

Treating Teen Depression



The following information is in relation to the treatment of unipolar depression in adolescents.

Treating depression in adolescents invariably requires a multimodal approach that takes into account the adolescent's context in terms of their age, their family circumstances, as well as their social and educational settings.

Antidepressant drugs need to be considered along with other management strategies but are only indicated as first-line treatment principally in adolescents with a melancholic depression.

Overview:

- Prevalence of depression in adolescents world-wide is 1 – 2% annually.
- Recurrence rates are high: 50 – 70% within 5 years.
- Onset of depression in early adolescence has a poorer prognosis.
- 20% of adolescents with depression don't improve in the short term despite adequate drug treatment, highlighting the need for more comprehensive management planning, combining psychological and pharmacological treatment.

General approach to management:

1. Engage the teenager and establish rapport.
2. Explain confidentiality to the teenager and parent/guardian, including empathic explanation of the need to involve others in the young person's care, especially when depressed, if they are self-harming or feeling suicidal.
3. Consider both the diagnosis of depression and the type of depression, remembering that depression can present differently in young people, frequently as irritability, behaviour problems and school refusal.
4. Assess risk of harm.
5. Consider co-morbid conditions.
6. Treat depression in parents if present.
7. In non-melancholic depression, initially try simple non-specific psychosocial strategies such as:
 - Psychoeducation of the teenager and their parents.
 - Problem solving skills
 - Anxiety management
 - Dealing with conflict
 - Diet
 - Exercise
 - Sleep hygiene
 - Liaising with schools
 - CBT (cognitive behaviour therapy) and IPT (interpersonal psychotherapy) – (there is some evidence that these are useful in non-melancholic depression.)
8. Try omega 3 (1-2 G/day) or, in non-melancholic depression, St John's wort (remember this acts on serotonin metabolism and can cause a serotonin syndrome. It also interacts with many other medications such as the contraceptive pill)

The use of antidepressants

Antidepressants are indicated in melancholic depression and in some expressions of non-melancholic depression, particularly when there is inadequate response to non-pharmacological management.

(Note: Adolescents prescribed antidepressant medication require close follow-up during the first few weeks to monitor any increase in suicidal or externalized aggressive behaviours).

1. Although, at present, no antidepressant drugs are approved by the TGA for use in young people, medications with a long half life such as fluoxetine are generally preferred, as missed doses are less problematic. Start with half the recommended dose and increase the dose if no response – and no significant side-effects – after 1-4 weeks.
2. If required, gradually keep increasing dose in increments as tolerated to the maximum dose recommended by the manufacturer.
3. SSRI's such as escitalopram (start at 10 mg) and sertraline (start at 25 mg) are alternative choices.
4. If no response:
 - Review the diagnosis and examine possible factors that may prevent improvement (e.g., non-adherence, family conflict, abuse, substance use) and address these appropriately.
 - Add or continue CBT or IPT.
 - Refer for specialist opinion.
5. Educate patients about the rationale for introducing medication, side-effects, not stopping medication suddenly or without consulting a medical practitioner.
6. Tricyclics should not be used in adolescents as they are generally ineffective and highly toxic in overdose.
7. Avoid concurrent use of benzodiazepines.

Side effects

1. Increasing agitation – this is dose related and may improve by reducing the dose.
2. Watch for “manic switch.”
3. Increased risk of suicidal ideation in first weeks after commencement of therapy, but overall, the benefits of antidepressants are considered greater than the risks of suicide attempts.

Ongoing monitoring

1. Monitor thoroughly and regularly, particularly during the first few weeks of medication.
2. Keep assessing for suicidal risk – risk keeps changing with time.
3. Monitor side-effects.
4. If good response, maintain medication for at least 9 months.

REFERENCES

1. Parker G and Eyers K. (2009) “Navigating Teenage Depression” Allen and Unwin.
 2. Rey J and Birmaher B (2009) “Treating Child and Adolescent Depression” Lippincott, Williams and Wilkins
 3. Thapar A et al (2010) “Managing and preventing depression in adolescents” BMJ 2010: 340
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