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Antidepressants in Children and Adolescents, to Give or Not to Give; When and What???!!

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Abstract

Depression in children is not rare; it is estimated to affect 2.8% of those younger than 13 years while such prevalence increases to 5.6% of those aged between 13 years and 18 years. Major depression disorder (MDD) in children and adolescents usually has its negative percussions on its sufferers physically, emotionally, and socially. It results from interplay between biological susceptibility and risky psychosocial and environmental stressors.

Keywords: Major Depressive Disorder (MDD); DSM 5; Cognitive Behaviour Therapy (CBT); Antidepressants; Selective Serotonin Reuptake Inhibitors (SSRIs); Suicidality

Introduction

Depression in children is not rare; it is estimated to affect 2.8% of those younger than 13 years while such prevalence increases to 5.6% of those aged between 13 years and 18 years [1]. Major depression disorder (MDD) in children and adolescents usually has its negative percussions on its sufferers physically, emotionally, and socially [2]. It results from interplay between biological susceptibility and risky psychosocial and environmental stressors [3]. Screening for depression may be useful for early picking up and treatment of cases among adolescents while there is no adequate data to indicate the value of such screening among younger children except for those with at least one risk factor for developing the disease [4]. Its definitive diagnosis is settled by mental health professionals using DSM 5 diagnostic criteria for MDD [5]. Combined cognitive behavior and interpersonal therapy is indicated in all cases of MDD either alone in mild cases or in addition to pharmacotherapy in moderate to severe cases [6]. The use of antidepressants in children is an issue of debate because of their indications, efficacy, and adverse effects as well as the proper choice of the drug to be given [6-8].

Manifestations of MDD

Pediatric sufferers from MDD usually manifest with anhedonia, boredom, hopelessness, hypersomnia, and weight changes (overweight or inappropriate weight milestones), drug or alcohol use, and suicidal attempts if they are adolescents while younger children usually present with somatic complaints, irritability, separation anxiety, phobias, and hallucinations. Mental age of the depressed child or adolescent is important as those with lower mental age (whether younger children or those with intellectual disability) may appear unhappy but fail to express their feelings or describe their sadness or depressed mood. Parents are usually more concerned with externalizing manifestations as restlessness and irritability while sufferers usually are more agonized with their sadness and unhappiness [5,6].

Indications of pharmacotherapy in pediatric MDD

To give or not to give medications in pediatric sufferers from MDD is an issue that needs to be dealt with cautiously. Children and adolescents with major depressive disorder are most likely to need pharmacotherapy if their depression is moderate to severe and if they had prior episodes of depression, needed medications for a prior episode, have family history of depression and significant response to antidepressants, persistent psychosocial and or environmental stressors, and failed trial of cognitive behavior and or interpersonal therapy [9].

Pharmacotherapy for MDD (antidepressants); an issue of debate

Antidepressants are drugs that are used to treat MDD and some other conditions such as anxiety disorders, eating disorders, chronic pain, snoring, migraine, attention deficit hyperactivity disorder (ADHD), addiction, and sleep disorders [10]. It has been hypothesized that depression is linked to hyperactive hypothalamic pituitary adrenal axis (HPA axis) in response to stress which can explain depressive manifestations; antidepressants may be useful in normalization of HPA axis functions [11].

The knowledge about antidepressants in children and adolescents is progressively increasing; nevertheless, it is still limited in comparison to similar knowledge in adults [8]. Tricyclic antidepressants are no longer indicated for children with MDD because of their limited to none usefulness [12]. Meanwhile, selective Serotonin Reuptake Inhibitors (SSRI) are the drugs of choice for treating moderate to severe depression in pediatric age group; namely fluoxetine, citalopram, and sertraline [13]. Specifically, fluoxetine is the drug with documented solid evidences of its efficacy in children and adolescents suffering from MDD [13,14]. Lowest doses of the drug must be used at the onset of therapy and titrated according to the response of the patient and the occurrence of side effects. Adverse effects include gastrointestinal manifestations, nervousness, restlessness, and headache [6]. Treatment is recommended to continue for 6 months

after remission with close monitoring of the depressive manifestations, patient's general condition, and the development of any adverse effects [15].

Discussion and Conclusion

Alarmingly, Food and Drug Administration (FDA) issued a public warning about an increased risk of suicidality (suicidal thoughts and or behavior) in depressed children and adolescents treated with SSRIs [8,16]. A comprehensive study that has been published in 2007, suggested that the usefulness of such medications in pediatric moderate to severe major depression and anxiety overweighs their risks [17]. However, patient and family education about the benefits and risks of the recommended treatment is crucial in addition to detailed discussion about their expectations concerning the disease prognosis [18]. Finally, follow up of MDD sufferers with close monitoring of their condition and the individualized efficacy of the used drugs as well as the development of their potential adverse effects is pivotal to improve the outcome of such emotionally, physically, and socially disturbing disease.

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