Family Docs Treating Adolescent Depression?
YES WE CAN

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Faculty/Presenter Disclosure

- **Faculty/Presenter: Dr. Sanjeev Bhatla**

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Objectives

- Define depression In adolescence
- Review treatment options
- To encourage family physicians to trust their ability to assess and treat adolescent depression

K.I.S.S.

- Diagnostic criteria SAME
- Risk factors “SAME”
- Treatment options “SAME”

Epidemiology

- 80% of adolescents do fine ☺
- Prevalence of MDD[1,2]
  - Age 3-5: 0.6%
  - Age 6-11: 2.3%
  - Age 12-17: 7.1-13% (female:male 2:1)
- 40-70% co-morbid psychiatric diagnosis[3-5]

40-70 % Co-morbidity!

1. Substance abuse (or etiology!)
2. Anxiety disorder
3. Disruptive behaviour disorders (ADHD,ODD,CD)

Risk factors[1]

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

Diagnostic Criteria

1. Persistent (>2 weeks)
2. Significant distress and/or interference with daily life.

Plus 5 of 9:

1. Depressed mood or irritability
2. Decreased interest
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

Clues in adolescents:

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

Don’t Forget:

- **Carefully screen for bipolar!**
- Drugs/marijuana (as etiology or co-morbidity)
- Collaborative history
- Mood reactivity: Can be cheered up by positive experiences
  - Don’t get falsely reassured
- Suicide assessment (including exposure to suicide)

Diagnostic Conundrum

- Developmental issues
- Definitional issues
- Overlapping diagnoses
- Multiple diagnoses
- Mental health diagnoses are continuous, not categorical, fluid, not static…
- **…Argh !!!**

...And yet timely diagnosis is key:

Importance of early Treatment

- **Divert negative trajectory**
- High rate of recurrence[6]
  - 40% recurrence over 2 years
  - 70% recurrence over 5 years
- More vulnerable neural circuitry ?

Treatment

- Psychosocial
- Pharmacologic
- Combination

Psychosocial

- Social support[7]
- Psychoeducation[7,8]
- CBT[9-11]
- IPT[12-14]
- Mindfulness

…How to Choose???

How to Choose?

- The best predictor of effective therapy lies in the quality of trust and respect in the relationship between patient and therapist
- Family physicians have this fundamental part of the relationship already established
- Don't fret over categorizing your "mode" of therapy (indeed, why restrict yourself?)

Integrating Therapies… A Generalist's "Specialty"

1. Basic **psychoeducation** can go a long way
2. Immerse sessions in **empathetic supportive therapy**
3. **CBT** and **IPT** embedded
4. **Role model mindfulness** (share reflections)

Getting Started:

1. HOPE and OPTIMISM
2. Ground rules of confidentiality
3. Overtly express commitment as “therapist” and set aside dedicated time
4. Collaboration (family, psychologist, school)
5. INDIVIDUALIZE (and adjust as needed)

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

The therapeutic journey will be unique…

…fun, gratifying, and never boring!

Toolkit

- **Talking tips:**
  - No jargon!
  - Patient-centered semantics
  - 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"

Toolkit Cont'd

- **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/anecdote
  - Normalize, but without ever losing focus on uniqueness of the patient in front of you.

Toolkit cont'd

- **Structure:**
  - CBT/IPT mood and behavior diaries
    - Only when ready
    - "Custom-made"(underlines 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 ("catch" him or her being kind, considerate, intelligent)
    - Adolescent can practice new behaviors with you
    - **"This room is the real world"**

Toolkit cont'd

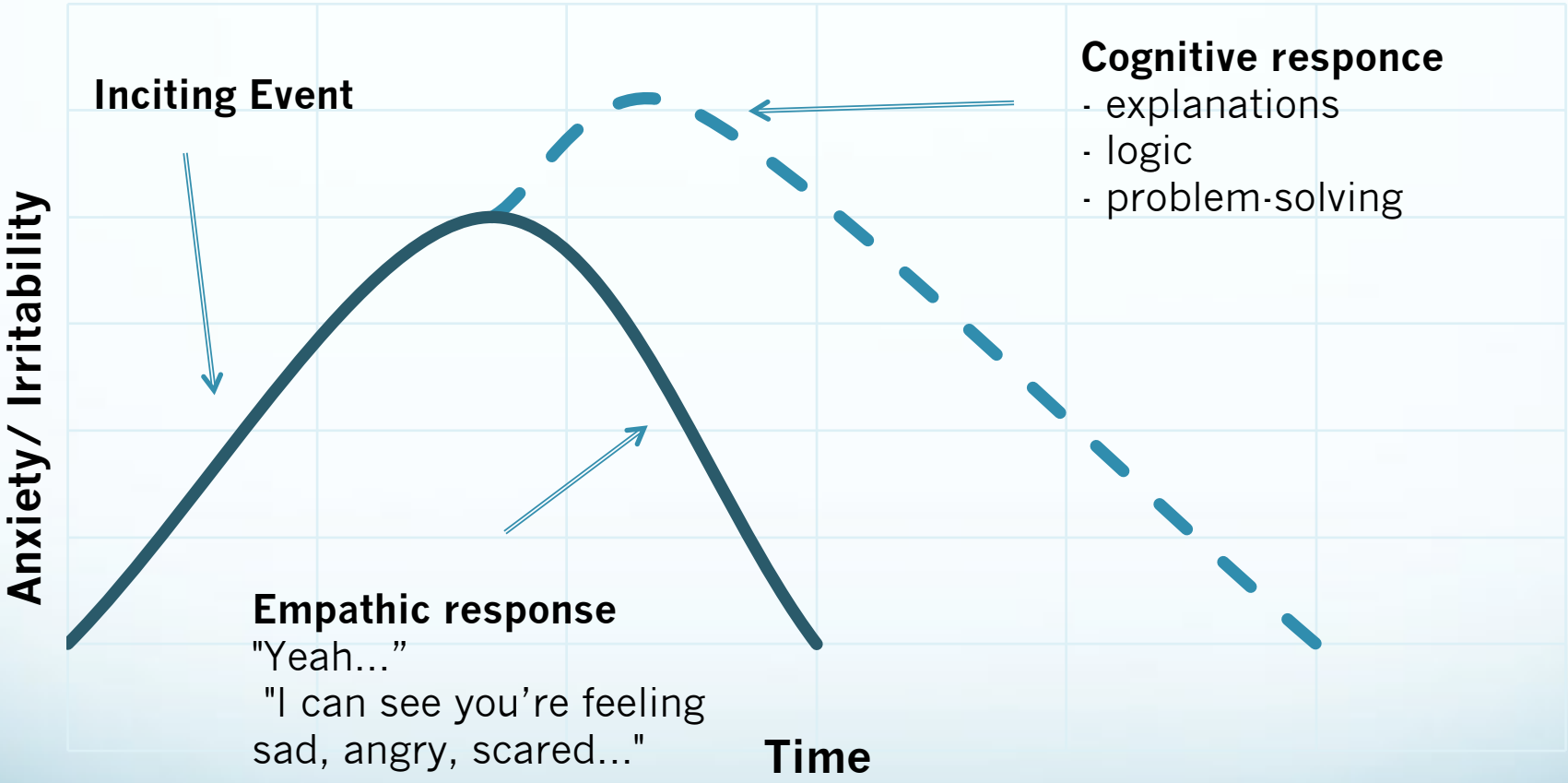
- **Improvise:**

- "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)

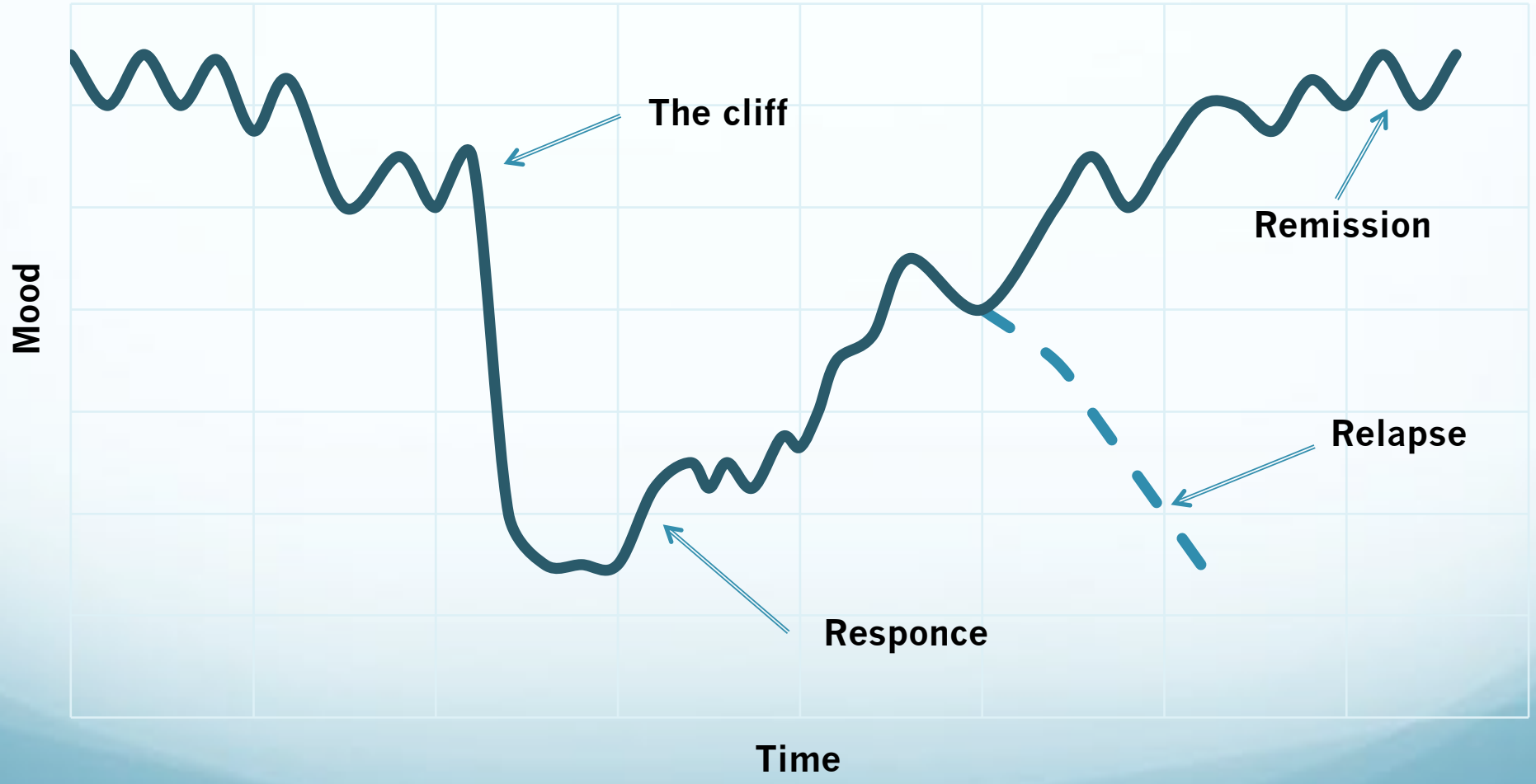
Visual Aids

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

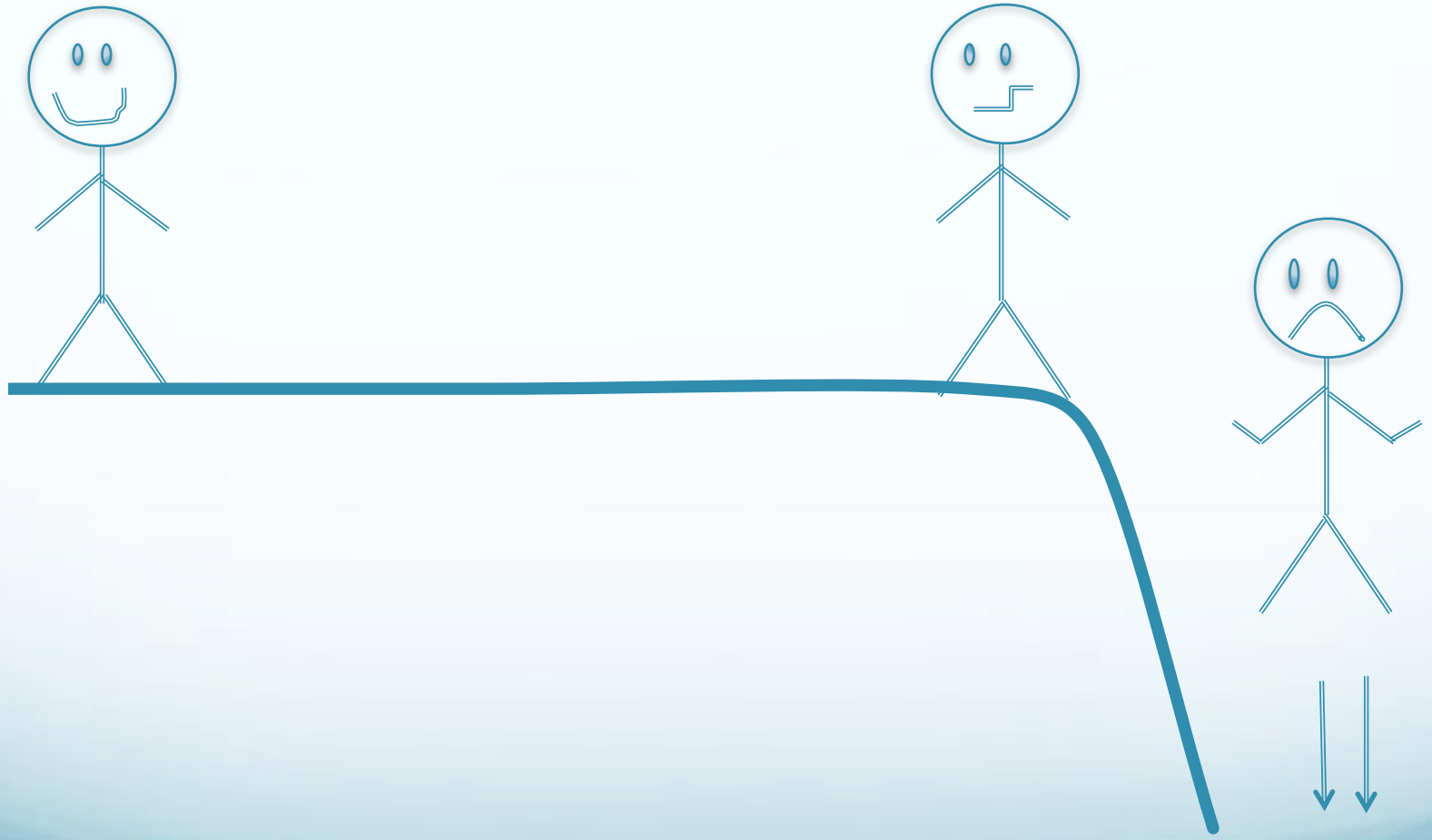
Empathetic Response Graph



5 Rs Graph



Staying Clear of The Cliff



Talking about suicide

1. Direct inquiry: “Have you had thoughts about suicide?”
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?

Talking about suicide cont'd

- 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

Talking about suicide cont'd

Safe or not ? :

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

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

Planning for the next Session

- Choose a date and time (book it for your patient)
- Avoid time away from school
- Avoid interfering with athletics/music/arts
- But DO set a firm date

Pharmacology

OK, I can do that…but prescribing antidepressants for a 14 year old?…

… we do have studies ☺ …

T.A.D.S[15,16]

(Treatment of Adolescent Depression Study)

- 4 groups
  - At 12 weeks:
    1. Fluoxetine + CBT: 71%
    2. Fluoxetine alone: 61%
    3. CBT alone: 43%
    4. Placebo alone: 35%
  - At 36 weeks: 3 treatment groups converged: > 80%

What about suicidality? (TADS)

Risk of suicide related events:

- Fluoxetine: 9%
- Combination: 5%
- CBT: 3%

Conclusions (TADS)

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

A.D.A.P.T.[17]

(Adolescent Depression and Psychotherapy Trial)

- **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**

Practice point

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

PHQ-9 Details

- 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” defined by a PHQ score?

Study design “bias”!

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

Severity is key

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**

What About Exercise?

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”

What about SSRIs and Suicide?[18,19]

- 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.**

When will I recommend an SSRI?

- Collaborative individualization (say what?!)
- Strong consideration of family history (looking for biological vulnerability clues)
- Don't mess around with moderate to severe depression
- Cognizant of importance of getting the adolescent back on his or her feet ASAP

Which SSRI? What dose?

- 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 fluoxetine, starting low (5-10mg), going slow

Medication Perspectives

- 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)

Medication Perspectives cont'd

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

Medication Perspectives cont'd

- 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?
- Concept of "borrowed confidence"
- How many patients have ever looked back and said "I wish I had never tried that medication"?

The Big Picture

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

Being holistic is about not excluding the biological in biopsychosocial

Take the Leap ☺

- Do you have help?
  - Shared mental health care?
  - Medical home MDT team?
  - Supportive corridor colleagues and/or telephone consultants?
- Remember, as a family physician, you are probably the doc an adolescent finds easiest to talk to....

Objectives Re-Visited

- Define depression In adolescence
- Review treatment options
- To encourage family physicians to trust their ability to assess and treat adolescent depression

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