CEP | Providers

Appendix
Youth Mental Health: Anxiety and Depression

Psychological Therapy

Therapy* (brief description)	Evidence/role			
	ANXIETY	**Evidence level - Anxiety disorders[3]**	**DEPRESSION**	**Evidence level- Depression[2,4,6]**

Cognitive behavioural therapy (CBT)
A brief, directive psychotherapy to promote realistic and adaptive thinking patterns, combat negative thinking, build coping skills, improve communication skills and peer relationships, face fears through controlled exposure, and regulate emotions.[1-3]
	• Is first-line therapy for anxiety
	  • Alone for mild anxiety
	  • Plus pharmacotherapy for more severe anxiety
	• Evidence is strongest for group, individual, and computer-based formats.[3]
	• Benefits are sustained for 2-5 years after completing CBT.[3]
	• Approaches that include family involvement may have additional benefit.[3]
		•••	• Is first-line therapy for adolescents and young adults with depression
			  • Alone for mild depression
			  • Plus pharmacotherapy for moderate to severe depression[2,4]
			• Usual duration is 10-16 sessions.[5]
				•••

Interpersonal therapy (IPT)
A highly structured psychotherapy that follows a time limited approach which usually lasts 12-16 weeks.[1]
It is focused on adapting to changes in relationships, transitioning personal roles, and forming interpersonal relationships.[2]
	• There is some evidence for IPT in anxiety, but much less than CBT.[1,3]
	  • Most evidence is in social anxiety disorder.[3]
		•••	• IPT is first-line therapy for adolescents and young adults with depression[5]
			  • Alone for mild depression
			  • Plus pharmacotherapy for moderate to severe depression[2,4]
			• IPT is at least as effective as CBT for depression.[2]
			• Usual duration is 10-16 sessions.[5]
				•••

Family therapy A form of psychotherapy that includes family members in the sessions to manage issues relating to family dynamics and their role in mental health, and provide education on strategies for the family to support the youth.[6]	• Family-based CBT has shown efficacy in treating anxiety. It is not as well-studied as CBT or IPT.[3]	•••	• Not as well-studied as CBT or IPT. There are a few studies of family therapy for youth depression and they show some efficacy although less than CBT. • Usual duration is 12-16 sessions of 90 minutes.[6]	•••
Psychodynamic therapy Also called insight-oriented therapy, this form of psychotherapy focuses on understanding how unconscious processes affect a patient's behaviour. It involves building self-awareness of how unresolved conflicts from the past can affect present behaviour.	• Evidence is limited, particularly in youth. One study in adults suggest that it works as well as CBT for reducing anxiety scores, but CBT was superior in measures of worry and depression. Psychodynamic therapy is not as well-studied as CBT or IPT.[3]	•••	• Evidence is limited, but suggests high rates of remission in moderate-to-severe therapy (similar to family therapy; family therapy may produce a quicker remission but results of psychodynamic therapy may last longer).[6]	•••

***LEGEND: CATEGORIES FOR LEVELS OF EVIDENCE (according to original guidelines' taxonomy)**

- ••• Highest level of evidence (meta-analyses; systematic reviews of RCTs; RCTs with varying levels of bias)
- •• Mid-level evidence (systematic reviews of case studies; high quality case control or cohort studies; experimental studies w/o randomization; case reports or studies)
- • Low-level evidence (expert opinion and/or clinical experiences of respected authorities/guideline development group)

SSRI side effects

Common SSRI side effects	Notes
Suicidal ideation	Most common in first 4 weeks[5] Use Ask Suicide – Screening Questions (ASQ) screening tool[9] SSRIs increase suicidal ideation, but untreated anxiety disorders increase suicide risk even more (6 to 8-fold increase in risk).[3] Adding CBT may help reduce the risk.[5]
Somnolence Gastrointestinal (GI) effects Nervousness Headache Restlessness[2]	Transient; usually improves after the first 2 weeks
Sexual dysfunction[5] Weight gain[3]	Not transient Can be particularly distressing to youth and reduce adherence[5]
Other SSRI side effects	**Notes**
	Mania/hyomania, activating effects, altered platelet function, fractures and hyponatremia[4]
Other SSRI warnings	
Citalopram is not recommended in congenital long QT syndrome, congenital heart disease, or hepatic impairment.[4]	
Abrupt discontinuation can lead to a discontinuation syndrome with GI, psychiatric, vasomotor, and other symptoms.[4]	
Additive effects with alcohol and other CNS depressants.[7]	
General Antidepressant Warnings	
• Prescribing must be done in the context of an ongoing therapeutic relationship and management plan.[5] • Begin treatment at the lowest dose for 4 weeks[4] and titrate based on patient response and adverse effects.[2] • Consider adjusting dose for younger/low body weight individuals.[3] • Obtain informed consent from the patient (and family if appropriate). • Neural pathways in youth may not be fully developed, and serotonin and norepinephrine systems have different maturation rates. Therefore, extrapolation of adult data on antidepressants to youth may not be accurate.[2]	

Other medication options

Therapy* (brief description)	Evidence/role			
	ANXIETY	**Evidence level ANXIETY disorders[3]**	**DEPRESSION**	**Evidence level DEPRESSION[2,4,6]**
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	Although SSRIs are the preferred treatment, there is also good evidence for venlafaxine (37.5 – 225 mg/day) in SAD.[3, 8]	Venlafaxine XR ••• (for SAD)	Venlafaxine is a second-line medication option for depression in youth. Start with an SSRI and if there is no response, switch to a different SSRI before trying venlafaxine.[4] Antidepressant treatment should continue for at least 6 months after remission.[2]	Venlafaxine •••
Tricyclic Antidepressants (TCAs)	Although SSRIs are the preferred treatment, there is also good evidence for clomipramine (primarily in OCD).[3]	Clomipramine ••• (for OCD)	TCAs should generally not be used to treat depression in youth.[2,5] Studies have shown little or no benefit[2], and side effects/risks are significant.	Not recommended (••• against use)
Benzodiazepines	Benzodiazepines are generally not recommended except for as short-term therapy in situations where rapid symptom reduction is needed to allow exposure - related psychotherapy (e.g., panic disorder, school refusal behaviour). May increase overdose risk if used with methadone or Suboxone therapy for addictions. Agents with good evidence in this context: • Alprazolam • Clonazepam[3]	Alprazolam • (for panic disorder); ••• (against use for SAD, GAD, and school-refusal) Clonazepam • (for panic disorder), ••• (against use for separation anxiety disorder)	Benzodiazepines do not have a role in managing depression in youth.[2,4,5]	Not recommended due to lack of evidence
Other treatments	SSRIs are preferred treatment. Some evidence for aripiprazole or riluzole for treatment-resistant OCD, particularly as adjunctive therapies. Some evidence for mirtazapine in treatment of SAD, though evidence is conflicting.[3]	Aripiprazole •• (for OCD) Riluzole • (for OCD) Mirtazapine •• (for SAD)	No role in depression	Adjunctive treatments: Currently, there is no research on which to base an evidence-based recommendation for adding a second anti-depressant or augmentation with a mood stabilizer for non-responsive or chronic depression in youth. Specialist consultation is recommended.[5] Repetitive transcranial magnetic stimulation (rTMS) may be considered for treatment-resistant depression.[4]

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- • Low-level evidence (expert opinion and/or clinical experiences of respected authorities/guideline development group)

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