Depression in Children and Adolescents

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Day in Psychiatry

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Adolescent Depression

Dr. Ola Mabifa

Declaration of Conflict of Interest:

I HAVE been a member of a Sunovion pharmaceutical company advisory board for the development of Latuda.

I INTEND to make therapeutic recommendations for medications that have not received regulatory approval (e.g. “off-label” use).

Adolescent Depression

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Lundbeck

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Janssen

Purdue

Shire

Sunovion

KW Guardian Pharmacy

HLS therapeutics

Adolescent Depression

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Mitigating Potential Conflicts of Interest:

I will not specifically address the clinical use of Sunovion pharmaceutical products (specifically Latuda) for which I have been an advisory board member.

I will specifically mention when my therapeutic recommendations have not received regulatory approval.

- Definition
- Epidemiology
- Age of Onset and Course
- Subtypes of Depression
- Etiology and Risk Factors
- Comorbidity
- Diagnosis
- Differential Diagnosis
- Rating Scales
- Treatment
- Barriers to Care
- Prevention

Pre-pubertal children: 1-2%

Adolescents: 5%

Cumulative prevalence

- Girls: 12%
- Boys: 7%

Table E.1.1 Differences in the presentation of depression according to age. These symptoms can all be present at any age but are more common in the age group specified.

Pre-pubertal children	Adolescents	Adults
• Irritability (temper tantrums, non-compliance) • Affect is reactive* • Frequently comorbid with anxiety, behavior problems, and ADHD • Somatic complaints	• Irritability (grumpy, hostile, easily frustrated, angry outbursts) • Affect is reactive* • Hypersomnia • Increased appetite and weight gain • Somatic complaints • Extreme sensitivity to rejection (e.g., falsely perceived putdown or criticism) resulting, for example, in difficulties maintaining relationships.	• Anhedonia • Lack of affective reactivity • Psychomotor agitation or retardation • Diurnal variation of mood (worse in the morning) • Early morning waking

*Ability to be momentarily cheered up in response to positive events (e.g., visit by peers).

Average episode: 7-9 months
40% probability of recurrence in 2 years
60% likelihood in adulthood
Predictors of recurrence:

poorer response, greater severity, chronicity, previous episodes, comorbidity, hopelessness, negative cognitive style,
family problems, low SES, abuse or family conflict

Types

Major depressive Disorder(MDD)
Persistent Depressive disorder(PDD)
Premenstrual Dysphoric Disorder (PMD)
Disruptive Mood Dysregulation Disorder(DMDD)
Other Specified Depressive Disorder(OSDD0
Unspecified Depressive disorder(USDD)

Specifier

MDD

Single episode- Mild

Moderate

Severe+/- Psychotic features

MDD

Recurrent - Mild

Moderate

Severe +/- Psychotic features

Partial remission

Full remission

With Anxious distress
Mixed features
Melancholic features
Atypical features
Mood congruent/incongruent psychotic features
Catatonic
Peripartum onset
Seasonal pattern (only in recurrent)

Grief Vs Depression

According to the way diagnostic categories were presented in the *DSM IV*, there were distinct differences between grief and major depression. Now, in the new manual, those differences have been eliminated. In other words, if someone is grieving for more than two weeks, they fall into the category of having major depression.(DSMV)

Comparing the differences and similarities in symptoms of grieving after a loss as opposed to major depression.

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Grief VS MDD

Grief:

- 1. Sadness, despair, mourning
- 2. Fatigue or low energy
- 3. Tears
- 4. Loss of appetite
- 5. Poor sleep
- 6. Poor concentration
- 7. Happy and sad memories
- 8. Mild feelings of guilt
- Gradually and after an undetermined amount of time, these feelings remit as the individual regains their equilibrium as they return to normal life. Many of these symptoms are shared by people with major depression but significantly different symptoms are part of the profile

Major Depression

- 1. Worthlessness
- 2. Exaggerated guilt
- 3. Suicidal thoughts
- 4. Low self-esteem
- 5. Powerlessness
- 6. Helplessness
- 7. Agitation
- 8. Loss of interest in pleasurable activities
- 9. Exaggerated fatigue
- In major depression, these feelings are unremitting and carry with them the real danger of suicide. Daily functioning at work and home are impaired and the individual feels as if they will never climb out of these feelings.

Aetiology

Genetics
Prenatal factors
Family relationships
Parental depression*
Cognitive style
Stressful life events
Lack of parental care

Comorbid Conditions

Anxiety disorders
Post Traumatic Stress Disorder
Conduct problems
Attention Deficit Hyperactivity Disorder
Obsessive Compulsive Disorder
Learning difficulties

Psychiatric Differential Diagnosis

Unipolar vs. bipolar
Psychotic depression vs. schizophrenia
Depression vs. substance use
Depression vs. adjustment disorder with depressed mood
Depression vs. demoralization from disruptive disorders

Medical Differential Diagnosis

Medications
Substances of abuse
Infections
Neurological disorders
Endocrine
Sleep disorder
Inflammatory conditions

Treatment

Robust evidence of effectiveness for:

Medication (moderate and severe depression)
Psychotherapy (milder depression)
- Cognitive behaviour therapy (CBT)
- Interpersonal psychotherapy (ITP)

CBT

Identify links between mood, thoughts, activities
Challenge negative thoughts
Increase enjoyable activities
Build skills to maintain relationships

Other Treatments

Electroconvulsive therapy (ECT): good evidence of effectiveness in severe cases

Transcranial Magnetic Stimulation (rTMS)

Light Therapy (in seasonal mood disorder)

Complementary and Alternative Medicine (CAM)

- St. John's Wort
- Omega 3 Fatty Acids
- S-Adenosyl Methionine (SAMe)

Exercise

Yoga

Meditation

Medication

Two considerations: effectiveness and safety

- SSRIs are safest
- Fluoxetine is most effective

Begin fluoxetine

- Start with 10mg of fluoxetine
- Increase to 20mg after one week
- 20mg for pre-pubertal children
- 30 or 40mg for adolescents

If not fluoxetine try another SSRI (e.g., sertraline or escitalopram)

Continue treatment 6 months after recovery

Treatment Resistance

Determining treatment resistance
Handling treatment resistance
Possible causes:
- Patient factors
- Family factors
- Environmental factors
- Clinician factors

Barrier to Treatment

Shortage of child psychiatrists and allied professionals

Few training programs

Stigma

Few medications

Minimal inpatient facilities

Cost

References

- Diagnostic and Statistical Manual of Mental Disorder -DSM -5
- IACAPAP Textbook of Child and Adolescent Mental Health-Joseph Rey
- Essential of Psychiatric Diagnosis- Allen Frances
- Oxford Textbook of Psychiatry
- CANMAT guidelines for Major Depressive Disorder
- Nice guidelines
- Maudsley guidelines

Thank you