Short Scale Assesses Child, Adolescent Depression

BY DAMIAN McNAMARA
Miami Bureau

BOCA RATON, FLA. — Major depression in children and adolescents can be assessed quickly using a 10-item scale designed for adults. Results correlate well with a standard 45-minute pediatric measure, according to a study presented at a meeting of the New Clinical Drug Evaluation Unit sponsored by the National Institute of Mental Health.

Major depression in pediatric patients is typically measured with the Child Depression Rating Scale–Revised (CDRS-R). This measure is not only time consuming but it requires clinician training to administer, said Dr. Shailesh Jain, a National Institute of Mental Health fellow at the Mood Disorders Research Program and Clinic at the University of Texas Southwestern Medical Center, Dallas.

Practitioners interview the child or adolescent first, then talk with the parent(s), and use clinical judgment to combine the components. "It takes a long time. For busy clinicians in child psychiatry, it's difficult to spend 45 minutes," Dr. Jain said. In addition, certain items on the scale rely on clinician judgment, and subjective assessments vary with clinician experience.

Dr. Jain and his associates compared the CDRS-R to the Montgomery-Asberg Depression Rating Scale (MADRS) in 96 children (aged 8-11 years old) and 123 adolescents (12-18 years).

All of the participants were outpatients with nonpsychotic major depressive disorder. The participants were culled from a randomized trial of fluoxetine 10 mg/day for one week followed by a titration to 20 mg/day continued for 8 weeks vs. placebo.

The researchers rated depressive symptoms using both measures.

"The MADRS has advantages—it has 10 items," Dr. Jain said in an interview at his poster presentation. "But the MADRS has been used primarily in adults, and little is known about its psychometric properties in evaluation of pediatric patients."

Total score correlation between CDRS-R and MADRS was 0.85 at study completion for both children and adolescents, which shows that both scales agree to a considerable extent for assessment of depression, Dr. Jain said.

"When measuring the effect of antidepressants (fluoxetine), CDRS-R was statistically more sensitive in detecting changes in symptoms in response to medication in both children and adolescents," Dr. Jain said. Effect size for CDRS-R was 0.78 in children and 0.61 in adolescents, compared with the MADRS 0.38 in children and 0.15 adolescents.

These differences are statistically significant, but the clinical difference is less important because it can take three times longer to complete the CDRS-R, Dr. Jain said. In addition, adolescents often do not like the CDRS-R requirement that clinicians ask parents about their functioning at each visit.

"This is not to suggest that clinicians completely circumvent parents, but the MADRS provides a reasonable alternative for assessment of depression severity and response to treatment," Dr. Jain said. "We now know how the scales correlate and, most importantly, the conversion factors between the scales."

Busy practitioners can quickly assess symptoms of major depression in adolescents with the MADRS. Dr. Jain said that the scale is also useful for children, who are typically poor historians and very influenced by environmental conditions.

The meeting was cosponsored by the American Society for Clinical Psychopharmacology. ■

Web-Based Therapy for Depression Will Target Adolescents

BY KATE JOHNSON
Montreal Bureau

SAN ANTONIO — Primary care physicians may be able to quickly and accurately assess and stratify an adolescent's 1-year risk of developing new-onset major depression using a 20-item checklist, Dr. Benjamin W. Van Voorhees said at the annual meeting of the Society for Prevention Research.

The information could then help physicians guide patients and parents toward reducing the risk using a variety of therapeutic interventions, including a Web-based approach that he has developed and is now testing, said Dr. Van Voorhees, a pediatrician and internist at the University of Chicago.

"Primary care physicians use a brief list of questions to stratify a person's 10-year risk of cardiovascular disease and to guide their interventions, so we wanted to make this depression risk model just as easy to use in the primary care setting," he said in an interview.

He said primary care providers now have no alternative to medications or psychotherapy referrals for patients with mild to moderate depression symptoms. "We are trying to create an alternative—to reshape the current paradigm," Dr. Van Voorhees said.

He and his colleagues developed their depression risk prediction model using data from the National Longitudinal Study of Adolescent Health, which involved 6,504 adolescents in grades 7 through 12. Baseline data on the subjects, collected in 1995, included home, school, and parent surveys. Follow-up data were collected 1 year later on 4,791 subjects.

Using a subsample of 3,814 subjects, none of whom had major depression at baseline and for whom 1-year follow-up data were available, Dr. Van Voorhees identified gender, ethnicity, weight, height, and age as well as 15 independent variables that could be used to predict the patient's development of major depression in the coming year. The model, which has a sensitivity of 74% and a specificity of 87%, includes information on the adolescent's social connectedness, quality of life, mood, and other factors.

His research group plans to formally test the prediction model in a prospective study of youth at risk for developing major depression.

In a separate analysis of the same subset, Dr. Van Voorhees also identified a list of factors that appeared to protect against the development of depression. For example, on a personal level, an adolescent's self-rated health, adequate sleep, and self-efficacy seemed protective. On a family and community level, participation, attachment, and competence seemed protective.

"My idea is that if we have a good risk prediction model, we can basically calculate an adolescent's risk at a well-child visit and then give that information to the child and parent," he said. "Then they can choose whether they want to be involved in a preventive intervention.

"We believe that such interventions could be done at low cost and, if designed well, could be efficacious and very acceptable to patients and physicians in community settings."

He suggests patients identified as having moderate risk might consider improving the protective factors in their lives, although whether changes in these areas could actually reduce risk is something that still needs to be explored in a randomized, controlled trial, he added.

For patients identified as having higher depression risk, he suggests a more structured intervention such as Project CATCH-IT, a combined primary care/Web-based intervention that he has developed.

Project CATCH-IT, designed for adolescents who are at moderate to high risk for depression, involves an initial "motivational interview" with a primary care physician aimed at helping the adolescent identify personal goals and understand how depression could jeopardize those goals.

During this session, the primary care physician also focuses on boosting the adolescent's motivation to change and increasing his or her interest in the Web-based intervention (a demonstration can be seen at www.animateband.com/siteX/Untitled-1.html). Adolescents can then work their way through the online modules, which are based on cognitive-behavioral and interpersonal psychotherapy.

The intervention concludes with a follow-up visit with the primary care physician. If no benefit is observed at this stage, Dr. Van Voorhees advises face-to-face sessions with a mental health professional.

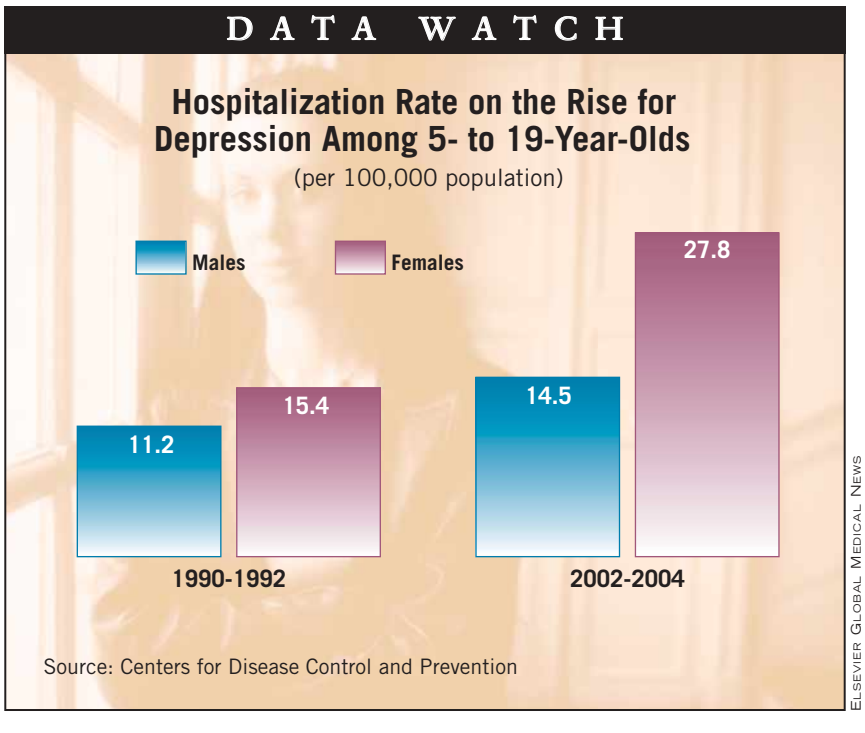
In a pilot test of Project CATCH-IT, Dr. Van Voorhees' group observed benefits of the intervention among 14 late adolescents who were at high risk for depression (Can. Child Adolesc. Psychiatry Rev. 2005;14:40-3). "Completers experienced favorable changes in known risk factors with effect sizes similar to those of other preventive interventions for depression," they wrote. However, with no control group in the study, "we cannot know to what degree these changes would have occurred without an intervention," they added.

Dr. Van Voorhees is now enrolling primary care practices to test the intervention in a larger study.

The aim of depression risk prediction and early intervention is to prevent the development of more serious mental illness, but Dr. Van Voorhees cautions about the potential adverse effects of this approach. "When you are dealing with young people who may be vulnerable and somewhat pessimistic, telling them that they are at risk for depression may make them feel stigmatized," he said. "So the way we approach this is to talk in terms of resiliency.

"We tell them they have high, medium, or low resiliency. High resiliency would mean almost no risk of depression, whereas low would mean they need to take care of themselves." ■

DATA WATCH



ELSEVIER GLOBAL MEDICAL NEWS