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ADOLESCENT DEPRESSION

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CHILDREN'S TIPS

Website <http://www.chp.edu/health-care-professionals/referring-physicians/childrens-tips>

2 GOALS & OBJECTIVES

- Identification of Depression
 - Use of screening tools
- How to use Children's TiPS
- Depression Interventions in Primary Care
 - Non-pharmacologic treatment
 - Pharmacologic treatment

- FUTURE TRAINING OPPORTUNITIES
 - AAP Webinars
 - Pittsburgh March 23, 2018

DEPRESSION

"I'm fine."

Feeling
I'm
Nothing
to **E**veryone



DEPRESSION: INCIDENCE/PREVALENCE

- In 2015, **30%** of H.S. students reported feeling sad or hopeless in the previous 12 months (CDC, 2016)
- **20%** of teens will become clinically depressed prior to adulthood
- 2% of children and 4-8% of teens are depressed at any one time (AACAP, 2007)
- Female to male ratio is 1:1 for children and 2:1 for adolescents
- Point prevalence for adolescents with depression being seen in primary care is up to 28% (GLAD-PC:II, 2007)

DEPRESSION: RISK FACTORS

- **Family history** of depression, mood disorders
- **Personal history** of depression
- Other **psychiatric disorders** (anxiety, externalizing disorders)
- **Substance use**
- **Trauma**
- Psychosocial adversity
- Chief complaint of emotional problem
- Medical/Chronic Illness
(AACAP, 2007)

DEPRESSION: DURATION AND RECURRENCE

- A teen depressive episode usually lasts **8+ months**
- 20-60% recurrence 1-2 years after remission
- 70% recurrence after 5 years
- Recurrence can persist throughout life

(AACAP, 2007)



DEPRESSION: COMORBIDITY

- Depressed teens have higher rates of:
 - **Risky sexual behavior**
 - **Physical illness and complaints**
- Depressed teens have lower rates of:
 - **Satisfaction in relationships**
 - **Attending higher education**
- Up to **50%** have 2 or more **co-morbid** psychiatric diagnoses (anxiety, dysthymia, substance use disorders, ADHD, disruptive disorders) (AACAP, 2007)



DEPRESSION & SUICIDE

- Untreated depression is the **number one** cause of suicide
- Over **90%** of children and teens who complete suicide have a **mental health diagnosis** (Mental Health: A Report of the Surgeon General)
- In 2015, H.S. students (CDC, 2016)
 - reported seriously contemplating suicide
 - **18%**
 - attempted at least once (in the preceding 12 months)
 - **9%**
- Suicide is the **#2** cause of death in the U.S. in those 10-24 years-old (NCHS)

DEPRESSION: A RANGE OF DISORDERS

- Major Depressive Disorder\
- Persistent Depressive Disorder (Previously: Dysthymia)
- Other Specified Depressive Disorder
- Adjustment Disorder
- Disruptive Mood Dysregulation Disorder
- Bipolar Disorder



DEPRESSION: ASSESSMENT WITH SIG-E-CAPS

- **Depressed and/or irritable mood PLUS....**
- Sleep problems
- Interest deficit (anhedonia)
- **Guilt** (worthlessness, hopelessness, regret)
- Energy deficit
- Concentration deficit
- **Appetite changes**
- **Psychomotor agitation or retardation**
- **Suicidality**



DEPRESSION: DEVELOPMENTAL ISSUES

Pre-pubertal Children

- Increased somatic complaints
- Psychomotor agitation
- Mood-congruent hallucinations
- School refusal
- Phobias, separation anxiety, increased worry

Adolescents

- Irritability
- Apathy: "I don't care" attitude
- Low self esteem
- Aggression / antisocial behavior
- Substance abuse
- Can give a reliable and detailed history

BIPOLAR DISORDER

- Expansive **mood**, tantrums that we could not replicate in terms of **energy** and duration. Behaviors not specific to home.
- Appear and feel energetic and overly confident, feel special, risk taker
- Talk rapidly, loudly, racing thoughts
- Increased goal-directed activity. Work / activities completed creatively, but disorganized
- Sexually preoccupied, uninhibited
- Decreased need for sleep
- A Change!!!!

DSM 5 CRITERIA: BIPOLAR DISORDER

- DSM 5 criteria:
 - Elevated mood + 3
 - Irritable mood + 4
 - Mania: 1 week
 - Hypomania: 4 days

- Distractibility
- Irresponsible behaviors, Inhibition is decreased
- Grandiosity (increased pleasurable activities)

- Flight of ideas
- Agitation or increased goal directed **A**ctivity
- **S**leep
- Talkative (increased)



DIFFERENTIAL DIAGNOSIS

- **Bipolar Disorder**
- **Drug and Alcohol Abuse:** Depressive symptoms occur in context of use
- **ADHD:** May occur co-morbidly with depression. Note specifics of low self esteem, concentration, amotivation
- **Adjustment Disorder:** If meets criteria for depression, diagnose it
- **Persistent depressive disorder:** May occur co-morbidly with depression (rare diagnosis)

ADDITIONAL DIFFERENTIAL DIAGNOSIS TO CONSIDER...

- **Thyroid:** check growth and development, family history, low threshold
- **Anemia** (complaints of fatigue, irritability, diet concerns): check CBC
- **CMP:** general work-up
- **Obstructive Sleep Apnea:** noted abnormal snoring
- **Adverse medication reaction:** prescribed and non-prescribed

RESPONSIBILITIES OF PRIMARY CARE PROVIDER



- **Identify and screen those at risk**
- **Evaluation for depression, basic differential diagnosis, co-morbid disorders**
- **Use behavioral screens**
- Perform risk assessment, complete a safety plan
- Perform psycho-educational , supportive counseling
- **Refer as needed**
- Establish responsibilities/roles of the provider, patient, family
- Schedule follow-up appointment and goals

PHQ-9

- **Wide spread testing** in primary care
- Self-report forms
- Exclusive for **depression**
- **5 minutes** to complete, seconds to score
- **Public** availability
- Accepted as a **gold standard** for depression screening
- Significant score is **11** or greater(15 increases specificity)
 - Always note questions about lethality!

	(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?				
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?

Yes No

Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt?

Yes No

- Probability of Detecting Major Depressive Disorder(MDD)
 - Sensitivity of 74%
 - Specificity of 75%
- Probability of Detecting MDD detected by PHQ-9
 - Sensitivity – 96%
 - Specificity – 82%
- Correlates with higher functional impairment, and higher parent-reported internalizing problems

- Downside –
 - You will miss some children with suicidality
 - Not useful for following response to treatment
- One approach
 - Screen all adolescents with PHQ 2 – and
 - Do the entire PHQ9 for all who screen positive

TREATMENT

CLINICAL PEARLS FOR ASSESSMENT

- Establish basic rules from the beginning: confidentiality and when confidentiality must be broken
- Interview with parents and alone
- Emphasize with patient that there are no wrong answers
- How long have you felt this way? When do you remember being happy/being yourself?
- Beware of assumptions
- Don't tell them they have a reason to be happy(or want to live)
- Don't lead them to the answer you want to hear

BEHAVIORAL SCALES

- Screening tools are *not diagnostic*
- Provide *talking points*
- Can be used to follow response to intervention

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OLIVIA

- A healthy 12 year old comes in for her well-child check. She has no history of behavioral health concerns, is cis-gender, attracted to boys. She has male and female friends who she hangs out with and texts. She is an athlete, an A student, and has no dating or sexual history. Mom wonders whether she has “hit puberty” or there is “something else going on” because she comes in the house and doesn’t talk to her.

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12 YEAR OLD FEMALE PHQ-2

	0	1	2	3
	Not at all	Severa l Days	More Than ½ the Days	Nearly Every Day
Feeling depressed?	xx			
Little interest or pleasure in doing things				xx

Total = 3

Total = 13

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	⁽⁰⁾ Not At All	⁽¹⁾ Several Days	⁽²⁾ More Than Half the Days	⁽³⁾ Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?			<input checked="" type="radio"/>	
2. Little interest or pleasure in doing things?				<input checked="" type="radio"/>
3. Trouble falling asleep, staying asleep, or sleeping too much?				<input checked="" type="radio"/>
4. Poor appetite, weight loss, or overeating?	<input checked="" type="radio"/>			
5. Feeling tired, or having little energy?				<input checked="" type="radio"/>
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?		<input checked="" type="radio"/>		
7. Trouble concentrating on things like school work, reading, or watching TV?		<input checked="" type="radio"/>		
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?	<input checked="" type="radio"/>			
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	<input checked="" type="radio"/>			
In the <u>past year</u> have you felt depressed or sad most days, even if you felt okay sometimes? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input checked="" type="checkbox"/> Extremely difficult				

ASKING ABOUT SUICIDE INTENT

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- **Normalize:**
 - Many times children who are feeling down or depressed describe having thoughts that they don't want to be alive. Have you ever felt that way?
 - Have you ever hurt yourself purposely?
- **Ask directly and in multiple ways:**
 - Are you having thoughts that **life isn't worth living**?
 - Are you having thoughts to **do something** to end your life?
 - Do you have a specific **plan** in mind?
 - **Have you ever** done something to try to hurt yourself?
 - Has the child told the parent, a caregiver, an adult or peer about feeling depressed and suicidal?
- **Ask about protective factors:**
 - What keeps you going?
 - What has stopped you from acting on these thoughts?
 - Are they **hopeful**?
 - Do they have **supports**? Talk about who these are...



ASSESSMENT OF LETHALITY

- To be assessed when
 - Child indicated strong, current suicidal intent
 - Child indicates having a current suicide plan
- When a child admits to prior suicide attempt(s)
useful questions
 - What was the method you used?
 - Was your intent at the time to die?
 - What were the medical consequences?

SAFETY PLAN

STRUCTURED PLAN THAT WILL BE IMPLEMENTED TO COPE WITH SUICIDAL THOUGHTS/URGES

- **Identify coping skills/tools for distraction** What can the child do that helps them calm down/feel better?
- Identify **adult(s)** who are available and whom the adolescent will contact
 - Discuss with child **the importance of sharing** information about depression and suicidality with the parent and caregiver
- Establish reasons to contact those adults
- Give **emergency numbers**
- Determine that the identified adults will use the emergency numbers
- Establish a **regular check in-time** with the adults and health professional
- *Remember, if there are safety concerns that the child/adolescent shares with you, this breaks the limits of confidentiality*

SAFETY PLAN STRATEGIES

- Avoid activities or situations that may trigger suicidal thoughts
- Internal: emotion regulation, distraction, exercise
- Interpersonal: Contact family, friend
- Clinical: contact therapist, crisis resources
- Write it down

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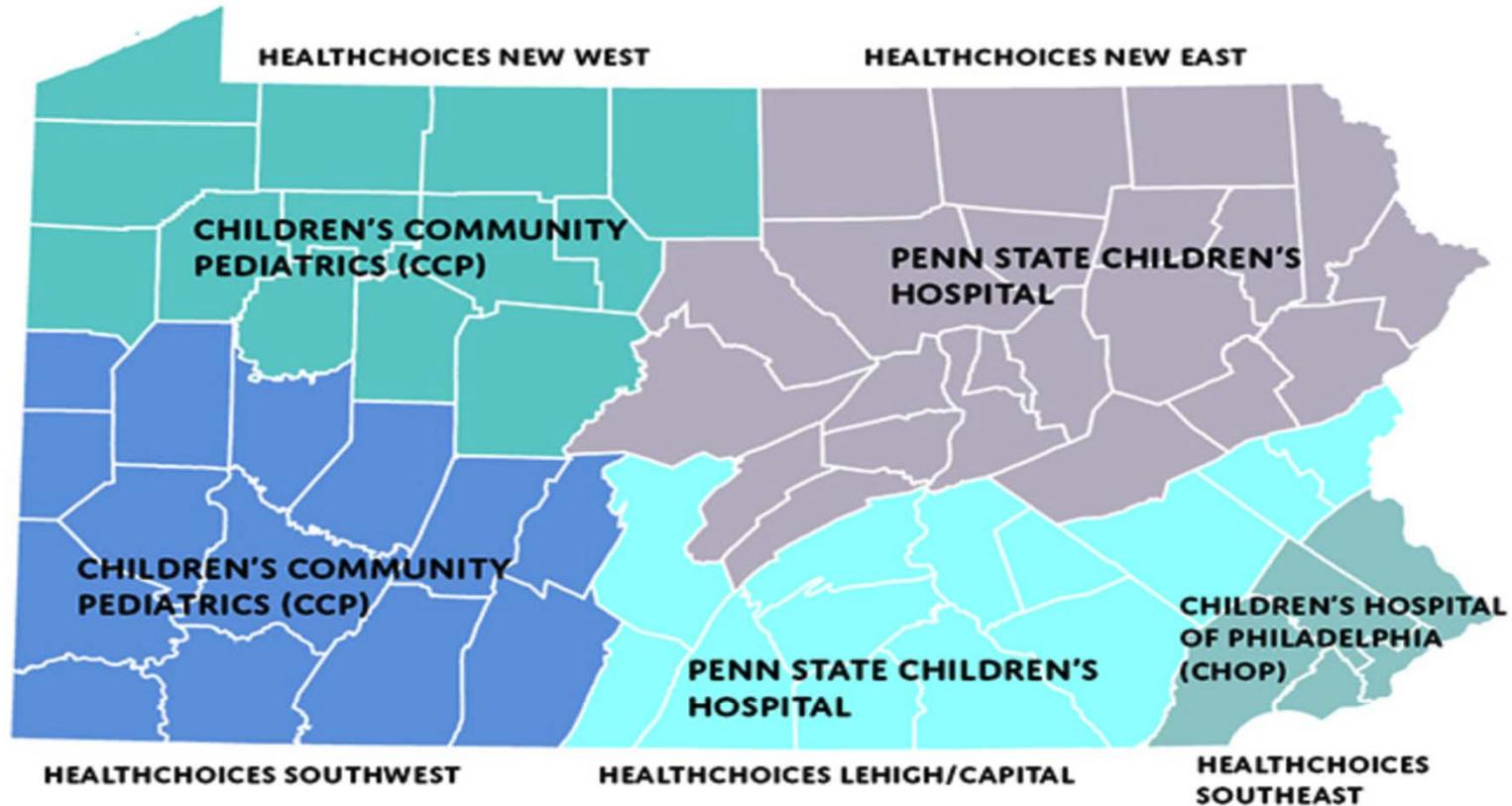
PENNSYLVANIA'S
TELEPHONIC PSYCHIATRIC
CONSULTATION SERVICE PROGRAM
(CHILDREN'S TIPS)
1-844-WPA-TIPS(1-844-972- 8477)

CALL CHILDREN'S TIPS

WEBSITE [HTTP://WWW.CHP.EDU/HEALTH-CARE-
PROFESSIONALS/REFERRING-PHYSICIANS/CHILDRENS-TIPS](http://www.chp.edu/health-care-professionals/referring-physicians/childrens-tips)

FUNDED BY: UPMC FOR YOU, GATEWAY, AMERIHEALTH, AETNA BETTER
HEALTH, UNITED HEALTHCARE OF PA

Regional TiPS teams



CHILDREN'S COMMUNITY PEDIATRICS (CCP)
844-972-8477

PENN STATE CHILDREN'S HOSPITAL
800-233-4082
"PRESS 4"

CHILDREN'S HOSPITAL OF PHILADELPHIA (CHOP)
267-426-1776

GOALS OF CHILDREN'S TIPS

- TiPS is a **FREE** service to help primary care clinicians(PCCs) deliver high quality psychotropic services for children and adolescents served by medicaid by providing:
 - Psychiatric curbside consultation Monday - Friday 9-5pm
 - Additional training on the use of psychotropic medication and responding to behavioral health issues in a primary care setting
 - September 15th in Erie
 - Direct consultation with patients when needed in Pittsburgh and Erie with a licensed therapist and/or child psychiatrist
 - Facilitated referrals to community providers when child/adolescent would benefit from additional behavioral health services

PROCESS

PCC has a question about psychotropic medication or a behavioral health concern

PCC obtains verbal consent & has patient information available



Call: 1-844-WPA-TIPS(1-844-972-8477)

Talk to TiPS team member, who will gather basic information and initiate a return call from a TiPS child psychiatrist (within 30minutes or at a time specified by PCP)



PCC and TiPS child psychiatrist consult via phone

TiPS care coordinator provides resources to PCC or family, if needed
Evaluation at a hub with a TiPS licensed therapist or child psychiatrist, if needed

WHAT THE PCC NEEDS FOR INITIAL CALL

- Tell the family you are calling Children's TiPS and get verbal consent for a call back from the Children's TiPS Team(if needed)
- Basic Information (initial call – does not need to be PCC)
 - Physician: name, return phone number & a requested call back time (if desired)
 - Child: name, birthdate, phone number, insurance plan, and foster care status (if known)
 - Reason for call: should be brief

PCC CALL WITH PSYCHIATRIST

- Patient history including medical and medication history, behavioral health(including service history), trauma, drug & alcohol history, diagnosis.
- Psychiatrist can activate care coordination if needed.
 - Care coordinator can only get activated by the psychiatrist
- Pediatrician's office will receive written feedback within 24 hours
 - Psychiatrist curbside consultation
 - Face-to-face visit
 - Care coordination interactions

INSURANCES ACCEPTED

MEDICAID PROVIDERS

- UPMC for You
- Gateway
- AmeriHealth
- Aetna Better Health
- United Healthcare of PA
- Medicaid Fee for Service

OTHERS

- All UPMC
- All CHIP
 - Geisinger Health Plan(GHP Kids)
 - Keystone health Plan West(Highmark)
 - United Healthcare Community Plan of PA
 - UPMC for Kids

DON'T FORGET THAT CHILDREN CAN HAVE MEDICAID IN PA FOR MANY REASONS RELATED TO PHYSICAL HEALTH AND BEHAVIORAL HEALTH CONDITIONS

CHILDREN'S TIPS IS DESIGNED TO HELP PCCS TALK TO A PSYCHIATRIST.

SITUATION

1. Acute psychiatric emergency
2. Access to outpatient services only
3. Psychiatric Medication prescriptions

WHERE TO TURN

1. Local crisis services
2. Preexisting resources
3. PCC or Community Providers

INITIAL ENROLLMENT PROCESS

- See one of our care coordinators TODAY at their table to
 - FIND OUT IF YOU'RE ENROLLED &
 - ENROLL IF YOU ARE NOT

OLIVIA

- 12 year old female who describes feeling easily annoyed by others and generally irritable most days for the past 3 months. Because of her irritability, she is not enjoying time with friends. She feels bad about being irritable and isolating . She is tired all the time, despite sleeping 12 hours a night and napping. She denies feeling depressed. No changes in appetite or energy level. She denies suicidality.
- She has no trauma history or no substance use.



OLIVIA

- 12 year old female who describes feeling easily annoyed by others and **generally irritable** most days for the past 3 months. Because of her irritability, she is **not enjoying time with friends**. **She feels bad** about being irritable and isolating . She is **tired all the time**, despite **sleeping 12 hours a night and napping**. She denies feeling depressed. No changes in appetite or energy level. She denies suicidality.
- She has no trauma history or no substance use.



HOW SHOULD WE HELP OLIVIA

DIAGNOSIS

- Major Depressive Disorder, mild

TREATMENT

- Treatment:
 - Education
 - Activation strategies
 - Get up and move instead of nap
 - Problem-Solving
 - Recommend Psychotherapy
- Active Follow-up - 1month

TREATMENT: NON-PHARM INTERVENTIONS

- **Psychoeducation!**
 - Depression is a change in mood that contributes to negativity, impaired functioning, low self-worth, amotivation, etc.
 - Destigmatize
- **Relaxation skills**
 - Including diaphragmatic breathing, progressive muscle relaxation, imagery, exercise, activities that are relaxing to patient
- **Activation**
- **Assist with Problem-solving**
 - Stressful situations that can be changed vs those that can't
- **Enhancing supports**
- **Psychotherapy**

Total = 21

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	⁽⁰⁾ Not At All	⁽¹⁾ Several Days	⁽²⁾ More Than Half the Days	⁽³⁾ Nearly Every Day
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OLIVIA

- Olivia has been in therapy for 8 weeks.
- Her symptoms are getting worse.
- Repeat PHQ 9: 21
- She hasn't been able to utilize the skills she learned in therapy.
- Getting to the point that she doesn't want to do any of her previous activities.



TITRATION SCHEDULES

Medication	Therapeutic range	Starting dose	Titration increments
fluoxetine	20-60 mg	10 mg daily 1 week then increase to 20 mg daily (can start at 5 mg daily)	5-10 mg
sertraline	50-200 mg	25 mg daily x6 days then increase to 50 mg daily (can start at 12.5 mg)	12.5-25 mg
citalopram	10-40 mg	5-10 mg daily (can start at 5mg)	5-10 mg
escitalopram	5-20 mg	5 mg daily	5 mg

TREATMENT: WHEN TO START MEDICATION

- **When to start meds:**
 - Symptoms are impairing functioning
 - Unable to make progress in therapy due to severity of symptoms and/or minimal improvement with therapy and/or worsening despite therapy
 - Degree of distress/severity of symptoms
- **Making the choice:**
 - Prozac and Zoloft have been the most studied in this population
 - Family members' response to SSRIs? Suggests a place to start...
 - Prozac has a long half life
 - Prozac less likely to cause sedation compared to Zoloft, Celexa and Lexapro
 - More side effects with Luvox(second line?)

SSRI “WORK-UP”

- Review family & personal history
 - Mania
 - Confirm no new trauma, suicidality or substances
- FOR OLIVIA –
- No family history of bipolar disorder (history of GAD and postpartum depression but no mania)
 - No history of periods of time not needing sleep or “unlike herself” happy, impulsive, etc.
 - No new trauma, suicidality, or substances since last visit

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SSRI CONSENT

- Rare and Concerning
 - Mania - stop med if mania happens
 - Suicidality – increase treatment/supports, medication will help depression

SSRI SIDE EFFECTS

- GI: nausea, abdominal pain, diarrhea, weight loss, weight gain
- Headaches
- Easier bruising
- Sweating
- Light-headedness/dizziness
- Nervousness/restlessness
- Sleep difficulties: sedation/insomnia, vivid dreams
- Sexual dysfunction
- Irritability/activation
- Potential risk for suicidal thinking
- Precipitation of mania

TADS – TREATMENT OF ADOLESCENT DEPRESSION STUDY -

- *Take home:* For moderate to severe depression, meds or meds+CBT accelerates response. Adding CBT increases safety by decreasing SI and attempts.

BLACK BOX WARNING(2004)

- STUDIES AFTER THE BLACK BOX
 - There was increased risk difference of suicidal ideation/suicide attempt the risk is
 - NOT statistically significant.
 - VERY LOW
- **Conclusions of Metanalysis:** benefits of antidepressants appear to be much greater than risks from SI.
 - For depression and anxiety

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fluoxetine	20mg	40mg	60mg	80mg
sertraline	50-75mg	100mg	150mg	200mg
citalopram	20mg	40mg		
escitalopram	10mg	20mg		

TREATMENT: DURATION

- **Titrate** medications as needed until efficacy and/or maximize dose
- **Maintenance**
 - Symptoms in remission AND 9-12 months of stability.
 - Continue therapy, mastering skills
- **Taper**
 - Relatively stress-free time, "cruise control"
 - **SLOWLY**

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OLIVIA SECOND DEPRESSION VISIT

- Visit to confirm family and personal history and consent
- **Start prozac** 5mg for 1 week increase to 10mg if no problems
- Follow-up with PCC in 2-4 weeks
- Escalate prozac to 20mg at next visit unless
 - Depression in complete remission and no impairment

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OLIVIA THIRD VISIT

- 4 weeks s/p starting medication
- No side effects with prozac 10mg
- PHQ9 slightly worse(went from 21 to 25)
- Treatment
 - Increase prozac to 20mg
 - Discuss importance of nonpharmacologic interventions
 - Follow-up 4 weeks

4 WEEKS LATER

- PHQ 9 unchanged 25
- Mom states that she is starting to look better, is getting out more
- Treatment options
 - Increase prozac to 30mg or follow-up in 2-4 weeks

8 WEEKS LATER

- PHQ 9 = 9
- Olivia agrees she is feeling better
- Next steps in treatment
 - Follow-up in 4-8 weeks
 - Reinforce importance of non-pharmacologic interventions

RESOURCES

- NAMI, www.nami.org
- Suicide Prevention Action Networks,
www.span.org
- American Academy of Child & Adolescent Psychiatry Resource Center,
www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Home.aspx

THANK YOU!

- Thanks to all the clinicians & staff who work to improve the lives of youth and families struggling with mental health concerns.

BIBLIOGRAPHY

- Brent, D., Kolko, D. (1998). Psychotherapy: Definitions, mechanisms of action, and relationship to etiological models. *Journal of Abnormal Child Psychology*, 26(1), 17-25.
- [Brent, D., Emslie, G., Clarke, G., Wagner, KD., Asarnow, JR., Keller, M., Vitiello, B., Ritz, L., Iyengar, S., Abebe, K., Birmaher, B., Ryan, N., Kennard, B., Hughes, C., DeBar, L., McCracken, J., Strober, M., Suddath, R., Spirito, A., Leonard, H., Melhem, N., Porta, G., Onorato, M., Zelazny, J.](#) (2008). Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression: the TORDIA randomized controlled trial, *JAMA*, 299(8), 901-13.
- Campo, J., Shafer, S., Strohm, J., Lucas, A., Cassesse, C., Shaeffer, D., Altman, H. (2005). Pediatric behavioral health in primary care: A collaborative approach. *Journal of American Psychiatric Nurses Association*, 11(5), 276-282.
- Cheung, A., Zuckerbrot, R., Jensen, P., Ghalib, K., Laraque, D., Stein, R. (2007). Guidelines for adolescent depression in primary care (GLAD-PC):II. Treatment and ongoing management. *Pediatrics*, 120, 1313-1395.
- Daviss, W., Birmaher, B., Melhem, N., Axelson, D., Michaels, S., Brent, D. (2006). Criterion validity of the mood and feelings questionnaire for depressive episodes in clinic and non-clinic subjects. *Journal of Child Psychology and Psychiatry*, 47, 927-934.

BIBLIOGRAPHY

- Freeman, J., Garcia, A., Leonard, H. (2002). Anxiety Disorders. In Lewis, M. (Ed.), Child and Adolescent Psychiatry, (pp. 821-831). Philadelphia. Lippincott Williams & Williams.
- Kovacs, M., (2003). Child's depression inventory technical manual update (Rev ed.). North Tonawanda: Multi-Health Systems Inc.
- March, J., Silvia S., Petrycki, S., Curry J., Wells K., Fairbank J., Burns B., Domino M.& McNulty S. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression, Treatment for adolescents with depression study (TADS) randomized controlled study. *Journal of the American Medical Association*, 292, 807-820.
- Mental Health Report: A Report of the Surgeon General. (2008). Available on line at www.surgeongeneral.gov/library/mentalhealth/chapter3/sec5.html
- Mental Health Report: A Report of the Surgeon General. (2008). Available on line at www.surgeongeneral.gov/library/mentalhealth/chapter3/sec6.html#autism
- Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. (2007). *Journal of American Academy of Child and Adolescent Psychiatry*, 46:11, 1503-1526.
- Practice parameter for the assessment and treatment of children and adolescents with bipolar disorder. (2007). *Journal of American Academy of Child and Adolescent Psychiatry*, 46:11, 107-121.
- Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. (2007). *Journal of American Academy of Child and Adolescent Psychiatry*, 46:2, 267-279.

BIBLIOGRAPHY

- ~~The use of medication in treating childhood and adolescent depression: Information for the patients and families. Available on line at ParentsMedGuide.org~~
- Walkup, J., Albano, A., Piacentini, J., Birmaher, B., Compton, S., Sherrill, J., Ginsburg, G., Rynn, M., McCracken, J., Waslik, B., Iyengar, S., March, J., Kendall, P. (2008). Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *New England Journal of Medicine*, 359, 1-14.
- Weller, E., Weller, R., Rowan, A., Svadjian, H. (2002). Depressive disorders in children and adolescents. In Lewis M. (Ed.), *Child and Adolescent Psychiatry* (pp. 767-781). Philadelphia, Lippencott Williams & Williams.
- Wren, F., Bridge, J., Birmaher, B. (2004). Screening for Childhood Anxiety Symptoms in Primary Care: Integrating Child and Parent Reports. *Journal of American Academy of Child and Adolescent Psychiatry*, 43, 1364-1370.
- Zuckerbrot, R., Cheung, A., Jensen, P., Stein, R., Laraque, D. (2007). Guidelines for adolescent depression in primary care (GLAD-PC): Identification, assessment, and initial management. *Pediatrics*, 120, 1299-1312.
- "Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents with Depression." *JAMA* 2004. Vol 292, No. 7.
- "The Treatment for Adolescents with Depression Study (TADS). Long-term Effectiveness and Safety Outcomes." *Arch Gen Psychiatry*. Vol 64, No 10. 2007.
- "Remission after acute treatment in Children and Adolescents with Anxiety disorders: Findings from CAMS." Ginsburg, Golda, et al. *Journal of Consult Clinical Psychology*. 2011. 79(6).
- "24 and 36-week Outcomes for the Child/Adolescent Anxiety Multimodal Study (CAMS)." Piacentini, et al. *JAACAP*. March 2014. 53(3): 297-310.

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BIBLIOGRAPHY

- Brent, D., Kolko, D. (1998). Psychotherapy: Definitions, mechanisms of action, and relationship to etiological models. *Journal of Abnormal Child Psychology*, 26(1), 17-25.
- [Brent, D., Emslie, G., Clarke, G., Wagner, KD., Asarnow, JR., Keller, M., Vitiello, B., Ritz, L., Iyengar, S., Abebe, K., Birmaher, B., Ryan, N., Kennard, B., Hughes, C., DeBar, L., McCracken, J., Strober, M., Suddath, R., Spirito, A., Leonard, H., Melhem, N., Porta, G., Onorato, M., Zelazny, J.](#) (2008). Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression: the TORDIA randomized controlled trial, *JAMA*, 299(8), 901-13.
- Campo, J., Shafer, S., Strohm, J., Lucas, A., Cassesse, C., Shaeffer, D., Altman, H. (2005). Pediatric behavioral health in primary care: A collaborative approach. *Journal of American Psychiatric Nurses Association*, 11(5), 276-282.
- Cheung, A., Zuckerbrot, R., Jensen, P., Ghalib, K., Laraque, D., Stein, R. (2007). Guidelines for adolescent depression in primary care (GLAD-PC):II. Treatment and ongoing management. *Pediatrics*, 120, 1313-1395.
- Daviss, W., Birmaher, B., Melhem, N., Axelson, D., Michaels, S., Brent, D. (2006). Criterion validity of the mood and feelings questionnaire for depressive episodes in clinic and non-clinic subjects. *Journal of Child Psychology and Psychiatry*, 47, 927-934.
- .

BIBLIOGRAPHY

- Freeman, J., Garcia, A., Leonard, H. (2002). Anxiety Disorders. In Lewis, M. (Ed.), Child and Adolescent Psychiatry, (pp. 821-831). Philadelphia. Lippincott Williams & Williams.
- Kovacs, M., (2003). Child's depression inventory technical manual update (Rev ed.). North Tonawanda: Multi-Health Systems Inc.
- March, J., Silvia S., Petrycki, S., Curry J., Wells K., Fairbank J., Burns B., Domino M. & McNulty S. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression, Treatment for adolescents with depression study (TADS) randomized controlled study. *Journal of the American Medical Association*, 292, 807-820.
- Mental Health Report: A Report of the Surgeon General. (2008). Available on line at www.surgeongeneral.gov/library/mentalhealth/chapter3/sec5.html
- Mental Health Report: A Report of the Surgeon General. (2008). Available on line at www.surgeongeneral.gov/library/mentalhealth/chapter3/sec6.html#autism
- Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. (2007). *Journal of American Academy of Child and Adolescent Psychiatry*, 46:11, 1503-1526.
- Practice parameter for the assessment and treatment of children and adolescents with bipolar disorder. (2007). *Journal of American Academy of Child and Adolescent Psychiatry*, 46:11, 107-121.
- Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. (2007). *Journal of American Academy of Child and Adolescent Psychiatry*, 46:2, 267-279.

BIBLIOGRAPHY

- ~~The use of medication in treating childhood and adolescent depression: Information for the patients and families. Available on line at ParentsMedGuide.org~~
- Walkup, J., Albano, A., Piacentini, J., Birmaher, B., Compton, S., Sherrill, J., Ginsburg, G., Rynn, M., McCracken, J., Waslik, B., Iyengar, S., March, J., Kendall, P. (2008). Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *New England Journal of Medicine*, 359, 1-14.
- Weller, E., Weller, R., Rowan, A., Svadjian, H. (2002). Depressive disorders in children and adolescents. In Lewis M. (Ed.), *Child and Adolescent Psychiatry* (pp. 767-781). Philadelphia, Lippencott Williams & Williams.
- Wren, F., Bridge, J., Birmaher, B. (2004). Screening for Childhood Anxiety Symptoms in Primary Care: Integrating Child and Parent Reports. *Journal of American Academy of Child and Adolescent Psychiatry*, 43, 1364-1370.
- Zuckerbrot, R., Cheung, A., Jensen, P., Stein, R., Laraque, D. (2007). Guidelines for adolescent depression in primary care (GLAD-PC): Identification, assessment, and initial management. *Pediatrics*, 120, 1299-1312.
- "Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents with Depression." *JAMA* 2004. Vol 292, No. 7.
- "The Treatment for Adolescents with Depression Study (TADS). Long-term Effectiveness and Safety Outcomes." *Arch Gen Psychiatry*. Vol 64, No 10. 2007.
- "Remission after acute treatment in Children and Adolescents with Anxiety disorders: Findings from CAMS." Ginsburg, Golda, et al. *Journal of Consult Clinical Psychology*. 2011. 79(6).
- "24 and 36-week Outcomes for the Child/Adolescent Anxiety Multimodal Study (CAMS)." Piacentini, et al. *JAACAP*. March 2014. 53(3): 297-310.