

Treatment of Depression and Anxiety in Pediatric Primary Care

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Overall Goals and Objectives

- Part I: Identification of Depression and Anxiety
- **Part II: Depression & Anxiety Interventions in Primary Care**
 - Non-pharmacologic treatment
 - Pharmacologic treatment
 - Understanding how to initiate care
- **Part III: Pulling it All Together**
 - Evaluating risks/benefits for pharmacologic vs. non-pharmacologic interventions
 - Providing rational interventions
 - Cases

Part II & III: Objectives

- Understand how to use behavioral scales to facilitate and evaluate monitoring and treatment
- Understand the **common evidence-based approaches** to intervention for internalizing disorders in primary care
- Understand how to initiate **treatment** for children/adolescents with depression and/or anxiety

Responsibilities of Primary Care Provider



- **Identify** those at risk
- **Evaluate** for depression, basic **differential diagnosis**, **co-morbid disorders**
- Use **behavioral screens**
- Perform **risk assessment**, complete a safety plan
- Perform psycho-educational , supportive **counseling**
- **Follow** until engaged in appropriate services and/or initiate treatment and/or follow through course of treatment
 - Establish responsibilities/roles of the provider, patient, family
 - Schedule follow-up appointment and goals
- **Refer as needed**

Clinical Pearls

- Tell me, in your own words, why you are here today
- Easy visit...talk, not in trouble for anything
- May try to solve some problems, make something go better
- Begin with social assessment
- Monitor family interaction
- Establish boundaries and expectations of visit

Assessment

- Establish basic rules from the beginning: confidentiality and when confidentiality must be broken
- Interview together and alone
- Emphasize with patient that there are no wrong answers
- How long have you felt this way?
- When do you remember being happy?
- Beware of assumptions
- 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

Olivia

- 8 year old female who describes feeling easily annoyed by others and generally irritable most days. Because of her irritability, she has been isolating more and not spending as much time with friends. She denies feeling depressed. No changes in sleep, appetite or energy level. Denies suicidality.



Olivia

- 8 year old female who describes feeling easily **annoyed** by others and generally **irritable** most days. Because of her irritability, she has been **isolating** more and not spending as much time with friends. She denies feeling depressed. **No changes in sleep, appetite or energy level.** Denies suicidality.



What is the diagnosis?

- Major Depressive Disorder
- Persistent Depressive Disorder
- Other Specified Depressive Disorder
- Adjustment Disorder
- Disruptive Mood Dysregulation Disorder
- Bipolar Disorder

- After reviewing the PHQ-9, child and parent scared and talking to the child and family you diagnose her with **unspecified depressive disorder**
- What is the appropriate treatment at this time?
- Therapy? Meds? Both?

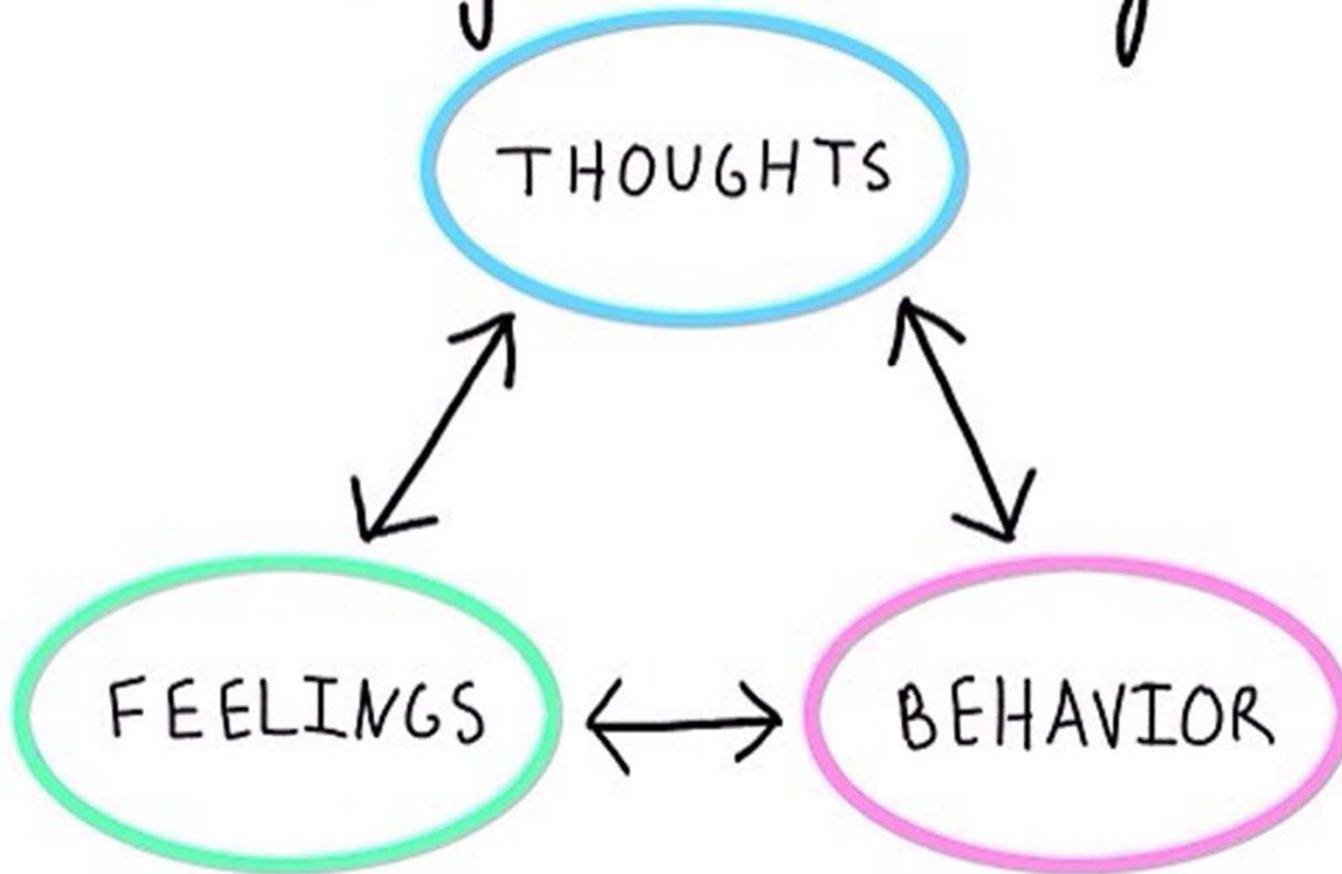
Treatment: Non-Pharm Interventions

- **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**

Cognitive Behavior Therapy (CBT)

- Developed by Albert Ellis and Aaron Beck
- Thoughts and behaviors affect feelings and automatic thoughts (mind reading, forecasting, catastrophizing, discounting)
- Feelings are not facts
- Spiral thinking
- Skills must be learned and practiced

The Cognitive Triangle



**I'VE
GOT
SKILLZ**



Olivia

- Olivia has been in therapy for 8 weeks.
- Her symptoms are getting worse.
- Repeat PHQ 9: 14
- 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.
- **What would you like to do?**



Treatment: SSRI's

- Selective Serotonin Reuptake Inhibitors(SSRI's): Inhibit reuptake of 5-HT
 - Fluoxetine(Prozac)
 - Sertraline(Zoloft)
 - Citalopram(Celexa)
 - Escitalopram(Lexapro)
 - Fluvoxamine(Luvox)



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?)

Treatment: Rationale

- **TADS: Treatment of Adolescents with Depression Study**

- N=439 children 12-17 years. 12 weeks of Prozac (10-40mg), CBT, combo or placebo.
- **Week 12:** combo (73%) > meds alone (62%) > CBT alone (48%) > placebo (35%). Suicidal thinking decreased in all groups, greatest decrease in the combo group.
- **Week 18:** combo (85%) > meds alone (69%) = CBT alone (65%)
- **Week 36:** Combo (86%) = meds alone (81%) = CBT alone (81%)

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

Titration Schedules

Medication	Therapeutic range	Starting dose	Titration increments
fluoxetine	20-60 mg	10 mg daily x6 days 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

Black Box Warning

- Issued by FDA in 2004 after review of RCTs available.
- Retrospectively looked at occurrence of suicidal thoughts in depressed teenagers:
 - Not on medication: 2%
 - On medication: 4%.
 - This included suicide attempts but no completed suicides.
- Paxil has not been recommended since 2003.
- NIMH partially funded follow-up study in 2007 to review efficacy/risk of SSRIs.
 - Meta-analysis of 27 trials of pediatric MDD (15), OCD (6) and anxiety disorders (6).
- While there was increased risk difference of suicidal ideation/suicide attempt across all trials and indications for drug vs placebo, risk differences within each indication were not statistically significant.
- **MDD**: 2% vs 3% (NNH 112); **OCD**: 0.3% vs 1% (NNH 200); **Anxiety**: 0.2% vs 1%(NNH 143)
- NO completed suicides

- **Conclusion of paper**: benefits of antidepressants appear to be much greater than risks from SI.

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

Approximate Dose Equivalents of Antidepressants					
SSRIs	fluoxetine	20 mg	40 mg	60 mg	80 mg
	paroxetine	20 mg	40 mg	60 mg	-
	sertraline	50 -75 mg	100 mg	150 mg	200 mg
	citalopram	20 mg	40 mg	-	-
	escitalopram	10 mg	20 mg	-	-
SNRIs	venlafaxine*	75 mg	150 mg	225 mg	300 mg
	desvenlafaxine	50 mg	100 mg	-	-
	duloxetine	30 mg	60 mg	90 mg	120 mg

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

Will

- 15 year old male who has a few close friends at school. Since starting high school, he has becoming increasingly anxious. He doesn't like to talk in class, and he prefers to avoid parties where there will be a lot of people. He doesn't like to go to social gatherings if he doesn't know everyone there ahead of time. He quit the basketball team because he felt like everyone was laughing at him and talking behind his back. His mother notes that he is a likable kid and did well socially until high school.



Will

- 15 year old male who has a few close friends at school. Since starting high school, he has becoming increasingly anxious. He **doesn't like to talk in class**, and he prefers to **avoid parties** where there will be a lot of people. He doesn't like to go to social gatherings if he doesn't know everyone there ahead of time. He **quit the basketball team** because he felt like everyone was laughing at him and talking behind his back. His mother notes that he is a likable kid and did well socially until high school.



What's the Diagnosis?

- Generalized Anxiety Disorder
- Social Anxiety Disorder
- Separation Anxiety Disorder
- Panic Disorder
- Other Specified Anxiety Disorder

Anxiety: Treatment

- Always begin with **psychoeducation**
- Therapy: **CBT** as well as **exposures** and **relaxation** (distraction, breathing techniques)
- Making a list of fears and grading them in order of severity
- **SSRIs** are **the first line** of medication management
 - Same rationale for starting and stopping meds as in treatment for depression
 - Course of treatment also similar

Treatment: Rationale

- CAMS: Child/Adolescent Anxiety Multimodal Study
 - N= 488. Children 7-17 years. Separation, social and generalized anxiety diagnoses.
 - *Remission* rates:
 - 12 weeks: combo (46-68%) > sertraline alone (34-46%) = CBT alone (20-46%) > placebo (15-27%)
 - 24 and 36 weeks: responders maintained positive response. Combo > med alone = CBT alone

Will: Starting Medication

- Will meets criteria for social anxiety disorder. It is impairing his functioning and you decide to start a combination of medication and therapy.
- What SSRI will you choose and how will you start it?



Will:

Talking about Medication

- Will is freaking out about possible side effects. Does that change your management?

Will: Treatment Choices

- He has been on 50 mg for 6 weeks and notices no change. What next? Time to change medication? Will has refused to go to school for the past 2 weeks. Now what?!

Factors that may lead to treatment resistance

- For depression, consider ruling out anemia, thyroid disease, chronic illness, nutritional deficiency
- Other medications & psychotropic effects
- Major stressors: being bullied, family conflict, sexual and/or gender orientation issues
- Parental mental health diagnoses
- Comorbidity: Anxiety, PTSD, Substance Abuse, Psychosis, ADHD, Bipolar Disorder

Back to Olivia...

- PHQ 9 now positive for suicidal ideation. Parent really doesn't want to take her to the hospital.
- **Now what?**



Assessment of Lethality

- **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?
- **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?
- **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...

Safety Plan

- Structured plan that will be implemented to cope with suicidal thoughts/urges
- What can the child do that helps them calm down/feel better?
Identify coping skills/tools for distraction
- Identify **adult(s)** who are available and whom the adolescent will contact
- 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

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.

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