Assessment and Treatment Strategies for Depression

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SAMHSA
Substance Abuse and Mental Health Services Administration

Mountain Plains (HHS Region 8)
MHTTC
Mental Health Technology Transfer Center Network
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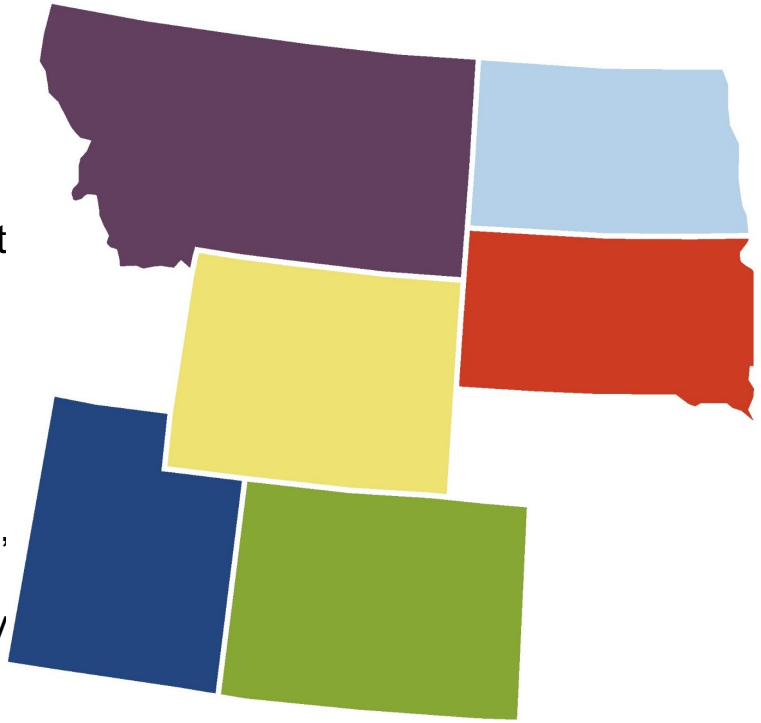
The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



Land Acknowledgement Statement

Today, the University of North Dakota rests on the ancestral lands of the Pembina and Red Lake Bands of Ojibwe and the Dakota Oyate - presently existing as composite parts of the Red Lake, Turtle Mountain, White Earth Bands, and the Dakota Tribes of Minnesota and North Dakota. We acknowledge the people who resided here for generations and recognize that the spirit of the Ojibwe and Oyate people permeates this land. As a university community, we will continue to build upon our relations with the First Nations of the State of North Dakota - the Mandan, Hidatsa, and Arikara Nation, Sisseton-Wahpeton Oyate Nation, Spirit Lake Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians.

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered and trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

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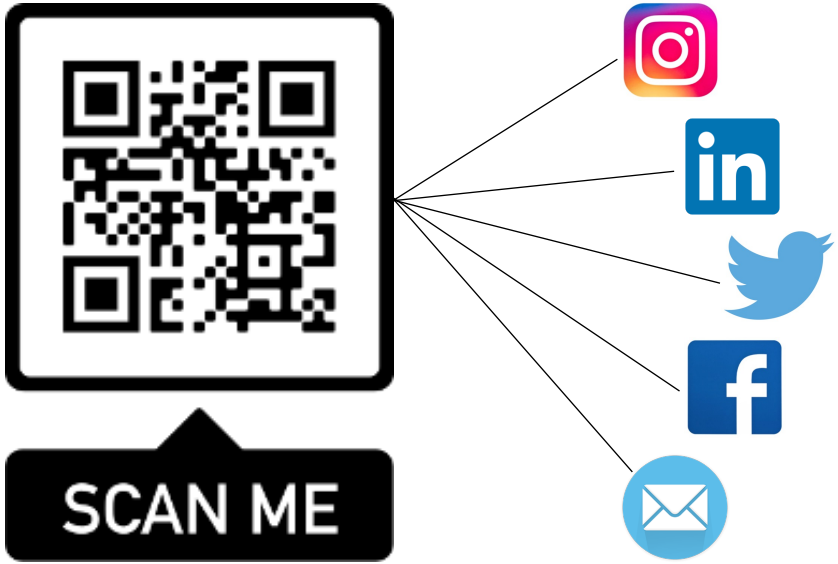

ASSESSMENT AND TREATMENT STRATEGIES FOR DEPRESSION

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Agenda

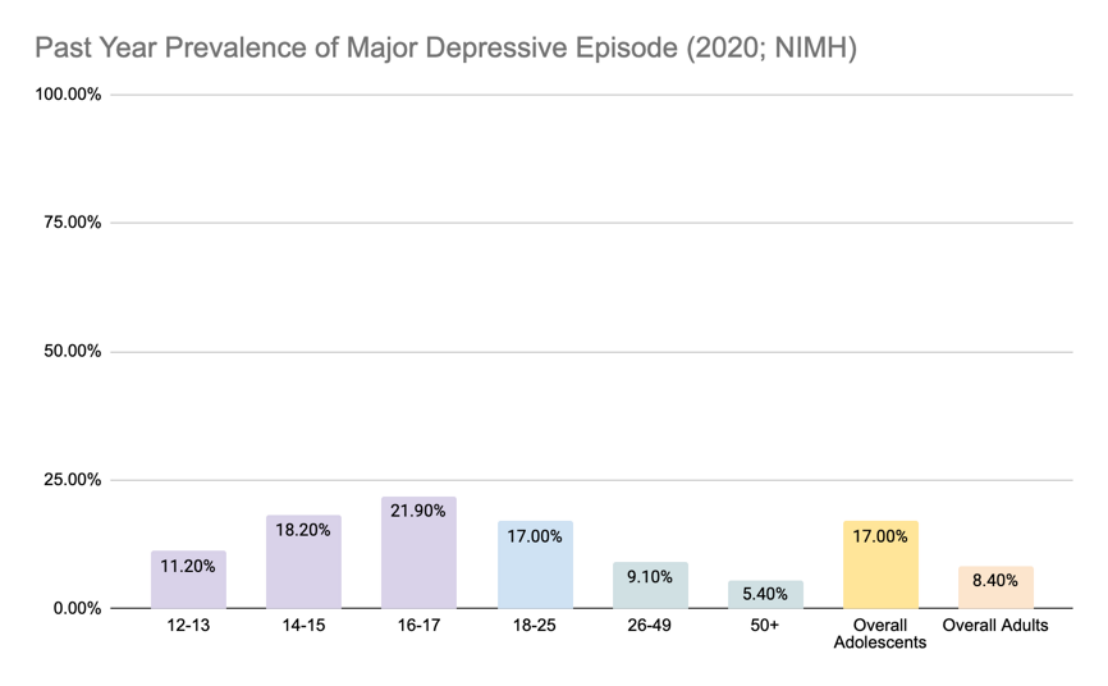
FACTS & FIGURES

CLINICAL SIGNS

SYMPTOM AND
RISK ASSESSMENT

INTERVENTION
STRATEGIES

Depression: Facts & Figures

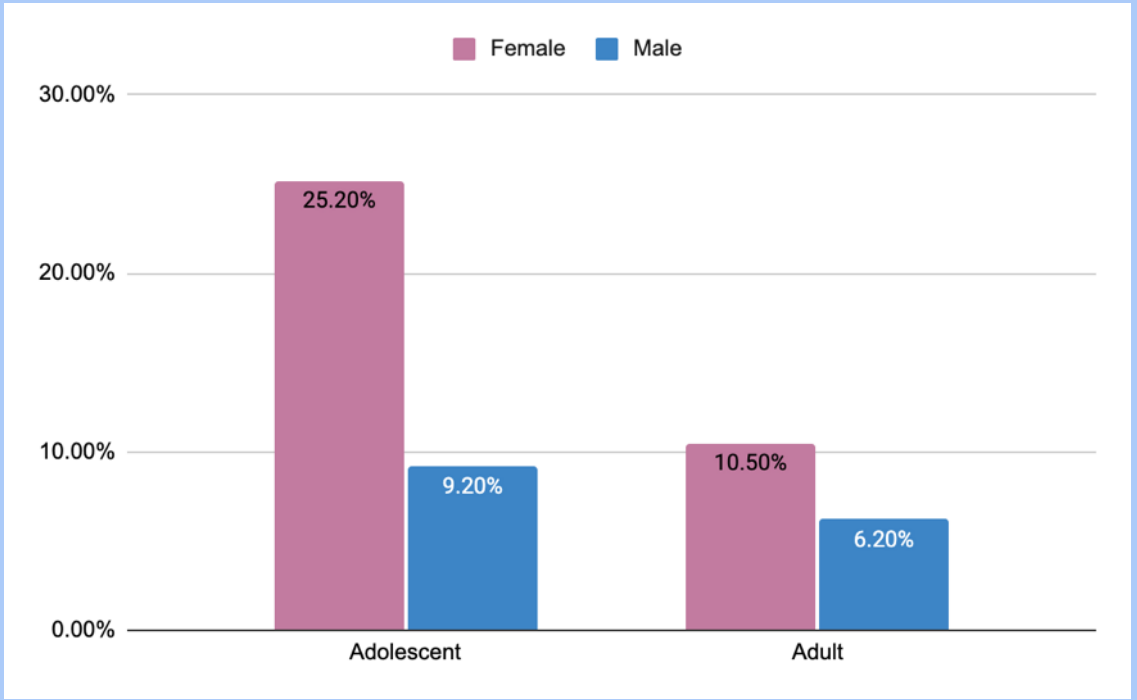


- Depression is **the leading cause of disability** in the U.S. for ages 15 to 44.
- Depression symptoms increased **more than 3-fold** during the COVID-19 pandemic, from **8.5% to 27.8%**.
- Persistent Depressive Disorder (previously Dysthymia) affects approximately **3.1 million adults (1.5%)**.

Ettman, et al., 2020; Hasin et al., 2018; Kauhanen, 2022; Mekonen, 2021; Mullen, 2018; NIMH, 2020

Sex Differences in Depression

- Individuals AFAB are diagnosed with depressive disorders at **1.95x higher rates** than those AMAB
- This difference emerges as early as 12 years old with a **peak at 13-15 years**



Ghandour, et al., 2018; NIMH, 2020; Salk, 2017

Depression & Suicide in Adolescents

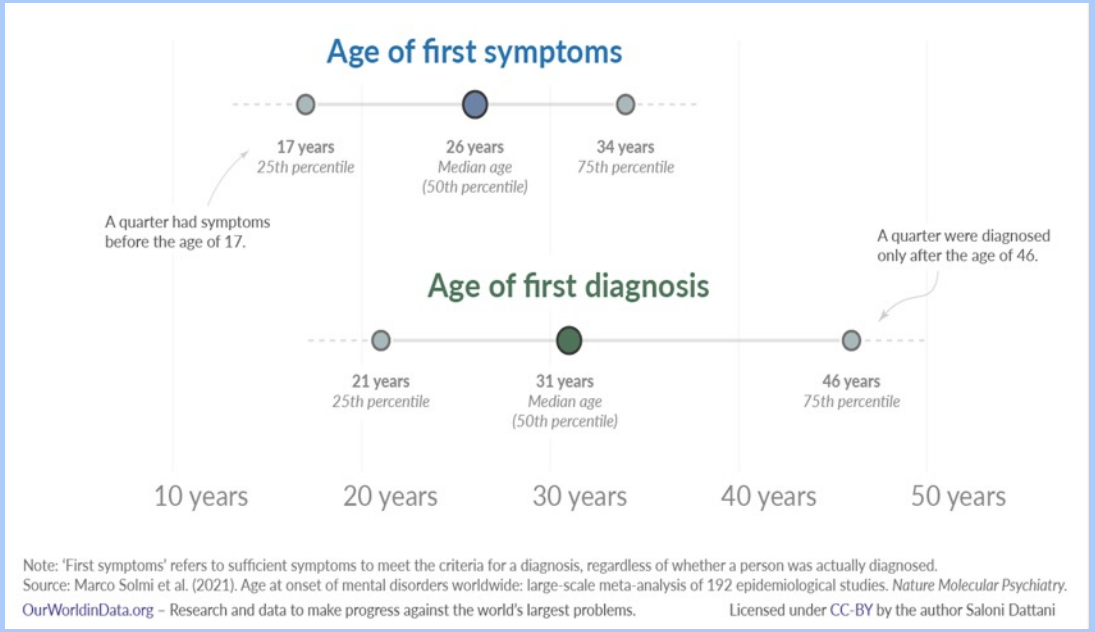
'It's Life or Death': The Mental Health Crisis Among U.S. Teens

Depression, self-harm and suicide are rising among American adolescents. For one 13-year-old, the despair was almost too much to take.

- In a national survey of adolescents:
  - *18.8% seriously considered attempting suicide.*
  - *15.7% made a suicide plan.*
  - *8.9% attempted suicide.*
  - *2.5% made a suicide attempt requiring medical treatment.*
- U.S. surgeon general warned of a "**devastating**" mental health crisis among adolescents.

Clinical Course

- Median length of depressive episode = 3 months
- An acute episode of depression can resolve without treatment
- **BUT…**depression is often **recurrent**
  - ***25–40%*** *of individuals experience a recurrence* ***within 2 years****, increasing up to 75% after 10 years, and 87% after 15 years.*



Chauvin et al., 2022; Monroe et al., 2019; Salk et al., 2017; Whiteford et al., 2013

Comorbidity

- Depression is **highly comorbid** with other psychiatric diagnoses
- **8x** more likely to have an **anxiety disorder**
- **5x** more likely to have **ADHD**
- Depression usually follows onset of other disorders
- Comorbid depression → greater symptom severity and impairment

Frank et al., 2021; Hasin et al., 2018; Van Amerigen, 2022

CLINICAL SIGNS

Major Depressive Disorder (MDD; DSM-5)

Five or more symptoms during the same 2-week period	Depressed, sad, or irritable mood
	Loss of interest in typical activities
	Appetite and/or weight changes
	Sleep disturbance (insomnia or hypersomnia)
	Slowed movement and/or restlessness
	Fatigue or loss of energy
	Feelings of worthlessness or excessive guilt
	Reduced concentration and/or decision-making
	Thoughts of death or suicide

Sadness or Major Depression? Consider intensity, duration, and impairment

Persistent Depressive Disorder (PDD; DSM-5)

Depressed mood for most of the day for the majority of days over at least a two year period (adults) or one year period (children and adolescents) *"Having more down/bad days than good"*

When depressed, two or more must be present:

- Appetite changes
- Sleep changes
- Low energy or fatigue
- Low self-esteem
- Poor concentration
- Feelings of hopelessness
- During the two year period, **the symptoms have not been absent for more two months at a time**

What Does Depression Look and Feel Like?

Mood	• *Down, depressed, sad, blue* • ***Irritable**, negative, snappy, mood swings** • "Bored" or "I just don't care"*
Physiological	• *Lack of energy, low drive* • *Sleeping and eating changes (inc in teens, dec in adults)*
Cognitive Process	• *Poor attention* • *Slowed processing speed* • *Rumination*

What Does Depression Look and Feel Like?

Cognitive "Content"

- *Self-critical, low self-esteem*
- *Global negativity*
- *Helplessness, hopelessness*

Behavioral

- *Anhedonia (boredom, trouble having fun)*
- *Crying, lack of energy*
- *Temper tantrums, aggression*
- *Social withdrawal/isolation*
- *Poor problem solving, passivity*

ASSESSMENT & SAFETY PLANNING

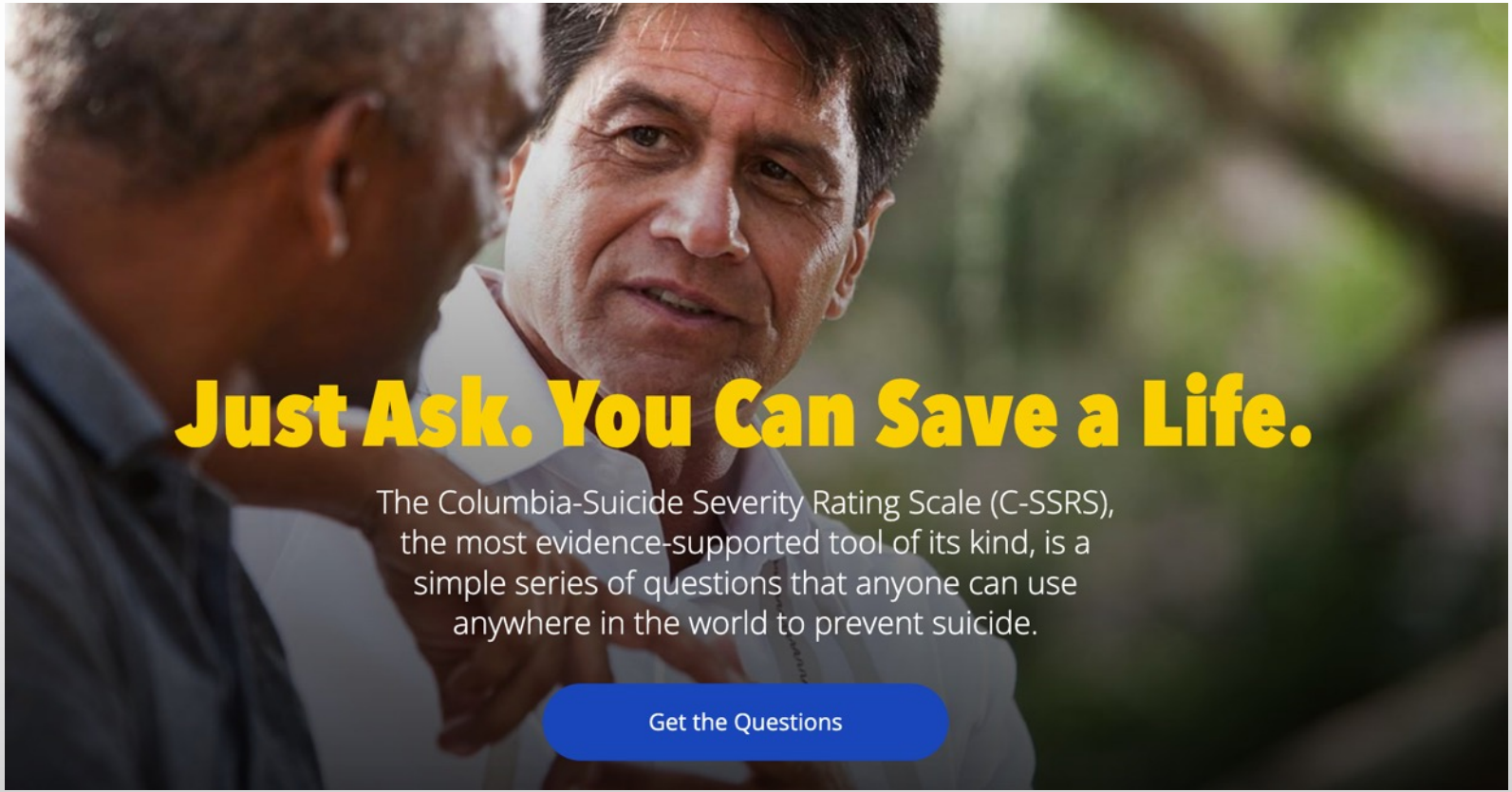
Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001)

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0 – 4	None-minimal	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 – 19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

Columbia– Suicide Severity Rating Scale (C-SSRS; Posner et al., 2008)



Columbia– Suicide Severity Rating Scale (C-SSRS; Posner et al., 2008)

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		**High Risk**

988 SUICIDE & CRISIS LIFELINE

Any YES indicates that someone should seek behavioral healthcare.

However, if the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room. STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

OPTIONS FOR TRAINING ON THE COLUMBIA TOOLS

The Columbia Lighthouse Project offers numerous free training options in more than 20 languages. The shortest training takes about 20 minutes, and almost all of them can be completed within an hour. Trainings are not setting specific. Choose the method that works best for you.

ONLINE OPTIONS

INTERACTIVE TRAINING MODULE

You can access an on-line training module created by the Center for Practice Innovation (CPI) here. This training works best in the Chrome browser. (Note: If you are not a registered NY clinician you will not be able to complete the post-test and get a certificate using this method. However, you may download a certificate of learning here).

Please contact us if you would like a copy of the SCORM files for this training for your internal Learning Management System (LMS).

WATCH A PRERECORDED WEBINAR

Watch a webinar on your own schedule by going to the Project's YouTube channel and selecting an archived webinar. They are available in 30 languages, and are less than an hour long.

PARTICIPATE IN A LIVE WEBINAR

Participate in a training in real time to get the latest information and immediate answers to your questions. Contact us to schedule one.

IN-PERSON TRAINING

In certain circumstances it may be possible to provide a training in your location. These usually run 90 min and are not limited in terms of the number of people who can attend. Travel reimbursement is not required but welcomed. Please contact us for more details.

Assess for Acute Risk Factors

Current and Past Psychiatric Dx:

- ☐ Mood Disorder
- ☐ Psychotic disorder
- ☐ Alcohol/substance abuse disorders
- ☐ PTSD
- ☐ ADHD
- ☐ TBI
- ☐ Cluster B Personality disorders or traits (i.e., Borderline, Antisocial, Histrionic & Narcissistic)
- ☐ Conduct problems (antisocial behavior, aggression, impulsivity)
- ☐ Recent onset

Presenting Symptoms:

- ☐ Anhedonia
- ☐ Impulsivity
- ☐ Hopelessness or despair
- ☐ Anxiety and/or panic
- ☐ Insomnia
- ☐ Command hallucinations
- ☐ Psychosis

Family History:

- ☐ Suicide
- ☐ Suicidal behavior
- ☐ Axis I psychiatric diagnoses requiring hospitalization

Precipitants/Stressors:

- ☐ Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated)
- ☐ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- ☐ Sexual/physical abuse
- ☐ Substance intoxication or withdrawal
- ☐ Pending incarceration or homelessness
- ☐ Legal problems
- ☐ Inadequate social supports
- ☐ Social isolation
- ☐ Perceived burden on others

Change in treatment:

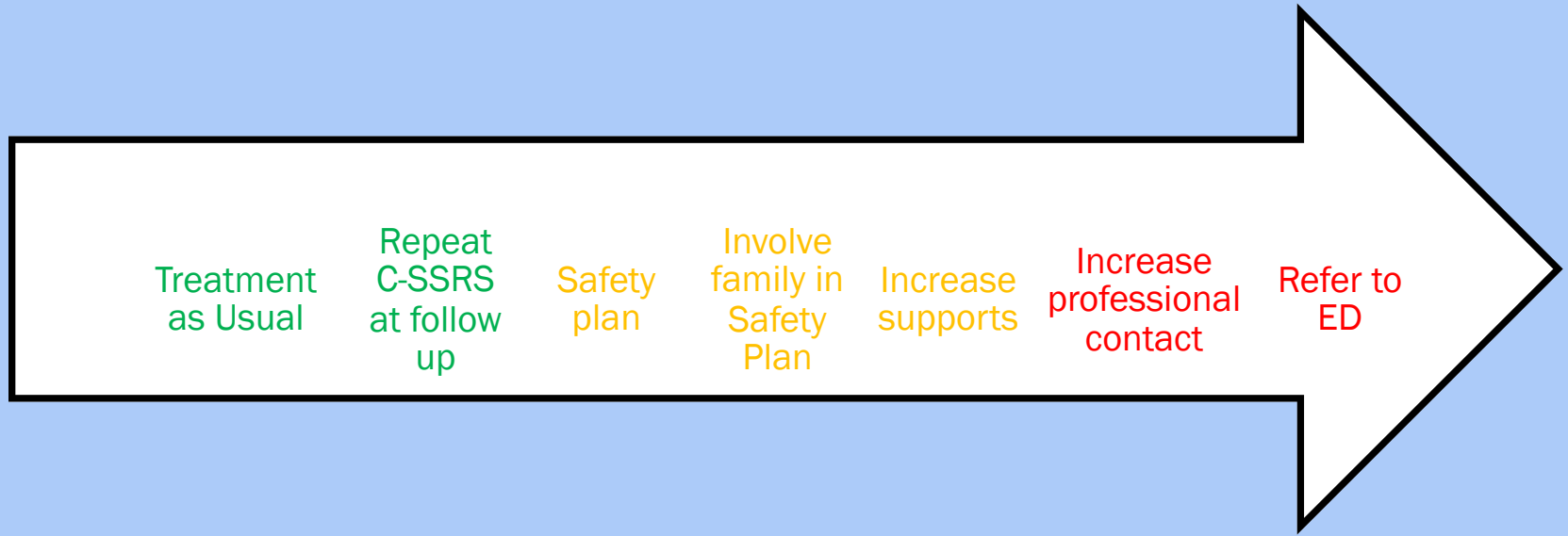
- ☐ Recent inpatient discharge
- ☐ Change in provider or treatment (i.e., medications, psychotherapy, milieu)
- ☐ Hopeless or dissatisfied with provider or treatment
- ☐ Non-compliant or not receiving treatment

☐ **Access to lethal methods:** Ask <u>specifically</u> about presence or absence of a firearm in the home or workplace or ease of accessing

Assess for Protective Factors

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)	
Internal: □ Ability to cope with stress □ Frustration tolerance □ Religious beliefs □ Fear of death or the actual act of killing self □ Identifies reasons for living	**External:** □ Cultural, spiritual and/or moral attitudes against suicide □ Responsibility to children □ Beloved pets □ Supportive social network of family or friends □ Positive therapeutic relationships □ Engaged in work or school

Decision Making based on Risk Assessment and Setting



Safety Planning

https://suicidesafetyplan.com/

SAFETY PLAN

Step 1: Warning signs (Thoughts, Feelings or Behavior):

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____
4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

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

1. Technician Name: _____ Phone_____
2. Technician Emergency Contact # _____
3. Community Worker Name: _____ Phone_____
4. Community Worker Contact #_____
5. Local Police Phone: #_____
6. Local Hospital: _____
7. Local Hospital Address: _____
8. Local Hospital Phone:

Making the environment safe:

1. _____
2. _____

Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*, 256-264

COPING/SAFETY PLAN

Step 1: Triggers

- Poor grades
- School breaks – alone time in my bed
- Fights with parents

Step 2: Warning signs that things are getting worse:

- Thinking about things I don't like about myself
- Feeling stuck in my bed
- Watching too much TV
- Enjoying things less

Step 3: Coping strategies:

- Getting dressed for the day
- Playing piano
- Get outside – get lunch with dad, take a walk
- Listen to my favorite albums
- Breathing exercise (https://www.youtube.com/watch?v=aNXKjGFUlMs)
- Watch comforting videos/songs
- Exercise (bike)
- Remind myself, there are people who care about me – my parents and close friends – and I'm deserving of care.

Step 4: People and social settings that help you take your mind off your problems and focus on other things:

1. Name: Friends (Mary, John)
2. Name: little brother, dog
3. Place: park, basketball

Step 5: People whom I can ask for help:

1. Name: Parents; Uncle Matt
2. Name: School counselor

Step 6: Professionals or agencies I can call during a crisis: ***CALL 911 IF THERE IS AN EMERGENCY OR GO TO CLOSEST ER AND ASK FOR PSYCHIATRIST ON CALL***
National suicide prevention hotline: **1-800-273-TALK** (1-800-273-8255- Available 24/7)
TEXT "HAND" TO 839683
Text START to 741-741

Step 7: Making the environment safe:

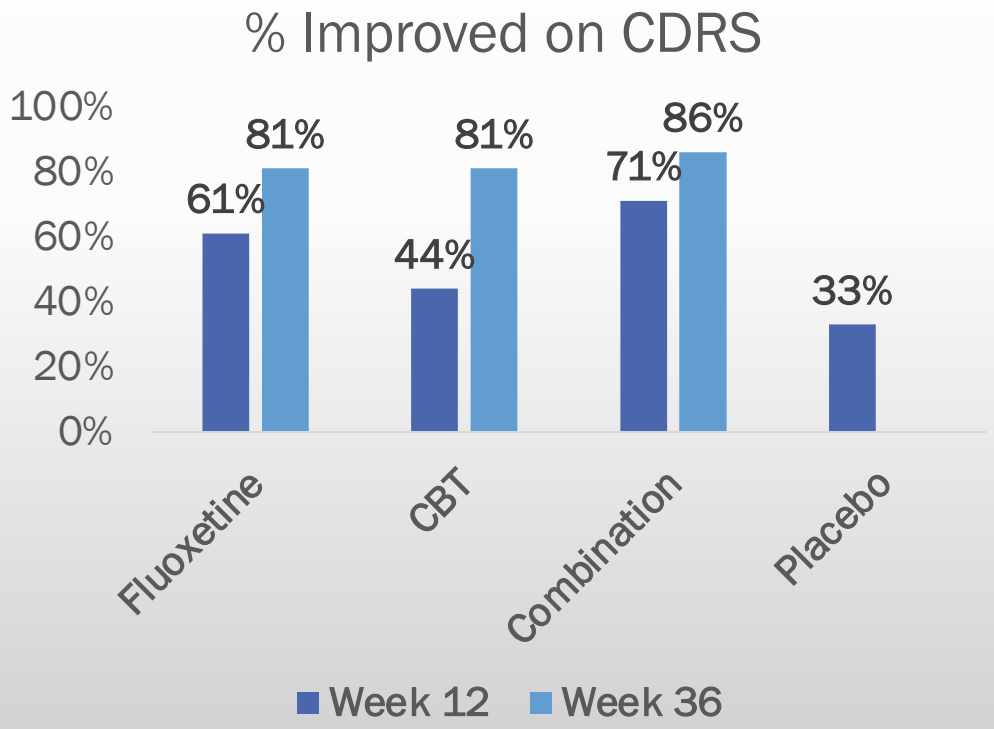
- Parents to dispense my medications for now
- Razors and sharps locked away

The thing(s) that motivate me to get help/work on feeling better: hope that things will get better and there are things to look forward to. My family

TREATMENT STRATEGIES

Treatment for Adolescents with Depression Study (TADS, 2004, 2007)

- 439 children
- 12-17 years old
- Multiple sites



Evidence-Based Treatments for Depression

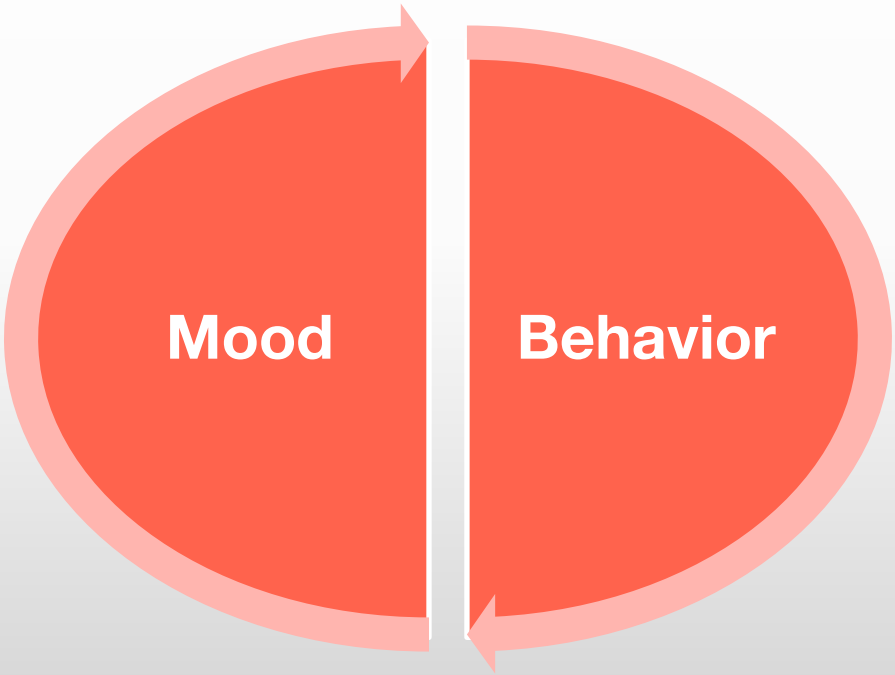
Treatment	Adolescents	Adults	Older Adults
SSRIs or second-generation antidepressants (e.g., Prozac)	✓	✓	✓
Cognitive Behavioral Therapy	✓	✓	✓
Interpersonal Psychotherapy	✓	✓	✓
Psychodynamic Therapies		✓	
Supportive Therapies		✓	
Group Life Review or Group-based CBT			✓

APA Clinical Practice Guidelines for the Treatment of Depression Across Three Age Cohorts, 2019

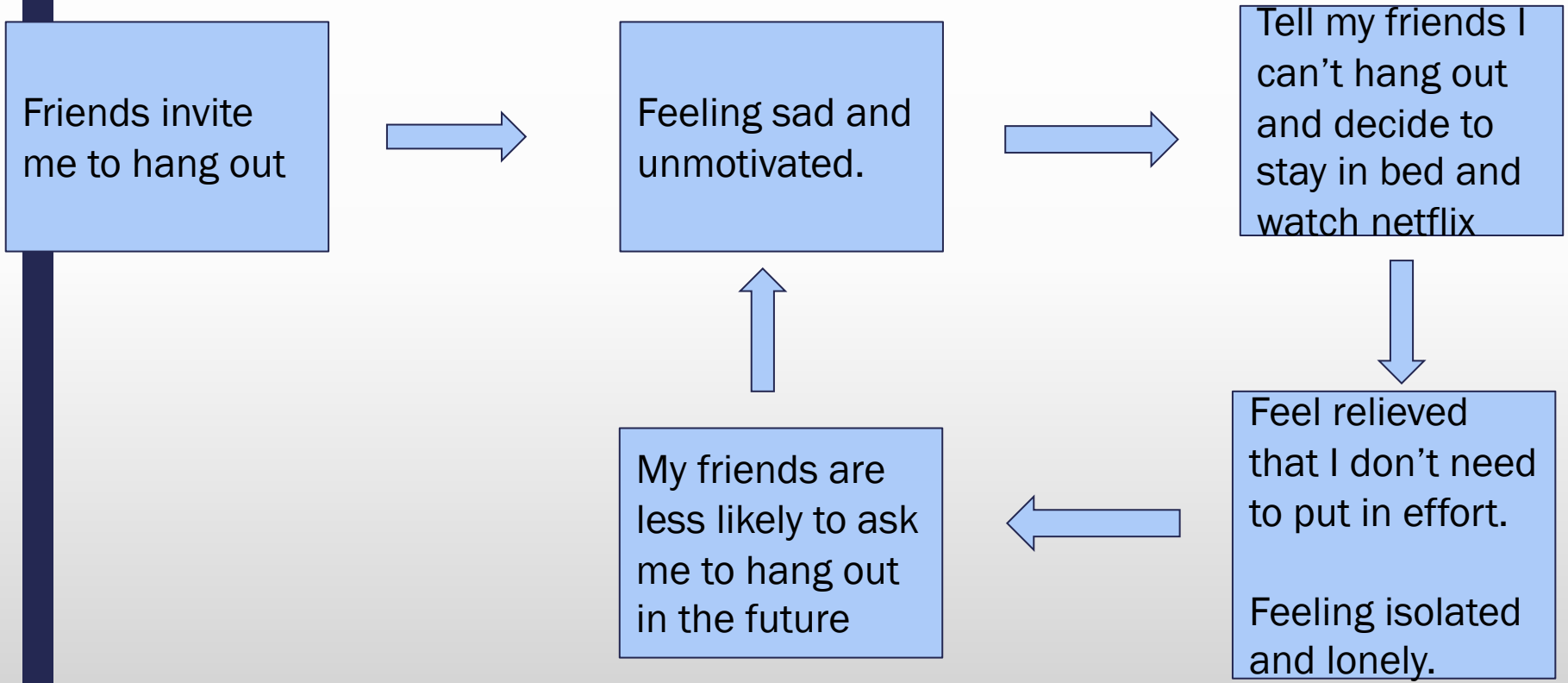
BEHAVIORAL ACTIVATION

Jacobson et al., 2001

Myth of Mood Dependent Behavior



The Distress Loop



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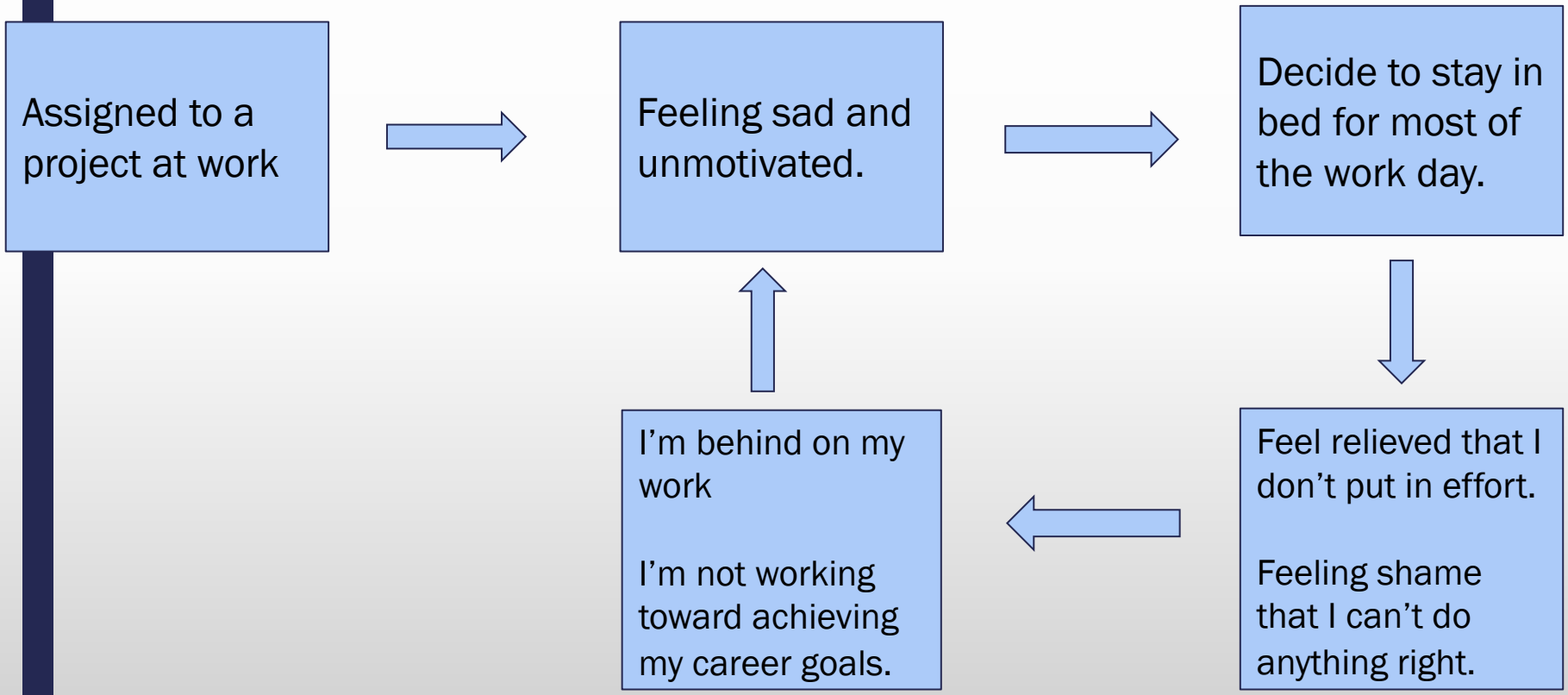
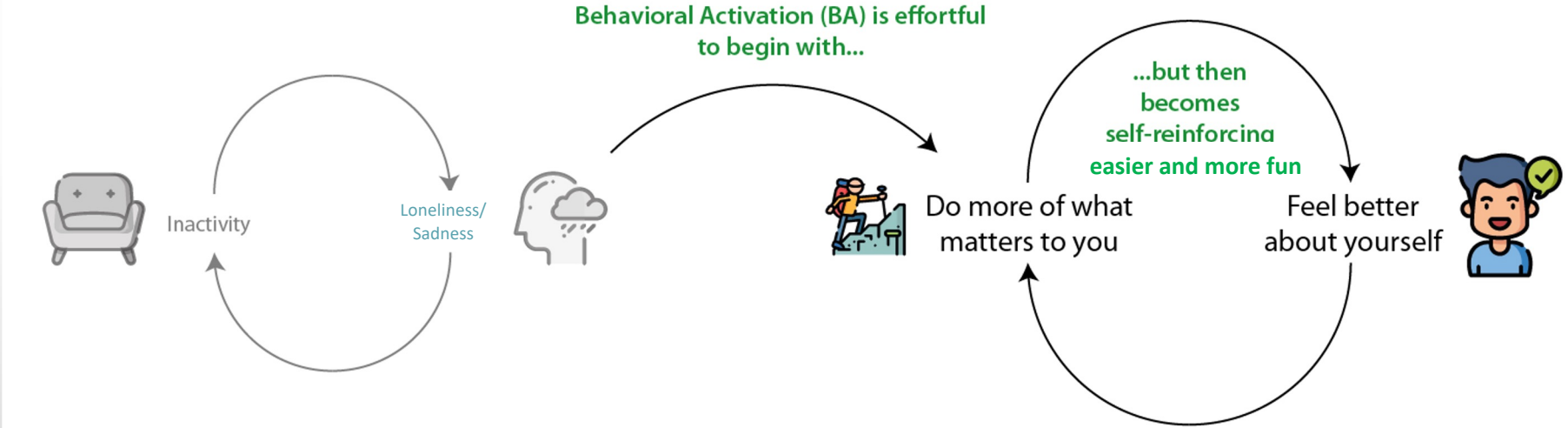


Take one step, even when you don't really feel like it



Goals of Behavioral Activation

1. Physical engagement - get up and moving!
2. Increase access to reinforcements in your environment.
3. Sense of mastery, effectiveness, and accomplishment
4. Reduce avoidance
5. Increase goal-dependent behavior and decrease mood-dependent behavior.

Strategies in Behavioral Activation

- Monitor daily activities.
- Link **activities and mood**.
- Re-engage in activities, interests, and responsibilities.
- Examine avoidance patterns and choose more adaptive actions.

Activity Tracker

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	• overslept (3) • breakfast w/ friend (6)	• Yoga (7) • Class (6)	• Caught up on work (5)	• Overslept (3) • Missed class (2)	• Yoga (6) • Breakfast w/friend (8)
Afternoon	• 2 classes (4) • Lunch w/ friends (5)	• Practiced guitar (6) • Binge-watched Netflix (5)	• 2 classes (4)	• Sat around apt (3) • Netflix (4)	• Class (8)
Evening	• Workout at home (6) • Fam facetime (8)	• Skipped dinner with friend (3)	• Virtual club event (7) • Up late playing video games (5)	• Argument with mom (3) • Video games until late (4)	• Happy hour (8) • Dinner with roommate (9)

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Patterns to look out for:

1. Does anything consistently come before a bad mood?
2. How do certain types of activities impact mood? Number of activities?
3. Time of Day
4. Certain people
5. Normal fluctuations

Activity Scheduling

USE INFORMATION TO CREATE A SCHEDULE

INCORPORATE ACTIVITIES THAT WILL BE MEANINGFUL AND ENGAGING

Activity Scheduling

Physical

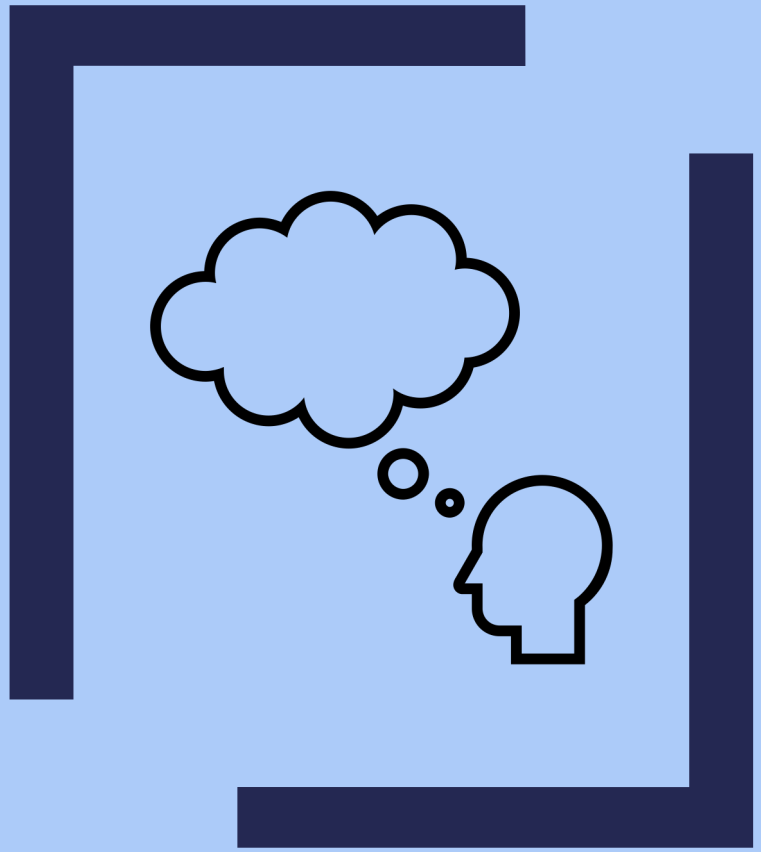
- Dancing
- Going running
- Playing sports
- Go for a bike ride
- Taking care of your pets
- Make a gift for someone
- Bake something for family
- Volunteer your time
- Going out with friends
- Spend time with family
- Go to a party
- Join a club / event
- Soaking in the bathtub.
- Thinking about a vacation .
- Reading
- Going to a movie
- Singing
- Listening to music
- Watch TV
- Reading
- Buy clothes
- Style your hair
- Enjoy cup of coffee or tea
- Drawing or doodling
- Fixing things around the house
- Cooking good food
- Play an instrument
- Writing

Service

Social

Fun

Mastery



COGNITIVE RESTRUCTURING

Identify Negative Thinking

Use BLUE thoughts to identify patterns of negative thinking

Blaming myself

Looking for the bad news

Unhappy guessing

Exaggerating - Imagining a disaster

Weisz et al., 2005

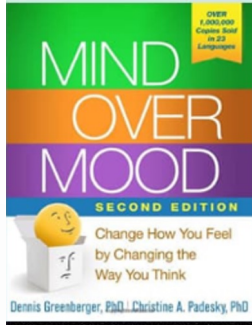
Changing BLUE Thoughts

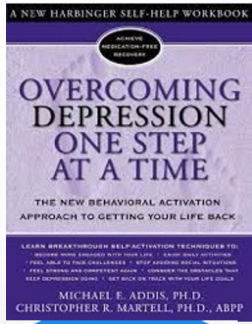
Situation	Automatic BLUE Thought	Alternative Thought
See a friend/colleague in the hallway and they don't stop to say hi.	"They ignored me on purpose. They don't like me." -- Unhappy guessing -- Looking for the bad news	"Maybe they didn't notice me since other people were in the hallway."
Got constructive feedback on a presentation.	"I did an absolutely terrible job. I'll probably fail / get fired." -- Blaming myself -- Exaggerating	"I'm here to learn and grow and it's okay that it wasn't perfect."

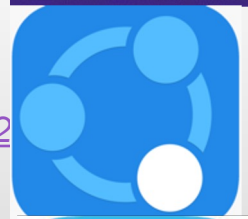
Weisz et al., 2005

Resources

- Anxiety and Depression Association of America (ADAA)
  - https://adaa.org/understanding-anxiety/depression/facts-statistics
- Jed Foundation
  - https://jedfoundation.org/resource/understanding-depression-and-depressive-disorders/
- Apps
  - *Moodivate, Calm, Happify, Grateful: A Gratitude Journal*
- Mind Over Mood by Drs. Dennis Greenberger & Christine Padesky
- Overcoming Depression One Step at a Time by Drs. Michael Addis & Christopher Martell
- APA Clinical Practice Guidelines
  - https://www.apa.org/depression-guideline/guideline.pdf
- Safety Planning Training
  - https://suicidesafetyplan.com/training/
- Find a Therapist Tools
  - https://services.abct.org/i4a/memberDirectory/index.cfm?directory_id=3&pageID=3282
  - https://members.adaa.org/page/FATMain
- Crisis Resources
  - *988*
  - *1-800-273-TALK (8255)*
  - *LGBTQ+ community: https://www.thetrevorproject.org/get-help/*







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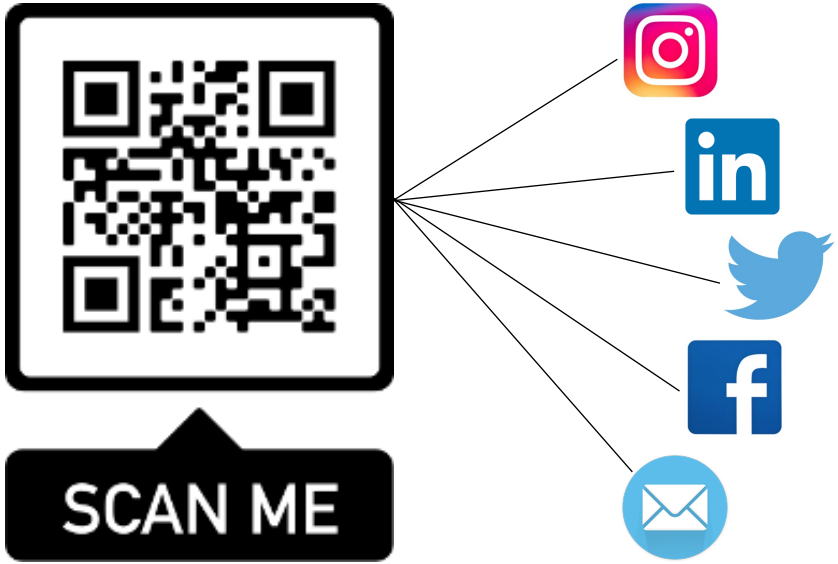

Assessment and Treatment Strategies for Depression

Thank You!

SAMHSA
Substance Abuse and Mental Health Services Administration

Mountain Plains (HHS Region 8)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration