Antidepressant Management in the Context of Suicidal Ideation

GRAHAM J. EMSLIE, M.D., BRUCE WASLICK, M.D., ELIZABETH B. WELLER, M.D., ANGELICA KLOOS, D.O., RONALD A. WELLER, M.D., AND CHRISTOPHER J. KRATOCHVIL, M.D.

A 15-year-old male presents with moderately severe depression, and fluoxetine 20 mg is initiated. When he returns 14 days later, he describes suicidal ideations for the first time. He has recurrent thoughts of wishing he were dead, a plan, but no intent to act.

HOW WOULD THIS AFFECT MEDICATION MANAGEMENT?

Graham Emslie, M.D.

The assumption from the vignette is that an in-depth assessment of suicidal ideation and behavior in the past and before initiating medication has been conducted, and that this is, in fact, the first time the patient has experienced suicidal ideation. The frequency at which such an event occurs in clinical practice is not known and is, I expect, rare. It is possible, even probable, that the ideation was present earlier but was not reported. However, living with the theoretical assumption proposed, further assessment is needed prior to making a judgment about medication. The first concern is for safety, and, therefore, a safety plan would be developed based on a variety of factors (e.g., social support, recent stressors, access to planned method); if necessary, more intensive treatment (e.g., increased frequency of visits, telephone calls between visits, hospitalization) may be required. If continuing outpatient treatment is appropriate, then further information is needed to guide medication management.

One of the first things to determine clinically is the status of the patient's depressive symptoms. Use of clinical ratings or self-report measures can be helpful. If overall the depressive symptoms are worsening, then the development of suicidal ideation may be in the context of a still-untreated or suboptimally treated depression. Similarly, intercurrent events (stressors) may have contributed to worsening (e.g., loss of relationship either secondary to or independent of depression) . In these contexts the patient would stay on the same dose and be reassured that the initial response may take at least 4 weeks before considering increasing the dose. If, however, the initial presentation was a severe melancholic episode with substantial anhedonia and psychomotor retardation, then it is possible that the suicidal ideation occurred in the context of increased energy, which may be indicative of beginning improvement.

This is a case vignette created to exemplify a complex clinical problem and does not refer to any specific patient.

This column aims to discuss practical approaches to everyday issues in pediatric pharmacotherapy. The cases and discussions specifically target aspects of clinical care related to psychopharmacology for which we do not have adequate applicable controlled trials. Given the need to address symptoms in youths with complex, severe, and comorbid disorders, recommendations are likely to be off-label from the perspective of the U.S. Food and Drug Administration. We fully appreciate that for virtually all disorders, medication is only one aspect of comprehensive care. This column focuses primarily on psychopharmacologic management. Although it is important that clinicians address psychosocial issues in the evaluation and treatment of their patients, such discussion is beyond the specific scope of this feature. These are not meant to be practice guidelines, but rather examples of thought processes that may go into pharmacotherapy decision making.

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Dr. Emslie is with the Department of Psychiatry, University of Texas Southwestern Medical Center at Dallas; Dr. Waslick is with the Division of Child Behavioral Health, Baystate Health, and Tufts University School of Medicine, Boston; Dr. E. Weller is with the Departments of Psychiatry and Pediatrics, University of Pennsylvania, and Children's Hospital of Philadelphia; Dr. Kloos is with Jefferson University, Philadelphia; Dr. R. Weller is with the University of Pennsylvania, Philadelphia; Dr. Kratochvil is with the Department of Psychiatry, University of Nebraska Medical Center, Omaha.

Correspondence to Dr. Christopher J. Kratochvil, University of Nebraska Medical Center, 985581 Nebraska Medical Center, Omaha, NE 68198-5581; e-mail: ckratoch@unmc.edu.

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Although there is considerable debate about whether de novo suicidal ideation is associated with prodromal symptoms, as noted in the U.S. Food and Drug Administration warning (e.g., akathesia, mood lability, irritability, disinhibition, hypomania), evaluating these symptoms is important. Clearly, assessing for a family history of bipolar disorder is important in evaluating associated symptoms. If the patient appears to be having new symptoms (noted above) that are not consistent with the previous behavior (a difficult clinical judgment), then reducing the dose or discontinuing the medication would be considered. In the context of clear mania, the medication would be discontinued. Some minor increases in agitation or mood lability may be transitory, and generally patients and parents are capable of deciding whether these associated symptoms are minor enough to work through or if the medication needs to be stopped. This highlights the most significant part of medication management: the development of a therapeutic relationship with the patient and family with adequate time to develop a therapeutic alliance, assess symptoms, environmental and family factors, and provide psychoeducation about depression and medication management.

One final note is that some of the agitation seen with antidepressants may be dose related. For example, in two fluoxetine trials with a fixed dose of 20 mg, there were no differences between drug and placebo in terms of increased suicidal ideation or behavior. Some increase in suicidality was seen in the Treatment for Adolescents With Depression Study (TADS); however, higher doses of fluoxetine were used. Whether this is, in fact, a function of dose or different populations is unclear at this time. However, in the scenario provided, unless the person was an unusual metabolizer, such agitation would be relatively rare in an adolescent taking 20 mg fluoxetine.

Bruce Waslick, M.D.

The controversy regarding the risk–benefit profile of antidepressant medications presents a major challenge for clinicians like me who attempt to practice evidence-based psychopharmacology. Our current level of evidence suggests the possibility that in certain individuals, antidepressant treatment can be causally associated with increasing the risk of suicidal crises and suicidal behavior in children and adolescents. I do not believe that we can say with any degree of certainty, before or during treatment, which individuals are most at risk of medication-induced suicidality or how to distinguish medication-induced worsening of suicidality from that associated with other causal mechanisms.

My approach to the vignette would be to first thoroughly evaluate the situation, generally through an in-person (ideally) or a telephone interview with the child and parents/caretakers. First, I would establish degree of the child's compliance with the medication. Second, I would want to establish whether the suicidality was in fact worsening or whether the child was now reporting suicidality that may have been present before beginning treatment but previously not accurately reported for some reason. Third, I would evaluate the child for the presence of other possible triggers for increased suicidality in adolescents (i.e., recent losses, interpersonal conflicts, pending disciplinary actions, worsening physical illnesses, peer influences, alcohol and drug use). Fourth, I would evaluate the underlying condition targeted by the antidepressant medication to get a sense of whether the depressive symptoms globally were worsening or whether suicidality was independently worsening relative to other depressive symptoms. Fifth, I would evaluate for signs or symptoms that the adolescent was developing other CNS side effects that could suggest the presentation of a mixed or manic episode or an intolerance of the antidepressant (i.e., worsening irritability or agitation, akathisia, worsening anxiety, insomnia). Finally, via a thorough current risk assessment, I would try to get a good sense of the level of care that was appropriate to the clinical situation: Does the child need to be emergently hospitalized due to the level of suicidal risk or can treatment be continued as an outpatient?

Ultimately, any treatment recommendations I would make would depend on my assessment of the risk–benefit considerations of various available treatment interventions after sifting all of the gathered information through my knowledge of evidence-based psychopharmacology principles and my clinical experience. If I concluded that there was enough evidence to suggest the child was demonstrating serious intolerance (including suicidal worsening) of the current medication treatment, then my recommendation likely would be that the family discontinue the medication, hopefully continue any current nonmedication treatments, and make sure that the child is monitored reasonably closely until the suicidal crisis resolved.