Guidelines for youth depression: time to incorporate new perspectives

Norman P Zimmerman

TO THE EDITOR: I cannot argue with the push by Hickie and McGorry for services for young people from 12 to 25 years of age who suffer from “depression”.1 But I question their sequencing of treatments model that pervades the beyondblue draft clinical practice guidelines about which they editorialise.

Their model presupposes a unitary entity of “major depression” that varies in severity, with milder conditions being treated by psychotherapy and more severe conditions being treated with antidepressant medication.

Consider the following case to show how the guidelines get it wrong. A 16-year-old girl presents with her first episode of moderately severe major depression. She is treated as per the guidelines for depression with a selective serotonin reuptake inhibitor (SSRI) and rapidly develops a severe psychotic mania. She is certified to a psychiatric facility and requires a prolonged admission. For the next 2 years she remains chronically hypomanic, refusing to try better treatment. Eventually, following a severe depressive episode, her treatment is reorganised and her condition stabilises. However, the trauma and psychosocial damage from the hospitalisation and prolonged period of illness are significant.

In the guidelines, bipolar disorder — arguably the only “biological” kind of depression in this age group — is separated from the body of recommendations for managing depression. The possibility that this episode of depression may be part of an as-yet-undeclared bipolar disorder needs to be thoroughly integrated into the understanding and management of “depression”.2

Features that would suggest possible bipolar disorder include psychomotor retardation and cognitive impairment,3 psychosis, reverse neurovegetative features (hypersomnia or hyperphagia),4 a few manic symptoms mixed with depression3 (racing thoughts, distractibility, flight of ideas, increased energy or psychomotor agitation), or the depression not making sense psychologically. Past episodes of depression, brief hypomania, anti-depressant-induced hypomania, or a family history of bipolar disorder also need to be documented. Doctors should then routinely discuss with patients and families the possibility that bipolar disorder could be diagnosed, and warn that the patient may experience a manic switch. If the likelihood is high, as part of a proper process of informed consent, the patient should be offered concurrent lithium or antipsychotic medication. The patient and family can be assured that expert clinical observation over time will clarify the diagnosis and what treatment is appropriate.

This approach not only involves the patient and family in decision making, giving knowledge and choices, but, importantly, incorporates the reality of diagnostic uncertainty.

Norman P Zimmerman, Psychiatrist
Clayton Community Mental Health Clinic, Melbourne, VIC.
norman.zimmerman@southernhealth.org.au

Ian B Hickie and Patrick D McGorry

IN REPLY: Zimmerman correctly highlights the intrinsic limitations of applying the current “evidence base” for managing severe depression in young people. In part, our critique of the new guidelines stems from our shared concern about their real utility in clinical practice. As we have outlined else-
where, we do not favour a simple “sequencing of treatments” model or recognise a clear separation between early phases of severe unipolar or bipolar depression.\textsuperscript{2} The real difficulty for clinicians is that young people presenting with severe depression are not only at high risk of immediate harm, but may also be on the path to a range of different psychiatric (and neurobiological) outcomes, including bipolar disorder, psychotic disorders and comorbid alcohol and substance misuse.\textsuperscript{2,3} Unfortunately, there are no clear clinical, neuropsychological or biomedical predictors of the relative risks of developing these adverse outcomes.\textsuperscript{2,3} Consequently, we have recommended the development of a broader clinical trials network that recognises this complexity and seeks to develop a more relevant evidence base in the future.\textsuperscript{5} For now, we need to continue to develop clinical service initiatives that not only engage young people but can provide the longitudinal and more specialised care that may be required for those who develop more complex disorders.\textsuperscript{5}

Ian B Hickie, Professor of Psychiatry and Executive Director\textsuperscript{1}
Patrick D McGorry, Professor of Youth Mental Health\textsuperscript{2}

1 Brain and Mind Research Institute, University of Sydney, Sydney, NSW.
2 University of Melbourne, Melbourne, VIC.
ianh@med.usyd.edu.au