

PRACTICAL PSYCHOPHARMACOLOGY

Persistence Critical in Severe Teen Depression

Major depressive disorder is one of the most common disorders among adolescents, with prevalence estimates as high as 20%-24%. Although it is less common in younger children, it nonetheless occurs and might signal a more severe lifetime course.

Often, depressed children and adolescents respond well to treatment, which might include pharmacologic interventions and psychotherapy.

However, a core group of pediatric patients presents with severe symptoms, including suicidality—the third leading cause of death beginning at age 15.

Moreover, relapse occurs in 34%-50% of adolescents, often early, and even after successful resolution of symptoms, according to Dr. Graham Emslie, professor of child and adolescent psychiatry at the University of Texas, Dallas, who has extensively studied adolescent depression. Relapse rates of as high as 70% have been reported over 6-7 years.

Initially, clinicians should be alert to potential risk factors that could point to a severe clinical course, including parental depression and “high genetic loading,” such as a family history of bipolar disorder, said Dr. Emslie in an interview.

Depression, of course, must be assessed developmentally, with melancholic depression less common in younger children.

Withdrawal, irritability, fears/social anxiety, destructive behavior, somatic complaints, and poor social or academic functioning are considered possible signs of depression in early to middle childhood, according to Bright Futures in Practice, a mental health guide for pediatricians sponsored by the Health Resources and Services Administration and the National Center for Education in Maternal and Child Health at Georgetown University in Washington.

In practice, severe and/or treatment-resistant depression in young children might be marked by psychotic features and might eventually develop into bipolar disorder, said Dr. David Brent, pro-

fessor of psychiatry, pediatrics, and epidemiology at the University of Pittsburgh and the cofounder and director of Services for Teens at Risk (STAR), a suicide prevention program funded by the Commonwealth of Pennsylvania.

Severe depression in adolescents, “as opposed to severe problems—family



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chaos, substance abuse, and so on—is characterized by high scores on severity scales...severe suicidal thought without the ability to develop a safety plan or nonresponse to adequate treatment,” said Dr. Emslie in an interview.

The scales Dr. Emslie prefers are the Quick Inventory of Depressive Symptomatology (16 items) or the Center for Epidemiologic Studies Depression Scale (20 items).

Other factors common to difficult-to-treat adolescent patients include comorbid psychiatric diagnoses, longstanding symptoms of depression, and substance abuse issues, Dr. Brent noted.

Both Dr. Emslie and Dr. Brent have been investigators in trials of various antidepressants for the primary treatment of adolescent depression and relapse prevention.

Current Food and Drug Administration-approved treatments for depression include fluoxetine for children and adolescents aged 8-17 years and escitalopram for adolescents aged 12-17.

Both experts participated in the recently published TORDIA study (Treatment of SSRI-resistant Depression in Adolescents), in which 334 adolescents who had failed one trial with an SSRI were randomly assigned to a switch to

another SSRI or venlafaxine, with or without cognitive-behavioral therapy.

Systematic (weekly) monitoring rather than spontaneous reports increased detection of suicidal self-injury (20.8% vs. 8.8%), and nonsuicidal self-injury (17.6% vs. 2.2%). The median time to a suicidal event was just 3 weeks into the trial, with more events reported among youth who had high baseline suicidal ideation, family conflict, and drug and alcohol use (*Am. J. Psychiatry* 2009;166:418-26).

Nonsuicidal self-injury also was an early event, with a median time to occurrence of 2 weeks. A previous history of nonsuicidal self-injury was an independent risk factor for a repeated, similar event.

In the paper reporting TORDIA results, and in interviews, Dr. Brent and Dr. Emslie emphasized early and aggressive monitoring of adolescents with risk factors, especially family conflict, suicidal ideation, and drug use.

Children and adolescents who are embroiled in family or school conflict, concerns about abuse and/or sexual identity, parental depression, or substance abuse likely need combination treatment that includes psychotherapy, Dr. Brent said.

Although polypharmacy is common, it has not been studied in adolescents.

“We prefer not to resort to it,” Dr. Brent said. “We do it when we have a patient who has shown some response to a medication but has not completely remitted, and we have pushed the dose as high as makes sense.”

Most commonly, that index drug is an SSRI, he said.

“Agents that are commonly used for augmentation are bupropion, especially if the patient has fatigue or symptoms of [attention-deficit/hyperactive disorder], thyroxine, lithium, and antipsychotics.”

All of these agents have been studied in adults, but none have been studied in adolescents, Dr. Brent emphasized.

In clinical practice, an antipsychotic might need to be the initial drug used to

treat psychotic depression, prescribed either alone or in combination with an antidepressant, Dr. Emslie said.

Further, more than one medication might be required in the face of acute symptoms, such as aggression, or comorbid conditions, such as ADHD, he said.

Both experts emphasized the need to closely follow resistant patients if the diagnosis is correct and the medication dosage has been maximized.

“Persistence is important,” Dr. Brent said. “Most patients will eventually respond to treatment.”

If they don’t respond, then revisit the diagnosis first, he advised, considering the possibility that what appears to be depression is really a manifestation of bipolar disorder, anxiety, an eating disorder, ADHD, or obsessive-compulsive disorder.

All of the above disorders also might be contributory to depression, complicating treatment. “You want to make sure that you are not missing things in dealing with someone who is treatment resistant,” Dr. Brent said.

Other considerations are compliance and metabolic absorption of a medication, the possibility of an undiagnosed medical condition such as hyper- or hypothyroidism, iron-deficiency anemia, or vitamin B₁₂ deficiency; and critically, the psychosocial milieu.

“Even severely depressed adolescents generally respond if treatment is continued and approached systematically, involving sequential treatments and psychosocial interventions,” Dr. Emslie said.

Dr. Brent reported that he had no relevant financial conflicts of interest. Dr. Emslie has received research support from Biobehavioral Diagnostics Inc. and Somerset Pharmaceuticals, and has served as a consultant for Biobehavioral Diagnostics, Eli Lilly & Co., Forest Laboratories, Pfizer Inc., and Wyeth Pharmaceuticals. ■

By Betsy Bates. Share your thoughts and suggestions at cpnews@elsevier.com.

EMRs May Help Physicians Tease Out Bipolar Depression

BY KATE JOHNSON

MONTREAL — Primary care physicians are not confident when it comes to diagnosing and managing patients with bipolar depression, according to a cross-sectional survey of providers participating in a national electronic health record database.

Among 85 primary care providers in GE Healthcare’s Medical Quality Improvement Consortium, self-rated confidence in managing bipolar disorder averaged 1.7 on a scale of 1-5, with 5 being “very confi-

dent,” said Dr. Dana King, who presented the findings as a poster at the annual meeting of the North American Primary Care Research Group.

“For other more common disorders such as reflux disease, heart disease, or diabetes, these physicians have more confidence in their ability to sort out complex problems and deal with them. But bipolar disorder is less common and people have less exposure to it during their training,” explained Dr. King, professor of family medicine at the Medical University of South Carolina, Charleston.

Eighty-six percent of the respondents had been using electronic health records (EHRs) for 3 or more years, and 94% had access to the Internet from their clinical workstations.

Although 72% of the respondents said they screened depressed patients for bipolar disorder, only 38% reported frequently using a standard screening tool, the most common being the Mood Disorder Questionnaire.

Informal screening was more common than was the use of standardized tools and consisted of “a few questions about man-

ic activity in patients with depression,” Dr. King said. Such information screening may involve questions such as “Do you go on spending sprees? Do you stay up all night? or Do you find yourself having ups and downs, including periods of high irritability, anger or stress?”

As the use of EHRs becomes more widespread, they may help prompt physicians to screen patients for bipolar disorder by offering pop-up information, he said. This represents an opportunity for quality improvement.

“Physicians seem to like the

idea that we could offer them quick medical information via the [EHR] that will give them some quick answers,” he said.

“Many of them are willing to comanage the patient but they first want the diagnosis to be confirmed, typed according to bipolar I or II, with an identification of the phase and recommended medications. That was the preference of most of them,” he concluded.

The study was part of a quality improvement project funded by Delaware Valley Outcomes Research and GE Healthcare. ■