Objectives

- To describe the symptoms of major depression and bipolar disorder
- To understand the risk factors for suicide
- To understand the treatment of depression and bipolar disorder
- To discuss the potential side effects of antidepressant medication
- To discuss the school’s role in treatment
Why Do We Think Mood Disorders Are Diseases?

- **Clinical syndromes** – Similar symptoms across individuals, cultures and time periods

- **Genetic evidence** – Family, adoption, and twin studies

- **Biological changes** – Specific brain injury can result in depression in some individuals
  - Left frontal cerebral cortex & basal ganglia strokes associated with depression
Depression and Neurologic Disorders

Prevalence of Depression

- Parkinson’s Disease: 40 %
- Multiple Sclerosis: 35-60 %
- Migraine Headaches: 40 %
- Alzheimer’s Disease: 15 – 50 %
- Amyotrophic Lateral Sclerosis: no increase

Mood Disorders: Clinical Syndrome

- Mood changes
- Vital sense changes (neurovegetative symptoms)
- Self-attitude change
Symptoms of Major Depression

- Depressed, irritable mood or feeling nothing
- Decreased interest or pleasure in activities (anhedonia)
- Change in appetite or weight
- Sleeping more or less than usual
- Feeling restless or slowed down
- Fatigue or loss of energy
- Decreased concentration
- Feelings of guilt or worthlessness
- Recurrent thoughts of death or suicide
- Hallucinations and delusions possible, but rare
Major Depression

- Five or more of the depressive symptoms present during the same two week period
- The symptoms cause clinically significant distress or impairment in functioning
- The symptoms are not due to the effects of alcohol or other substances or a medical condition (but comorbidity common)
- Depressive episodes only, no manic or hypomanic episodes
Depressive Symptoms in Young Children

- Physical complaints
- Picky eating or change in appetite
- Withdrawn, sad appearance, and clingy
- Poor self-esteem
- Behavioral regression such as bed wetting, baby talk or thumb sucking
- Separation problems including school phobia
Depressive Symptoms Common in Adolescents

- Irritable Mood
- Anhedonia – enjoying nothing
- Sense of Hopelessness
- Anxiety symptoms
  - Separation, Social, Panic Attacks
- Social isolation and dropping out of usual activities/change from baseline
- Somatic complaints
- Substance Abuse
What I had begun to discover is that, mysteriously and in ways that are totally remote from normal experience, the gray drizzle of horror induced by depression takes on the quality of physical pain. But it is not an immediately identifiable pain, like that of a broken limb. It may be more accurate to say that despair, owing to some evil trick played upon the sick brain by the inhabiting psyche, comes to resemble the diabolical discomfort of being imprisoned in a fiercely overheated room. And because no breeze stirs this caldron, because there is no escape from this smothering confinement, it is entirely natural that the victim begins to think ceaselessly of oblivion.
“Dementors are among the foulest creatures that walk this earth.

Get too near a dementor and every good feeling, every happy memory will be sucked out of you.

You’ll be left with nothing but the worst experiences of your life.”
Depression: Clinical Syndrome

- Mood changes – Depressed, irritable or feeling nothing
- Vital sense (neurovegetative symptoms) – decreased
- Self-attitude – decreased
What Percent of Teenagers Describe Adolescence as:

- A time of severe emotional upheaval and turmoil?
  - 20%
  - 30%
  - 40%
  - 60%
  - 100%

Epidemiology of Major Depression

- Prevalence
  - 1-2% prepubertal children
  - 5% in adolescence
  - Lifetime rates
    - Women 10-25%
    - Men 5-12%

- Gender ratios
  - Females = Males prepubertally
  - Females > Males (2:1) in adolescence
Comparative Prevalence Rates

- 1/6 adolescents are obese
- 1/10 children have allergies
- 1/11 school-aged children have Asthma
- 1/20 teenagers have Depression
- 1/250 children have Type I Diabetes
<table>
<thead>
<tr>
<th>STAGE</th>
<th>DISORDERS</th>
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<tbody>
<tr>
<td>Infant</td>
<td>Autism</td>
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<tr>
<td>Toddler</td>
<td>Pervasive developmental disorder, Attention-deficit/hyperactivity disorder</td>
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<tr>
<td>School-Age</td>
<td>Separation anxiety disorder, GAD, OCD, Tourette’s disorder</td>
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<tr>
<td>Adolescent</td>
<td>Major depression, Bipolar disorder, Substance abuse disorders, Social phobia, Panic disorder, Anorexia &amp; Bulimia, Schizophrenia</td>
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Tasks of Adolescence

- Develop and apply:
  - abstract thinking skills
  - perspective taking
  - new coping skills, conflict resolution

- Relationships:
  - form mutually close friendships
  - renegotiate relationships with adults
  - adjust to sexually maturing bodies and feelings

Simpson 2001
Symptoms of Mania

- Elevated, expansive, or irritable mood
- Inflated self-esteem or grandiosity
- Decreased need for sleep
- More talkative or pressure to keep talking
- Racing thoughts
- Distractibility
- Increased activity or agitation
- Excessive involvement in pleasurable activities
- Engages in risky behaviors
- Hallucinations and delusions possible, but rare
Bipolar Disorder Type I

- Manic-Depressive illness
- Depressive episodes
- Manic episodes
  - At least three of the mania symptoms
  - Symptoms for at least one week
- Prevalence ~1% of the population
- Equal rates in men and women
When you’re high it’s tremendous. The ideas and feelings are fast and frequent like shooting stars, and you follow them until you find better and brighter ones. Feelings of ease, intensity, power, well-being, financial omnipotence, and euphoria pervade one’s marrow. But, somewhere, this changes. The fast ideas are far too fast, and there are far too many; overwhelming confusion replaces clarity. Memory goes. Humor and absorption on friends’ faces are replaced by fear and concern. Everything previously moving with the grain is now against – you are irritable, angry, frightened, uncontrollable, and enmeshed totally in the blackest caves of the mind. You never knew those caves were there. It will never end, for madness carves its own reality.
Mania: Clinical Syndrome

- Mood changes – elevated, expansive or irritable
- Vital sense (neurovegetative symptoms) – increased
- Self-attitude – increased, at times grandiose
Genetics of mood disorders

- **Depressed Parents**
  - Children of a depressed parent are three times as likely to develop MDD.
  - If parent is affected, lifetime risk of developing MDD is 15 to 45%.

- **Depressed Child**
  - First degree relatives have 20 to 45% lifetime prevalence rate of depression.
  - Early onset depression (< 20 years old) is associated with a higher risk for depression running in families.
Suicide and Psychiatric Illness

- 90% of completed suicides have a diagnosed psychiatric disorder
- Depressive disorders most common ~ 80%
- Comorbid alcohol abuse common
- Patients with depressive disorders and schizophrenia often commit suicide early in the course of their illnesses
Clinical Risk Factors for Suicide

- Hopelessness
- History of prior attempts
- Lethality of plan and access to means
- Lack of social supports
- No established treatment relationship
Protective Factors for Suicide

- Marriage
- Having dependent children
- Pregnancy and the first year of the child’s life
- Religious beliefs
- Relationships
Treatment of Mood Disorders

- Medications – antidepressants & mood stabilizers
- Individual psychotherapy
- Education and support
- Family involvement and/or family therapy
- Control of behaviors (alcohol abuse, substance abuse, eating disorders, and cutting)
- Other treatments
  - Electro-convulsive therapy (ECT)
  - Bright Light Therapy
Treatment Goals and Challenges

- Depression
  - Goal: elevating mood back to baseline
  - Challenges: delay in medication effectiveness, side effects, and compliance

- Bipolar Disorder
  - Goal: mood stabilization
  - Challenges: potential for destabilizing mood (e.g. antidepressant triggering manic symptoms) and compliance especially when manic
Treatment Stages for Mood Disorders

- **Acute**
  - Diagnosis, education, support, safety assessment, initiating medication treatment

- **Improvement**
  - Serial assessment, support, identifying stressors, relationship issues, manage medication issues (side effects, partial response)

- **Recovery**
  - Long-term medication management
  - Potential for more intensive psychotherapy
# Differences Between Pediatric and Adult Care

<table>
<thead>
<tr>
<th>Pediatric care</th>
<th>Adult care</th>
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<tbody>
<tr>
<td>Family oriented</td>
<td>Individual focused</td>
</tr>
<tr>
<td>Developmental aspects considered</td>
<td>Specifically focused on health</td>
</tr>
<tr>
<td>Coordinates with schools and social services</td>
<td>Less communication with social services or workplace</td>
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<tr>
<td>More help with treatment regimen</td>
<td>More accepting of treatment refusal</td>
</tr>
<tr>
<td>Paternalistic</td>
<td>Shared treatment decisions</td>
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Antidepressants

- Selective Serotonin Reuptake Inhibitors
  - Prozac, Zoloft, Paxil, Lexapro, Luvox, Celexa
- Tricyclics
  - Nortriptyline, Desipramine, Imipramine
- Selective Serotonin-Norepinephrine Inhibitors
  - Effexor, Cymbalta
- MAO Inhibitors
  - Parnate, Nardil, Marplan, Eldepryl, Emsam patch
- Others
  - Wellbutrin, Remeron, Nefazodone, Trazodone
Mood Stabilizers

- Lithium
- Divalproex sodium (Depakote)
- Carbamazepine (Tegretol)
- Lamotrigine (Lamictal)
- Gabapentin (Neurontin)
- Topiramate (Topamax)
- Atypical neuroleptics
Compliance for Effective Trials

- Goal: adequate doses for sufficient time periods (up to 8 weeks at a therapeutic dose)
- Methods to increase compliance:
  - Discuss availability of multiple options
  - Ask about most concerning side effects
  - Education about time needed for benefits
  - Follow-up in 1-2 weeks for a brief visit
Psychotherapy – Acute Illness

- Support and Education focus
- Physicians need to repeat the same information every time they see their patients
  - You have an illness causing these symptoms
  - The illness is treatable
  - Your family would not recover if you kill yourself
  - You must take your medication and come for your appointments
Course of Recovery from Major Depression
Practical Supplemental Treatments

- Adequate, regular sleep
- Exercise or physical activity
- Healthy eating habits
- No alcohol, drugs, destructive behaviors
- Distracting activities (movies, easy books, or seeing friends)
- Regular schedule – get up, take a shower, and leave the house
- Smoking cessation may worsen symptoms
Psychotherapy – Improvement

- Careful serial assessment of mood
- Goal of recovery, not just improvement
- Assessing underlying issues that may trigger stress and mood symptoms
- Dealing with the inevitable chaos following a depressive or manic episode
  - Relationships, work, financial, etc.
“But from that moment on, Hermione Granger became their friend. There are some things you can’t share without ending up liking each other, and knocking out a 12-foot mountain troll is one of them.”
Psychotherapy – Recovery

- Strong therapeutic alliance developed during the acute/improvement stages of treatment
- Assessment of need for more intensive psychotherapy
- Issues related to having a potentially recurrent, debilitating illness
- Long-term management of medication (maintenance treatment for at least 6-12 months for depression, longer for bipolar)
No pill can help me deal with the problem of not wanting to take pills; likewise, no amount of psychotherapy alone can prevent my manias and depressions. I need both. It is an odd thing, owing life to pills, one’s own quirks and tenacities, and this unique, strange, and ultimately profound relationship called psychotherapy.
Course of Depressive Disorders in Adolescents

- Major Depressive Episode 7-9 months
- 66% have another episode before age 18
- Up to 10% have episodes lasting 2 years
- 20% develop bipolar disorder
Adolescent Depression Significantly Increases Risk During Early Adulthood

- Major depression and anxiety disorders
- Nicotine dependence, alcohol abuse or alcohol dependence
- Suicide attempts
- Educational underachievement
- Unemployment
- Early parenthood

Fergusson & Woodward, *Arch Gen Psychiatry*, 2002
Major Depression and Comorbidities

- 40% to 70% of children with MDD have a comorbid psychiatric disorder
- Dysthymia
  - Double depression
- Anxiety Disorders
- Disruptive Disorders (ADHD+)
- Substance Abuse
Treatment of Coexisting Conditions

- ADHD
  - Onset by age 7
  - Prioritize the disorders
  - Side effect of a stimulant
  - Use of bupropion (Wellbutrin)

- Substance abuse
  - Onset of Depression before substance abuse
Behaviors Seen with Mood Disorders

- Eating disorders
  - Anorexia nervosa
  - Bulimia nervosa
- Alcohol abuse
- Substance abuse
- Self-injurious behaviors (cutting)
24 Pediatric Antidepressant Trials (SSRIs primarily)

- Approximately 4,000 children and adolescents
- No completed suicides in the trials
- Small risk for suicidality for medication treatment compared to placebo
  - Relative Risk is 2:1 (4% vs 2%)
  - Risk Difference is 2%

- Black Box warning for all antidepressants
Why an Association Between Antidepressants and Suicidality?

- Activation/Akathisia
- Historically, energy improves before mood
- Discontinuation of medicine
- Emergence of mania or mixed states
- Potential role of substance abuse
The School’s Role in Treatment

- Identification of students with mood disorders
- Support of the student and the treatment team
  - Balance of support and expectations
  - Flexibility in schedules
Conclusions

- Mood disorders are common, treatable diseases
- Antidepressant and mood stabilizer trials must be of adequate length at therapeutic doses
- Treatment of depression should always include psychotherapy – the focus should change as clinically indicated