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ADOLESCENT DEPRESSION

Help your patient emerge from the darkness

When should you pursue active support and monitoring vs cognitive behavioral therapy or interpersonal therapy? Is medication needed? This second installment in our 2-part series will help you refine your treatment approach.

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Last month, we introduced you to 15-year-old Jane, a teenager whose once bubbly personality had in the last few months been reduced to a mood of quiet sadness. Her responses to your questions were muted, unenthusiastic. While Jane gets to school every day and can often shake off her down mood when she's with friends, her responses to the Kutcher Adolescent Depression scale suggest that she's struggling. You conclude that Jane is experiencing an episode of mild depressive disorder.

How would you manage Jane's case? And what would you do if her symptoms worsened?

What's the preference of patient and family?

Begin your initial management of a patient like Jane by considering the treatment preferences of the patient and her family, the severity and urgency of the case, the availability of mental health services, and your own comfort level with managing mental health disorders. A key conclusion of the GLAD-PC (**G**uide**L**ines for **A**dolescent **D**epression in **P**rimary **C**are) collaborative, described in Part 1 of this series, was that family physicians, alone or in collaboration with mental health professionals, are competent to manage adolescent depression.[1] You may or may not choose to manage a patient like Jane yourself, but even if you refer, your initial management provides an essential bridge until the patient and her family are seen by mental health professionals.

Your initial management should include the following:

- education
- a treatment plan
- safety planning.

Step 1: Educate patient and parents

Help your patient to better understand what it means to have depression. Describe the signs and symptoms that led to the diagnosis of depression and review the natural history of the illness, including the chronic nature of the disorder and its tendency to recur. Explain, too, the impact that depression can have on different areas of functioning, such as school performance and peer relationships, and then review the treatment options. You or someone on

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TABLE 1

Online resources

SOURCE	WEBSITE
American Academy of Child and Adolescent Psychiatry	http://www.aacap.org/cs/root/facts_for_families/the_depressed_child
Families for Depression Awareness	www.familyaware.org
National Alliance on Mental Illness	http://www.nami.org/depression
National Institute of Mental Health	http://www.nimh.nih.gov/health/publications/depression

your staff can provide this patient education initially, but it is also critical to connect the family to specific community resources for additional education, advocacy, and peer support.[1]

To do this effectively, you need to establish links with mental health resources in the community, including mental health service providers, as well as patients and families who have dealt with adolescent depression and are willing to serve as resources to other teens and their families. The GLAD-PC toolkit, available at www.gladpc.org, provides patient education handouts and links to reputable Web sites, advocacy organizations, and peer support groups. Additional online resources are listed in **TABLE 1**.

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Establishing a safety plan is especially important during the period of diagnosis and initial treatment, when suicide risk is highest.

Step 2: Work out a treatment plan

Developing a treatment plan that the patient and her parents can accept is critical. A plan that includes psychotherapy with a mental health provider, for example, won't be acceptable to some patients and parents. They may refuse to participate, or their underlying mistrust may affect the outcome of treatment.[2,3] Other families may reject any therapeutic approach that includes psychotropic drugs.

Expectations about the benefits of treatment influence outcomes significantly, so that, too, is a topic to explore as the treatment plan is worked out.[3,4] Finally, the plan should include agreed-upon goals of treatment. For Jane, planned goals might include getting back into gymnastics or trying out for the school play.

Step 3: Plan for safety

Suicidality, including ideation, behaviors, or attempts, is common among adolescents with depression.[5,6] In studies of completed suicide, more than 50% of the victims had a diagnosis of depression.[5] To keep your patient safe, develop an emergency communication mechanism for handling increased suicidality or acute crises. If the patient's risk is high, as shown by a clear plan or intent, immediate hospitalization may be necessary.

If you determine that inpatient treatment is not needed, you need to be sure that adequate adult supervision and support are available; that the teenager does not have access to potentially lethal medications, knives and other sharp objects, or firearms; and that both the patient and parents understand that drugs and alcohol weaken inhibitions. You need to set up a contingency plan with the family that includes checking in with you at reasonable intervals to assure the teen's safety.[5]

Establishing a safety plan is especially important during the period of diagnosis and initial treatment, when suicide risk is highest.[6] Confidentiality is the norm in adolescent medicine, but a patient like Jane must understand that you will breach confidentiality if that is necessary to keep her safe from harm.

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GLAD-PC Recommendation I: Family physicians should educate and counsel families and patients about depression and options for the management of the disorder (strength of recommendation [SOR]: **C,** expert opinion). Family physicians should also discuss the limits of confidentiality with the adolescent and family (SOR: **C,** expert opinion).

GLAD-PC Recommendation II: Family physicians should develop a treatment plan with patients and families (SOR: **C,** expert opinion) and set specific treatment goals in key areas of functioning, including home, peer, and school settings (SOR: **C,** expert opinion).

GLAD-PC Recommendation III: The family physician should establish relevant links/collaboration with mental health resources in the community (SOR: **C,** expert opinion), which may include patients and families who have dealt with adolescent depression and are willing to serve as resources to other affected adolescents and their family members (SOR: **C,** expert opinion).

GLAD-PC Recommendation IV: Management must include the establishment of a safety plan, which includes restricting lethal means, engaging a concerned third party, and implementing an emergency communication mechanism should the patient deteriorate, become actively suicidal or dangerous to others, or experience an acute crisis associated with psychosocial stressors, especially during the period of initial treatment when safety concerns are highest (SOR: **C,** case control study and expert opinion).

Treatment options: When active support is best

Selecting the appropriate treatment modality for your patient hinges, of course, on the severity of the teen's depression. (For more information on how to determine the severity of a depressive episode, see the first installment of this series, "Adolescent depression: Is your young patient suffering in silence?" *J Fam Pract*. 2009;58:187-192.)

When caring for a patient like Jane who is suffering from mild depression, consider providing active support and monitoring during 6 to 8 weekly or biweekly visits before recommending antidepressant medication or psychotherapy. This approach is also indicated when depressed patients or their parents refuse other treatments.[7]

Active support and monitoring may include education, frequent follow-up, a prescribed regimen of exercise and leisure activities, referral to a peer support group, and review of self-management goals. Other resources for active monitoring can be found in the GLAD-PC toolkit (available at www.gladpc.org). Evidence from randomized controlled trials (RCTs) shows that a sizable percentage of young people with depression respond to nondirective supportive therapy and regular symptom monitoring.[7] Furthermore, emerging data from the research literature, expert opinion, and patient and family preferences indicate that active support and monitoring from family physicians is an important therapeutic strategy.[7,8]

Is therapy needed—and if so, what kind?

Adolescents with moderate or severe depression or patients with mild depression whose symptoms do not improve with active support and monitoring alone will likely require treatment with one of the evidenced-based treatments, such as psychotherapy or antidepressants. Referral to a mental health provider for further assessment or treatment may also be required, depending on the training of the physician.[7,8] If so, you and the mental health provider will need to negotiate your roles and responsibilities for ongoing management, with the input and approval of the patient and family.

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A sizable percentage of young people with depression respond to nondirective supportive therapy and regular symptom monitoring.

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TABLE 2

6 questions to ask prospective therapists

1. What type of therapy can you provide—cognitive behavioral therapy (CBT), interpersonal therapy for adolescents (IPT-A), psychodynamic psychotherapy, supportive therapy, counseling, or eclectic (including elements of IPT-A and CBT)? *The evidence suggests that CBT and IPT-A are the treatments of choice for teens with depression.*
2. Have you received training in that therapy for adolescents with depression? Where and when? *The therapist should have been trained in a clinical program (social work, nursing, psychology) that involved adolescents.*
3. Have you received clinical supervision in that therapy? Where? For how long? How many cases? *Generally, therapists should be supervised for at least 3 to 4 cases before they are considered proficient.*
4. Are there specific tasks scheduled for each session? *There should be for CBT, but not for IPT-A.*
5. Is the therapy time-limited? *CBT and IPT-A are both time-limited.*
6. What are the goals of the therapy? *The goals for both CBT and IPT-A should be the resolution of depressive symptoms.*

Source: This list has been adapted by Amy Cheung, MD, from her contributions to the forthcoming book tentatively entitled *Assessment and Treatment of Pediatric Depression: State of the Science; Best Practices* (Editors: Peter S. Jensen, MD, Amy Cheung, MD, Ruth Stein, MD, and Rachel A. Zuckerbrot, MD), to be published by Civic Research Institute, Inc. All rights reserved.

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Only fluoxetine has been approved by the FDA for children and adolescents with depression.

Both cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) have been adapted to address major depressive disorder (MDD) in adolescents and have been shown to be effective in community as well as specialized settings.[9-11]

CBT is time-limited and delivered individually or by 1 or 2 clinicians working with a group. Clinicians follow a manual to guide each session.[12] (A manual for therapists and a workbook for adolescents and parents can be downloaded from the Kaiser Permanente Center for Health Research Web site at http://www.kpchr.org/public/acwd/acwd.html.)

The focus of CBT is to change patients' perception of themselves, their world, and others. CBT treats depression by identifying behavioral and cognitive patterns associated with depressive cycles. Examples of such patterns include the propensity to withdraw from pleasurable activities, or irritability that alienates family and friends just when the teenager needs them most. CBT helps teens identify these self-defeating patterns, encourages them to take part in activities they enjoy, helps develop or reactivate social skills important for maintaining positive social interactions, and helps teens to develop problem-solving strategies for resolving stressful situations.

CBT also aims to correct maladaptive beliefs associated with the patient's depression. If, for instance, a patient believes she is worthless if she's not accepted by the "popular" group at school, she is likely to become depressed and stay depressed as long as she is having difficulty connecting with her peers. CBT would help her examine that belief and learn to feel worthwhile even if she is not accepted by the "in" group. In general, CBT sessions are scheduled on a weekly basis for 12 to 16 weeks. In each session, the therapist and patient complete specific tasks and exercises that are provided in a CBT manual. There are also tasks for the patient to complete between sessions and review later with the therapist. CBT has been used in primary care with preliminary positive results.[13,14] However, the results of a recent RCT conducted in psychiatric settings demonstrated superior efficacy of combination therapy (fluoxetine and CBT) vs CBT alone.[15]

IPT for adolescents (IPT-A) is like CBT in that it is time-limited and clinicians are guided by a manual.[16] A course of therapy can last anywhere from 12 to 16 sessions

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with optional maintenance treatment. The theoretical basis for IPT-A is the observed negative impact of depressive symptoms on interpersonal relationships, and the effect poor relationships have in causing and perpetuating depression. In deciding whether a patient may be suitable for IPT-A, you need to find out whether she would be willing to share her experiences of ongoing relationship conflicts with a therapist or therapeutic group. The relationship difficulties IPT-A is designed to help with arise from 1 of 4 sources: grief, fights with peers or family members (interpersonal disputes), transitions from one social surround to another (role transition), and friendlessness (interpersonal deficits).

IPT-A focuses on grief only when someone of significance to the patient has died. Therapy for teens who quarrel frequently with peers or family members is focused on interpersonal disputes, and this is the most common focus in IPT-A. A focus on role transition is called for when the teen's social world has undergone a drastic change, such as a when a teen has moved to a new school or broken up with a boyfriend. Finally, therapy for a teen with no significant relationships outside the immediate family focuses on interpersonal deficits. In these cases, the goal of therapy is to increase social contact and help the patient build relationships. If your preliminary assessment identifies your patient's difficulties as rooted in 1 of these 4 areas, IPT-A may be for her.

Because few family physicians are trained in CBT or IPT-A, most psychotherapy will be provided by mental health professionals. What you *can* provide is familiarity with available community mental health resources. To get to know the therapists in your community, you may want to reach out to a few of them and ask them the questions in **TABLE 2**. You may also want to share this list with parents who want to find their own therapist.

Choose an antidepressant, monitor with care

Studies have shown that up to 42% of family physicians in the United States had recently prescribed selective serotonin reuptake inhibitors (SSRIs) for more than 1 adolescent under the age of 18.[17] When the diagnosis of MDD without comorbid conditions is clear and the patient and family are amenable, you may want to prescribe an SSRI.[7,8]

If you do, warn the patient and family that antidepressants can sometimes have adverse effects, including a switch from depressive to manic symptoms, signs of behavioral activation including agitation, hostility or restlessness, and suicidal ideation or behavior. If the patient can tolerate the medication without significant adverse effects, you need to prescribe the effective dose for at least 6 to 8 weeks to ensure an adequate trial.[7]

TABLE 3 provides some guidance for prescribing antidepressants for adolescents with depression.[7] Among the antidepressants, only fluoxetine has been approved by the FDA for children and adolescents with depression. Fluoxetine is also the SSRI with the strongest evidence for efficacy in the adolescent population, as demonstrated in 4 RCTs.[18] Two studies involving fluoxetine for depression have also shown efficacy in children as young as age 7 (range, 7-12 years).[19]

Effective dosages for antidepressants are lower for adolescents than for adults. Initiate medications at a low dose and increase in recommended increments every 2 weeks if no significant adverse effects emerge. With the exception of fluoxetine, SSRI medications must be discontinued slowly to minimize the risk of discontinuation effects.

Once treatment begins, you or a member of your staff will need to stay in touch with the patient and family to review their continued adherence to the treatment plan. An FDA black-box warning recommends observing for "clinical worsening, suicidality, and unusual changes in behavior" during initial

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Families who know what to expect with antidepressants are most likely to stay with treatment for the duration.

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TABLE 3

A guide to prescribing antidepressants for adolescents

MEDICATION	STARTING DOSE	EFFECTIVE DOSE	MAXIMUM DOSE	NOT TO BE USED WITH	COMMON ADVERSE EFFECTS
Citalopram	10 mg/d	20 mg	60 mg	MAOIs	Headache, GI upset, insomnia
Fluoxetine	10 mg/d	20 mg	60 mg	MAOIs	Headache, GI upset, insomnia, agitation, anxiety
Fluvoxamine	25-50 mg/d	150 mg	300 mg	MAOIs and pimozide	Headache, GI upset, drowsiness
Paroxetine	10 mg/d	20 mg	60 mg	MAOIs	Headache, GI upset, insomnia
Sertraline	25 mg/d	100 mg	200 mg	MAOIs	Headache, GI upset, insomnia
Escitalopram	5 mg/d	10-20 mg	20 mg	MAOIs	Headache, GI upset, insomnia

MAOI, monoamine oxidase inhibitor.

Source: This table has been adapted by Amy Cheung, MD, from her contributions to the forthcoming book tentatively entitled, *Assessment and Treatment of Pediatric Depression: State of the Science; Best Practices* (Editors: Peter S. Jensen, MD, Amy Cheung, MD, Ruth Stein, MD, and Rachel A. Zuckerbrot, MD), to be published by Civic Research Institute, Inc. All rights reserved.

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Drug therapy for teens should continue at the same dosage for 6 to 12 months after symptoms resolve.

visits or "at times of dose changes, either increases or decreases." Develop a regular, frequent monitoring schedule with input from the teen and her (or his) parents to ensure compliance.[7,20]

Make sure follow-up appointments are not missed, using flags in patient records or in the clinic schedule. The duration of treatment for teens with depression is yet to be determined through clinical trials. Most guidelines suggest drug therapy be continued at the same dosage for 6 to 12 months after symptoms resolve. Guidelines for the treatment of adolescent depression can be found at www.gladpc.org.

Keeping teenagers on an antidepressant regimen can be challenging, given the side effects, the amount of time it takes before they experience an improvement, and the lengthy duration of treatment. Families that know what to expect and are getting continuing support from you and others are most likely to stay with treatment for the duration.

GLAD-PC Recommendation V: After initial diagnosis in cases of mild depression, family physicians should consider a period of active support and monitoring before starting other evidence-based treatments (SOR: **C,** expert opinion).

GLAD-PC Recommendation VI: If a family physician identifies an adolescent with moderate or severe depression or complicating factors/conditions such as co-existing substance abuse or psychosis, consultation with a mental health specialist should be considered (SOR: **C,** expert opinion). Appropriate roles and responsibilities for ongoing management by the family physician and mental health provider should be communicated and agreed upon (SOR: **C,** expert opinion).

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The patient and family should be consulted and approve of the roles negotiated by the family physician and mental health professionals (SOR: **C,** expert opinion).

GLAD-PC Recommendation VII: Family physicians should recommend scientifically tested and proven treatments (eg, psychotherapies such as cognitive behavioral therapy or interpersonal therapy, and/or antidepressant treatment such as SSRIs) whenever possible and appropriate to achieve the goals of the treatment plan (SOR: **A,** RCTs).

GLAD-PC Recommendation VIII: Family physicians should monitor for the emergence of adverse events during antidepressant treatment (SSRIs) (SOR: **C,** expert opinion).

Should you screen every teen? Guidelines have changed

The US Preventive Services Task Force now recommends screening all adolescents (12-18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive behavioral therapy or interpersonal therapy), and follow-up. Previously, the Task Force concluded that the evidence was insufficient to recommend for or against the practice. For more on the Task Force's recommendations, go to www.ahrq.gov/clinic/uspstf09/depression/chdeprrs.htm.

What about Jane?

As the family's physician, your initial management began with you educating Jane and her parents about mild depressive disorder and its likely course. You set up a series of weekly visits to monitor her symptoms and provide active support. You helped Jane find a peer support group and encouraged her to get back into gymnastics. You taught Jane and her family about the importance of keeping her safe while she is depressed, and they were cooperative about safety-proofing their home and setting up a plan to handle emergencies.

Jane's depressive symptoms gradually ebbed, and she returned to her previous level of energy and social activity. You warned her and her family about the possibility that the disorder might recur, so they would be prepared. ■

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Disclosures

Dr. Cheung served on Eli Lilly's speakers' bureau between 2004 and 2005. Dr. Jensen serves as a consultant to Shire, Inc., Janssen-Ortho, Inc., McNeil Pharmaceuticals, and Best Practice, Inc. Drs. Ewigman and Zuckerbrot reported no conflict of interest relevant to this article.

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For more on the USPSTF's recommendations on screening and treating depression in adolescents, go to www.ahrq.gov/clinic/uspstf09/depression/chdeprrs.htm

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