the development of unique types of relationships for the depressed adolescents, and family-based therapies offer the potential to improve the environment surrounding the adolescent. Family members may be empowered to contribute to the adolescent’s recovery, or have attention brought to their own sufferings that may relate to or compound those of the adolescent.

The advantage of all psychotherapeutic approaches include empowering the patient to manage their problems acutely, the potential for lifetime change in approach to difficult life circumstances and the avoidance or minimization of the need for medication. Some adolescents and families favor a psychological approach, as they associate a greater stigma with the use of antidepressants, seeing medications as both a confirmation of mental illness and a ‘short cut’ to restored mood.

The major disadvantage of psychotherapy is that it is ‘operator dependent’; it is difficult to ensure consistency of approaches and skill across therapists. In addition, the availability of experienced, evidence-based psychotherapists is inconsistent across geographic regions, so therapy may be unavailable. Psychotherapy requires a significant time commitment, which the adolescent and their family may find challenging. Sometimes managed care policies may have limited benefits and do not support therapy at a level consistent with the evidence-based standard. Finally, some adolescents will refuse to attend therapy, or will make very little use of it when it is provided.

Q What are the common difficulties encountered with pharmacologic approaches? How do you approach these?

Probably the most common difficulty encountered with pharmacologic approaches is adherence. The most common reason for medications not to work, by far, is that the adolescent is not taking them. There are three common reasons for noncompliance: stigma, side effects and, oddly enough, the fact that the medication was useful in symptom relief.

Issues surrounding the stigmatization of psychotropics are best handled by directly addressing misconceptions regarding medications with both the adolescent and the family. Prescribers need to understand the exact influences that prejudice individuals and families against taking medications. These include the media, anecdotes of relatives' or friends' experiences on medications and irrational fears concerning medications' mechanisms and dangers. Prescribers are obligated to make their knowledge and decision-making process absolutely transparent to youth and their families. Prescribers must also discuss the risks of not taking medication in circumstances where medications are indicated. Failures in the development of self-esteem, educational progress and social and family functioning carry their own disabling consequences and associated stigma.

The contribution of side effects to non-adherence is addressed through preparatory education, active monitoring and timely responsiveness to patient and family concerns. Common and dangerous side effects need to be discussed openly prior to initiating treatment. Ideally, only idiosyncratic side effects should come as a surprise. Teens and families that feel adequately prepared will rarely abandon psychopharmacology altogether, when side effects occur. Side effects where tolerance is expected (e.g., gastrointestinal distress and headache) will be willingly endured if families understand that these are time-limited and that the medication will be adjusted or stopped if these problems endure. Assessment of side effects must be continuous, including inquiries regarding sexual dysfunction, which most adolescents will be reluctant to mention spontaneously. Teens

need to know that their doctors are dedicated to them more than their compliance. Simply stating, when appropriate, that this medication does not necessarily have to be forever, or that you will stop or change the medication if it proves intolerable goes a long way. This common sense approach remains elusive to patients when it is not explicitly stated.

Finally, patients often discontinue medications prematurely as their symptoms improve. This is best handled through good psychoeducation regarding the known patterns of recovery from a depressive episode. Patients and families should understand up front that in a perfect scenario of remission, that maintenance of remission requires continued treatment for an additional 9–12 months, even when it seems unnecessary.

Q What do the results of the Treatment of SSRI-Resistant Depression In Adolescents Week 24 Outcome study tell us about how we can treat resistant depression?

The good news is that approximately 40% of youths who fail their first treatment with a selective serotonin reuptake inhibitor will have their depression remit (i.e., minimal symptoms) after a switch in antidepressant. Those youth who responded (i.e., substantial reduction in symptoms) by week 12 had higher remission rates than those who responded after 12 weeks. The not so good news is that those whose depression was severe at baseline or complicated by comorbid anxiety, prominent suicidal thoughts, hopelessness (demoralization) and family problems did less well. The take home message from Treatment of SSRI-Resistant Depression In Adolescents (TORDIA) and the data from the Treatment of Adolescents for Depression Study [5] is that quality outcomes are associated with good and early pharmacological responses in those who are relatively uncomplicated. For those adolescents who have complicated depression or who are slow to respond, their clinicians need to be vigilant of the complications (anxiety, demoralization, suicidal thoughts and family problems), more assertive in their pharmacological management and use psychosocial treatments tailored to their patient's specific needs.

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Q Previous studies have reported an association between youth suicidal behavior & antidepressant use; what is your understanding of this? What factors should be considered in the clinic?

In 2004, the US FDA performed a *post-hoc* analysis of 24 studies involving 4400 children with either depression or anxiety and reported a statistically significant increase in suicidality of 3.8% compared with 2.1% on placebo, resulting in the black box warning we have today for the use of antidepressants in children [6]. For the purposes of this analysis increased suicidality was defined by new onset or worsening of suicidal thinking or behavior. In 2005, the FDA clarified their original statement, describing an association as opposed to a causal link.

While these findings are important when considering antidepressants in children, it should be noted that there were no suicide deaths and most reports were of suicidal thinking, not behavior. Of the 4400 patients, only 78 had any measure of suicidality. Adherence was not monitored; so it is not known how many had suicidality in the context of not taking prescribed medication or after medication discontinuation. This is a nontrivial matter as studies examining adolescents that died by suicide while being prescribed an antidepressant have revealed no detectable level of antidepressants at the time of suicide, suggesting nonadherence as a factor [7]. Although the analysis identified activation as a common side effect of antidepressants in this population, there was no association between activation and suicidality.

Subsequent analyses have looked at the relative benefit and relative risk of antidepressants in terms of the number of individuals who must be treated to see benefit and the number of individuals who must be treated before suicidal behavior caused by medication is observed [8]. In a population similar to those in the study, a clinician would have to treat over 100 patients with depression, obsessive-compulsive disorder or another anxiety disorder before seeing one patient who would develop suicidal thoughts/attempts that could be attributed to antidepressants. On the other hand, the

clinician would benefit anywhere from one in three or four patients by prescribing medication.

Adolescent suicidality steadily rose from the 1950s to the 1990s. It declined 30% during the period of widespread use of SSRIs in adolescents. In some studies, it appeared to rise again after the release of the black box warning [9]. It is possible that governmental efforts to protect children from the risk of antidepressants may expose them to the suicidal risk of untreated anxiety and mood disorders.

The implications of the above in practice are that clinicians need to make teens and families aware of the increased level of concern regarding antidepressants and suicide. Clinicians and families need to be vigilant in their continuous reassessment of mood and suicidality in teens on antidepressants, as should be indicated by the depressive condition itself. Patients should be monitored closely, at least weekly, when treatment is initiated or changed.

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