Management of Depression & Anxiety in Adolescence

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Welcome!
Objectives:

• Discuss the prevalence of depression and anxiety in adolescents
• Discuss the assessment and diagnosis of depression in the adolescent population
• Discuss the assessment and diagnosis of anxiety disorders in the adolescent population
• Describe non-pharmacological and pharmacological interventions for depression and anxiety in adolescents
• Discuss resources to help primary care providers manage adolescent depression and anxiety
### Depression in Adolescents

<table>
<thead>
<tr>
<th>Age</th>
<th>Major Depressive Episode Past Year Prevalence:</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>9.4%</td>
</tr>
<tr>
<td>14</td>
<td>12.7%</td>
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<tr>
<td>15</td>
<td>13.9%</td>
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<tr>
<td>16</td>
<td>17.4%</td>
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<tr>
<td>17</td>
<td>17%</td>
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<tr>
<td>18-25</td>
<td>10.9%</td>
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<tr>
<td>General Adult Population (18+)</td>
<td>6.7% (F: 8.4%, M: 4.8%)</td>
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<tr>
<td>Age 12-17: Females, Males</td>
<td>19.4%, 6.4%</td>
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(NIMH, 2017)
Anxiety Prevalence in Adolescents

• Lifetime prevalence of any anxiety disorder (per DSM-IV criteria) was 31.9% among all adolescents
• Females: 38%
• Males: 26.1%
• Severe impairment: 8.3% of all adolescents
  (NIMH, 2017)

Despite the high prevalence, about 60% of adolescents do not receive the mental health treatment they need (SAMHSA, 2014)
Common Anxiety Disorders in Adolescents:

Generalized Anxiety Disorder
• Marked by generalized worry and anxiety; unable to control multiple worries

Social Anxiety Disorder
• Excessive fears of negative peer evaluation; performance anxiety; anxiety about eating/drinking in front of others or general social interactions

Panic Disorder
• Unexpected panic attacks and subsequent vicious cycle of worry about panic attacks
## Overlap of Depression & Anxiety Symptoms:

<table>
<thead>
<tr>
<th>Depression</th>
<th>Both</th>
<th>Anxiety</th>
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</thead>
<tbody>
<tr>
<td>Depressed mood (down, depressed, empty)</td>
<td>Sleep issues</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Anhedonia (loss of pleasure, interest)</td>
<td>Decreased concentration</td>
<td>Worry</td>
</tr>
<tr>
<td>Guilt</td>
<td>Fatigue</td>
<td>Muscle tension</td>
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<tr>
<td>Low self-esteem/feelings of worthlessness</td>
<td>Irritability</td>
<td>Trouble relaxing</td>
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<tr>
<td>Death thoughts or suicidality</td>
<td>Appetite/weight changes</td>
<td>Avoidance behaviors</td>
</tr>
<tr>
<td></td>
<td>Somatic complaints</td>
<td>Panic attacks</td>
</tr>
<tr>
<td></td>
<td>Psychomotor agitation or retardation</td>
<td>(NEI, 2018)</td>
</tr>
</tbody>
</table>
Adolescent Considerations:

• Adolescent psychiatric signs/symptoms may also include:
  • Irritability
  • Body aches, upset stomach, or other somatic complaints
  • Angry outbursts
  • Risky behaviors, “acting out”
  • Extreme sensitivity to rejection (or perceived rejection, criticism)
  • School absenteeism/school refusal/truancy
  • Avoidance behaviors
  • Drop in grades/academic performance
Screening & Assessment of Adolescents in Primary Care
Pediatric Symptom Checklist (PSC, Y PSC)

• Does not provide or correlate with a specific psychiatric diagnosis, but does help guide further assessment
• Masshealth approved screening
• 35-item (cut-off score 30) or 17-item version (cut-off score 15)
• PSC is completed by the parent
• Y PSC is completed by the youth (self-report)
• Rated never (0), sometimes (1), often (2) on each item
• Clinical judgment re: f/up with PCP versus specialty consult
Strengths & Difficulties Questionnaire (SDQ)

Version for ages 11-16 with measures for parent, teacher, and self. Masshealth approved screening; again used for general further inquiry.

25 psychological attributes divided into 5 scales of 5 items each:

1. Emotional problems
2. Conduct problems
3. Hyperactivity/inattention
4. Peer relationship problems
5. Prosocial behavior

1-4 are totaled to form the total difficulties score of 0-40; parent scores above 14, teacher scores above 12, and self scores above 16 generally considered a positive screen.
Patient Health Questionnaire-9 (PHQ-9)

Screening for Major Depressive Disorder (Masshealth approved screening)

- 9-item self-report questionnaire, Sx duration over 2 weeks
- Each item scored 0-3 (not at all, several days, more than half the days, nearly every day)
- “If you checked off any problems, 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?”
- Scoring: 0-4 = None; 5-9 = Mild; 10-14 = Moderate; 15-19 = Moderately severe; 20+ = Severe
Mood and Feelings Questionnaire (MFQ)

Child and adult versions, short and long versions (use the long)

Child version: 33-items, 0-3 scale (not true, sometimes, true)

Adult version: 34-items, 0-3 scale (not true, sometimes, true)

Used in MCPAP Guidelines for depression

Cut-off 29 for child, 27 for child version
GAD-7

Screening for Generalized Anxiety Disorder

7-item self-report questionnaire, Sx duration over 2 weeks

• Each item scored 0-3 (not at all, several days, more than half the days, nearly every day)
• Used in MCPAP Guidelines for anxiety
  • Cut-point 10 for moderate, 15 for severe
The Screen for Child Anxiety Related Disorders (SCARED)

Child and parent versions

5 Factors, total of 41-items with a 3-point scale

Aligned with DSM-IV anxiety disorders

Used in MCPAP Guidelines for anxiety

Cut-off 25 or higher for parent or child versions is a positive screen

Quite a bit more useful for the adolescent population than just the GAD-7
Assessing Adolescents (continued)

- Reminder/PSA: screenings are not diagnostic in and of themselves
  - Can have false positives or false negatives
- HPI - systematic approach (identify each symptom & its OLD CARTS)
  - Onset
  - Location
  - Duration
  - Character
  - Aggravating factors
  - Relieving factors
  - Timing
  - Severity
Assessing Adolescents (continued)

- General medical work-up
- Family history of any mental illness and any suicide attempts/completed suicides
- Family social history/family environment
- Personal developmental & mental health history
- Temperament, personality traits
- Social history/present functioning (e.g. school performance)
Assessing Adolescents (continued)

• Substance or ETOH use
• Any other risky behaviors including self-injurious behavior
• Acute stressors presently or history of trauma
• History of hypomanic or manic episodes
• Any history of or current suicidal or homicidal thoughts or attempts
• Any history of or current psychotic symptoms
• Impairment from depression or an anxiety disorder will typically manifest across environments (e.g. home, school, extra-curriculars, etc.)
Differential Diagnosis

• Normal development/normal life response to stressor or maturational challenge/normative shyness
• Victim of bullying or other abuse
• Underlying medical diagnosis
• Adjustment disorders (e.g. with anxiety, with depression)
• Substance or alcohol induced mood or anxiety disorder
• Attention Deficit Hyperactivity Disorder (ADHD)
• Acute stress reaction or Post-Traumatic Stress Disorder (PTSD)
• Disruptive mood dysregulation disorder or other mood disorder
• Obsessive-Compulsive Disorder (OCD)
Treatment of Depression & Anxiety in Adolescents
MCPAP (2018) Treatment Guidelines for Depression:

- Screening: PSC-17; PHQ-2 or PHQ-9 & any imminent risk
- Positive screen → focused assessment (clinical interview + a rating scale)
  - PHQ-9 or MFQ
- Subclinical to mild depression: guided self-management w/ f/up
- Moderate depression or unsuccessful self-management: refer for therapy; consider medication
- Severe depression: refer to specialty care for therapy & med management until stable
MCPAP (2018) Treatment Guidelines for Anxiety:

• Screening: PSC-17 & any imminent risk
• Positive screen → focused assessment (clinical interview + a rating scale)
  • SCARED or GAD-7
• Subclinical to mild anxiety: guided self-management w/ f/up
• Moderate anxiety or unsuccessful self-management: refer for therapy; consider medication
• Severe anxiety: refer to specialty care for therapy & med management until stable
Non-pharmacological Treatment

- Therapy, specifically CBT shown to be helpful (MCPAP, 2018)
- Coordination of care is essential - build and use the team
- Social rhythm: routine eating, sleeping, activity/exercise, leisure, navigating “screen time”/social media
- How do you “pitch” therapy?
- Therapy is “new learning”
  - Thoughts-Feelings-Behavior triad
  - The “brain imbalance” conundrum: diabetes analogy
Pharmacological Tx:

• SSRI medication is a mainstay of tx
• 4.8% of adolescents take an antidepressant medication (CMS, 2015)
• Before starting tx: review potential risks/benefits/side effects/alternatives, informed consent from parent/guardian, review FDA Black Box Warning
• 1st month: Monitor weekly for agitation, suicidality, and other side effects; for severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency evaluation; consult with MCPAP or other specialist as needed; monitor bi-monthly x next month or after dose change; then monthly
Pharmacological Treatment of Depression:

FDA-approved:

• Fluoxetine: Age 12+: start 10mg daily x 1 to 2 weeks, increase to 20mg daily if tolerated
• Escitalopram: Age 12+: start 5mg daily x 1 to 2 weeks, increase to 10mg daily if tolerated

Evidence-based: sertraline: Age 12+: start 25mg daily x 1 to 2 weeks, increase to 50mg daily if tolerated
Pharmacological Treatment of Depression:

Reassess after 4 weeks: if rating scale still above cut-point with impairment, consult MCPAP or other specialist.

If rating scale below cut-point with mild or no impairment, continue medication for 6 to 12 months, monitoring twice monthly x 1 month, then monthly thereafter.
Pharmacological Treatment of Anxiety:

Anxiety disorders, evidence-based:

- Fluoxetine: 5mg daily x 1 to 2 weeks, then increase to 10mg daily if tolerated
- Sertraline: 12.5mg daily x 1 to 2 weeks, then increase to 25mg daily if tolerated

Duloxetine is FDA-approved for GAD in ages 7+ but not preferred in MCPAP guidelines; may be less well tolerated generally; starting dose 30mg daily x 1 to 2 weeks, then increase to 60mg daily if tolerated

For severe distress, can consider adding PRN hydroxyzine 25 to 50mg up to twice daily (4 hours minimum between doses)
Pharmacological Treatment of Anxiety:

Reassess after 4 weeks: if rating scale still above cut-point, increase medication dose again if tolerated (e.g. fluoxetine 20mg daily, sertraline 50mg daily)

Reassess in another 4 weeks and continue to increase medication gradually as tolerated to treat to target based on assessment and rating scale (fluoxetine 30mg daily x 2 weeks then 40mg daily; sertraline 75mg daily x 2 weeks then 100mg daily)

After 12 weeks of tx, if rating scale > cut-point, consult MCPAP or specialty. If below cut-point and mild/no impairment, continue medication x 6 to 12 months

Remember to coordinate care with therapist and consult others as needed
Stopping SSRI Medication

After 6 to 12 months, administer rating scale again and if below cut-point & no impairment, consider gradual taper and d/c of med

- Reduce by 25% to 50% every 2 to 4 weeks until starting dose, then d/c
- Ideally during time of minimal stress

Continue to monitor for sx relapse for months after taper

Consider self- and parent tracking tools (e.g. symptom diary/mood chart/sx relapse prevention plan)

Encourage ongoing therapy
Clinical Pearls:

• Should generally avoid using medication as monotherapy; adolescent should be engaged in therapy (verify this and coordinate care)
• Selection of initial agent: consider past tx/favorable response and also favorable response in any first-degree relatives
• Anxiety disorders typically require lower starting doses and slower titration, but may also need higher target doses
• If intolerable anxiety, insomnia, agitation, akathisia, or activation occur - consider another underlying disorder, assess risk, and consult with specialty
• Educate not to suddenly stop - discontinuation syndrome & rebound sx

(MCPAP, n.d.; NEI, 2018)
SSRI/SNRI Selected Side Effects:

• Nausea, GI upset, especially earlier in tx, tends to resolve but may recur after dose increases (r/o pregnancy)
• Dry mouth, constipation/diarrhea
• Dizziness, headache, increased sweating
• Sexual side effects
• Worsening of anxiety, initially
• Vivid dreams, disturbed sleep (timing of admin may impact)
• Disinhibition, agitation, mental status changes, SI
FDA Black Box Warning for Antidepressants:

FDA Black Box Warning issues for all antidepressants in individuals age 24 and under:


In individuals age 24 and under, short term studies of antidepressants showed increased risk of suicidal thinking and behavior compared to placebo.

Balancing risks/clinical need, especially given the role of antidepressants in effective tx plans

Education, frequent monitoring, and coordination of care
Suicidality

• Assess for suicidality at each visit
• Clinical interview/assessment
• Screenings can also play a role such as PHQ-9 question #9, Columbia Suicide Severity Rating Scale (CSSRS), or the Ask Suicide-Screening Questions (ASQ)
• Use of specialty resources, MA section 12, emergency/crisis resources
• Safety plan NOT “contract for safety”
  • If you’ve decided to section 12, follow office protocol
• Reduction of means (remove or secure dangers in environment)
Assessing Suicide Risk

SAFE-T Framework:

- Risk factors
- Protective factors
- Suicide inquiry
- Determine risk level/intervention to match risk level
- Document (and f/up plan)
Assessing Suicide Risk

Many excellent guidelines and toolkits, ASQ is one (linked to in resources):
Safety Plan:

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

Step 3: People and social settings that provide distraction:

Step 4: People whom I can ask for help:

Step 5: Professionals or agencies I can contact during a crisis:

On-Call Numbers, Mobile Crisis, Emergency Services Program Numbers, National Suicide Prevention Helpline Talk: 1-800-273-8255, Local Police: 911

Step 6: Making the environment safe:

The one thing that is most important to me and worth living for is:

(Adapted from the National Suicide Prevention Lifeline, 2008)
Selected Resources:

- DMH Resource Guides: [https://www.mass.gov/service-details/dmh-resource-guides](https://www.mass.gov/service-details/dmh-resource-guides) (There is an Emergency Support Program and a Young Adult resource guide)
- Mobile Crisis Intervention teams in MA: 1-877-382-1609 to connect to local team 24/7/365 (anyone can call)
- Massachusetts General Hospital School Psychiatry Curriculum (emotional regulation, conflict resolution, etc.): [https://www.massgeneral.org/psychiatry/services/treatmentprograms.aspx?id=2086&display=curriculum](https://www.massgeneral.org/psychiatry/services/treatmentprograms.aspx?id=2086&display=curriculum)
- Suicide Prevention Lifeline: [https://suicidepreventionlifeline.org](https://suicidepreventionlifeline.org) (has phone call, text, and e-chat options)
- Young Mania Rating Scale: [https://www.mcpap.com/pdf/YoungManiaScale.pdf](https://www.mcpap.com/pdf/YoungManiaScale.pdf)
Questions?
Thank you!
References:

References: (continued)

- MCPAP. (n.d.). Depression “clinical pearls” for primary care providers. Retrieved from https://docs.google.com/presentation/d/1mT_mRAPU04fZc1qJul66EKVPnYSdoNtkaSDV3dHudIl/edit#slide=id.g51c35f2b9e_0_28
References (continued)


