

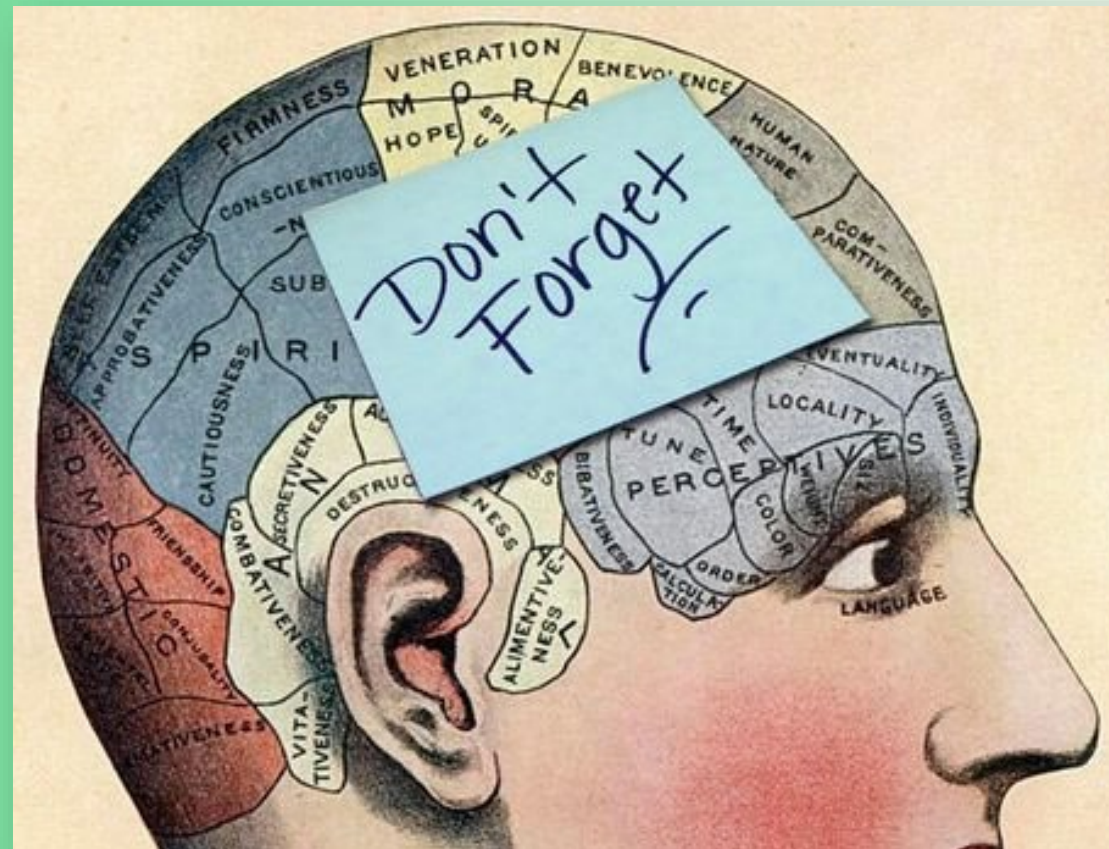
Break – back at 2:30

Clinical Pearls of Depression

Reality testing intact or improved



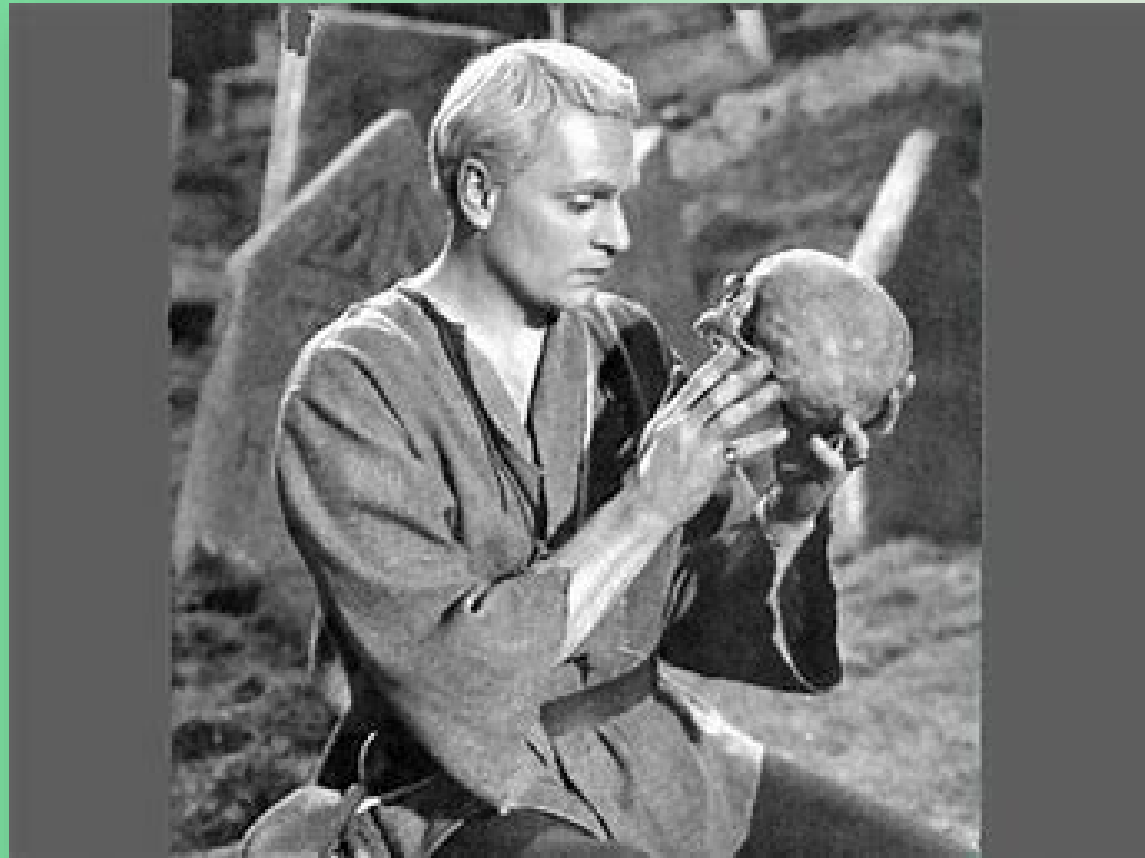
Depressive episodes are remembered



Not necessarily a life long illness with one episode

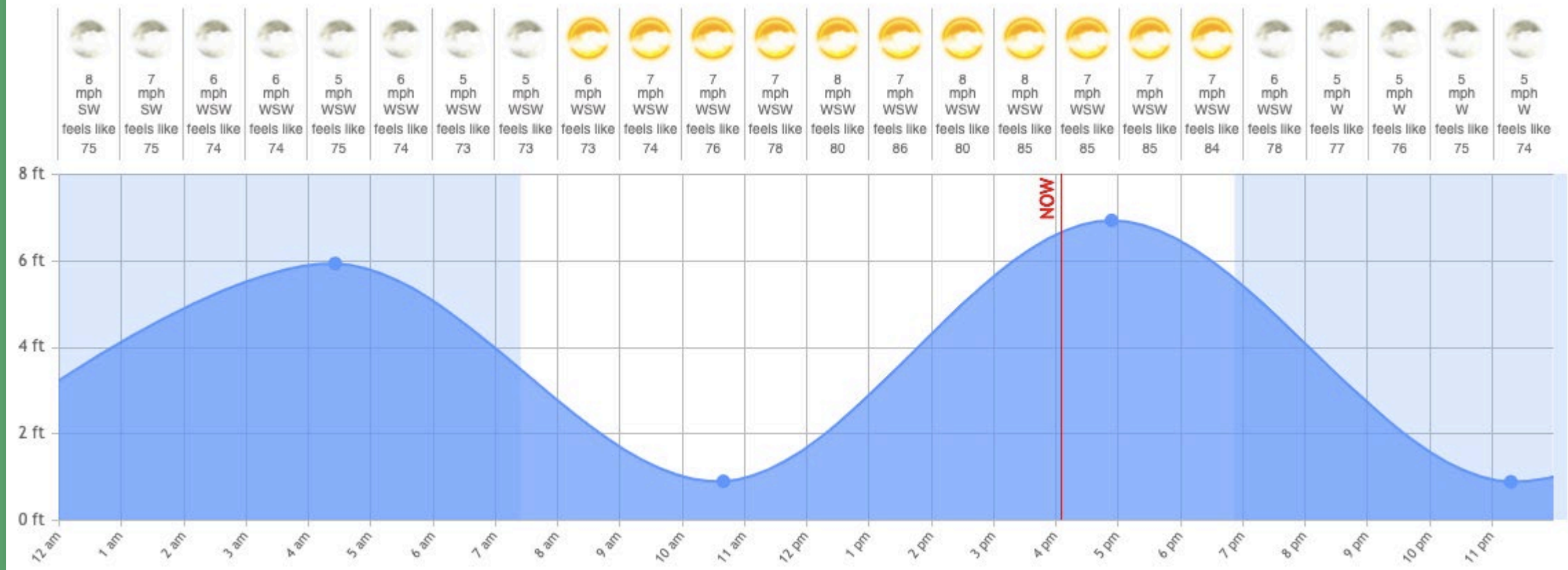


Melancholic – decreased sleep, decreased appetite, diurnal variation



Diurnal Variation

Date: **Monday, Oct 12th**



Joy Returns Last

Joy Returns Last: Anhedonia and Treatment Resistance in Depressed Adolescents

David H. Rubin, M.D.

This month's issue of the *Journal* features a study by McMakin et al.¹ that examines the impact of anhedonia on the rates of recovery for adolescents with treatment-resistant depression.¹ Based on data collected in the Treatment of Selective Serotonin Reuptake Inhibitor-Resistant Depression in Adolescents (TORDIA) study,^{2,3} the article establishes that anhedonia uniquely predicts a more protracted course of depression and emphasizes the importance of anhedonia for diagnosis and prognosis. Thanks to landmark studies such as the Treatment for Adolescents with Depression Study (TADS)⁴ and TORDIA, cognitive behavioral therapy and pharmacotherapy in concert are widely accepted as the evidence-based treatment of choice for depression in adolescents. However, anhedonia, a key symptom in major depression, presages a poorer outcome even in the face of well-delivered, empirically based treatments.

McMakin et al. establish anhedonia as an important predictor of outcome by examining data collected in the original TORDIA study; a randomized controlled trial of adolescents ($N = 334$) refractory to initial selective serotonin reuptake inhibitor treatment. Enrolled youth were subsequently randomized to a new selective serotonin reuptake inhibitor or venlafaxine, with or without cognitive-behavioral therapy, and followed for 24 weeks. Depression severity was assessed using the Childhood Depression Rating Scale-Revised. McMakin et al.¹ analyzed the ability of five dimensions of that scale—reported depressed mood, anhedonia, somatic symptoms, morbid thoughts, and observed depression—to predict the time of remission and depression-free days over the following 6 months. Only one dimension, anhedonia, was able to predict a longer and more severe course of depression.

Anhedonia is uniquely impairing in teen depression and has implications for clinical care.

The *DSM-IV* describes anhedonia as “not feeling any enjoyment in activities that were previously considered pleasurable.” Anhedonia nullifies intrinsic motivation and then deprives the affected individual of reinforcement from appetitive behavior. Processes central to life—sleeping, eating, and libidinal drives—and higher-order behaviors such as engagement in leisure time activities and work lose their luster and import.

Advances in neurobiology have shown, in the most oversimplified sense, that anhedonia is a function of decreased activation in the ventral striatum,⁵ which contains the dopaminergic mesolimbic structures that mediate the conversion of emotional motivation into the motor behaviors of action. “Top-down” processes, such as cognitions of futility, and “bottom-up” processes, such as inflammatory and hormonal changes, work together to create the broad impact of anhedonia on living. The net result of these interwoven processes is a severe, protracted lack of reactivity to routine pleasurable experiences from which no behavior is immune. Anhedonia in this context is a hallmark symptom of depression and perhaps a “super-symptom.”

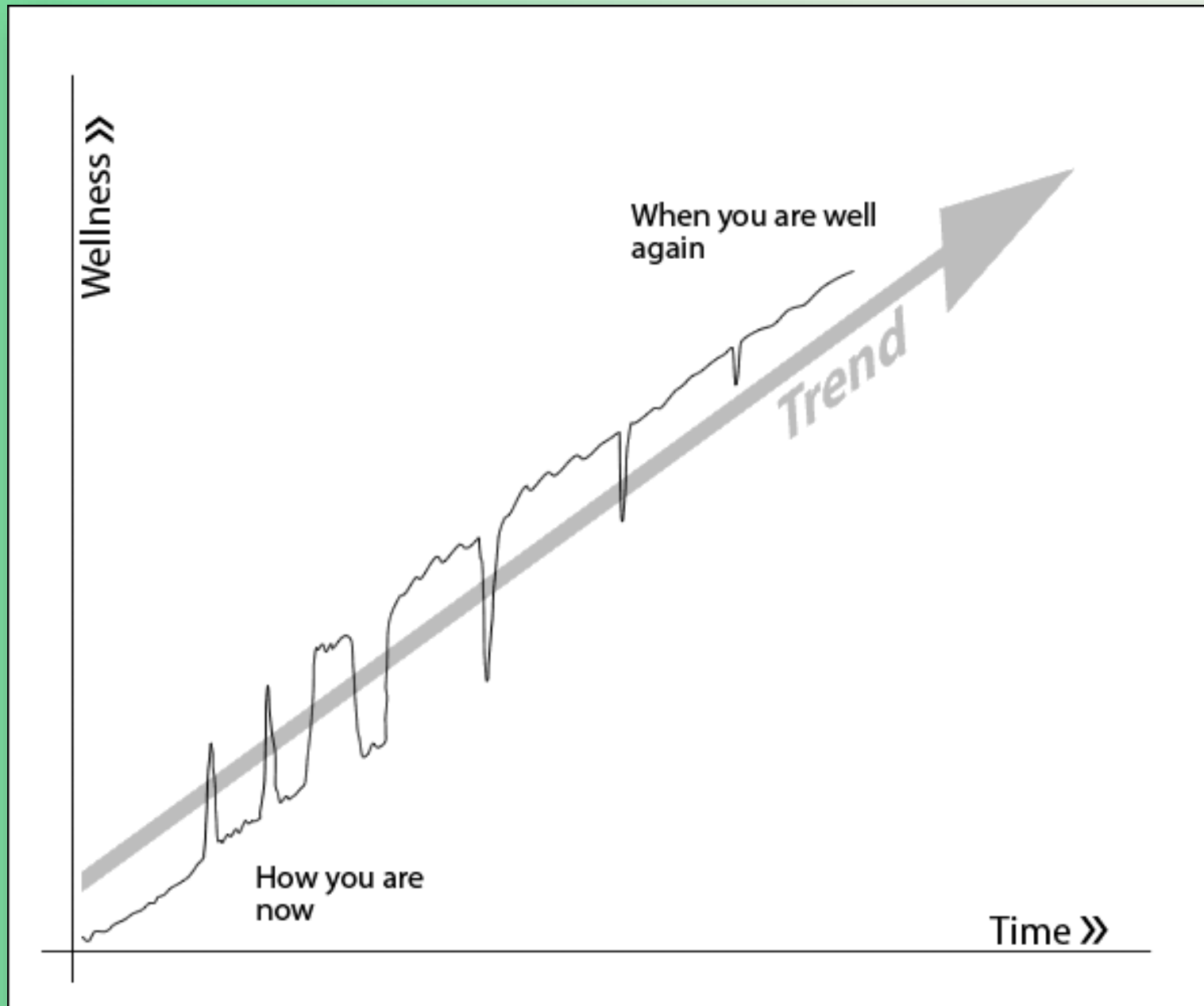
The added burden of anhedonia across symptom domains translates into a greater lack of responsiveness to current evidence-based treatments. In this light, anhedonia can be considered a special multiplier of severity. As with the presence of suicidality, psychosis, or inability to function, anhedonia precludes a conceptualization of depression as mild to moderate; its presence should compel the designation of a depression as severe. Single-modality treatment, justifiable in only mild to moderate cases of depression by the current evidence base, probably has no place in the treatment of the anhedonic individual.

The patients in TORDIA² had an overall greater chronicity of symptoms compared with those in



BRIDGES TO MENTAL HEALTH

Two steps
forward,
one step back



Rethink start low, go slow



Patient last to know depressed, last to know recovery

