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Treatment Modalities in Pediatric Depression

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Purpose

The purpose of this evidence-based project is to answer the following question: In pediatric patients with Major Depressive Disorder (MDD), how does combination treatment with a Selective Serotonin Reuptake Inhibitor (SSRI) and cognitive behavior therapy (CBT) affect symptoms of depression, when compared with using only an SSRI?

Background

- Pediatric MDD 11.7%,[6] increasing >50% by 2020, will be in top 5 causes of mortality and morbidity in children.[4]
- Common symptoms: chronic pain, headaches, risky sexual behaviors, STIs, poor eating/sleeping; Increased health costs; poor performance in school and relationships.[1,2,7]
- Suicide 3rd leading cause of death for teens.[6]
- Many PCPs uncomfortable treating pediatric patients, especially very young (<12 years old).[3,6] Only 1 in 5 children with MDD receive appropriate treatment.[7]
- Clinical practice guidelines lacking in pediatric population; metabolism, response to medications in the brain & developmental processes not well understood and are different than adults; treatment has been very conservative.[6]

Evidence Appraisal

Multiple databases searched: CINAHL, MEDLINE, and a general medical database search. Keywords used include “pediatric,” “depression,” “MDD,” “SSRI,” “CBI,” “non-pharmacological,” “psychotherapy,” and “nutrition.” Four studies were included with level of evidence and validity generally average to high quality.

Evidence Synthesis

- Depression scores on standardized tests decreased with combo therapy – not statistically significant, however.
- Suicidality decreased significantly in both groups, showing positive effect of SSRI with or without CBT.
- Time to remission of symptoms not significantly less with combo therapy, however rate of relapse was much lower, showing a clinical significance in adding CBT to treatment.

Translation to Practice

- Education and counseling on depression.
- Refer to social worker or therapist if needed. Assess for safety, potential for self-harm, follow up in 2-4 months.
- Start low dose SSRI. Titrate up to min effective dose & continue for 6-12 months after remission of symptoms..[3]
- CBT: provide education & treatment plan for MDD, teach relaxation, coping & problem-solving, encourage goal-setting, & increase engagement and cooperation, decrease of symptoms.[7]
- Considerations – children and teens can be especially difficult to treat due to lack of knowledge and understanding of importance of these treatments, adherence issues. Obtain parental support for CBT & assist with accessibility. Arrange so social impact as low as possible for the patient – not during school time or interfering with social activities.

Proposed Evaluation

- Follow up 4wks, 6mo, and 1yr – instability/adherence issues require closer management.
- Standardized testing to evaluate results include:
  - ❖Beck’s Depression Inventory (BDI) - self-reported symptoms: dysphoria, anhedonia, suicidality, sleep dysfunction, cognitive function, and appetite changes.[2]
  - ❖Children’s Global Assessment Scale – Revised (CGAS-R) - Provider-reported symptoms [5]
  - ❖Child-Behavior Checklist (CBCL) – Parent checklist on behavior, problem-solving, and somatic symptoms.[1]

Conclusion

- CBT should be considered as an effective treatment in all forms and severities of depression.
- SSRI treatment for moderate-severe depression.
- Regular evaluation of efficacy of treatments and assessment for further symptoms is critical to ensure remission and prevent relapse.

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