MANAGING ADOLESCENT DEPRESSION AND ANXIETY

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OBJECTIVES

- Explore diagnostic criteria for depressive disorders in adolescents and children
- Define the treatment algorithms for depression treatment in children and adolescents
- Explore medication management of depression in children and adolescents

FINANCIAL DISCLOSURES/CONFLICTS

- None to disclose

DEPRESSION IN CHILDREN AND ADOLESCENTS

- Definition (DSM-V)
  - episodic, recurring disorder characterized by
    - persistent and pervasive sadness or unhappiness, loss of enjoyment of everyday activities, irritability, and associated symptoms such as negative thinking, lack of energy, difficulty concentrating, and appetite and sleep
  - Core symptoms
    - Persistent and pervasive sadness or unhappiness, Loss of enjoyment of everyday activities, Irritability

- Associated symptoms
  - Negative thinking and low self-esteem, Hopelessness, Unavoidable ideas of guilt, remorse or...ness, suicide thoughts or thoughts of death, lack of energy, increased fatigue, diminished activity, difficulty concentrating, Appetite disturbances (decrease or increase), Sleep problems (insomnia or hypersomnia)

- Variations
  - Recurrence, chronicity, severity

- Appropriate terms
  - "depression" or "depressive episode" refers to the DSM definition of Major Depressive Disorder

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EPIDEMIOLOGY/PREVALENCE

- Pre-pubertal children: 1-2%
- Adolescents: 5%
- Cumulative prevalence
  - Girls: 12%
  - Boys: 7%

- When looking at prevalence we are normally looking for current, last 3 months, last year – from both the patient and a reliable adult.
Pre-Puberty Adolescents

Irritability (tantrums) Irritability (grouchy, angry, easily frustrated)

Affect is reactive Affect is reactive

Some comorbidity with ADHD, anxiety, and behavioral issues Hypersomnia (more than 12 hours per day, sleeping all night and then napping)

Somatic complaints (stomach ache, headache) Somatic complaints

Sensitivity to criticism (so great that it interferes with relationships)

Characteristics differ by age

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Clinical course

- Recurring, spontaneously remitting, seasonal, correlated with menstrual cycles.
- Average episode: 7-9 months (longer with comorbid issues)
- 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, abrupt medication cessation

Subtypes

- Catatonic depression
- Post-psychotic depression
- Premenstrual dysphoric disorder
- Seasonal depression
- Mood disorder NOS
- Adjustment disorder with depressed mood
- Minor depression
- Unipolar depression
- Bipolar depression
- Psychotic depression
- Manic depressive disorder
- Dyshymic disorder
- Double depression

Etiology

- Genetics
- Prenatal factors (low birth weight, addiction at birth)
- Family relationships (divorce, raised with grandparents, single parent household)
- Parental depression*
- Cognitive style (positive or negative)
- Stressful life events (moves, death, trauma, homelessness)
- Lack of parental care (related to addictions, neglect, etc)

Comorbidities

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

Suicidal characteristics

- Suicidal thoughts:
  - 1/6 girls
  - 1/10 boys
  - 100:1 ratio of attempts to completions
  - 50% depressed youth have thoughts of suicide
  - Data from ET survey reports an average of 10% of adolescents have thought about or attempted suicide.
  - 30% depressed youth make a suicide attempt
  - Risk factors: family history, previous attempt (and lethality of attempts), comorbidities, aggression, impulsivity, access to lethal means, negative life events
WHAT IS NEEDED FOR DIAGNOSIS

- Core symptoms
- Associated symptoms
- Duration
  - Minimum of 2 weeks?
- Impairment or distress
  - School, Home, Work?
- Prevalence
  - All aspect of life
- Number of core symptom
- Duration
- Impairment or distress
- School, Home, Work?

DIFFERENTIAL DIAGNOSES

- Medications
  - Accutane, Levaquin
- Substances of abuse
  - Opiates, marijuana, alcohol
- Infections
  - MRSA
- Neurological disorders
- Endocrine
  - Thyroid
- PANDA?
**TREATMENT OPTION**

Depending on severity:
- Watchful waiting
- Supportive management
- Psychosocial interventions
  - Cognitive Behavioral Therapy (CBT)
  - Interpersonal Psychotherapy (IPT)
- Medication

**TYPES OF THERAPY**

- Cognitive Behavioral Therapy (CBT)
- Interpersonal Psychotherapy (IPT)

**COGNITIVE BEHAVIORAL THERAPY**

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

**INTERPERSONAL PSYCHOTHERAPY**

- Similar to CBT
- Focus on the present
- Premise=Interpersonal conflicts → loss of social support → depression
- Improvement of interpersonal skills
- Psychoeducation about depression
- Increase enjoyable activities

**MEDICATION**

- Strong placebo effect
- Evidence different for adults
- Key aspects for informed consent
- Undertreatment is common
- Most evidence for Selective Serotonin Reuptake Inhibitors (SSRIs)
  - Fluoxetine: approved >8 year olds
  - Escitalopram: approved for adolescents in the US

**AE’S**

- Suicidality*
- Manic switch
- Akathisia
- Agitation
- Irritability
- Disinhibition
- Nightmares/sleep disturbances
- Gastrointestinal
- Weight gain
- Sexual
- Bleeding
- Possible congenital
- Withdrawal syndrome
- Serotonin Syndrome
WHAT IF I DON’T WANT TO PRESCRIBE MEDICATIONS?

- Electroconvulsive therapy (ECT): good evidence of effectiveness in severe cases
- Transcranial Magnetic Stimulation (TMS)
- Light Therapy (in seasonal mood disorder)
- Complementary and Alternative Medicine (CAM)
  - St. John’s Wort
  - Omega 3 Fatty Acids
  - S-Adenosyl Methionine (SAMe)
  - Exercise

TREATMENT OF UNIPOLAR DEPRESSION

- Mild: supportive management, CBT, or IPT→no response→CBT, IPT, or antidepressant medication
- Moderate: supportive management, CBT, IPT, or medication→no response→add medication
- Severe: CBT/IPT and medication

- Psychotic depression: CBT/IPT and medication and second generation antipsychotic drug
  - Seroquel, Abilify, and Latuda have pediatric indications

TREATMENT OF BIPOLAR DEPRESSIVE EPISODE

- 1st Line: lithium carbonate or quetiapine
- 2nd Line:
  - lithium or valproate with an SSRI
  - olanzapine and an SSRI, or
  - lamotrigine
- No evidence for antidepressants alone
- Lithium and valproate should be avoided in women of childbearing age

HOW DO I PICK?

- 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 RESISTENT DEPRESSION

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

BARRIERS

- Shortage of child psychiatrists and allied professionals
- Few training programs
- Stigma
- Few medications
- Minimal inpatient facilities
PREVENTATIVE MEASURES

• Cognitive restructuring
• Social problem-solving
• Interpersonal communication skills
• Coping
• Assertiveness training

REFERENCES


Stanley, Angela; Chelvakumar, Gayathri; Cody, Paula; Sadhir, Mandakini; Nugent, Melodee; Hoffmann, Raymond; and Simpson, Pippa, "Resident Training Curriculum in Adolescent Depression and Suicide Screening" (2016). Pediatrics Faculty Publications. 271. https://uknowledge.uky.edu/pediatrics_facpub/271
