CHILD/ADOLESCENT DEPRESSION

EVALUATION AND MANAGEMENT IN PRIMARY CARE SETTING

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Sadness of mood for most of the day, nearly every day, and/or loss of pleasure for a period of two weeks (or more), with five or more symptoms.
DIAGNOSTIC CRITERIA
DSM-IV*

(1) Depressed mood most of the day, nearly every day.
(2) Diminished interest or loss of pleasure in all, or almost all activities, nearly every day
(3) Decreased or Increased appetite (more than 5% change in body weight)
(4) Insomnia or hypersomnia
(5) Psychomotor agitation or retardation
(6) Fatigue or loss of energy
(7) Feelings of guilt
(8) Poor concentration, attention or indecisiveness
(9) Recurrent thoughts of death/suicidal ideation or plan

*Diagnostic and Statistical Manual
EXCLUSIONS

- The symptoms cause clinically significant distress in important areas of functioning
- The symptoms are not due to the direct physiological effects of a substance or a general medical condition
- The symptoms are not due to bereavement
DIAGNOSTIC CRITERIA

- Depressed mood most of the day, nearly every day
  - Irritability, poor frustration tolerance
  - Tearfulness, crying excessively
- Diminished interest or loss of pleasure in all, or almost all activities, nearly every day
  - Not playing with favorite toys
- Decreased or Increased appetite (more than 5% change in body weight)
  - Failure to gain weight
- Insomnia or hypersomnia
  - Sleeping less than 6 hours
- Psychomotor agitation or retardation
  - Poor emotional reactivity
Fatigue or Loss of energy
Often seen in children

Feelings of guilt
May be more clearly identifiable in adolescent

Poor concentration, attention or indecisiveness
Commonly present

Recurrent thoughts of death/suicidal ideation or plan
Homicidal ideation or plan
ETIOLOGY

MULTIFACTORIAL

Biological
Low levels of 5-HT
Low Catecholamine -NE, Dopamine
Genetic vulnerability
Stress diathesis model

Psychological
Psychodynamic -losses
Cognitive- negative views
Behavioral- lack of social skills
Learned helplessness- past failures
**Rating Scales**

<table>
<thead>
<tr>
<th>Rating Scale</th>
<th>Ages</th>
<th>Person completing</th>
<th>Items</th>
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</thead>
<tbody>
<tr>
<td>Children's Depression Rating Scale-Revised (CDRS-R)</td>
<td>6-12 and A.</td>
<td>Clinician</td>
<td>17</td>
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<tr>
<td>Center for Epidemiological Studies Depression Scale Modified for Children (CES-DC)</td>
<td>6-17</td>
<td>Patient</td>
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<td>Reynolds Child/Adolescent Depression Scales-RCDS (Child) RADS-2 (Adolescent)</td>
<td>C- 8-12 A-11-20</td>
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<tr>
<td>Weinberg Depression Scale for Children and Adolescents (WDSCA)</td>
<td>5-21 7-17</td>
<td>Patient</td>
<td>56</td>
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<tr>
<td>Child Depression Inventory (CDI)</td>
<td>7-17</td>
<td>Parent, Teacher, Patient</td>
<td>17, 12, 27</td>
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<td>Rating Scale</td>
<td>Ages</td>
<td>Person completing</td>
<td>Items</td>
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<td>Beck Depression Inventory for Youth (BDI-Y) and BDI-II</td>
<td>BDI 7-14</td>
<td>Patient</td>
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<td>BDI-II -13+</td>
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<td>Multiscore Depression Inventory for Adolescents and Adults (MDI)</td>
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<td>Multiscore Depression Inventory for Children (MDI-C)</td>
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<td>Patient</td>
<td>79</td>
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<td>Mood and Feelings Questionnaire (MFQ)</td>
<td>13-18</td>
<td>Parent /Teacher</td>
<td>L 33</td>
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<td>Patient 34/13</td>
<td></td>
<td>S 13</td>
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<tr>
<td>Kiddie Schedule for Affective Disorders and Schizophrenia (Kiddie-SADS)</td>
<td>6-18</td>
<td>Clinician</td>
<td>90-120</td>
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</tbody>
</table>
Mild- meets criteria
Moderate- meets criteria but all symptoms may not be present
Severe- meets criteria, all symptoms may be present with increased severity, additional symptoms contributing, worsening functional impairment
Preschool children - 1%
School age children - 2%
Adolescent - 8%
Pre-puberty incidence is equal in boys and girls
Incidence higher in adult females vs. males
Average duration of an episode - 4-12 months

Lifetime prevalence is 16.2 %
12 month prevalence is 6.6%
Rule out medical and substance induced causes
Rule out other psychiatric conditions with mood components
Rule out social stressors
Differential Diagnoses

Psychiatric Illnesses
Bipolar disorder
Dysthymia
Adjustment disorder
ADHD
Bereavement
Schizoaffective disorder
Medical illnesses
Endocrine-
  Thyroid disorders
Anemia
Substance Induced
Treatment Interventions are based on:
- Severity of illness
- Safety
- Previous treatments
Based on biopsychosocial treatment plan:
Biological
Psychological
Social
MANAGEMENT

Biological treatment
Selective Serotonin Reuptake Inhibitors
Serotonin Norepinephrine Reuptake Inhibitors
Tricyclic Antidepressants
Atypical Antidepressants
Monoamine Oxidase Inhibitors
Other treatment options
Selective Serotonin Reuptake Inhibitors
Includes sertraline, fluoxetine, paroxetine, escitalopram and citalopram
Trazodone

Considered first line of treatment except trazodone
Advantages: well tolerated, minimal side effects
Disadvantages: None
Serotonin Norepinephrine Reuptake Inhibitors
Includes venlafaxine, desvenlafaxine, duloxetine

Advantages: effective, helps in pain conditions
Disadvantages: withdrawal syndrome, patient compliance needed

Considered first line in adults only
Tricyclic Antidepressants
Includes amitryptiline, imipramine, doxepin, trimipramine, clomipramine, nortriptyline, desipramine, protryptiline

Heterocyclic Antidepressants
Include amoxapine, maprotiline

Advantages: Effective.
Disadvantages: Side effects, needs monitoring and dangerous in overdose
Atypical Antidepressants

Mirtazapine
Advantages: improves sleep and appetite
Disadvantages: As above

Bupropion
Advantages: improves depression, alertness, concentration
Disadvantages: Effectiveness not established in children
Monoamine Oxidase Inhibitors
Includes phenelzine, tranylcypromine, isocarboxazid, selegiline

Advantages: effective for atypical depression
Disadvantages: Severe dietary restrictions, side effects, unsafe in overdose
Other treatments:
- Electroconvulsive Therapy
- Phototherapy
- rTMS - repetitive Trans cranial Magnetic Stimulation
- Vagus nerve stimulation
- Dietary – St. John’s Wort, SAM-e, Omega 3 Fatty Acids
- Exercise
Psychological Treatment
Psychotherapy - *which one?*
Selection of intervention based on need
Social
School- bullying, academics, participation
Home- family environment
Abuse- interventions
Phases
Acute Phase- 0-16 weeks
Continuation Phase- 6-9 months
Maintenance Phase- begins after recovery
Choosing an antidepressant
Follow up within 1-3 weeks
Some improvement usually seen within 4 weeks; if no improvement in 8-10 weeks, consider changing
With some improvement, dose should be optimized

Treatment should be continued for at least one year

Psychosocial treatments should be concurrent
Safety assessment continuous
Thank you