Fast and Effective Treatment of Anxiety and Depression in the Primary Care Office

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- I have had the following financial relationships with the manufacturers of any commercial products and/or provider of commercial services discussed in this CME activity. Research support from: Eli Lilly – Clinical Trials involving atomoxetine and olanzapine.
Objectives

- Review the diagnosis and treatment of Depression and Anxiety Disorders in children and adolescents
- Look at practical steps to keeping treatment fast and effective
- Understand the controversy of increased suicidality in adolescents treated with SSRIs.

Pediatricians (and other Primary Care Providers) can treat Depression and Anxiety
AAP Policy

Mental Health Competencies

- www.aap.org/commpeds/dochs/mentalhealth
- Currently a goal, not a expectation
- Target disorders:
  - ADHD
  - Anxiety
  - Depression
  - Substance Abuse
- Recognize Psychiatric and Social Emergencies
- Building Resiliency in Children
- Community Advocacy

Fast Steps

- Recognition
- Attitude
- Triage
- Treat
Step One - Recognition

- Rarely is Depression a chief complaint
  - Pattern of frequent visits, school absentees, vague somatic complaints
- Anxiety – more likely to be chief complaint, but not always...
  - Also can present as somatic complaint
  - Can present as troublesome behavior

Depression
### Lifetime Prevalence of Common Psychiatric Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Lifetime Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depressive disorder</td>
<td>17.1%</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>14.1%</td>
</tr>
<tr>
<td>Social anxiety disorder</td>
<td>13.3%</td>
</tr>
<tr>
<td>Posttraumatic stress disorder (PTSD)</td>
<td>7.8%</td>
</tr>
<tr>
<td>Generalized anxiety disorder (GAD)</td>
<td>5.1%</td>
</tr>
<tr>
<td>Premenstrual dysphoric disorder (PMDD)</td>
<td>5%*</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>3.5%</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder (OCD)</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

*In menstruating women.


### Prevalence in Children

- **Depression Prevalence in Community Samples**
  - Roughly 2-3%
- **Male:Female Ratio 1:1**
- **Presents more with irritability than sadness**

http://www.aafp.org/afp/20030201/british.html
Prevalence in Adolescents

- Depression Prevalence in Community Samples
  - Roughly 2-6%
  - Sharp rise of prevalence at onset of puberty
- Male:Female Ratio 1:2
- Presents more with irritability or withdrawal than sadness

Leading causes of Mortality in Adolescents

- 1- Unintentional Injuries
- 2- Homicide
- 3- Suicide
- 4- Malignant Neoplasms
- 5- Heart Disease
### MDD – Children and Adolescents

Five or more of the following symptoms are present most of the day, nearly every day, during a period of at least 2 consecutive weeks and cause significant dysfunction (DSM-IV-TR™ 2000)

<table>
<thead>
<tr>
<th>At least 1 of these 2 symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depressed mood <em>(Note: In Children or Adolescents, can be irritable mood)</em></td>
</tr>
<tr>
<td>2. Loss of interest or pleasure in all, or almost all, usual activities</td>
</tr>
<tr>
<td>3. Significant weight loss or weight gain <em>(Note: In Children, consider failure to make expected weight gains)</em></td>
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<tr>
<td>4. Insomnia or hypersomnia</td>
</tr>
<tr>
<td>5. Psychomotor agitation or retardation</td>
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<tr>
<td>6. Fatigue or loss of energy</td>
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<tr>
<td>7. Feelings of worthlessness or excessive or inappropriate guilt</td>
</tr>
<tr>
<td>8. Diminished ability to think or concentrate or indecisiveness</td>
</tr>
<tr>
<td>9. Recurrent thoughts of death or suicide</td>
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</tbody>
</table>

### Depression (DSM-IV-TR)

- **B** - The symptoms do not meet criteria for a Mixed Episode.
- **C** - The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- **D** - The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- **E** - The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.
How Depression Really Presents

- Overall, 69% of depressed patients (range 45%-95%; \( P=.002 \)) present with somatic complaints that can complicate diagnosis, such as
  - Headaches
  - Weakness
  - Constipation
  - Back pain
  - Joint pain
  - Abdominal pain

Simon 1999; Depression in Primary Care 1 (AHCPR), 1993.

Bottom Line for Diagnosis

- Clinical depression presents with significant dysfunction, especially from baseline function
- Ask about irritability
- Vague Physical Symptoms with no Signs
PMDD (formerly PMS)

- Pre-menstrual Dysphoric Disorder
- Can begin in adolescence
- Treatment
  - Lifestyle change – quit smoking, eat right
  - SSRIs for severe symptoms
  - regulation of cycle/hormonal fluctuations –
    BCP – only limited evidence of benefit
- Seasonique/Seasonale – not fully tested

Anxiety Disorders

- Separation Anxiety/ School Phobia
- Generalized Anxiety Disorder
- Obsessive-Compulsive Disorder
- PTSD
- Social Anxiety
- Panic Disorder/ Agoraphobia
- Aspergers/ Autism Spectrum
Anxiety is Normal

- Infant – loud noises, stranger
- Toddler – separation, monsters, dark
- School-Age – injury, natural events
- Adolescents – school performance, social competence
- Adults – Finances, taxes, lectures about coding

Separation Anxiety

- Common in 4-5 year olds, abnormal at other ages
- Treat quickly at all ages
- Can present as somatic symptoms
- Get back in school quickly
- Involve all parties – parents, teachers, bus driver, school nurse
Generalized Anxiety Disorder

- The nervous child
- Is it dysfunctional?
- Chronic worry about schoolwork, social interactions, family, world events
- Also need at least one somatic symptom (e.g. headache, stomachache)
- Frequently seek reassurance

Obsessive-Compulsive Disorder

- Relatively rare in children in isolated form
- High comorbidity with Tourette’s, Autism spectrum
- Treat with SSRIs, sometimes higher doses are needed.
PTSD

- Post-Traumatic Stress Disorder
- Treatment with Trauma Focused – Cognitive Behavioral Therapy (TFCBT)
- SSRIs occasionally for depressive symptoms
- Tenex, Clonidine for hyperarousal
- Prazosin, for better sleep, less nightmares

Social Anxiety

- Develops in Adolescence
- Different than a shy temperament
- Symptoms more based on fear of embarrassment in social situations, avoidance of these situations
- Treatment – CBT, and sometimes Medication (SSRIs)
- Performance Anxiety – pre-performance propranolol (10mg) if moderate-severe
Anxiety in Aspergers

- A common precipitant to many troublesome behaviors for children and adolescents with Aspergers or high-functioning autism.
- Outbursts of aggression in social situations were social cues are missed.
- Tantrums/ irritability related to change in routine/expected consequence.

Step Two - Attitude

- 80% of Pediatricians believe they should be responsible for recognition of all mental health problems (except learning disorders).
- Less than one-third felt they should be responsible for treating (except ADHD).
Attitude - Art of Listening

- Listen first
- Then focus in on what you can help

Practical Approach to Adolescents

- Address them first
- See them alone if possible first, then with parents
- Explain your role (for them)
- Show interest in their interests
- Establish boundaries for confidentiality
- Gain their consent for therapies/meds
- Hand prescriptions, appointments to them
Step Three - Triage

- Counseling/Therapy
- Social Worker
- School Interventions
- Bibliotherapy
- Medication

Depression – Treatment Guidelines for Children and Adolescents

- Psychotherapy
  - Cognitive Behavioral Therapy (CBT)
  - Interpersonal Therapy (IPT)
- Pharmacotherapy
  - SSRIs – first line
  - TCAs – usually not indicated – never showed efficacy over placebo
- Combined Psychotherapy/Pharmacotherapy
- Continue treatment for 6-12 months after remission achieved.

Books to recommend

- CBT for adolescents

Book Recommendations

By Dawn Huebner

By Craske And Barlow
Step Four - Treat

- Only use medicines when:
  - Dysfunction is severe
  - Repeated History
  - Family History
  - Compliant Family

SSRI Approvals for Children and Adolescents

- Prozac – MDD – approved for ages 8-17
- Lexapro – MDD – approved for ages 12-17
- Prozac – OCD – approved for ages 7-17
- Zoloft – OCD – approved for ages 6-17
- Luvox – OCD – approved for ages 8-17
- Paxil – none
- Celexa – none
- Effexor – none
- Pristiq – none
- Wellbutrin SR – none
- Remeron – none
- Cymbalta – none
SSRIs – Practical Considerations in Children and Adolescents

DEMONSTRATED EFFICACY

- Prozac – start 5-10mg qam, increase to 10-20mg
  - Generic Tablets – 10mg, variable split-ability
  - Liquid (20mg/5cc), mint flavor, mixed reviews
- Zoloft – start low, 12.5mg qam (1/2 tab of 25mg) for 4-6 days, can start at 25mg in adolescents
  - 25mg Tablet – easy to split
  - Liquid (20mg/ml) has 20% alcohol
  - Must be mixed in juice, ginger ale, alcohol aftertaste

SSRIs – Practical Considerations in Children and Adolescents

USE ONLY WITH CAUTION DUE TO POOR RISK/BENEFIT

- Celexa – start 10mg qam, increase to 20mg qam
  - Liquid (10mg/5cc), peppermint flavor (best)
- Luvox CR – start 25mg qhs, increase to 50mg qhs
  - no Liquid, does not have adult MDD indication
- Lexapro – start 5mg qam, move to 10mg qam
  - Liquid (5mg/5cc), peppermint flavor (best)
- Paxil – Paxil CR, start 12.5 mg qam, increase to 25mg
  - Susp. (10mg/5cc), orange flavor, Palatable, start 10 mg qam, increase to 20 mg qam
Second Line Therapies

SSRIs are first line in child and adolescent depression

Second Line: Combined Serotonin and Norepinephrine Reuptake Inhibitors
- Venlafaxine (Effexor XR) – one RCT with no benefit over placebo, cardiac arrhythmias in overdose
- Duloxetine (Cymbalta) – no studies yet
- Nefazodone (Serzone) – may be taken off market due to rare hepatotoxicity
- Mirtazapine (Remeron) – good for sleep but large weight gain
- Pristiq (desvenlafaxine) – no studies yet

Second Line Therapies

Dopamine/ Norepinephrine Reuptake Inhibitor
- Wellbutrin SR/XL (maybe useful if need to avoid SSRI induced mania in Bipolar patients who are depressed)

Anticonvulsants
- Lamotrigine (Lamictal)

EMSAM – Selegeline patch

Rare
- ECT (a few case reports in adolescents)
Step 4 - Treat

- Best strategy is to pick one or two of the SSRIs you are most comfortable using and get good at prescribing them.

Anxiety Treatment

- CBT (Cognitive Behavioral Therapy) has a large body of evidence of working for most anxiety diagnosis and severity.
- SSRIs are the medicine of choice:
  - For moderate to severe impairment
  - Well-tolerated
  - Start a little lower, go a little slower
  - Caution if strong family history of Bipolar
Benzodiazepines

- No proven benefit in clinical trials for children and adolescents, actually worse than placebo for PTSD
- May have use as short term anxiety treatment, or waiting for SSRI to start working

Side Effects - SSRIs

SSRIs are contraindicated until at least 14 days have passed since discontinuing a monoamine oxidase inhibitor (MAOI) and an MAOI is contraindicated for at least 14 days after discontinuation of an SSRI.

**Common – Use in gaining consent**

GI: Nausea, diarrhea, dyspepsia, anorexia (decreased with low starting doses)

Sexual: ejaculation failure (primarily ejaculatory delay), libido decreased (decreased desire)

Sleep: insomnia, somnolence

**Less Common**

Fatigue, dry mouth, weight gain, induction of manic phase

Tremor, increased sweating

**What about advising for possible suicide risk?**
Accountability in a Pharmaceutical Age

- Take time to consider true causes of disease and consequences of behavior

Biopsychosocial Model of Depression

- Generic Vulnerabilities (personality, physiology, brain structure)
- Traumatic Early Experiences (abuse, stress, loss of parent, drug/alcohol use, illness)
- Vulnerability to Depression
- Exercise
- Antidepressants
- Psychotherapy
- Daily Stress
- Traumatic Event
- Life Event
- Depression
Adolescents and Suicide

- SSRIs are not the cause
- Causes
  - Depression
  - PTSD (from abuse, trauma)
  - Substance Abuse (esp. alcohol)

Alcohol and Teens

- In surveys of high school seniors, 66% report having used alcohol in the past month.
- Alcohol is believed to be the major cause of fatal and nonfatal traffic accidents involving teenage drivers and is linked to thousands of drownings, suicides, and injuries.
- Adolescents who spend most of their free time with peers are more likely to use drugs than those who spend most of their free time alone or with their family.

National Institute on Alcohol Abuse and Alcoholism
Depression and Suicide Rates in Adolescents

From the Oregon YRBS http://www.dhs.state.or.us/publichealth/chs/yrbsdata.cfm

Suicide Rates by Age (CDC)
Suicide Rate In Adolescents by Year (CDC)

Do SSRIs cause suicidal behaviors in adolescents?

- March 22, 2004 - FDA issued Public health Advisory advising close monitoring of patients at the beginning of antidepressant therapy
- August 18, 2004 - FDA released documents and summary
- September 14, 2004 - FDA reports that they will require use of a warning label of potential risk for increase in suicidal behaviors, details to be announced
- FDA notes that among 25 pediatric antidepressant clinical trials, there were no completed suicides
SSRIs decrease Adolescent Suicide

- Slow steady decline in adolescent suicide since the late 1980s
- Small correlation with recent hospitalization for suicide attempt and increased risk of subsequent suicide attempt with SSRI
- Although the leading cause of death from 15-19, suicide so rare, it is hard to get “outcome-based data”.

Olfsen, MD, 2006, APA Institute

Suicide Rates Going Up

- Suicides < 19 years rose by 14%
  - 2003 to 2004
  - the biggest annual increase since systematic recording began in 1979
- 22% decrease in the number of SSRI scripts
- Netherlands
  - prescriptions of SSRIs fell just as fast
  - adolescent suicides rose by 49% from 2003 to 2005.

Gibbons et al., Amer.J.Psych., 2007
Preventative Treatment of Suicidality

- Hospitalize if suicidality with a plan
- Educate at start of medication
- Be sure to ask about guns in home, access to medications
- Arrange for follow-up visit of phone-call soon after start of medication (I would suggest within 10 days)
- Arrange for therapist when indicated
- Encourage use of family-support and community-support services
  - Youth Groups
  - School Counselor / Comp.Care
  - Pastor/ Church support
  - Social Services when low SEC or abuse involved

Conclusions

- Pediatricians and other primary care providers are front line in recognizing Anxiety and Depression in children and adolescents
- Treating Anxiety and Depression involves proper referrals and medication choices
- Counsel properly regarding rare risk of increased suicidality in adolescents treated with SSRIs