Adolescent Depression:

Treatment Guidelines

Michael Malus, M.D.C.M., C.C.F.P.
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Studies have shown that up to 9% of teenagers meet criteria for depression at any one time, with as many as one in five teens having a history of depression at some point during adolescence.[1] In 2003, 8.3% (approximately one in 12) of American teenagers reported having attempted suicide one or more times in the past year.[2] Our teenage suicide rates in Canada are similar to those in the U.S–both show an increase by a factor of five in the last 40 years. Due to limited access to psychiatrists and psychologists, FPs are left holding the bag.

A group of psychiatrists from Columbia University in New York and the University of Toronto created a Task Force of primary care physicians, along with psychiatric and psychological experts on adolescent depression, to create guidelines to help primary care physicians work their way through the minefield of caring for depressed teenagers. In focus groups, primary care physicians were asked what information they would find useful. The task force members reviewed the current literature and held meetings with experts in the field to seek a consensus on current management.

The Guidelines were published in Pediatrics in November 2007 simultaneously with the opening of a summary Toolkit for Adolescent Depression at www.glad-pc.org.[3] The recommendations are divided in sections including Assessment and Diagnosis, Initial Management, Treatment and Ongoing Management and Follow Up.

Meet Clayton

Clayton, a 16 year old in grade ten has been referred by a guidance counselor at school with the agreement of his parents.

A previously good student, is now failing for the first time and feels sad most of the time. Some days he stays in bed and refuses to go to school; will lie in bed and stare at the wall for hours. He has distanced himself from his group of friends, and spends most of his time alone.

He describes feeling extremely angry and having thoughts about doing physical harm to a girl who had embarrassed him in grade six and was now once again in his class. He says they are only thoughts and he would never do it, but the anger and the thought is recurrent.

Several years ago he felt suicidal and had also been cutting himself. He saw a counselor for three months. He presently is not suicidal, but said he felt depressed and wanted help to deal with his depression.He has occasionally used alcohol and marijuana for the last two years

Assessment and diagnosis

The guidelines define major depressive disorder (MDD) as follows: "Major depressive disorder is a specific diagnosis described in Diagnostic and Statistical Manual of Mental Disorders, 4th Edition which includes symptoms of low mood, anhedonia and other neurovegetative symptoms (*i.e.*, insomnia, decreased concentration, low energy, *etc.*)"[3] The authors note an important distinction between adolescent and adult depression: "Because adolescents with depres-

sion may not be able to clearly identify depressed mood as their presenting complaint, providers need to be aware of common presenting symptoms that may signal depressive disorder. These may include insomnia, weight loss, decline in academic functioning, family conflict, as well as other symptoms of depressive disorders…"[3]

The guidelines suggest that in addition to interviewing a family with a Home & Environment, Education & Employment, Activities, Drugs, Sexuality, Suicide/Depression (HEADSS) approach and interviewing the family, the primary care physician should also substantiate his assessment and diagnosis with a formal depression questionnaire like the Beck Depression Inventory for older teenagers and the Children's Depression Inventory (CDI) for younger teens. These are brief questionnaires which are given to the patient to answer. They take less than 15 minutes to be answered and scored. They are helpful for diagnosis and for grading the severity of depression.

The CDI consists of 27 questions (Table 1). Clayton, the 16-year-old in our case scored 31 (*i.e.* severely depressed). See the Toolkit at: www.glad-pc.org for assessment tools and depression scales, *etc.*

Initial management

After making an assessment and diagnosis, the physician should share his management and treatment plan with the patient and his family. He should fully explain the nature of depression and arrange for a safety plan including clear lines of communication should the patient deteriorate and become suicidal.

Treatment

For mild depression, supportive office psychotherapy with guidance on specific issues may suffice. For moderate depression psychotherapy with a psychologist or psychiatrist is ideal. The FP and the psychologist together may decide if medication is indicated and the psychiatrist will decide for himself. For severe depression psychiatric consultation and transfer is mandatory.

Table 1
Depression diagnosis scores

- A score of less than 10 suggests that the diagnosis is not MDD
- A score of 10-18 =mild depression
- A score of 19-29 = moderate depression
- A score of 30+ = severe depression

*MDD: Major depressive disorder

Psychotherapy

There are two types of psychotherapy that have recently been found to be successful with teenagers. They are:

- **Cognitive behavioural therapy (CBT):** A basic principle in this form of psychotherapy is to empower the patient to reduce negative thoughts (cognitive restructuring) and improving assertiveness and problem solving skills to reduce feelings of hopelessness
- **Interpersonal therapy (IPT):** Essential elements of interpersonal therapy include identifying an interpersonal problem area, improving interpersonal problem-solving skills and modifying communication patterns

Clayton, the 16-year-old depressed teenager of our case was referred to a psychologist who treats teenagers with cognitive behavioural therapy. He began treatment in October. The psychologist's notes show how Clayton came to see his depression stemming largely from poor self-esteem. He saw himself caught in a cycle where feelings of self-abasement and self-pity triggered maladaptive, aggressive and self-destructive responses. Within several months he acquired insight into this cycle and developed rational coping tools to break it. He

passed the school year with good marks. By August 2007, he felt he was well enough to stop therapy and was confident he could go on applying what he learned. His Beck Depression score in August at termination of therapy was nine: (*i.e.*, not depressed).

Medication

In the year 2000, an American study showed that 42% of FPs had recently prescribed selective serotonin reuptake inhibitors (SSRIs) for more than one adolescent under the age of 18. Since then the number no doubt increased, but then recently fell in the U.S due to the black box warning released by the FDA on the prescription of SSRI's to children and teenagers. The warning related to reported suicidal ideation associated with the medication. Since the FDA, warning the rate of teenage suicide in US has risen.[4] In Canada we are not bound by FDA rulings and in this case it is probably for the better. The data relates to a slight increase in suicidal ideation (not suicide). The warning also singles out fluoxetine as the relatively safer SSRI for showing slightly less of this effect. There is however one clinical guideline that Canadian physicians can absorb from the black box affair. The warning advises physicians to check weekly for adverse effects—including suicidal ideation—for the first six weeks after prescribing an SSRI to a teenager and biweekly for another month, then at 12 weeks and as clinically indicated beyond 12 weeks. The online Toolkit at www.glad-pc.org provides dosages of SSRIs. Recent studies have shown both sertraline and citalopram as effective in adolescent depression. The Toolkit also provides excellent information on adverse effects.

Dr. Michael Malus is an Associate Professor of Family Medicine, McGill University; Chief, Department of Family Medicine, Jewish General Hospital; and Director, Teenage Health Unit, Herzl Family Practice Center, Montreal, Quebec.

Take-home message

- Adolescent depression is extremely common
- Depression scales are simple to use and very helpful in the assessment, diagnosis and treatment of depression
- Cognitive behaviour is an effective method of psychotherapy with teenagers
- What to do until the psychiatrist comes ? Consult: www.glad-pc.org

Further management and follow-up

The guidelines suggest reassessment after six to eight weeks of treatment. If improvement has not occurred a psychiatric consultation is in order. Reassessment with the same depression scale used initially is a very useful tool. Where remission occurs one should continue medication from six months to one year with periodic visits during that time.

References
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