

Treating Adolescent Depression In Your Office

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1. Diagnose depression In adolescence
2. A practical approach to office-based management
3. Treatment options

- 80% of adolescents do fine 😊
- Prevalence of MDD (age 12-17): 7.1- 13 % ^{1,2}
- Studies are few, but many trends similar to adults

1. Persistent (>2 weeks)
2. Significant distress and/or interference with daily life.
Plus 5 of 9 (must have symptom #1 and/or #2 below):

1. **Depressed mood or irritability**
2. **Loss of interest or pleasure**
3. Impaired concentration/decision making
4. Guilt/worthlessness
5. Thoughts of death or suicide
6. Sleep impairment
7. Appetite/weight change
8. Low energy
9. Psychomotor changes

NB: May be subjective or observed by others

- Family history
- Prior psychiatric history
- Substance Abuse
- Family, peer, academic problems
- Chronic illness
- **Negative style of interpreting events or coping with stress**

- Depressed mood: **IRRITABILITY:**
 - “annoyed”
 - “bothered”
 - picking fights (especially if with friends)
- Loss of interest:
 - “boring”
 - “stupid”
- Behavioral attempts to improve mood
 - substance abuse, promiscuity, thrill-seeking
- **Collaborative history** (parents, school)

- 40-70 % Co-morbidity!³⁻⁵
 - Substance abuse (or etiology!)
 - Anxiety disorder
 - Disruptive behaviour disorders (ADHD, ODD, CD)

- Distinguishing from normal developmental stages



Screen For Bipolar

Divert negative trajectory

1. Psychosocial
2. Pharmacologic
3. Combination

- Social support⁷
- Psychoeducation^{7,8}
- Problem Solving (Solution focused therapy)
- CBT⁹⁻¹¹
- IPT¹²⁻¹⁴
- Mindfulness

...How to Choose???

- The best predictor of effective therapy: the quality of trust and respect in the relationship between patient and therapist
- There is no need to have a defined psychotherapeutic modality
- In fact, why not benefit from multiple modalities?

After all...

Your adolescent patient is
unique
You as a therapist are unique...

The Therapeutic Journey will be Unique!

And hopefully fun, gratifying, and never boring...

Session 1:

1. PHQ-9 modified for teens* (baseline score)
2. Ground rules of confidentiality
3. Define realistic specific goals
4. Psychoeducation (assume nothing!)
5. Message of optimism
6. Next appointment date and time (avoid school hours, avoid valued extracurriculars)

* See appendix

1. PHQ-9 monitoring
2. Session 1 reflections
3. Today's goal (specific event if possible, PHQ-9 clues?)
4. Psychoeducation and problem-solving
5. Embed CBT and IPT and mindfulness
6. What has **changed** for you?
 - A perception?
 - A new behaviour to try?
7. Brainstorm a way to enact **change** (“homework” or “change plan”). Write it down.
8. Invite parent into room
9. Message of optimism
10. Next appointment date and time

1. PHQ-9 monitoring
2. Session 1 and 2 reflections and reveal links, threads
3. Today's goal
4. Psychoeducation and problem-solving
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■ Talking tips:

- Patient-centered semantics (no jargon)
- Be interested/curious/fascinated
- Conversational flow (“artful” history-taking)
- Understandable language for cognitive distortions
 - “assumption” (covers many cognitive distortions)
 - “mindreading” (practice within the encounter!)
 - “thought trap

■ Respect:

- Request permission when entering new territory (establishes trust and security) and check in frequently
- Beware assumptions (e.g. sexual orientation)
- Overtly express patient's situation as "challenging"
- Write detailed notes and review regularly **prior** to each visit (demonstrates your attentiveness and recognition of the adolescent as a unique individual)
- Humility (don't be an expert on someone else's life)...but do convey confidence when needed
- It's OK to share your own experiences/anecdotes
- Normalize, but without ever losing focus on uniqueness of the patient in front of you.

■ Structure:

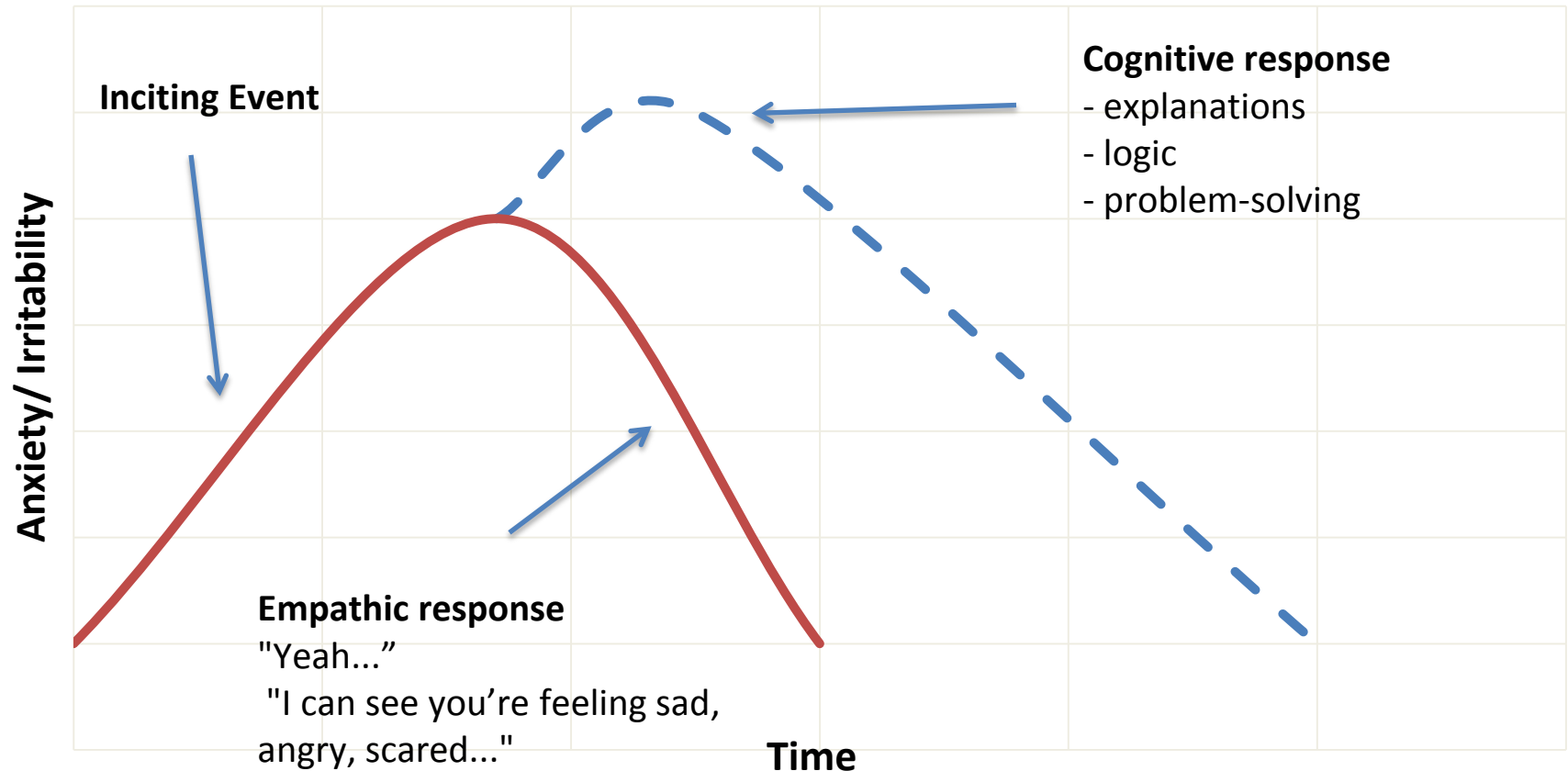
- CBT/IPT mood and behavior diaries
 - Only when ready
 - “Custom-made”(recognizes patient’s individuality)
- Clear short-term goals vs “parking lots”
- Write notes that adolescent can keep
- The session is a microcosm of the real world
 - Point out behaviors **that arise in the session** that challenge adolescent’s perceptions (e.g.“catch” him or her being kind, considerate, intelligent)
 - Adolescent can practice new behaviors with you
 - **“This room is the real world”**

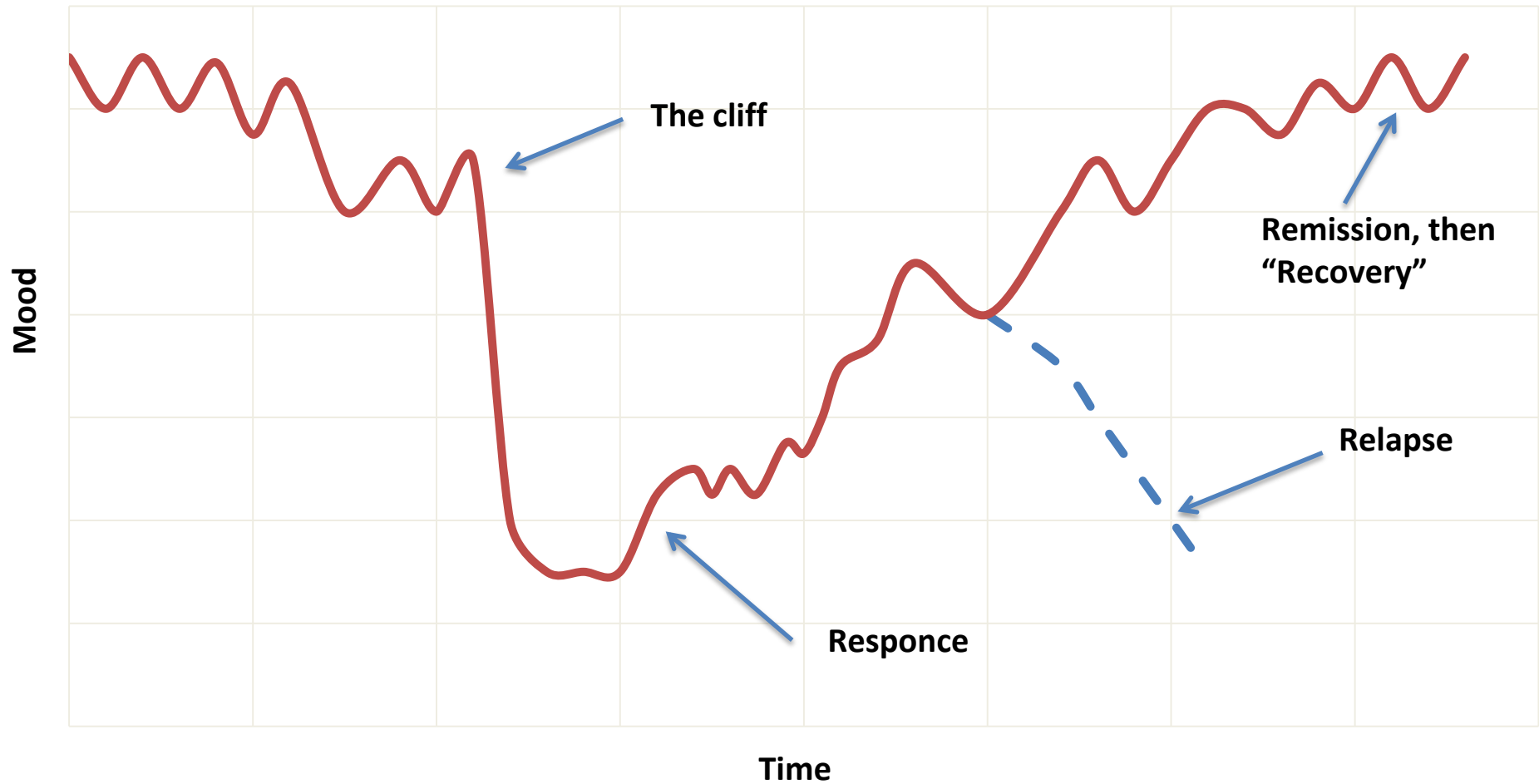
■ **Improvise:**

- “Mottos” that are easy to remember:
 - “Perfect is the enemy of good”
- Incorporate healthier cognitions into daily practice:
 - Why do we say to children “so long as you try your best?”
- Ideas from websites
- Visual aids (graphs, charts, images)

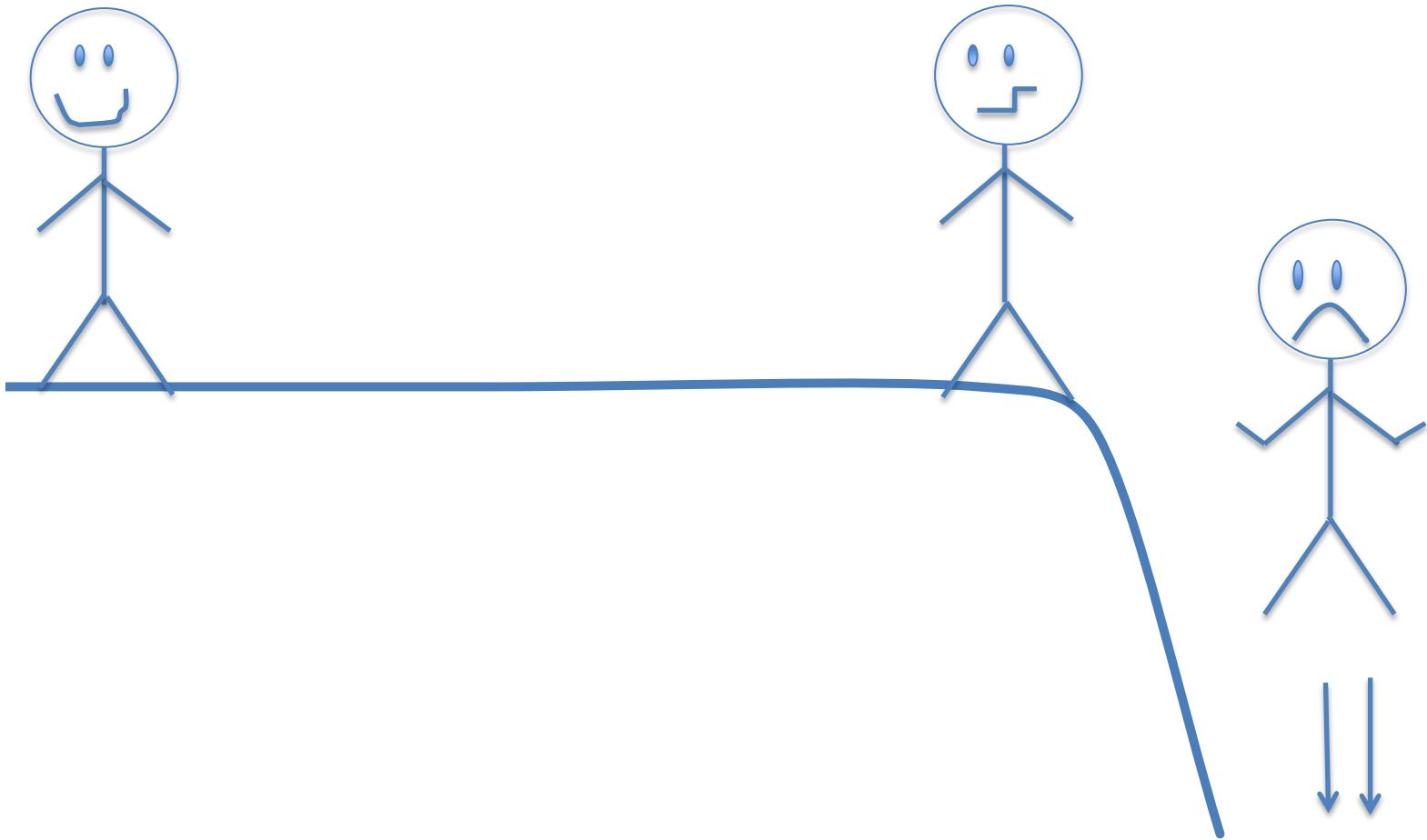
- Empathic Response Curve
- 5 Rs (Response, Relapse, Remission, Recovery, Recurrence) Graph
- Staying Clear of The Cliff image

Empathic Response Curve





Staying Clear of The Cliff



1. Direct inquiry: “Have you had thoughts about suicide or harming yourself ?”
2. Progression of inquiry:
 - Do you feel that things won’t improve?
 - Do you feel trapped?
 - Does it feel hopeless?
 - Do you think family/friends would be better off if you were gone?
 - Have you ever tried to harm yourself, like cutting?
 - Have you had thoughts of hurting or killing yourself?

- Detailed history (5 Ws).
- Lethality (perceived and actual).
- **Intent (“what’s stopping you?”).**
- Access.
- Additional risk factors:
 - Mental illness
 - Impulsiveness/recklessness
 - Substance use and access
 - Extreme withdrawal or anger
 - Exposure to abuse, violence, suicidal friends

Safe or not ? :

1. Would you reach out?
2. How?
3. Is that support readily available?

**Assessing intent to reach out is as important as
assessing intent to harm**

Prescribing antidepressants for a 14 year old?...

1999 NIMH funded, 327 adolescents aged 12-17 with MDD

4 groups:

At 12 weeks:

1. Fluoxetine + CBT: 71%
2. Fluoxetine alone: 61%
3. CBT alone: 43%
4. Placebo alone: 35%

At 36 weeks:

- 86%
- 81%
- 81%
-

Risk of suicide related events (over 36 weeks):

- Fluoxetine: 14.7%
- Combination: 8.4%
- CBT: 6.3%

1. Combination therapy appears to be superior
2. Fluoxetine monotherapy is an option for moderate to severe depression if CBT not readily available.
3. CBT appears to be protective against medication-emergent suicidal events

- **Moderate to severe population (more ill)**
- Combination therapy was **not** more effective than fluoxetine alone
- CBT did **not** appear to be protective for suicidality
- Similar to more severe subgroup of TADS
- **Conclusion: Fluoxetine monotherapy should be considered if CBT treatment delayed**

In determining treatment direction, we need to distinguish 2 “types” of “depression”(not 3):

1. Mild
2. Moderate to severe

So...what is “mild” depression?

.....depends on who you ask

PHQ-9 Depression Questionnaire

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total ____ =	_____	+ _____	+ _____	+ _____

PHQ-9 Score ≥ 10 : Likely major depression.

Depression score ranges:

5 to 9: mild

10 to 14: moderate

15 to 19: moderately severe

≥ 20 : severe

- Were PHQ Scores used in studies for classifying depression? (not what the PHQ was designed for)
- A score that might be classified as “mild depression” is unlikely to be true MDD
- A score that might be classified as “moderate depression” may or may not be true MDD
- So, what is the validity for an intervention that has been shown to be effective for “mild to moderate depression” if defined by a PHQ score?

- How did they choose to define mild, moderate, severe?
- How was “improvement” defined?
- Who is the author?
- Which journal published it?
- Who sponsored it?
- Good luck!...

BMJ 2013;347:f5585:

Review from the Cochrane Library
(35 trials, 1356 patients)

- Trials considered high quality: “effect of exercise was small and not statistically significant”

National Institute of Mental Health (JAMA 2010;303(1):47-53:

Meta-analysis of 6 trials (718 patients):

- HAM-D ≤ 18 : NNT 16
- HAM-D 19-22: NNT 11
- HAM-D ≥ 23 : NNT 4
- **BENEFIT PROPORTIONAL TO SEVERITY**

- 2004 FDA: SSRIs have been associated with increased risk of suicidal ideation and behavior
- Multiple studies since then have shown:
 1. RR 2.0 (tends to occur in initial weeks?)
 2. No documented completed suicides
 3. No cause and effect link made
 4. Depression itself is the highest risk for suicide
- And, for 2 years after the warning was published:
 1. Decreased incidence of depression diagnosis (access of care implications)
 2. Decreased use of antidepressants
 3. Increased incidence of suicide
- **Don't withhold treatment...inform, document, monitor.**

“Collaborative individualization”

Pivotal considerations:

1. Strong family history (looking for biological vulnerability clues)
2. Don't mess around with moderate to severe depression (true MDD)
3. Cognizant of importance of getting the adolescent back on his or her feet ASAP

- No SSRI is approved by Health Canada for under the age of 18
- FDA has approved fluoxetine age 8 and above
- FDA has approved escitalopram age 12 and above
- Fluoxetine has the largest database
- Fluoxetine has the longest half life
- In the absence of considerations such as family history, my first choice is usually fluoxetine, starting low (5-10mg) going slow

Table 2: SSRI dosing and adverse effects

	Medication	Starting Dose*	Increments	Effective Dose	Maximum Dosage	Not to be used with	Common Adverse Effects	RCT Evidence for Efficacy
First Line	Fluoxetine	10 mg /od	10-20 mg	20 mg	60 mg	MAOI's***	Headaches, GI upset, insomnia, agitation, anxiety	Y**
Second Line	Escitalopram (first-line: 12 and older)	5 mg /od	5 mg	10-20 mg	20 mg	MAOI's	Headaches, GI upset, insomnia	Y**
	Citalopram	10 mg /od	10 mg	20 mg	60 mg	MAOI's	Headaches, GI upset, insomnia	Y
	Sertraline	25 mg /od	12.5-25 mg	100 mg	200 mg	MAOI's	Headaches, GI upset, insomnia	Y

*Younger adolescents should be started on lower doses

** FDA approved

*** MAOI, monoamine oxidase inhibitor

†Results from 3 trials considered to be negative by FDA

- ☐ FDA approval for adolescents
- Success of prior medication trials
- Family history of successful medication treatment
- SSRI half-life
- ☐ Interactions with other medications
- ☐ Side effect profiles
- Patient preference

1. Start slow
2. Side effects first, therapeutic effects later ☹️
3. Side effects often taper
4. Full therapeutic effect of a dose at 4-8 weeks
5. Generally, do not increase dose sooner than 4 weeks
6. Switch to another SSRI if no response after 4 weeks at maximum dose or if excessive side effects
7. If partial response on 1st or 2nd SSRI, consider medication augmentation (consult psychiatrist)
8. If no response after 2nd SSRI consult psychiatrist

9. Frequent reconsideration of diagnosis

- Bipolar disorder?
- Substance abuse?
- Overwhelming psychosocial circumstances or abuse?
- Dysthymia?

10. Treat to full remission

11. Then another 6-12 months

12. “Kindling” effect (goal is to get to full remission, as soon as possible)

A physician's duty of care ? ...

Given that sound decision-making can be challenged by depression, how can the ethical physician abstain from giving non-ambivalent treatment advice?

Do we hide behind “First do no harm” to avoid the risk of giving our patients medication that may get blamed for an adverse outcome?

Inadvertent collusion with stigmatization?

Would physicians question the logic of providing thyroid replacement?...physicians generally assume that the risk of the chemical imbalance outweighs the risk of correcting the imbalance. What's the difference for neurochemistry?

Helping patients give themselves permission:

- It is a **trial**
- We could re-visit the decision after seeing what the effect of medication is
- Decision is not “forever”
- “But what if it really helps and I can’t come off the medication?..”
- Offer to make a parallel with ANY other health condition (etiology and treatment)
- ?Harmful neurobiological substrates of the Illness^{21,22}
- Concept of “borrowed confidence”
- How many patients have ever looked back and said “I wish I had never tried that medication”?

Every condition we see has social, psychological,
and biological contributors

Being holistic is about not excluding the “bio” in
biopsychosocial

Family physicians CAN treat adolescent
depression

We have the RELATIONSHIP

We have the SKILLS



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Appendix: PHQ-9: Modified for Teens

Name: _____ Clinician: _____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an “X” in the box beneath the answer that best describes how you have been feeling.

	⁽⁰⁾ Not At All	⁽¹⁾ Several Days	⁽²⁾ More Than Half the Days	⁽³⁾ Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				

Appendix: PHQ-9:Modified for Teens

8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
☐ Yes ☐ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you EVER , in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? <input type="checkbox"/> Yes <input type="checkbox"/> No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Scoring the PHQ-9 modified for Teens

Scoring the PHQ-9 modified for teens is easy but involves thinking about several different aspects of depression.

To use the PHQ-9 as a diagnostic aid for Major Depressive Disorder:

- Questions 1 and/or 2 need to be endorsed as a "2" or "3"
- Need five or more positive symptoms (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9).
- The functional impairment question (How difficult....) needs to be rated at least as "somewhat difficult."

To use the PHQ-9 to screen for all types of depression or other mental illness:

- All positive answers (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9) should be followed up by interview.
- A total PHQ-9 score ≥ 10 (see below for instructions on how to obtain a total score) has a good sensitivity and specificity for MDD.

To use the PHQ-9 to aid in the diagnosis of dysthymia:

- The dysthymia question (In the past year...) should be endorsed as "yes."

To use the PHQ-9 to screen for suicide risk:

- All positive answers to question 9 as well as the two additional suicide items **MUST** be followed up by a clinical interview.

To use the PHQ-9 to obtain a total score and assess depressive severity:

- Add up the numbers endorsed for questions 1-9 and obtain a total score.
- See Table below:

Total Score	Depression Severity
0-4	No or Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression