L.A. Care
HEALTH PLAN

Dear Doctor:

L.A. Care's Behavioral Health Services Department is pleased to provide you with this copy of the Behavioral Health Provider Toolkit. As we move forward with health care reform, we recognize that primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat members with behavioral needs. We believe that integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for members with multiple healthcare needs. We are committed to helping primary care clinics, mental health agencies and substance abuse programs work together seamlessly, coordinating whole-person care for easier access, greater member satisfaction and better outcomes. Our goal is to partner with you to deliver effective behavioral health services to our Members at the right place and at the right time.

This toolkit offers clinical guidelines, resources, and patient education materials to assist you in the care of your patients. This Toolkit is an example of our efforts to assist you with the evaluation and management of these Behavioral Health conditions.

This toolkit offers clinical guidelines, resources, and patient education materials to assist you in the care of your patients. We hope you find the enclosed guidelines, resources, and patient education materials useful. We urge you to utilize the information and resources we have provided and join us in the effort to improve behavioral health treatment practices.

We truly appreciate your service and the difference you have made in the health and well-being of our members. Please contact us at our BH phone line: 1-844-858-9940 or BH email behavioralhealth@lacare.org if you have questions, would like to provide feedback, or would like further information.

Sincerely,

Clayton Chau, MD, PhD
Medical Director
Behavioral Health Services

Behavioral Health Provider Toolkit

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Practice Parameter for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders

ABSTRACT

This revised practice parameter reviews the evidence from research and clinical experience and highlights significant advancements in the assessment and treatment of anxiety disorders since the previous parameter was published. It highlights the importance of early assessment and intervention, gathering information from various sources, assessment of comorbid disorders, and evaluation of severity and impairment. It presents evidence to support treatment with psychotherapy, medications, and a combination of interventions in a multimodal approach. *J. Am. Acad. Child Adolesc. Psychiatry,* 2007;46(2):267–283. **Key Words:** anxiety disorders, treatment, practice parameter.

Anxiety disorders represent one of the most common forms of psychopathology among children and adolescents, but they often go undetected or untreated. Early identification and effective treatment may reduce the impact of anxiety on academic and social functioning in youths and may reduce the persistence of anxiety disorders into adulthood. Evidence-supported treatment interventions have emerged in psychotherapy and medication treatment of childhood anxiety disorders that can guide clinicians to improve outcomes in this population.

Accepted September 11, 2006.

This parameter was developed by Sucheta D. Connolly, M.D., Gail A. Bernstein, M.D., and the Work Group on Quality Issues: William Bernet, M.D., and Oscar Bukstein, M.D., Co-Chairs, and Valerie Arnold, M.D., Joseph Beitchman, M.D., R. Scott Benson, M.D., Joan Kinlan, M.D., Jon McClellan, M.D., Ulrich Schoettle, M.D., Jon Shaw, M.D., Saundra Stock, M.D., and Heather Walter, M.D. AACAP Staff: Kristin Kroeger Ptakowski. Research Assistants: Heena Desai, M.D., and Anna Narejko.

A group of invited experts also reviewed the parameter. The Work Group on Quality Issues thanks Boris Birmaher, M.D., Phillip Kendall, Ph.D., Ann Layne, Ph.D., Barbara Milrod, M.D., Thomas Ollendick, Ph.D., Daniel Pine, M.D., and Moira Rynn, M.D., for their thoughtful review.

This parameter was reviewed at the member forum at the 2004 annual meeting of the American Academy of Child and Adolescent Psychiatry.

During September 2005 to January 2006, a consensus group reviewed and finalized the content of this practice parameter. The consensus group consisted of representatives of relevant AACAP components as well as independent experts: William Bernet, M.D., Work Group Co-Chair; Sucheta D. Connolly, M.D., and Gail A. Bernstein, M.D., authors; R. Scott Benson, M.D., Allan K. Chrisman, M.D., and Saundra Stock, M.D., members of the Work Group on Quality Issues; Efrain Bleiberg, M.D., Rachel Z. Ritvo, M.D., and Cynthia W. Santos, M.D., Council Representatives; Gabrielle Shapiro, M.D., Assembly of Regional Organizations Representative; Boris Birmaher, M.D., and Thomas H. Ollendick, Ph.D., independent expert reviewers; and Amy Hereford, Assistant Director of Clinical Practice. Members of the consensus group were asked to identify any conflicts of interest they may have with respect to their role in reviewing and finalizing the content of this practice parameter. One of the consensus group members was on the speakers' bureau for the following pharmaceutical companies: Eli Lilly, Novartis, Ortho-McNeil, and Shire.

This practice parameter was approved by AACAP Council on June 17, 2006.

This practice parameter is available on the Internet (www.aacap.org).

Reprint requests to the AACAP Communications Department, 3615 Wisconsin Avenue, NW, Washington, DC 20016.

DOI: 10.1097/01.chi.0000246070.23695.06

METHODOLOGY

The list of references for this parameter was developed by searches of *Medline*, *OVIDMedline*, *PubMed*, and *PsycINFO*; by reviewing the bibliographies of book chapters and review articles; and by asking colleagues for suggested source materials. The searches covered the period 1996 to 2004 and used the following text words: child, adolescent, and anxiety disorders. Each of these papers was reviewed, and only the most relevant references were included in the present document.

DEFINITIONS

The terminology in this practice parameter is consistent with the *DSM-IV-TR* (American Psychiatric Association, 2001). The major anxiety disorders included in the *DSM-IV-TR* are separation anxiety disorder (SAD), generalized anxiety disorder (GAD), social phobia, specific phobia, panic disorder (with and without agoraphobia), agoraphobia without panic disorder, posttraumatic stress disorder, and obsessive-compulsive disorder. Selective mutism may have a multifactorial etiology, but it is included in this practice

parameter as research indicates that in most cases children with selective mutism also meet criteria for social phobia (Bergman et al., 2002). This practice parameter addresses all of the above-mentioned anxiety disorders with the exception of posttraumatic stress disorder and obsessive-compulsive disorder, which have their own practice parameters.

DEVELOPMENTAL CONSIDERATIONS

Fear and worry are common in normal children. Clinicians need to distinguish normal, developmentally appropriate worries, fears, and shyness from anxiety disorders that significantly impair a child's functioning. Infants typically experience fear of loud noises, fear of being startled, and later a fear of strangers. Toddlers experience fears of imaginary creatures, fears of darkness, and normative separation anxiety. School-age children commonly have worries about injury and natural events (e.g., storms). Older children and adolescents typically have worries and fears related to school performance, social competence, and health issues (Muris et al., 1998; Vasey et al., 1994). Fears during childhood represent a normal developmental transition and may develop in response to perceived dangers, but they become problematic if they do not subside with time and if they impair the child's functioning.

In children of preschool age, there is some emerging evidence that clear subtypes of anxiety may be less differentiated than in primary schoolchildren (Spence et al., 2001). The clinical impact of these anxiety symptoms may be significant even if full criteria are not met.

CLINICAL PRESENTATION

Children with anxiety disorders may present with fear or worry and may not recognize their fear as unreasonable. Commonly they have somatic complaints of headache and stomachache. The crying, irritability, and angry outbursts that often accompany anxiety disorders in youths may be misunderstood as oppositionality or disobedience, when in fact they represent the child's expression of fear or effort to avoid the anxiety-provoking stimulus at any cost. A specific diagnosis is determined by the context of these symptoms.

Youths with SAD display excessive and developmentally inappropriate fear and distress concerning separation from home or significant attachment figures. This distress can be displayed before separation or during attempts at separation. These children worry excessively about their own or their parents' safety and health when separated, have difficulty sleeping alone, experience nightmares with themes of separation, frequently have somatic complaints, and may exhibit school refusal.

Specific phobia is fear of a particular object or situation that is avoided or endured with great distress. A specific fear can develop into a specific phobia if symptoms are significant enough to result in extreme distress or impairment related to the fear. It is common for youths to present with more than one specific phobia, but this does not constitute a diagnosis of GAD.

GAD is characterized by chronic, excessive worry in a number of areas such as schoolwork, social interactions, family, health/safety, world events, and natural disasters with at least one associated somatic symptom. Children with GAD have trouble controlling their worries. These children are often perfectionistic, show high reassurance seeking, and may struggle with more internal distress than is evident to parents or teachers (Masi et al., 1999). The worries of GAD are not limited to a specific object or situation, and worry is present most of the time.

Social phobia is characterized by feeling scared or uncomfortable in one or more social settings (discomfort with unfamiliar peers and not just unfamiliar adults) or performance situations (e.g., music, sports). The discomfort is associated with social scrutiny and fear of doing something embarrassing in social settings such as classrooms, restaurants, and extracurricular activities. These children may have difficulty answering questions in class, reading aloud, initiating conversations, talking with unfamiliar people, and attending parties and social events.

It is common for youths with GAD to have worries in the social domain, but these differ in several ways from worries associated with social phobia. Youths with GAD worry about a variety of areas and not just performance and social concerns. Youths with GAD worry about the quality of their relationships rather than experiencing embarrassment or humiliation in social situations. The anxiety associated with social phobia usually dissipates upon avoidance or escape from the social situation, but anxiety associated with GAD is persistent.

Children with selective mutism persistently fail to speak, read aloud, or sing in specific situations (e.g., school) despite speaking in other situations (e.g., with family and in the home environment). These children may whisper or communicate nonverbally with select individuals such as peers or teachers in some situations. Most of these children also have symptoms of social phobia, and selective mutism may be a subtype or earlier developmental manifestation of social phobia (Bergman et al., 2002). An audio- or videotape that substantiates normal speech and language in at least one setting is recommended, along with ruling out a communication disorder, neurological disorder, or pervasive developmental disorder.

Panic disorder is characterized by recurrent episodes of intense fear that occur unexpectedly. These uncued, episodic panic attacks include at least 4 of 13 symptoms from *DSM-IV-TR* such as pounding heart, sweating, shaking, difficulty breathing, chest pressure/pain, feeling of choking, nausea, chills, or dizziness. Youths with panic disorder fear recurrent panic attacks and their consequences, and they may develop avoidance of particular settings where attacks have occurred (agoraphobia). Cued panic attacks can occur with any of the anxiety disorders, are common among adolescents, and need to be distinguished from panic disorder, which occurs at a much lower rate (Birmaher and Ollendick, 2004). The uncued attacks of panic disorder are not limited to separation, a feared object/situation, social situations/evaluation, or other environmental cues.

EPIDEMIOLOGY

Prevalence rates for having at least one childhood anxiety disorder vary from 6% to 20% over several large epidemiological studies (Costello et al., 2004). Strict adherence to diagnostic criteria and consideration of functional impairment, rather than just the presence of anxiety symptoms, bring the rates down substantially. Referral biases can also dramatically alter prevalence rates. This is complicated by evidence that disability can be associated with subthreshold anxiety symptoms that may not meet full criteria for a *DSM-IV* diagnosis (Angold et al., 1999).

In general, girls are somewhat more likely than boys to report an anxiety disorder, but more specifically this has been shown for specific phobia, panic disorder, agoraphobia, and SAD. The average age at onset of any single anxiety disorder varies widely between studies, but panic disorder often emerges later in the mid-teen years (Costello et al., 2004).

The long-term course of childhood anxiety disorders remains controversial. Despite remission of some initial anxiety disorders, children may develop new anxiety disorders over time (Last et al., 1996) or in adolescence (Aschenbrand et al., 2003). The more severe the anxiety disorder and the greater the impairment in functioning, the more likely it is to persist (Dadds et al., 1997, 1999; Manassis and Hood, 1998). Children and adolescents with anxiety disorders are at risk of developing new anxiety disorders, depression, and substance abuse. A prospective study found anxiety and depressive disorders in adolescence predicted approximately a two- to threefold increased risk of anxiety or depressive disorders in adulthood (Pine et al., 1998). A longitudinal study of New Zealand children found that adolescents with anxiety disorders have elevated rates of anxiety, major depression, illicit-drug dependence, and educational underachievement as young adults (Woodward and Fergusson, 2001).

The sequelae of childhood anxiety disorders include social, family, and academic impairments. Anxiety disorders disrupt the normal psychosocial development of the child (e.g., children with severe social phobia may not socialize with other children; children with SAD may not have the opportunity to develop independence from adults). Social problems include poor problem-solving skills and low self-esteem (Messer and Beidel, 1994). Anxious children interpret ambiguous situations in a negative way and may underestimate their competencies (Bogels and Zigterman, 2000). In a prospective study, first graders who reported high levels of anxiety symptoms were at significant risk of persistent anxiety symptoms and low achievement scores in reading and math in fifth grade (Ialongo et al., 1995).

RISK AND PROTECTIVE FACTORS

The development of anxiety disorders in children and adolescents involves an interplay between risk and protective factors (Spence, 2001). Biological risk factors include genetics and child temperament. Several twin studies present evidence of genetic and shared environmental contributions to childhood anxiety (Eley, 2001). The temperamental style of behavioral inhibition in early childhood increases the likelihood of anxiety

disorders in middle childhood (Biederman et al., 1993) and social phobia in adolescence (Kagan and Snidman, 1999). Parental anxiety disorder has been associated with increased risk of anxiety disorder in offspring (Biederman et al., 2001; Merikangas et al., 1999) and high levels of functional impairment in children with childhood anxiety disorders (Manassis and Hood, 1998).

Studies of environmental risk factors in the development of childhood anxiety disorders have focused on parent-child interactions and parental anxiety. Anxious parents can model fear and anxiety, reinforce anxious coping behavior, and unwittingly maintain avoidance, despite their desire to be of help to their child (Dadds and Roth, 2001; Muris et al., 1996). Overprotective, overcontrolling, and overly critical parenting styles that limit the development of autonomy and mastery may also contribute to the development of anxiety disorders in children with temperamental vulnerability (Hirshfeld et al., 1997; Rapee, 1997). Insecure attachment relationships with caregivers (Manassis et al., 1994) and, specifically, anxious/resistant attachment (Warren et al., 1997) can increase the risk of childhood anxiety disorders.

Children's coping skills have been considered to be protective factors in childhood anxiety disorders (Spence, 2001). Learning to use active coping strategies, distraction strategies, and problem-focused rather than avoidant-focused coping have been encouraged in anxious youths (Ayers et al., 1996).

RECOMMENDATIONS

Each recommendation in this parameter is identified as falling into one of the following categories of endorsement, indicated by an abbreviation in brackets following the statement. These categories indicate the degree of importance or certainty of each recommendation.

[MS] *Minimal standards* are recommendations that are based on rigorous empirical evidence (such as randomized, controlled trials) and/or overwhelming clinical consensus. Minimal standards are expected to apply more than 95% of the time (i.e., in almost all cases).

[CG] *Clinical guidelines* are recommendations that are based on empirical evidence and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time (i.e., in most cases). These practices should almost always be considered by the clinician, but there are significant exceptions to their universal application.

[OP] *Options* are practices that are acceptable, but there may be insufficient empirical evidence and/or clinical consensus to support recommending these practices as minimal standards or clinical guidelines.

[NE] *Not endorsed* refers to practices that are known to be ineffective or contraindicated.

The recommendations of this parameter are based on a thorough review of the literature as well as clinical consensus. The following coding system is used to indicate the nature of the research that supports the recommendations:

[rdb] *Randomized, double-blind clinical trial* is a study of an intervention in which subjects are randomly assigned to either treatment or control groups and both subjects and investigators are blind to the assignments.

[rct] *Randomized clinical trial* is a study of an intervention in which subjects are randomly assigned to either treatment or control groups.

[ct] *Clinical trial* is a prospective study in which an intervention is made and the results are followed longitudinally.

SCREENING

Recommendation 1. The Psychiatric Assessment of Children and Adolescents Should Routinely Include Screening Questions About Anxiety Symptoms [MS].

With the high prevalence of anxiety disorders in children and adolescents, routine screening for anxiety symptoms during the initial mental health assessment is recommended. Screening questions should use developmentally appropriate language and be based on *DSM-IV-TR* criteria. Obtaining information about anxiety symptoms from multiple informants including the youths and adults (parents and/or teachers) is essential because of variable agreement among informants (Choudhury et al., 2003). Children may be more aware of their inner distress and parents or teachers may underestimate the severity or impact of anxiety symptoms in the child (e.g., GAD). However, adults may better appreciate the impact of anxiety on family or school functioning (e.g., SAD, social phobia). In addition, the anxious child's concerns

about performance during the assessment and desire to please the interviewer can affect the child's report (Kendall and Flannery-Schroeder, 1998).

For youths 8 years and older, self-report measures for anxiety such as the Multidimensional Anxiety Scale for Children (March et al., 1997) or Screen for Child Anxiety Related Emotional Disorders (Birmaher et al., 1999) can assist with screening and monitoring response to treatment. Further details on these and other anxiety measures are available in recent excellent reviews by Langley et al., 2002 and Myers and Winters, 2002). Screening tools for young children with anxiety disorders are being studied and focus on parent report measures (Spence et al., 2001).

EVALUATION

Recommendation 2. If the Screening Indicates Significant Anxiety, Then the Clinician Should Conduct a Formal Evaluation to Determine Which Anxiety Disorder May Be Present, the Severity of Anxiety Symptoms, and Functional Impairment [MS].

For anxiety disorders, this evaluation should include differentiating anxiety disorders from developmentally appropriate worries or fears. Significant psychosocial stressors or traumas should be carefully considered during the evaluation to determine how they may be contributing to the development or maintenance of anxiety symptoms. Research in very young children is limited, but using play narrative assessment along with pictures, cartoons, and puppets to communicate during the diagnostic interview can be helpful (Warren and Dadson, 2001). Differentiating the specific anxiety disorders can be challenging.

Although formal psychological testing or questionnaires are not required for the evaluation of anxiety disorders, there are several instruments that may be helpful in supplementing the clinical interview in youths 6-17 years old and in differentiating the specific anxiety disorders. Clinicians may use sections of the available diagnostic interviews such as the Anxiety Disorders Interview Schedule for *DSM-IV*-Child Version (ADIS; Silverman and Albano, 1996) or a checklist based on *DSM-IV* criteria (Langley et al., 2002; Silverman and Ollendick, 2005). Measures for assessment and follow-up of specific anxiety disorders including social phobia, selective mutism, and specific phobia are also available (Myers and Winters, 2002).

The clinician should ask the parent and child about symptom severity and impairment in functioning along with the presence of anxiety symptoms during the assessment for childhood anxiety disorders (Manassis and Hood, 1998). The ADIS has a Feelings Thermometer (ratings from 0-8) to help children quantify and self-monitor ratings of fear and interference with functioning. The ADIS has clinicians ask how much [type of anxiety] has ''messed things up'' for the child and stops the child from doing things he or she likes to do. Younger children may use more developmentally appropriate visual analogues such as smiley faces and upset faces to rate severity and interference.

Recommendation 3. The Psychiatric Assessment Should Consider Differential Diagnosis of Other Physical Conditions and Psychiatric Disorders That May Mimic Anxiety Symptoms [MS].

Psychiatric conditions that may present with symptoms similar to those seen in anxiety disorders include attention-deficit/hyperactivity disorder (ADHD; restlessness, inattention); psychotic disorders (restlessness and/or social withdrawal); pervasive developmental disorders, especially Asperger's disorder (social awkwardness and withdrawal, social skills deficits, communication deficits, repetitive behaviors, adherence to routines); learning disabilities (persistent worries about school performance); bipolar disorder (restlessness, irritability, insomnia); and depression (poor concentration, sleep difficulty, somatic complaints; Manassis, 2000).

Physical conditions that may present with anxiety-like symptoms include hyperthyroidism, caffeinism (including from carbonated beverages), migraine, asthma, seizure disorders, and lead intoxication. Less common in youths are hypoglycemia, pheochromocytoma, CNS disorder (e.g., delirium, brain tumors), and cardiac arrhythmias. Prescription drugs with side effects that may mimic anxiety include antiasthmatics, sympathomimetics, steroids, selective serotonin reuptake inhibitors (SSRIs), antipsychotics (akathisia), haloperidol, pimozide (neuroleptic-induced SAD), and atypical antipsychotics. Nonprescription drugs with side effects that may mimic anxiety include diet pills, antihistamines, and cold medicines.

Childhood anxiety disorders are commonly associated with somatic symptoms, such as headaches and abdominal complaints. The mental health assessment should be considered early in the medical evaluation

process for youths with somatic complaints. It is important to assess somatic symptoms at baseline before initiating treatment to help the child and parents understand these symptoms and their relationship to the anxiety. Documenting physical symptoms before treatment with medication will decrease the likelihood of mistaking baseline somatic complaints as medication side effects.

TREATMENT

Recommendation 4. Treatment Planning Should Consider a Multimodal Treatment Approach [CG].

A multimodal treatment approach for children and adolescents with anxiety disorders should consider education of the parents and the child about the anxiety disorder, consultation with school personnel and primary care physicians, cognitive-behavioral interventions, psychodynamic psychotherapy, family therapy, and pharmacotherapy. Selection of the specific treatment modalities for an individual child and family in clinical practice involves consideration of psychosocial stressors, risk factors, severity and impairment of the anxiety disorder and comorbid disorders, age and developmental functioning of the child, and family functioning. In addition, child and family factors such as attitudes or acceptance of a particular intervention and provider-practitioner factors such as training, access to evidence-based interventions, and affordability of such interventions need to be considered.

Recommendation 5. Treatment Planning Should Consider Severity and Impairment of the Anxiety Disorder [CG].

Until evidence from comparative studies inform clinical practice, treatment of childhood anxiety disorders of mild severity should begin with psychotherapy. Valid reasons for combining medication and treatment with psychotherapy include the following: need for acute symptom reduction in a moderately to severely anxious child, a comorbid disorder that requires concurrent treatment, and partial response to psychotherapy and potential for improved outcome with combined treatment (March, 2002; Ollendick and March, 2004). Residual anxiety disorder symptoms can increase the risk for maintenance or relapse of the same or a comorbid anxiety disorder (Birmaher et al., 2003 [rdb]; Dadds et al., 1997 [rct]). Therefore, it is recommended that functional impairment, not just anxiety symptom reduction, be monitored during the treatment process.

Several studies suggest that for youths with anxiety disorders, greater severity of anxiety symptoms or older age have been predictors of poor treatment response for cognitive-behavioral therapy (CBT) alone (Barrett et al., 1996 [rct]; Last et al., 1998 [rct]; Layne et al., 2003; Southam-Gerow et al., 2001) and SSRIs alone (Birmaher et al., 2003 [rdb]; RUPP Anxiety Group, 2003). Southam-Gerow et al. (2001) suggested the ''dose'' or intensity of treatment may need to be increased (based on symptom severity or age), integration of a parent/family component to treatment may need to be considered, and adjunctive interventions may be needed to target specific symptoms in some youths (e.g., social skills training for social phobia) to improve treatment outcome. Only one published controlled study has examined a combined treatment approach with medication and psychosocial interventions. In school-refusing adolescents with severe anxiety and depression, imipramine plus CBT was more efficacious than placebo plus CBT in improving school attendance and reducing depressive symptoms (Bernstein et al., 2000 [rdb]). However, without continued intensive treatment, a substantial number of subjects met criteria for anxiety and/or depressive disorders 1 year after treatment (Bernstein et al., 2001).

Controlled studies are under way that examine the comparative efficacy of medications versus psychothera peutic interventions alone and in combination for youths with anxiety disorders. These studies may help the clinician choose the most effective treatment modalities in a given child and for a specific anxiety disorder. The Child/Adolescent Anxiety Multimodal Treatment Study is a placebo-controlled study that compared the effectiveness of sertraline, CBT, CBT plus sertraline, and pill placebo in youths with SAD, social phobia, and GAD (National Institutes of Health Clinical Trials Web Site, 2003).

Recommendation 6. Psychotherapy Should Be Considered as Part of the Treatment of Children and Adolescents With Anxiety Disorders [CG].

Among the psychotherapies, exposure-based CBT has received the most empirical support for the treatment of anxiety disorders in youths (Compton et al., 2004). CBT is a psychotherapeutic intervention

supported by numerous randomized, controlled trials in youths with anxiety disorders. However, although CBT has been shown to reduce anxiety symptoms and to be superior to waitlist control (WLC), relative efficacy and effectiveness versus alternative therapeutic interventions still needs to be investigated.

COGNITIVE-BEHAVIORAL THERAPY

In CBT, the clinician teaches the child adaptive coping skills and provides practice opportunities to develop a sense of mastery over anxiety symptoms or situations that are associated with distress and impairment. Albano and Kendall (2002) describe five components of CBT for childhood anxiety disorders: psychoeducation with child and parents about the illness and CBT, somatic management skills training (e.g., relaxation, diaphragmatic breathing, self-monitoring), cognitive restructuring (e.g., challenging negative expectations and modifying negative self-talk), exposure methods (e.g., imaginal and in vivo exposure with gradual desensitization to feared stimuli), and relapse prevention plans (e.g., booster sessions and coordination with parents and school). Depending on the anxiety disorder, different components are emphasized more strongly. Positive, contingent reinforcement schedules help to increase motivation for children to attempt exposures that increase their anxiety initially. Parents learn relaxation techniques and function as CBT coaches. Adherence to the CBT model is important, but flexibility that considers the individual and family factors, comorbidity, and psychosocial stressors is necessary for treatment success (Albano and Kendall, 2002).

The most widely used and best researched manual-based CBT protocol for youths with anxiety disorders (ages 7–14) is the Coping Cat program (Kendall, 1990) and adaptations of this program in Australia (Coping Koala) and Canada (Coping Bear). The Coping Cat program has been given the designation "probably efficacious" based on standards of empirical support (Ollendick and King, 1998). The program is designed for children with SAD, GAD, and social phobia. Several studies comparing individual CBT and WLC used the Coping Cat and found clinically significant improvement with active treatment versus WLC (Kendall, 1994 [rct]; Kendall and Southam-Gerow, 1996 [rct]; Kendall et al., 1997 [rct]). Treatment gains were maintained at 1 year (Kendall, 1994 [rct]; Kendall et al., 1997 [rct]) and at long-term follow-up assessments (2–5 years; Kendall and Southam-Gerow, 1996). A number of studies have also demonstrated efficacy of group CBT (with and without parental involvement) in youths (Barrett, 1998 [rct]; Flannery-Schroeder and Kendall, 2000 [rct]; Manassis et al., 2002 [ct]; Muris et al., 2001 [ct]; Silverman et al., 1999a [rct]). Some of these studies suggested that individual CBT may be preferred to group CBT in some subgroups of children such as those with comorbid ADHD or severe trauma (Muris et al., 2001) or in children with high levels of social anxiety (Manassis et al., 2002).

Several CBT studies have examined CBT in the treatment of anxiety-related school refusal behavior. One study compared individual CBT plus parent and teacher training to WLC (King et al., 1998 [rct]). The children treated with CBT showed significantly greater improvement compared with controls in multiple areas of functioning. Another randomized study compared CBT to educational support for youths with school refusal (Last et al., 1998 [rct]). Both treatments showed significant treatment gains, and CBT was not superior to educational support. Clinically, learning disorders and language impairments should also be considered. A multimodal approach that included CBT and medication was found to be more effective than CBT plus placebo for adolescents with anxiety-based school refusal and comorbid depression (Bernstein et al., 2001 [rdb]).

CBT for specific phobia differs from CBT for GAD, social phobia, and SAD in its focus on graded exposure (Velting et al., 2004). Treatment is also likely to include cognitive modification of unrealistic fears and participant modeling (demonstrations by therapist and parent of approaching feared objects or situations). Treatment outcome studies that have included children with specific phobias have indicated that their response to treatment is positive and comparable with that of children with other anxiety disorders (e.g., Berman et al., 2000).

To provide modifications for social phobia, Spence et al. (2000) have advocated for the inclusion of social skills training and increased social opportunities along with the core CBT components. Compared with nonanxious peers, children with social phobia showed poorer social skills (Spence et al., 1999) and functional limitations such as few friends, low participation in

activities, and common use of avoidant coping (Beidel et al., 1999). Spence et al. (2000 [rct]) reported that in comparison with WLC, children with social phobia receiving group CBT plus social skills training had significantly greater reductions in social anxiety and increased ratings of social skills.

Modification of standard CBT for panic disorder and selective mutism may benefit from some unique components that require further study to establish efficacy. The components suggested for panic disorder are interoceptive exposure (exposure to physical sensations associated with panic such as dizziness, shortness of breath, and sweating by using exercises that induce these sensations) and education about the physiological processes that lead to these physical sensations (Ollendick, 1995 [ct]). Case studies in selective mutism encourage individualized, multimodal treatment plans. Modifications suggested for selective mutism include parents and teachers as part of the ''management team'' to monitor the child's communication at home and school and emphasize positive reinforcement when the child attempts steps on a graded exposure ladder. Steps that precede full verbalization may include relaxed nonverbal participation, mouthing words, speaking to parent at school, and whispering to peers or teachers. Adults, siblings, and classmates are encouraged not to speak for the child (Fung et al., unpublished, 2006, Meeky Mouse Therapy Manual: A Cognitive Behavioural Treatment Program for Children with Selective Mutism. Contact: Sandra Mendlowitz, Ph.D., Department of Psychiatry, Hospital for Sick Children, 555 University Avenue, Toronto, Ontario M5G 1X8.).

The critical components of the full CBT program that are essential to treatment gains still need to be explored. For information about modifications of the standard CBT protocol that have been recommended in older adolescents and young children, see Hirshfeld-Becker and Biederman (2002); Southam-Gerow et al. (2001), and Warren and Dadson (2001). It is interesting that educational support (as an attention-placebo control condition) had a high response rate in two studies and efficacy comparable with the CBT condition in youths with anxiety disorders (Last et al., 1998 [rct]; Silverman et al., 1999b [rct]). This control condition included nonspecific support and psychoeducation about the nature, causes, and course of anxiety disorders. These studies suggest that psychoeducation and supportive therapy may lead to self-directed exposure and in turn reduce anxiety. Thus, additional research is needed to determine whether CBT is superior to alternative psychosocial interventions for children with anxiety disorders.

In some parts of the United States, a comprehensive CBT program for anxiety disorders may not be readily available. In such instances, the following components of CBT may be considered: educational support (provide supportive treatment and educate the child and family about anxiety disorders) (Last et al., 1998 [rct]; Silverman et al., 1999b [rct]) and psychoeducation based on CBT principles, parent training (guidance to establishing a structured program for monitoring anxious behavior in the home that includes setting up expectations, rewards, and contingencies) and case management support that includes contact with the school (Chavira and Stein, 2002 [ct]; Labellarte et al., 1999). The child and family may also be encouraged to read about childhood anxiety disorders and interventions with CBT (Connolly et al., 2006; Manassis, 1996; Rapee et al., 2000).

The current evidence offers support for the short-term efficacy (Flannery-Schroeder and Kendall, 2000; Kendall et al., 1997; Silverman et al., 1999a) and long-term effectiveness (Barrett et al., 2001; Kendall et al., 2004) of child-focused CBT for childhood anxiety. However, child-focused CBT is not effective for all children with anxiety disorders, and about 20% to 50% may continue to meet criteria for an anxiety disorder after treatment (Barrett et al., 1996; Kendall, 1994; Kendall et al., 1997). Given limitations in the translation of CBT to community practice, a broad array of psychosocial interventions and multimodal treatments need to be flexibly considered so that individual children and families receive the most comprehensive treatment available to them.

PSYCHODYNAMIC PSYCHOTHERAPY

Numerous case studies indicate the benefits of psychodynamic psychotherapy (Goldberger, 1995; McGehee, 2005; Novick, 1974). However, there is limited research on efficacy or effectiveness of psychodynamic psychotherapy alone, in combined treatments, or compared with other modalities (Lis et al., 2001). A few empirical studies evaluate the effectiveness of psychodynamic psychotherapy for anxious youths and young adults (Milrod et al., 2005; Muratori et al., 2003;

Target and Fonagy, 1994). These studies highlight the importance of considering ''dosing'' or intensity of treatment interventions.

Psychodynamic therapists understand anxiety as a signal of internal distress and conflict that motivates the individual to employ internalized, largely unconscious coping strategies, defense mechanisms, and compromise formations. Anxiety disorders result when the signaling system becomes dysfunctional and the signals interfere with normal behavior and development. The goal of psychodynamic psychotherapy is to bring the anxiety back to functional levels and for the child to regain a healthy developmental trajectory.

Psychodynamic psychotherapy for anxiety disorders uses a case formulation informed by one or more of several psychodynamic theoretical perspectives (ego psychology, object relationships, attachment, temperament, motivational, self-psychology, and intersubjective) and incorporates the assessment of the patient's developmental accomplishments and difficulties. Supportive and expressive techniques are used to decrease internal conflict and enhance regulation of affect and impulses, allowing the individual to develop appropriate signal anxiety.

A retrospective chart review from the Anna Freud Centre included 352 children who met *DSM-III-R* criteria for anxiety or depressive disorders (Target and Fonagy, 1994). Children received full psychoanalysis or psychodynamic therapy one to three times per week for an average of 2 years. There was improvement in adaptation based on Children's Global Assessment Scale ratings in 72% of children who received either treatment for at least 6 months. Children with anxiety disorders, with or without other comorbidities, showed more improvement than children with other disorders. Anxiety disorders with focused symptoms such as phobic disorders were most likely to remit with equal response to either treatment, and more pervasive anxiety disorders were less likely to remit or required more frequent and intensive treatment for remission.

A 2-year follow-up in Italy of time-limited (11-week) psychodynamic psychotherapy with children who met *DSM-IV* criteria for depressive or anxiety disorders (mainly dysthymia, SAD, or phobias) evaluated short- and long-term effects (Muratori et al., 2003 [nonrandomized controlled trial]). Children were assigned to psychodynamic therapy or community services as usual (comparison group). The psychodynamic protocol included parents in the therapeutic process. Significant improvement in the psychodynamic therapy group versus comparison group was demonstrated on the Children's Global Assessment Scale at 6-month follow-up ($p < .05$) and the Child Behavior Checklist scale scores at 2-year follow-up ($p < .05$ to $p < .01$). Also, a benefit of the psychodynamic intervention was suggested by less frequent use of mental health services by patients who received this treatment versus comparison group.

An open case series examined panic-focused psychodynamic psychotherapy with modifications for adolescents and young adults in eight patients (18-21 years old) with panic disorder using a 12-week, twice-weekly, manual-based protocol (Milrod et al., 2005 [ct]). The adolescents met *DSM-IV* criteria for panic disorder with agoraphobia and were seriously impaired. The protocol is designed to address psychodynamic core conflicts in panic disorder such as separation and dependency, recognition and management of anger toward attachment figures and significant others, and perceived dangers of sexual excitement. The protocol is flexible and includes the possibility of parent participation based on developmental needs of the patient. Results showed remission of panic disorder in all eight subjects.

In summary, although there is extensive clinical experience with psychodynamic psychotherapy for childhood anxiety disorders, clinical trials research is sparse. More controlled studies are needed to delineate the efficacy and effectiveness of psychodynamic treatments for anxious youths.

PARENT-CHILD AND FAMILY INTERVENTIONS

Research and clinical experience suggest that parents and families may play an important role in the development and maintenance of childhood anxiety. Parental anxiety, parenting styles, insecure attachment, and parent-child interactions are risk factors that may not be addressed by child-focused interventions. Interventions that improve parent-child relationships, strengthen family problem solving, reduce parental anxiety, and foster parenting skills that differentially reinforce adaptive coping and appropriate autonomy in the child are often incorporated into a range of

psychotherapeutic interventions with anxious children. Clinicians who conduct CBT and psychodynamic psychotherapy with anxious children routinely involve parents in the treatment process.

Involvement of parents in the CBT process for child anxiety (beyond standard psychoeducation and coaching) was examined in several trials primarily with WLCs (Barrett, 1998 [rct]; Barrett et al., 1996 [rct], 2001 [rct]; Cobham et al., 1998 [ct]; Mendlowitz et al., 1999 [ct]; Spence et al., 2000 [rct]). One of these studies showed significant additional benefit on several outcome measures when a parent component is added to child CBT (Barrett et al., 1996). Another study found additional benefit for child anxiety when parental anxiety management was added to child CBT if there was an anxious parent (Cobham et al., 1998). A recent study compared group CBT for children, group CBT for children plus parent training group, and no-treatment control (Bernstein et al., 2005 [rct]). CBT was significantly more effective than no-treatment control in decreasing child anxiety and associated functional impairment. Group CBT plus parent training compared to group CBT alone resulted in additional benefits for children on several outcome measures. The benefits of adding a parental component to standard CBT for childhood anxiety as well as other interventions targeting parents or family need further study. Parent involvement may be most critical when the parent is anxious.

Family therapy examines issues in the context of family structure and process rather than focusing on an individual. A number of parenting and family variables have been examined in families of children with anxiety disorders (Ginsburg and Schlossberg, 2002). High maternal emotional overinvolvement appears be connected with SAD in at-risk children (Hirshfeld et al., 1997), and maternal criticism and control may be associated with childhood anxiety (Rapee, 1997; Siqueland et al., 1996). Dadds and Roth (2001) propose an integrative model for family treatment with anxious children that considers the established interaction between attachment and parent-child learning processes, taking into account behavioral and temperamental characteristics of both the child and parent. Further empirical studies in family therapy with anxious children and integration with other established interventions are needed.

Recommendation 7. SSRIs Should Be Considered for the Treatment of Youths With Anxiety Disorders [CG].

SSRIs have emerged as the medication of choice in the treatment of childhood anxiety disorders. When anxiety disorder symptoms are moderate or severe or impairment makes participation in psychotherapy difficult, or psychotherapy results in a partial response, treatment with medication is recommended (Birmaher et al., 1998; Labellarte et al., 1999). Recent randomized, placebo-controlled trials with the SSRIs have established the short-term efficacy of SSRIs in the treatment of childhood anxiety disorders (Table 1), including selective mutism with social phobia (Black and Uhde, 1994 [rdb]), GAD, social phobia, and SAD (Birmaher et al., 2003 [rdb]; RUPP Anxiety Study Group, 2001 [rct]; Rynn et al., 2001 [rdb]; Wagner et al., 2004 [rdb]). In February 2004, the U.S Food and Drug Administration issued a black-box warning and advised clinicians to carefully monitor pediatric patients receiving treatment with antidepressants (including SSRIs) for worsening depression, agitation, or suicidality, particularly at the beginning of medication treatment or during dose changes. This warning is based on review of studies with adolescents whose primary diagnosis was depression, not studies of youths with anxiety.

SSRIs have generally been well tolerated for childhood anxiety disorders, with mild and transient side effects that included gastrointestinal symptoms, headaches, increased motor activity, and insomnia. Less common side effects such as disinhibition should also be monitored. The clinician should routinely screen for bipolar disorder or family history of bipolar in youths before treatment with an SSRI.

Greater severity of illness and presence of social phobia predicted a less favorable outcome for youths with SAD, GAD, and social phobia when fluvoxamine was compared with placebo (RUPP Anxiety Group, 2003). In another study, youths with social phobia and GAD responded significantly better to fluoxetine than placebo (Birmaher et al., 2003 [rdb]). However, clinical response to fluoxetine for youths with SAD was not significantly different from that to placebo. Severity of illness at intake and positive family history of anxiety disorders predicted poorer response at posttreatment.

TABLE 1
Placebo-Controlled Pharmacological Treatment Studies

Author	Treatment	Demographics	Diagnoses	Results
SSRIs				
Black and Uhde, 1994 [rdb]	Fluoxetine (12–27 mg/d)	*N* = 15, 6–11 y.o.	SM plus SoP or AD	Fluoxetine > PLC
RUPP, 2001 [rct]	Fluvoxamine (50–250 mg/d child, max 300 mg/d adolescent)	*N* = 128, 6–17 y.o.	SoP, SAD, GAD	Fluvoxamine > PLC
Rynn et al., 2002 [rdb]	Sertraline (50 mg/d)	*N* = 22, 5–17 y.o.	GAD	Sertraline > PLC
Birmaher et al., 2003 [rdb]	Fluoxetine (20 mg/d)	*N* = 74, 7–17 y.o.	GAD, SoP SAD	Fluoxetine > PLC Fluoxetine = PLC
Wagner et al., 2004 [rdb]	Paroxetine (10–50 mg/d)	*N* = 322, 8–17 y.o.	SoP	Paroxetine > PLC
Other antidepressants				
Gittleman-Klein and Klein, 1971 [rdb]	Imipramine (100–200 mg/d)	*N* = 35, 6–14 y.o.	School phobia with anxiety disorders	Imipramine > PLC
Berney et al., 1981 [rdb]	Clomipramine (40–75 mg/d)	*N* = 51, 9–14 y.o.	School refusal	Clomipramine = PLC
Klein et al., 1992 [rdb]	Imipramine (75–275 mg/d)	*N* = 21, 6–15 y.o.	SAD with or without school phobia	Imipramine = PLC
Benzodiazepines				
Bernstein et al., 1990 [rdb]	Alprazolam (0.75–4.0 mg/d) vs. Imipramine (50–175 mg/d)	*N* = 24, 7–18 y.o.	School refusal, SAD	Alprazolam = Imipramine = PLC
Simeon et al., 1992 [rdb]	Alprazolam (0.5–3.5 mg/d)	*N* = 30, 8–17 y.o.	OAD, AD	Alprazolam = PLC
Graae et al., 1994 [rdb]	Clonazepam (0.5–2.0 mg/d)	*N* = 15, 7–13 y.o.	SAD	Clonazepam = PLC

Note: SSRIs = selective serotonin reuptake inhibitors; y.o. = years old; SM = selective mutism; SoP = social phobia; AD = avoidant disorder; PLC = placebo; SAD = separation anxiety disorder; GAD = generalized anxiety disorder; OAD = overanxious disorder.

This study and the RUPP Anxiety Study (2001) indicate that clinicians should consider increasing SSRI doses for patients if significant improvement is not achieved by the fourth week of treatment.

No controlled studies are available for medication treatment of childhood-onset panic disorder. A trial of SSRIs in adolescents with panic disorder (Renaud et al., 1999 [ct]) and chart review (Masi et al., 2001) in adolescents with panic disorder showed significant improvement in panic symptoms with SSRIs.

Whereas controlled trials have established the safety and efficacy of short-term treatment with SSRIs for childhood anxiety disorders, the benefits and risks of long-term use of SSRIs have not been studied. Pine (2002) recommends that clinicians may consider a medication-free trial for children who have a significant reduction in anxiety or depressive symptoms on an SSRI and maintain stability in these symptoms for 1 year. This trial off medication should be during a low-stress period, and the SSRI should be reinitiated if the child or adolescent relapses.

There is no empirical evidence that a particular SSRI is more effective than another for treatment of childhood anxiety disorders. Clinically, the choice is often based on side effects profile, duration of action, or positive response to a particular SSRI in a first-degree relative with anxiety (Manassis, 2000). In addition, the risk-benefit ratio for a medication trial needs to be carefully assessed because CBT has been shown to be effective and long-term side effects of medications have not been studied in youths (Birmaher et al., 1998).

At this time, there are no specific dosing guidelines for children and adolescents with anxiety disorder. Review articles recommend starting at low doses, monitoring side effects closely, and then increasing the dose slowly on the basis of treatment response and tolerability (Birmaher et al., 1998; Labellarte et al., 1999). Clinicians need to appreciate that anxious children and anxious parents may be especially sensitive to any worsening in the child's somatic symptoms or emergence of even transient side effects of medications.

Recommendation 8. Medications Other Than SSRIs May Be Considered for the Treatment of Youths With Anxiety Disorders [OP].

The safety and efficacy of medications other than SSRIs for the treatment of childhood anxiety disorders have not been established. However, noradrenergic antidepressants (venlafaxine and tricyclic antidepressants [TCAs]), buspirone, and benzodiazepines have

been suggested as alternatives to be used alone or in combination with the SSRIs (Birmaher et al., 1998; Labellarte et al., 1999). Data are limited in childhood anxiety disorders to guide treatment with combinations of medications when a single medication is not effective in managing anxiety symptoms. Comorbid diagnoses are strongly considered in selection of medication.

Preliminary findings from controlled trials of extended-release venlafaxine in the treatment of youths with GAD (Rynn et al., 2002 [rdb]) and social phobia (Tourian et al., 2004 [rdb]) suggest it may be well tolerated and effective for GAD and social phobia relative to placebo. Since the introduction of SSRIs, TCAs have been used less often because of the need for close cardiac monitoring and greater medical risk with overdose of TCAs. Controlled trials with TCAs for pediatric anxiety disorders have shown conflicting results and have not established efficacy for this use (Table 1). Clomipramine is a TCA with serotonergic properties that is used alone or to boost the effect of an SSRI when there is a partial response. It has been shown to be efficacious in the treatment of childhood obsessive-compulsive disorder through controlled studies, but it has not been systematically examined in the treatment of other anxiety disorders (Geller et al., 2003). It should be introduced at a low dose in youths and closely monitored for anticholinergic and cardiac side effects.

Buspirone may be an alternative to SSRIs for GAD in youths, but there are no published controlled trials. Buspirone may be well tolerated at doses of 5 to 30 mg twice daily in anxious adolescents and at lower doses of 5 to 7.5 mg twice daily in anxious children (Salazar et al., 2001 [ct]). The most common adverse side effects in youths were lightheadedness, headache, and dyspepsia.

Benzodiazepines have not shown efficacy in controlled trials in childhood anxiety disorders (Table 1), despite established benefit in adult trials. Clinically they are used as an adjunct short-term treatment with SSRIs to achieve rapid reduction in severe anxiety symptoms that may permit initiation of the exposure phase of CBT (e.g., panic disorder, school refusal behavior; Birmaher et al., 1998; Renaud et al., 1999 [ct]). Clinicians should use benzodiazepines cautiously because of the possibility of developing dependency (Riddle et al., 1999). They are contraindicated in adolescents with substance abuse (Birmaher et al., 1998). Possible side effects include sedation, disinhibition, cognitive impairment, and difficulty with discontinuation (Labellarte et al., 1999).

Recommendation 9. Treatment Planning May Consider Classroom-Based Accommodations [OP].

The clinician could consider the following classroom-based accommodations when anxiety disorders interfere with school functioning. If anxiety interferes with homework completion, then the length of homework assignments should be modified to an amount commensurate with the student's capacity. If anxiety is overwhelming at school, then an adult outside the immediate classroom should be identified who can assist the child with problem-solving or anxiety management strategies. If performance or test anxiety is present, then testing in a quiet, private environment may reduce excess anxiety. It is often helpful to educate the classroom teacher about the nature of the child's anxiety and suggest strategies that facilitate the student's coping. The clinician may recommend that these specific accommodations for the anxiety disorder be written into the student's 504 Plan or Individualized Educational Plan.

COMORBIDITY

Recommendation 10. Comorbid Conditions Should Be Appropriately Evaluated and Treated [MS].

Anxiety disorders are highly comorbid with other anxiety disorders and with other psychiatric disorders including depression (Angold and Costello, 1993; Lewinsohn et al., 1997), ADHD (Kendall et al., 2001), and substance abuse (Schuckit and Hesselbrock, 1994). Other commonly co-occurring conditions include oppositional defiant disorder, learning disorders, and language disorders (Manassis and Monga, 2001). Comorbid disorders may affect functioning and treatment outcome. They should be assessed and may benefit from being treated concurrently with the anxiety disorder (Manassis and Monga, 2001). Diagnosis is complicated by overlapping symptoms between anxiety disorders and comorbid conditions, which can lead to misdiagnosis and underdiagnosis of comorbidity. Inattention, for example, may be present in anxiety, ADHD, depression, learning disorders, and substance abuse. A common clinical phenomenon is

the recognition of a comorbid diagnosis once the primary diagnosis is treated and additional symptoms become more evident.

The presence of comorbid major depression increases with older age, is associated with greater severity and impairment of the anxiety disorder, is more likely to be associated with social anxiety, and may be a poor prognostic indicator (Bernstein, 1991; Manassis and Menna, 1999). A child with severe depression may not be able to participate in CBT effectively. Treatment of depression needs to be prioritized with initiation of an SSRI antidepressant medication recommended early in the treatment process (Labellarte et al., 1999; March, 2002). Careful monitoring of suicide risk is recommended.

Clinical studies have shown that as many as one third of children with ADHD have co-occurring anxiety disorders (MTA Cooperative Group, 2001 [rct]). The MTA Group suggests that for youths with ADHD comorbid with anxiety, a combination of medication management for the ADHD and behavioral management, at least parent training, are recommended as initial interventions (March et al., 2000). The MTA Group and others found the presence of comorbid anxiety does not alter the response of core ADHD symptoms to methylphenidate, and side effects to stimulants were not significantly greater in children with ADHD and anxiety than in those with ADHD alone (Abikoff et al., 2005 [rct]; Diamond et al., 1999 [ct]).

Children with anxiety disorders are at greater risk of alcohol abuse in adolescence (Schuckit and Hesselbrock, 1994). Comorbid alcohol abuse/dependence in adolescents should be assessed and considered in treatment planning with anxiety disorders (Manassis and Monga, 2001). Based on the temporal relationship between childhood anxiety disorders and risk of alcoholism in adolescents (Schuckit and Hesselbrock, 1994), it is suggested that some adolescents use alcohol to reduce anxiety symptoms. CBT may be effective in reducing anxiety if the alcohol abuse is treated, and developing alternative coping strategies to address anxiety may help to reduce alcohol consumption. A 7.4-year follow-up study suggested that children who were successfully treated with CBT for their anxiety disorders, as compared with less positive responders, had a reduced amount of substance use involvement and related problems at long-term follow-up (Kendall et al., 2004).

The presence of comorbid bipolar disorder is an important factor in medication choice because of the possibility that SSRIs and other antidepressants may exacerbate symptoms of bipolar disorder. Youths with anxiety disorders should be screened for bipolar disorder and family history of bipolar disorder before initiating a medication trial.

PREVENTION

Recommendation 11. Early Assessment and Intervention May Be Considered in Treatment and Prevention of Childhood Anxiety Disorders [OP].

With older age, increased severity of symptoms, parental psychopathology, and family functioning difficulties as significant predictors of poorer treatment outcome, early intervention, and prevention offer a proactive method for alleviating anxiety symptoms in youths (Crawford and Manassis, 2001; Dadds et al., 1997 [rct], 1999 [2-year follow-up]; Hirshfeld-Becker and Biederman, 2002; Southam-Gerow et al., 2001). In addition, targeting empirically based risk factors that are amenable to change with evidence-supported intervention satisfies the prerequisites for effective prevention (Spence, 2001). Opportunities for early intervention and prevention exist for childhood anxiety disorders and may include community screening and early assessment, early interventions in community settings, media-based and community-based psychoeducational programming, classroom-based programs, parent skills-training programs, and screening and treatment of parental anxiety disorders. Several of these are discussed in further detail.

Community screening and early assessment can identify anxious youths at greatest risk by using brief self-report screening measures such as the Multidimensional Anxiety Scale for Children and the Screen for Child Anxiety Related Emotional Disorders for anxiety symptoms (Dierker et al., 2001; Muris et al., 2002) and/or by teacher nomination (Layne and Bernstein, 2003). Group interventions with CBT in school and other community settings can provide effective early treatment for children with mild to moderate anxiety disorders, which may improve long-term functioning (Dadds et al., 1997 [rct], 1999; Muris et al., 2001 [ct]). Clinicians are encouraged to refer patients for early-intervention CBT even if anxiety symptoms are mild or subclinical. Adaptation of protocol-based CBT interventions to fit diverse

populations and take into account the limitations of community resources, including those of inner-city minority youths, can make evidence-supported treatments feasible and transportable (Ginsburg and Drake, 2002 [rct]; U.S. Department of Health and Human Services, 2000). Parent skills-training programs that teach parents anxiety management and foster healthy parent-child relationships may reduce the development of anxiety disorders in young children at risk (Hirshfeld-Becker and Biederman, 2002).

SCIENTIFIC DATA AND CLINICAL CONSENSUS

Practice parameters are strategies for patient management, developed to assist clinicians in psychiatric decision making. American Academy of Child and Adolescent Psychiatry practice parameters, based on evaluation of the scientific literature and relevant clinical consensus, describe generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures. These parameters are not intended to define the standard of care nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The clinician–after considering all of the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources–must make the ultimate judgment regarding the care of a particular patient.

Disclosure: The authors have no financial relationships to disclose.

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Screening for Posttraumatic Stress Disorder in Children After Accidental Injury Justin A. Kenardy, BSc, PhD, MAPS, Susan H. Spence, BSc, MBA, PhD, Alexandra C. Macleod, BPsySc

Objective: Children who have experienced an accidental injury are at increased risk of developing posttraumatic stress disorder. It is, therefore, essential that strategies are developed to aid in the early identification of children at risk of developing posttraumatic stress disorder symptomatology after an accident. The aim of this study was to examine the ability of the Child Trauma Screening Questionnaire to predict children at risk of developing distressing posttraumatic stress disorder symptoms 1 and 6 months after a traumatic accident. *Methods:* Participants were 135 children (84 boys and 51 girls; with their parents) who were admitted to the hospital after a variety of accidents, including car-and bike-related accidents, falls, burns, dog attacks, and sporting injuries. The children completed the Child Trauma Screening Questionnaire and the Children's Impact of Events Scale within 2 weeks of the accident, and the Anxiety Disorders Interview Schedule for *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Child Version,* was conducted with the parents to assess full and subsyndromal posttraumatic stress disorder in their child 1 and 6 months after the accident. *Results:* Analyses of the results revealed that the Child Trauma Screening Questionnaire correctly identified 82% of children who demonstrated distressing posttraumatic stress disorder symptoms (9% of sample) 6 months after the accident. The Child Trauma Screening Questionnaire was also able to correctly screen out 74% of children who did not demonstrate such symptoms. Furthermore, the Child Trauma Screening Questionnaire outperformed the Children's Impact of Events Scale. *Conclusions:* The Child Trauma Screening Questionnaire is a quick, cost-effective and valid self-report screening instrument that could be incorporated in a hospital setting to aid in the prevention of childhood posttraumatic stress disorder after accidental trauma. **Pediatrics** 2006;118:1002–1009.

Practice Parameter for the Assessment and Treatment of Children and Adolescents With Depressive Disorders

ABSTRACT

This practice parameter describes the epidemiology, clinical picture, differential diagnosis, course, risk factors, and pharmacological and psychotherapy treatments of children and adolescents with major depressive or dysthymic disorders. Side effects of the antidepressants, particularly the risk of suicidal ideation and behaviors are discussed. Recommendations regarding the assessment and the acute, continuation, and maintenance treatment of these disorders are based on the existent scientific evidence as well as the current clinical practice. *J. Am. Acad. Child Adolesc. Psychiatry,* 2007; 46(11):1503–1526. **Key Words:** major depressive disorder, dysthymic disorder, evaluation, treatment, antidepressants, selective serotonin reuptake inhibitors, psychotherapy, practice parameter.

Depressive disorders are often familial recurrent illnesses associated with increased psychosocial morbidity and mortality. Early identification and effective treatment may reduce the impact of depression on the family, social, and academic functioning in youths and may reduce the risk of suicide, substance abuse, and persistence of depressive disorders into adulthood. Evidence-supported treatment interventions have emerged in psychotherapy and medication treatment of childhood depressive disorders that can guide clinicians to improve outcomes in this population.

Accepted June 7, 2007.

This parameter was developed by Boris Birmaher, M.D., and David Brent, M.D., principal authors, and the AACAP Work Group on Quality Issues: William Bernet, M.D., Oscar Bukstein, M.D., and Heather Walter, Co-Chairs, and R. Scott Benson, M.D., Allan Chrisman, M.D., Tiffany Farchione, M.D., Laurence Greenhill, M.D., John Hamilton, M.D., Helene Keable, M.D., Joan Kinlan, M.D., Ulrich Schoettle, M.D., and Saundra Stock, M.D. AACAP Staff: Kristin Kroeger Ptakowski and Jennifer Medicus.

The authors acknowledge the following experts for their contributions to this parameter: Jeffrey Bridge, Ph.D., Amy Cheung, M.D., Greg Clarke, Ph.D., Graham Emslie, M.D., Philip Hazell, M.D., Stan Kutcher, M.D., Laura Mufson, Ph.D., Kelly Posner, Ph.D., Joseph Rey, M.D., Karen Wagner, M.D., and Elizabeth Weller, M.D.

This parameter was made available for review to the entire AACAP membership in February and March 2006.

From July 2006 to February 2007, this parameter was reviewed by a Consensus Group convened by the Work Group on Quality Issues. Consensus Group members and their constituent groups were as follows: Work Group on Quality Issues (Oscar Bukstein, M.D., Helene Keable, M.D., and John Hamilton, M.D.); Topic Experts (Graham Emslie, M.D., and Greg Clarke, Ph.D.); AACAP Assembly of Regional Organizations (Syed Naqvi, M.D.); and AACAP Council (David DeMaso, M.D., and Michael Houston, M.D.).

Disclosures of potential conflicts of interest for authors and Work Group chairs are provided at the end of the parameter. Disclosures of potential conflicts of interest for all other individuals named above are provided on the AACAP Web site on the Practice Information page.

This practice parameter was approved by the AACAP Council on June 1, 2007.

This practice parameter is available on the Internet (www.aacap.org).

Reprint requests to the AACAP Communications Department, 3615 Wisconsin Avenue, NW, Washington, DC 20016.

DOI: 10.1097/chi.0b013e318145ae1c

METHODOLOGY

The list of references for this parameter was developed by searching *PsycINFO*, *Medline*, and *Psychological Abstracts*; by reviewing the bibliographies of book chapters and review articles; by asking colleagues for suggested source materials; and from the previous version of this parameter (American Academy of Child and Adolescent Psychiatry, 1998), the recent American Psychiatric Association/AACAP guidelines "The Use of Medication in Treating Childhood and Adolescent Depression: Information for Physicians" published by *ParentsMedGuide.org*, the American Psychiatric Association guidelines for the treatment of adults with MDD (American Psychiatric Association, 2000a; Fochtmann and Gelenberg, 2005), the Texas algorithms for the treatment of children and adolescents with MDD (Hughes et al., 2007), and the National Institute of Health and Clinical Excellence (NICE; 2004) guidelines for the treatment of depressed youths. The searches, conducted in 2005, used the following text words: "major depressive disorder," "dysthymia,"

antidepressants," and "psychotherapy" (e.g., interpersonal, psychodynamic, cognitive) combined with the word "child." The searches covered the period 1990 to January 2007 and only articles that included depressive disorders were included. Given space limitations, we mainly cited review articles published in refereed journals and added new relevant articles not included in the reviews.

DEFINITIONS

The terminology in this practice parameter is consistent with the *DSM-IV-TR* (American Psychiatric Association, 2000b). Unless specified, the term "depression" encompasses both major depressive disorder (MDD) and dysthmic disorder (DD). Impairment means reduced functioning in one or more major areas of life (academic performance, family relationships, and peer interactions).

The information included in this parameter pertains mainly to MDD. There are few clinical studies and no controlled trials for the treatment of DD in youths. However, based on the limited adult literature (American Psychiatric Association, 2000a), efficacious treatments for MDD may also be useful for the management of DD.

In this parameter, unless otherwise specified, the terms "child" and "youths," respectively, refer to children and adolescents. "Parent" refers to parent or legal guardian.

EPIDEMIOLOGY

The prevalence of MDD is estimated to be approximately 2% in children and 4% to 8% in adolescents, with a male-to-female ratio of 1:1 during childhood and 1:2 during adolescence (Birmaher et al., 1996). The risk of depression increases by a factor of 2 to 4 after puberty, particularly in females (Angold et al., 1998), and the cumulative incidence by age 18 is approximately 20% in community samples (Lewinsohn et al., 1998).

Approximately 5% to 10% of children and adolescents have subsyndromal symptoms of MDD. These youths have considerable psychosocial impairment, high family loading for depression, and an increased risk of suicide and developing MDD (Fergusson et al., 2005; Gonzales-Tejera et al., 2005; Lewinsohn et al., 2000; Pine et al., 1998). The few epidemiological studies on DD have reported a prevalence of 0.6% to 1.7% in children and 1.6% to 8.0% in adolescents (Birmaher et al., 1996).

Studies in adults and one study in youths have suggested that each successive generation since 1940 is at greater risk of developing depressive disorders and that these disorders have their onset at a younger age (Birmaher et al., 1996).

CLINICAL PRESENTATION

Clinical depression manifests as a spectrum disorder with symptoms ranging from subsyndromal to syndromal. To be diagnosed with a syndromal disorder (MDD), a child or adolescent must have at least 2 weeks of persistent change in mood manifested by either depressed or irritable mood and/or loss of interest and pleasure plus a group of other symptoms including wishing to be dead, suicidal ideation or attempts; increased or decreased appetite, weight, or sleep; and decreased activity, concentration, energy, or self-worth or exaggerated guilt (American Psychiatric Association, 2000b; World Health Organization, 1992). These symptoms must represent a change from previous functioning and produce impairment in relationships or in performance of activities. Furthermore, symptoms must not be attributable only to substance abuse, use of medications, other psychiatric illness, bereavement, or medical illness.

Overall, the clinical picture of MDD in children and adolescents is similar to the clinical picture in adults, but there are some differences that can be attributed to the child's physical, emotional, cognitive, and social developmental stages (Birmaher et al., 1996; Fergusson et al., 2005; Kaufman et al., 2001; Klein et al., 2005; Lewinsohn et al., 2003a; Luby et al., 2004; Yorbik et al., 2004). For example, children may have mood lability, irritability, low frustration tolerance, temper tantrums, somatic complaints, and/or social withdrawal instead of verbalizing feelings of depression. Also, children tend to have fewer melancholic symptoms, delusions, and suicide attempts than depressed adults.

There are different subtypes of MDD, which may have prognostic and treatment implications. Psychotic depression has been associated with family history of bipolar and psychotic depression (Haley et al., 1988; Strober et al., 1993), more severe depression, greater long-term morbidity, resistance to antidepressant monotherapy, and, most notably, increased risk of bipolar

disorder (Strober and Carlson, 1982). MDD can be manifested with atypical symptoms such as increased reactivity to rejection, lethargy (leaden paralysis), increased appetite, craving for carbohydrates, and hypersomnia (Stewart et al., 1993; Williamson et al., 2000). Youths with seasonal affective disorder (SAD; Swedo et al., 1995) mainly have symptoms of depression during the season with less daylight. SAD should be differentiated from depression triggered by school stress because both usually coincide with the school calendar.

DD consists of a persistent, long-term change in mood that generally is less intense but more chronic than in MDD. As a consequence, DD is often overlooked or misdiagnosed. Although the symptoms of dysthymia are not as severe as in MDD, they cause as much or more psychosocial impairment (Kovacs et al., 1994; Masi et al., 2001). For a *DSM-IV* diagnosis of DD, a child must have depressed mood or irritability on most days for most of the day for a period of 1 year, as well as two other symptoms from a group including changes in appetite or weight and changes in sleep; problems with decision-making or concentration; and low self-esteem, energy, and hope (American Psychiatric Association, 2000b).

COMORBIDITY

Both MDD and DD are usually accompanied by other psychiatric and medical conditions, and often they occur together (the so-called double depression). Depending on the setting and source of referral, 40% to 90% of youths with depressive disorder also have other psychiatric disorders, with up to 50% having two or more comorbid diagnoses. The most frequent comorbid diagnoses are anxiety disorders, followed by disruptive disorders, attention-deficit/hyperactivity disorder (ADHD), and, in adolescents, substance use disorders. MDD and DD usually manifest after the onset of other psychiatric disorders (e.g., anxiety), but depression also increases the risk of the development of nonmood psychiatric problems such as conduct and substance abuse disorders (Angold et al., 1999; Birmaher et al., 1996; Fombonne et al., 2001a,b; Lewinsohn et al., 1998, 2003a; Rohde et al., 1991).

DIFFERENTIAL DIAGNOSIS

Several psychiatric (e.g., anxiety, dysthymia, ADHD, oppositional defiant disorder, pervasive developmental disorder, substance abuse) and medical disorders (e.g., hypothyroidism, mononucleosis, anemia, certain cancers, autoimmune diseases, premenstrual dysphoric disorder, chronic fatigue syndrome) as well as conditions such as bereavement and depressive reactions to stressors (adjustment disorder) may co-occur with or mimic MDD or DD. These conditions may cause poor self-esteem or demoralization, but should not be diagnosed as MDD or DD unless they meet criteria for these disorders. Moreover, the symptoms of the above-noted conditions may overlap with the symptoms of depression (e.g., tiredness, poor concentration, sleep and appetite disturbances), making the differential diagnosis complicated. Also, medications (e.g., stimulants, corticosteroids, contraceptives) can induce depression-like symptomatology. The diagnosis of MDD or DD can be made if depressive symptoms are not due solely to the illnesses or the medications and if the child fulfills the criteria for these depressive disorders.

Because most children and adolescents presenting to treatment are experiencing their first episode of depression, it is difficult to differentiate whether their depression is part of unipolar major depression or the depressive phase of bipolar disorder. Certain indicators such as high family loading for bipolar disorder, psychosis, and history of pharmacologically induced mania or hypomania may herald the development of bipolar disorder (Birmaher et al., 1996). It is important to evaluate carefully for the presence of subtle or short-duration hypomanic symptoms because these symptoms often are overlooked and these children and adolescents may be more likely to become manic when treated with antidepressant medications (Martin et al., 2004). It is also important to note that not all children who become activated or hypomanic while receiving antidepressants have bipolar disorder (Wilens et al., 1998).

CLINICAL COURSE

The median duration of a major depressive episode for clinically referred youths is about 8 months and for community samples, about 1 to 2 months. Although most children and adolescents recover from their first depressive episode, longitudinal studies of both clinical and community samples of depressed youths have shown that the probability of recurrence reaches 20% to 60% by 1 to 2 years after remission and climbs to 70% after 5 years (Birmaher et al., 2002; Costello et al.,

2002). Recurrences can persist throughout life, and a substantial proportion of children and adolescents with MDD will continue to suffer MDD during adulthood. Moreover, between 20% and 40% will develop bipolar disorder, particularly if they have the risk factors described above (Geller et al., 1994; Strober and Carlson, 1982).

Childhood depression, compared with adult-onset depression, appears to be more heterogeneous. Some children may have a strong family history of mood disorders and high risk of recurrences, whereas others may develop bipolar disorder or be more likely to develop behavior problems and substance abuse than depression (Birmaher et al., 2002; Fombonne et al., 2001a,b; Harrington, 2001; Weissman et al., 1999). Although there are some differences, for the most part the predictors of recovery, relapse, and recurrence overlap. In general, greater severity, chronicity, or multiple recurrent episodes, comorbidity, hopelessness, presence of residual subsyndromal symptoms, negative cognitive style, family problems, low socioeconomic status, and exposure to ongoing negative events (abuse, family conflict) are associated with poor outcome (Birmaher et al., 2002; Lewinsohn et al., 1998).

Childhood DD has a protracted course, with a mean episode length of approximately 3 to 4 years for clinical and community samples, and is associated with an increased risk of subsequent MDD and substance use disorders (Klein et al., 1988; Kovacs et al., 1994; Lewinsohn et al., 1991).

COMPLICATIONS

If untreated, MDD may affect the development of a child's emotional, cognitive, and social skills and may interfere considerably with family relationships (Birmaher et al., 1996, 2002; Lewinsohn et al., 2003b). Suicide attempts and completion are among the most significant and devastating sequelae of MDD with approximately 60% report having thought about suicide and 30% actually attempt suicide (American Academy of Child and Adolescent Psychiatry, 2001; Brent et al., 1999; Gould et al., 1998). The risk of suicidal behavior increases if there is a history of suicide attempts, comorbid psychiatric disorders (e.g., disruptive disorders, substance abuse), impulsivity and aggression, availability of lethal agents (e.g., firearms), exposure to negative events (e.g., physical or sexual abuse, violence), and a family history of suicidal behavior (Beautrais, 2000; Brent et al., 1988; Gould et al., 1998).

Children and adolescents with depressive disorders are also at high risk of substance abuse (including nicotine dependence), legal problems, exposure to negative life events, physical illness, early pregnancy, and poor work, academic, and psychosocial functioning. After an acute episode of depression, a slow and gradual improvement in psychosocial functioning may occur unless there are relapses or recurrences. However, psychosocial difficulties frequently persist after the remission of the depressive episode, underscoring the need for continuing treatment for the depression as well as treatment that addresses associated psychosocial and contextual issues (Fergusson and Woodward, 2002; Hammen et al., 2003, 2004; Lewinsohn et al., 2003b).

In addition to the depressive disorder, other factors such as comorbid psychopathology, physical illness, poor family functioning, parental psychopathology, low socioeconomic status, and exposure to negative life events may affect the psychosocial functioning of depressed youths (Birmaher et al., 1996; Fergusson and Woodward, 2002; Lewinsohn et al., 1998, 2003b).

RISK FACTORS

High-risk, adoption, and twin studies have shown that MDD is a familial disorder, which is caused by the interaction of genetic and environmental factors (Birmaher et al., 1996; Caspi et al., 2003; Kendler et al., 2005; Pilowsky et al., 2006; Pine et al., 1998; Reinherz et al., 2003; Weissman et al., 2005, 2006b). In fact, the single most predictive factor associated with the risk of developing MDD is high family loading for this disorder (Nomura et al., 2002; Weissman et al., 2005).

The onset and recurrences of major depression may be moderated or mediated by the presence of stressors such as losses, abuse, neglect, and ongoing conflicts and frustrations. However, the effects of these stressors also depend on the child's negative attributional styles for interpreting and coping with stress, support, and genetic factors. Other factors such as the presence of comorbid disorders (e.g., anxiety, substance abuse, ADHD, eating disorders), medical illness (e.g., diabetes), use of medications, biological, and sociocultural factors have also been related to the development and maintenance of depressive symptomatology (Caspi et al., 2003; Costello

et al., 2002; Garber and Hilsman, 1992; Kaufman et al., 2001; Kendler et al., 2005; Lewinsohn et al., 1998; Pine et al., 1998, 2002, 2004; Rey et al., 2004; Weissman et al., 2005; Williamson et al., 1998).

EVIDENCE BASE FOR PRACTICE PARAMETERS

The AACAP develops both patient-oriented and clinician-oriented practice parameters. Patient-oriented parameters provide recommendations to guide clinicians toward the best treatment practices. Treatment recommendations are based both on empirical evidence and clinical consensus and are graded according to the strength of the empirical and clinical support. Clinician-oriented parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are primarily based on expert opinion and clinical experience.

In this parameter, recommendations for best treatment practices are stated in accordance with the strength of the underlying empirical and/or clinical support, as follows:

- [MS] *Minimal Standards* are applied to recommendations that are based on rigorous empirical evidence (e.g., randomized controlled trials) and/or overwhelming clinical consensus. Minimal standards apply more than 95% of the time (i.e., in almost all cases).
- [CG] *Clinical Guidelines* are applied to recommendations that are based on strong empirical evidence (e.g., non-randomized controlled trials) and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time (i.e., in most cases).
- [OP] *Option* is applied to recommendations that are acceptable based on emerging empirical evidence (e.g., uncontrolled trials or case series/reports) or clinical opinion, but lack strong empirical evidence and/or strong clinical consensus.
- [NE] *Not Endorsed* is applied to practices that are known to be ineffective or contraindicated.

The strength of the empirical evidence is rated in descending order as follows:

- [rct] *Randomized controlled trial* is applied to studies in which subjects are randomly assigned to two or more treatment conditions
- [ct] *Controlled trial* is applied to studies in which subjects are nonrandomly assigned to two or more treatment conditions
- [ut] *Uncontrolled trial* is applied to studies in which subjects are assigned to one treatment condition
- [cs] *Case series/report* is applied to a case series or a case report

CONFIDENTIALITY

Recommendation 1. The Clinician Should Maintain a Confidential Relationship With the Child or Adolescent While Developing Collaborative Relationships With Parents, Medical Providers, Other Mental Health Professionals, and Appropriate School Personnel [MS].

At the outset of the initial contact, the clinician should clarify with the patient and parents the boundaries of the confidential relationship that will be provided. The child's right to a confidential relationship is determined by law that varies by state. Each state has mandatory child abuse reporting requirements. Parents will expect information about the treatment plan, the safety plan, and progress toward goals of treatment. The child should expect that suicide or violence risk issues will be communicated to the parents. The clinician should request permission to communicate with medical providers, other mental health professionals involved in the treatment, and appropriate school personnel. Clinicians should provide a mechanism for parents to communicate concerns about deterioration in function and high-risk behaviors such as suicide threats or substance use.

SCREENING

Recommendation 2. The Psychiatric Assessment of Children and Adolescents Should Routinely Include Screening Questions About Depressive Symptomatology [MS].

Clinicians should screen all children and adolescents for key depressive symptoms including depressive or sad mood, irritability, and anhedonia. A diagnosis of a depressive disorder should be considered if these symptoms are present most of the time, affect the child's psychosocial functioning, and are above and beyond what is expected for the chronological and psychological age of the child. To screen for depressive symptoms, clinicians

could use checklists derived from the *DSM* or *ICD-10* criteria for depressive disorders, clinician-based instruments, and/or child and parent depression self-reports (American Academy of Child and Adolescent Psychiatry, 1997; Klein et al., 2005; Myers and Winters, 2002).

EVALUATION

Recommendation 3. If the Screening Indicates Significant Depressive Symptomatology, the Clinician Should Perform a Thorough Evaluation to Determine the Presence of Depressive and Other Comorbid Psychiatric and Medical Disorders [MS].

A comprehensive psychiatric diagnostic evaluation is the single most useful tool available to diagnose depressive disorders. The psychiatric assessment of depressed children and adolescents must be performed by a developmentally sensitive clinician who is able to achieve good rapport with children. For example, children may either have difficulties verbalizing their feelings or alternatively deny that they are depressed. Thus, the clinician should also be attentive to observable manifestations of depression such as irritability, changes in sleep habits, decline in school performance, and withdrawal from previous pleasurable activities.

Clinicians should evaluate the child's and family's strengths. Also, the evaluation should be sensitive to ethnic, cultural, and religious characteristics of the child and his or her family that may influence the presentation, description, or interpretation of symptoms and the approach to treatment.

The evaluation should include direct interviews with the child and parents/caregivers and, ideally, with the adolescent alone. Also, whenever appropriate, other informants including teachers, primary care physicians, social services professionals, and peers should be interviewed. Subtypes of depressive disorders (seasonal, mania/hypomania, psychosis, subsyndromal, symptoms of depression), comorbid psychiatric disorders, medical illnesses, and (as indicated) physical examinations and laboratory tests are among the areas that should be evaluated. Because of the prognostic and treatment implications, as described under Differential Diagnosis above, it is crucial to evaluate for the presence of lifetime manic or hypomanic symptoms.

Several standardized structured and semistructured interviews are available for the evaluation of psychiatric symptoms in children older than 7 years (American Academy of Child and Adolescent Psychiatry, 1997; Klein et al., 2005; Myers and Winters, 2002) and more recently in younger children (Luby et al., 2003). However, many of these interviews are too long to be carried out in clinical settings, require special training, and have low parent–child agreement. Parents' reports also may be influenced by their own psychopathology, highlighting the importance of obtaining information not only from parents but also from the child and other sources, including teachers.

In the assessment of the onset and course of mood disorders, it is helpful to use a mood diary and a mood timeline that uses school years, birthdays, and so forth as anchors. Mood is rated from very happy to very sad and/or very irritable to nonirritable, and normative and non-normative stressors as well as treatments are noted. The mood timeline can help children and their parents to visualize the course of their mood and comorbid conditions, identify events that may have triggered the depression, and examine the relationship between treatment and response. At present, no biological or imaging tests are clinically available for the diagnosis of depression.

Evaluation of a child's functioning can be done through the use of several rating scales (American Academy of Child and Adolescent Psychiatry, 1997; Winters et al., 2005). Among the shortest and simplest ones are the Children's Global Assessment Scale (Shaffer et al., 1983) and the Global Assessment of Functioning (American Psychiatric Association, 2000b).

Finally, the clinician, together with the child and parents, should evaluate the appropriate intensity and restrictiveness of care (e.g., hospitalization). The decision for the level of care will depend primarily on level of function and safety to self and others, which in turn are determined by the severity of depression, presence of suicidal and/or homicidal symptoms, psychosis, substance dependence, agitation, child's and parents' adherence to treatment, parental psychopathology, and family environment.

Recommendation 4. The Evaluation Must Include Assessment for the Presence of Harm to Self or Others [MS].

Suicidal behavior exists along a continuum from passive thoughts of death to a clearly developed plan and intent to carry out that plan (American Academy of Child and Adolescent Psychiatry, 2001; Gould et al.,

1998). Because depression is closely associated with suicidal thoughts and behavior, it is imperative to evaluate these symptoms at the initial and subsequent assessments (American Academy of Child and Adolescent Psychiatry, 2001; Gould et al., 1998). For this purpose, low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can be used. Also, it is crucial to evaluate the risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g., religious belief, concern not to hurt family) that may influence the desire to attempt suicide. Both current severity of suicidality and the most severe point of suicidality in episode and lifetime should be assessed. The presence of guns in the home should be ascertained, and the clinician should recommend that the parents secure or remove them (Brent et al., 1993b).

Clinicians should also differentiate suicidal behavior from other types of self-harm behaviors, the goal of which is to relieve negative affect. This type of behavior most commonly involves repetitive self-cutting, with clear motivation to relieve anger, sadness, or loneliness rather than to end one's life.

Homicidal behavior follows a continuum similar to suicidality, from fleeting thoughts of homicide to ideas with a plan and intent. It is important to note that suicidal and homicidal ideation can occur in the same individual; fully one third of adolescent suicide victims in one study had homicidal ideation in the week before their suicide (Brent et al., 1993a). The clinician should conduct an assessment similar to that described for suicidal ideation with regard to what factors are influencing, either positively or negatively, the degree of likelihood the patient will carry out a homicidal act. As is the case for patients at risk for suicidal behavior, it is important to restrict access to any lethal agents, particularly guns (Brent et al., 1993b).

Recommendation 5. The Evaluation Should Assess for the Presence of Ongoing or Past Exposure to Negative Events, the Environment In Which Depression Is Developing, Support, and Family Psychiatric History [MS].

As noted above, depression often results from an interaction between depressive diathesis and environmental stressors; thus, the need for a careful evaluation of current and past stressors such as physical and sexual abuse, ongoing intra- and extrafamilial conflicts, neglect, living in poor neighborhoods, and exposure to violence. If the abuse is current, then ensuring the safety of the patient is the first priority of treatment. It is also important to assess the sequelae of the exposure to negative events such as posttraumatic stress disorder.

Depression often occurs in a recurring pattern involving conflict with peers, parents, and other adult authority figures such as teachers. The relationship between conflict and depression is often bidirectional because depression can make a person more irritable, which then increases interpersonal tension, causing others to distance themselves from the depressed person, which then leads to an experience on the part of the patient of loneliness and lack of support. An assessment of the key relationships in the patient's social network is a critical component to the implementation of one type of psychotherapy for adolescent depression for which there is evidence of efficacy, namely, interpersonal psychotherapy (IPT; Mufson et al., 2004). Involvement in deviant peer groups may lead to antisocial behavior, generating more stressful life events and increasing the likelihood of depression (Fergusson et al., 2003).

The presence of family psychopathology should be evaluated to assist in both diagnosis and treatment because parental psychopathology can affect the child's ability and willingness to participate in treatment, may be predictive of course (e.g., bipolar family history), and may have an influence on treatment response. The clinician should assess for discord, lack of attachment and support, and a controlling relationship (often referred to as "affectionless control") because these can be related to risk for other psychiatric conditions such as substance abuse and conduct disorder that can complicate the presentation and course of depression (Nomura et al., 2002). For further information regarding assessment of the family, refer to the Practice Parameter for the Assessment of the Family (American Academy of Child and Adolescent Psychiatry, 2007).

TREATMENT

Recommendation 6. The Treatment of Depressive Disorders Should Always Include an Acute and Continuation Phase; Some Children May Also Require Maintenance Treatment [MS].

The treatment of depression is usually divided into three phases: acute, continuation, and maintenance. The main goal of the acute phase is to achieve response

and ultimately full symptomatic remission. The following are the definitions of outcome (Birmaher et al., 2000 [ut]; Emslie et al., 1998; Frank et al., 1991):

- *Response*: No symptoms or a significant reduction in depressive symptoms for at least 2 weeks
- *Remission*: A period of at least 2 weeks and <2 months with no or few depressive symptoms
- *Recovery*: Absence of significant symptoms of depression (e.g., no more than 1–2 symptoms) for ≥2 months
- *Relapse*: A *DSM* episode of depression during the period of remission
- *Recurrence*: The emergence of symptoms of depression during the period of recovery (a new episode)

Continuation treatment is required for all depressed youths to consolidate the response during the acute phase and avoid relapses. Finally, maintenance treatment is used to avoid recurrences in some youths who have had a more severe, recurrent, and chronic disorder.

Treatment strategies for each one of these three treatment phases are discussed in detail below. In general, the choice of treatment at each of these phases should be governed by factors such as the subject's age and cognitive development, severity and subtype of depression, chronicity, comorbid conditions, family psychiatric history, family and social environment, family and patient treatment preference and expectations, cultural issues, and availability of expertise in pharmacotherapy and/or psychotherapy.

Recommendation 7. Each Phase of Treatment Should Include Psychoeducation, Supportive Management, and Family and School Involvement [MS].

Psychoeducation. Psychoeducation refers to education of family members and the patient about the causes, symptoms, course, and different treatments of depression and the risks associated with these treatments as well as no treatment at all. Education should make the treatment and decision-making process transparent and should enlist parent and patient as collaborators in their own care. Depression is presented as an illness, not a weakness, which is no one's fault but has genetic and environmental contributions. The difficulties that the patient experiences in function are not manipulation, but the manifestations of an illness. The patient and family should be prepared for what is likely to be a recurrent and often chronic illness that may have a prolonged period of recovery. This enables the patient and family not to be overly disappointed if recovery is prolonged, and it prepares them for the necessity of continuation and adherence to treatment. Parents also need guidance about how to parent: when to be strict and when to be lax in light of their child's depression.

Written material and reliable Web sites about depression and its treatment can help parents and their child to learn about depression and monitor the child's progress and, if the child is taking medications, potential emerging side effects.

There are no controlled trials of psychoeducation, but psychoeducation seems to improve adherence to treatment and reduce the symptoms of depression (Brent et al., 1993c [ut]; Renaud et al., 1998 [ut]). For families with depressed parents, psychoeducation with or without further interventions have also showed improvement in how families problem solve around parental illness and children's behavior and attitudes (Beardslee et al., 2003).

Supportive Management. In addition to psychoeducation, all subjects require supportive psychotherapeutic management, which may include active listening and reflection, restoration of hope, problem solving, coping skills, and strategies for maintaining participation in treatment.

Family Involvement. Even in the absence of formal family therapy, it is virtually impossible to successfully treat a child or adolescent patient without the close involvement of parents. First, the clinician has to recognize that motivation for treatment comes often from the parents, and therefore the treatment contract must involve them. Second, the parents may observe aspects of the child's functioning or symptoms that the child either is not aware of or does not wish to share, and this information is vital to the development of a realistic and effective treatment contract. Third, the parents are able to monitor their child's progress and serve as a safety net.

As described in the section about psychotherapies (Recommendation 9), despite the scarce and weak empirical evidence, knowledge of risk factors suggests that interventions with families are an important part of clinical management. These interventions should take into account the family's cultural and religious background and focus on strengthening the relationship between the identified patient and caregiver(s), provide

parenting guidance (e.g., management of conflicts), reduce family dysfunction, and facilitate treatment referral for caregivers or siblings with psychiatric disorders and for marital conflict (Asarnow et al., 1993 [rct]; Birmaher et al., 2000 [ut]; Diamond et al., 2002 [ut]; Garber et al., 2002; Hammen et al., 2004; Nomura et al., 2002; Sanford et al., 2006). During the acute phase of treatment, especially if both parent and child are depressed, it may be difficult to do much productive family work when multiple family members are depressed and irritable. Family work that is conducted after some symptomatic relief is still important because parent– child conflict is associated not only with prolongation of depressive episodes but also with relapse and recurrence (Birmaher et al., 2000 [ut]).

School Involvement. School personnel also need psychoeducation to help them understand the disease model of depression. Issues related to confidentiality also need to be discussed. The clinician, along with the family, should advocate for some accommodations (e.g., schedule, workload) to the patient's current difficulties until recovery has been achieved. If after recovery the child continues to have academic difficulties, then one should suspect that there is still some subsyndromal depression or that there are other comorbid conditions (e.g., developmental learning disorders, ADHD, anxiety, substance abuse) or environmental factors that may explain the child's persistent difficulties.

Students with a depressive disorder may qualify for the Emotional Disturbance Disability categorization under the Individuals with Disabilities Education Act and therefore be eligible to receive school-based services (e.g., counseling) and accommodations that enable them to continue to learn (see Practice Parameter for Psychiatric Consultation to Schools, American Academy of Child and Adolescent Psychiatry, 2005).

Recommendation 8. Education, Support, and Case Management Appear to Be Sufficient Treatment for the Management of Depressed Children and Adolescents With an Uncomplicated or Brief Depression or With Mild Psychosocial Impairment [CG].

The current acute RCTs with psychotherapy or pharmacotherapy have reported that up to 60% of children and adolescents with MDD respond to placebo (Bridge et al., 2007 [rct]; Cheung et al., 2005 [rct]) and 15% to 30% respond to brief treatment (Goodyer, et al., 2007[rct]; Harrington et al., 1998; Renaud et al., 1998 [ut]). In fact, supportive treatment, compared with either cognitive-behavioral therapy (CBT) or IPT, is equally efficacious for those with mild depression. When patients are more severely depressed and have significant melancholic symptoms, hopelessness, or suicidal ideation/behaviors, however, supportive treatment is inferior to both of these indicated therapies (Barbe et al., 2004a [rct]; March et al., 2004 [rct]; Mufson et al., 1999 [rct]; Renaud et al., 1998 [ut]). Thus, it is reasonable, in a patient with a mild or brief depression, mild psychosocial impairment, and the absence of clinically significant suicidality or psychosis, to begin treatment with education, support, and case management related to environmental stressors in the family and school. It is expected to observe response after 4 to 6 weeks of supportive therapy.

Recommendation 9. For Children and Adolescents Who Do Not Respond to Supportive Psychotherapy or Who Have More Complicated Depressions, a Trial With Specific Types of Psychotherapy and/or Antidepressants Is Indicated [CG].

In children and adolescents with moderate to severe depression, chronic or recurrent depression, considerable psychosocial impairment, suicidality, agitation, and psychosis, supportive psychotherapy and case management are usually not adequate. For these children and adolescents interventions with more specific types of psychotherapies or pharmacological treatments for depressive disorders are indicated.

As reviewed below, moderate depression may respond to CBT or IPT alone. More severe depressive episodes will generally require treatment with antidepressants. Treatment with antidepressants may be administered alone until the child is amenable to psychotherapy or if appropriate, they can be combined with psychotherapy from the beginning of treatment. Finally, depressed youth who do not respond to prior monotherapy treatment, either psychotherapy or antidepressants, require a combination of these two treatment modalities.

In general, in addition to considering the severity and chronicity of the depressive symptoms, prior response to treatment, and other familial and environmental factors, the decision about which type of monotherapy to offer may be dictated by availability and patient and family preference. For example, children and/or their families may not wish to participate in psychotherapy or may object to taking any medications. Specific types

of psychotherapies such as CBT or IPT may not be available. Children may not have responded previously to psychotherapy (e.g., 6–8 weeks of CBT or IPT). Children may be too agitated or psychotic or have low motivation, poor concentration, or sleep disturbances to participate in psychotherapy other than supportive treatment plus pharmacotherapy until they are feeling better, or they may have disorders (e.g., autism, mental retardation) for which CBT or IPT may not be appropriate.

The extant literature regarding the acute psychotherapy and pharmacological treatments and their side effects and clinical use for children and adolescents with depressive disorders is summarized below.

Psychotherapy. A recent rigorous meta-analysis of 35 RCTs for depressed youths showed that although some studies demonstrated large effects, overall the effects of psychotherapy for the acute treatment of depressed youths are modest (Weisz et al., 2006). Treatments were equally efficacious for children and adolescents, individual and group psychotherapy, samples identified as having depressive disorders versus depressive symptomatology, efficacy versus effectiveness studies, and whether the studies used cognitive techniques (CBT) or other approaches (e.g., IPT, behavior problem-solving, relaxation, attachment-based therapy). Outcomes were significantly better when the informant was the youth when compared with his or her parents, indicating the importance of interviewing both children and parents. There was no correlation between duration of treatment and response, suggesting that brief treatments may be an efficacious and economical way to treat depressed youths. However, the few studies that included follow-up after the acute treatment showed that the beneficial effects of psychotherapy appear durable for the initial months, but not for 1 year. Thus, more studies are needed to evaluate the effects of "boosters" and continuation therapy. Only six studies assessed suicidality as an outcome. On average, these studies showed a small reduction in suicidality, emphasizing the need for more target techniques to address this worrisome symptom. Finally, the effects of the psychotherapy for depressed youths also improved anxiety, but not externalizing symptoms.

Other meta-analyses have also shown that CBT is effective for the treatment of youths with MDD (Compton et al., 2004; Harrington et al., 1998). CBT appears to be more efficacious even in the face of comorbidity, suicidal ideation, and hopelessness, but when there is a history of sexual abuse or when one of the parents is depressed, CBT does not appear to perform as well (Barbe et al., 2004b [rct]; Brent et al., 1998 [rct]; Lewinsohn et al., 1998; Melvin et al., 2006 [rct]; Rohde et al., 2004 [rct]).

In sharp contrast with most CBT studies (Weisz et al., 2006), a recent large RCT did not find differences between CBT and placebo for adolescents with MDD (March et al., 2004, 2006b [rct]). Moreover, although the combination of CBT and fluoxetine showed a more rapid decline in depressive symptom reduction (Kratochvil et al., 2006), rates of clinical improvement and baseline-adjusted symptom ratings at endpoint were not different between combination treatment and medication alone. Also, the combined treatment was better than fluoxetine alone mainly for teens with mild to moderate depression and for depression with high levels of cognitive distortion, but not for severe depression (Curry et al., 2006 [rct]). The combination treatment did result in a greater rate of remission than in any of the other treatments, but the effects were modest (remission rate of 37% in combined treatment; Kennard et al., 2006 [rct]). It is unclear why CBT did not differ from placebo in this study with regard to acute treatment. Possible explanations include that the adolescents were not blind to medication assignment in the two CBT cells, treatment delivered a "low dose" of a large number of skills and techniques, whereas some of the more successful treatment studies with CBT used a flexible protocol that focused mainly on cognitive restructuring and behavior activation (Brent, 2006; Brent et al., 1997 [rct]; Weersing and Weisz, 2002 [ct]; Wood et al., 1996 [ct]). Although the results of the Treatment of Adolescents With Depression Study (TADS) may also suggest that CBT is difficult to disseminate, one quality improvement study suggested that CBT (sometimes delivered in combination with medication) can be delivered effectively in primary care settings to depressed adolescents and results in better outcomes than treatment as usual (Asarnow et al., 2005 [rct]).

It seems to be clinically intuitive and consistent with some studies of adult depressives that the combination of CBT and medication would be superior to medication alone (Keller et al., 2000). In the TADS, on the primary outcomes, the differences between combination and medication alone were either nonexistent or

modest, although all positive contrasts did favor the combination (March et al., 2006b; Vitiello et al., 2006). The rate of remission was higher in combination, but, similar to other studies, was disappointingly low (37% in combination versus 23% in medication alone). Three other RCTs examining the effects of combined treatment versus medication alone have also been disappointing. Goodyer and colleagues (2007[rct]) found that in moderately to severely depressed adolescents who did not respond to a brief psychosocial treatment, the combination of CBT and a selective serotonin reuptake inhibitor (SSRI, mainly fluoxetine) was no better than the SSRI alone in the relief of depressive symptoms or improvement in overall outcome. Melvin and colleagues (2006 [rct]) were unable to demonstrate the superiority of combined sertraline and CBT over either treatment alone for adolescents with mild to moderate depression. After acute treatment, CBT was found to be superior to sertraline alone, which may suggest an advantage of CBT, but may also be explained by the relatively low sertraline dose. Finally, Clarke and colleagues (2005 [rct]) compared the addition of CBT to SSRI management in primary care and found some modest improvement on quality of life but not on the primary outcome. Moreover, an unexpected result of the combined treatment was that those patients were more likely to discontinue their SSRIs.

IPT is emerging as another efficacious psychotherapy for adolescent depression for which it has been shown to be superior to twice-monthly supportive clinical management, with differences most prominent in those who were moderately or severely depressed and in older teens (Mufson et al., 1999, 2004 [rct]). IPT has been shown to be at least as efficacious as CBT for adolescent depression (Rossello and Bernal, 1999 [rct]). IPT appears to be relatively easy to disseminate insofar as therapists in school-based health clinics with brief training and supervision were able to improve depression using IPT compared with treatment as usual (Mufson et al., 2004).

Most of the above-noted clinical trials in clinically referred populations were carried out with adolescents rather than in younger children, but some randomized CBT trials for symptomatic volunteers have been successfully used in younger children (Reynolds and Coates, 1986 [rct]; Stark et al., 1987 [rct]; Weisz et al., 1997 [rct]), although in some, but not all, studies CBT was better than waitlist control, but not an alternative treatment. Most clinicians recommend the adaptation of cognitive, interpersonal, and psychodynamic techniques for younger children. In addition, because of the prominent role of family issues in early-onset depression and the greater dependency of the child on parents, some form of family intervention is recommended. However, no RCTs have been conducted in clinically referred depressed children.

Because family interaction is related to the onset and course of adolescent depression (Asarnow et al., 1993 [rct]; Birmaher et al., 2000 [ut]; Nomura et al., 2002; Pilowsky et al., 2006), the improvement of family interactions is a logical treatment target of adolescent depression. However, only one RCT has examined the impact of family therapy and found that CBT was superior to a systemic behavioral family therapy in the short-term reduction of adolescent depression (Brent et al., 1997 [rct]). One form of family treatment termed attachment therapy has shown promise as an intervention and was superior to waitlist control for relief of depressive symptomatology (Diamond et al., 2002 [ut]).

There is a substantial case-based literature on the treatment of depression with individual psychodynamic psychotherapy as well as substantial clinical experience indicating that individual psychodynamic psychotherapy can address a broad range of the comorbidities in depressed youths including developmental, interpersonal, and intrapersonal factors important to social, peer, and educational functioning. In addition to close monitoring of medications and symptomatology, psychodynamic interventions can be useful to help change patients' depressive beliefs, world expectations, and challenge notions of futility and the meaning of life. Recent open trials and an RCT comparing psychodynamic psychotherapy plus parent support versus family therapy for the treatment of youths with depressive disorders are promising, but further studies with state-of-the-art methodology are necessary (Crits-Christoph et al., 2002 [ut]; Muratori et al., 2003 [ut]; Trowell et al., 2007 [rct]).

It is important to emphasize that although the above-noted research studies try to isolate specific diagnostic entities for clinical trials, most cases in clinical practice have multiple factors necessitating a multimodal treatment approach including a combination of options such as CBT, IPT interventions, individual psychodynamic

psychotherapy, family therapy school/learning interventions, and/or community consultation.

Pharmacotherapy. One way to conceptualize the efficacy of treatment is to calculate the number needed to treat (NNT) to get one response that it is attributable to active treatment and not placebo. Across all of the published and unpublished SSRI RCTs, depressed patients treated with SSRIs have a relatively good response rate (40%–70%), but the placebo response rate is also high (30%–60%), resulting in an overall NNT of 10 (95% confidence interval [CI] 7–14; Bridge et al., 2007 [rct]; Cheung et al., 2005 [rct]; Wagner, 2005 [rct]). With the exception of the fluoxetine studies (e.g., Emslie et al., 1997 [rct]), due to the high placebo responses, significant differences between SSRIs and placebo were only found in depressed adolescents (Bridge et al., 2007). The difference between the response to SSRIs and placebo is inversely related to the number of sites involved in the study (Bridge et al., 2007; Cheung et al., 2005). Fluoxetine is the only medication to be approved by the U.S. Food and Drug Administration (FDA) for the treatment of child and adolescent depression, and it shows a larger difference between medication and placebo than do trials with other antidepressants. It is not clear whether this is due to actual differences in the effect of the medication, to other related properties of the medication (long half-life may lessen the impact of poor adherence to treatment), or the studies involving fluoxetine were better designed and conducted or used more severely depressed patients.

Several studies showed small or no differences between the SSRI and placebo, in part because the rates of placebo response were high (e.g., Wagner et al., 2003 [rct]). Thus, it is possible that the depressive symptoms in youths may be highly responsive to supportive management, these studies included subjects with mild depressions, or other methodological issues are responsible for the lack of difference between medication and placebo, such as including subjects with mild to moderate depression and low medication doses (for a review of the limitations of current pharmacological trials, see Cheung et al., 2005).

The rate of remission (e.g., Children's Depression Rating Scale-Revised score $\leq$ 28 [Poznanski and Mokros, 1995]), a more stringent and yet more clinically relevant outcome, ranged between 30% and 40% (Emslie et al., 1997, 2002 [rct]; Goodyer et al., 2007 [rct]; Kennard et al., 2006 [rct]; March et al., 2004 [rct]; Wagner et al., 2003 [rct]). Possible explanations for the low rate of remission are that optimal pharmacological treatment may involve a higher dose or longer duration of treatment, the lack of treatment of comorbid conditions may affect depressive symptoms, and/or some children and adolescents need to receive a combination of both pharmacological and psychosocial interventions.

Few trials have evaluated the effects of other classes of antidepressants for the treatment of depressed youths. So far these RCTs have shown no differences between venlafaxine or mirtazapine and placebo (Bridge et al., 2007; Cheung et al., 2005 [rct]; Emslie et al., 2007 [rct]; Wagner, 2005 [rct]). Secondary analysis of the venlafaxine trials showed an age effect, with these medications being better than placebo for depressed adolescents, but not depressed children (Emslie et al., 2007 [rct]); however, children were treated with low venlafaxine doses. One study showed better response in most measurements between nefazodone and placebo for adolescents with MDD, but a second study including depressed children and adolescents was negative (Cheung et al., 2005). The response rates for the above-noted antidepressants and for placebo are comparable with those of the SSRIs. Small open-label studies have suggested bupropion's effectiveness in treating adolescent MDD with and without ADHD (e.g., Daviss et al., 2001 [ct]), but there are no RCTs. Similarly, no controlled studies using duloxetine have been reported for the treatment of youths with MDD. Finally, RCTs as well as a meta-analysis have shown that tricyclic antidepressants are no more efficacious than placebo for the treatment of child and adolescent depression (Hazell et al., 2006) and should not be used as a first-line medication. Moreover, they are associated with more side effects than the SSRIs and can be fatal after an overdose.

Side Effects. Overall, the SSRIs and other novel antidepressants have been well tolerated by both children and adolescents, with few short-term side effects. The side effects of the SSRIs and other serotonergic and/or adrenergic reuptake inhibitors novel antidepressants appear to be similar and dose dependent and may subside with time (Cheung et al., 2005; Emslie et al., 2006; Findling et al., 2002; Leonard et al., 1997; Safer and Zito, 2006). The most

common side effects include gastrointestinal symptoms, sleep changes (e.g., insomnia or somnolence, vivid dreams, nightmares, impaired sleep), restlessness, diaphoresis, headaches, akathisia, changes in appetite (increase or decrease), and sexual dysfunction. Approximately 3% to 8% of youths, particularly children, also may show increased impulsivity, agitation, irritability, silliness, and "behavioral activation" (Martin et al., 2004; Safer and Zito, 2006; Wilens et al., 1998). These symptoms should be differentiated from mania or hypomania that may appear in children and adolescents with, or predisposed to develop, bipolar disorder (Wilens et al., 1998). More rarely, the use of antidepressants has been associated with serotonin syndrome (Boyer and Shannon, 2005), increased predisposition to bleeding (e.g., easy bruising, epistaxis; Lake et al., 2000; Weinrieb et al., 2005), and increased suicidality (see below for details). Because of the risk for bleeding, patients treated with SSRIs and other antidepressants who are going to have surgery should inform their physicians because they may wish to discontinue treatment during the preoperative period. Venlafaxine and perhaps other noradrenergic reuptake inhibitors may elevate the blood pressure and cause tachycardia. Mirtazapine, a serotonin and adrenergic receptor blocker, may increase appetite, weight, and somnolence. Trazodone, a serotonin 2A receptor blocker and weak serotonin reuptake inhibitor, and mirtazapine are mainly used as adjunctive and transient treatments for insomnia. Trazodone should be used with caution in males because it can induce priapism. Nefazodone, a serotonin 2A receptor blocker and weak serotonin reuptake inhibitor, was taken off the market amid rare reports of hepatic failure being associated with its use. Although the rate of serious hepatic involvement is four times higher than in SSRIs, the absolute rate is still extremely low. The use of non–long-acting preparations of bupropion was associated with seizures, particularly if the doses were higher than 400 mg/day or were increased rapidly and possibly if subjects had bulimia. The long-term side effects of all antidepressants have not been systematically evaluated in children and adolescents.

Suicidal Ideation/Attempts. The FDA, in collaboration with Columbia University, evaluated the effects on suicidality of nine antidepressants used in 24 acute RCTs (16 MDD, 4 OCD, 2 generalized anxiety disorder, 1 SAD, and 1 ADHD; Hammad et al., 2006; Posner et al., 2007). The primary outcomes were spontaneously reported occurrences of suicidal ideation and behavior, "suicidal adverse events," and using the suicidal items of depressive ratings scales, representing emergence or worsening of suicidality. The suicide adverse events analyses showed an overall risk ratio (RR) for suicidality of 1.95 (95% CI 1.28–2.98). The overall RR for suicidal ideation was 1.74 (95% CI 1.06–2.86) and for suicidal attempts, it was 1.9 (1.0–2.86). When analyses were restricted to MDD trials for SSRIs, the overall RR was 1.66 (95% CI 1.02–2.68). Among the antidepressants, only the venlafaxine (and more recently fluoxetine in the TADS; Hammad et al., 2006) showed a statistically significant association with suicidality. Interestingly, however, the majority of the venlafaxine suicidal events involved ideation and not behavior. In general, these results translate to one to three spontaneously reported suicide adverse events for every 100 youths treated with one of the antidepressants included in the FDA meta-analyses. There were few suicidal attempts and no completions. In contrast to the analyses of the suicide adverse events, evaluation of the incidence of suicidal ideation and attempts ascertained through rating scales in 17 studies did not show significant onset or worsening of suicidality (RRs approximately 0.90; Hammad et al., 2006).

The above results need to be understood in the context of the limitations of the FDA study such as using the metric of relative risk, which is limited to trials with at least one event, inability to generalize the results to populations not included in RCTs, short-term data, not including all of the available RCTs, and multiple comparisons and the methodological limitations of spontaneously generated data (Hammad et al., 2006).

A more recent, thorough meta-analysis extended the FDA analyses by including more published and unpublished antidepressant RCTs (15 MDD, 6 OCD, and 6 anxiety disorders; Bridge et al., 2007). Using statistical methods similar to those used by the FDA study, this meta-analysis found a comparable overall small but significant increased relative risk for spontaneous reported suicidality (Bridge et al., 2007). When using pooled random effects analyses of risk differences instead of relative risk, both the new analyses of the FDA data and the recent meta-analyses yielded a small, but significant overall risk difference (drug minus placebo; FDA: 0.80, 95% CI 0.1–1.5 versus Bridge

et al.: 0.7, 95% CI 0.1–1.3). However, there were no longer significant differences for MDD (Bridge et al., 2007). Moreover, the overall number needed to harm (NNT to observe one adverse event that can be attributed to the active treatment) for MDD was 112 (Bridge et al., 2007). As stated above, the overall NNT for the antidepressants in pediatric depression is 10. Thus, taking into account the limitation of any meta-analysis, nearly 11 times more depressed patients may respond favorably to antidepressants than may spontaneously report suicidality.

As stated by the FDA (Hammad et al., 2006), the implications and clinical significance regarding the above-noted findings are uncertain because with the increase in use of SSRIs, there has been a dramatic decline in adolescent suicide (Olfson et al., 2003). Moreover, pharmacoepidemiological studies, while correlative rather than causal, support a positive relationship between SSRI use and the reduction in the adolescent and young adult suicide rate (Gibbons et al., 2005, 2006; Olfson et al., 2003; Valuck et al., 2004). Also, two recent studies showed increased suicide attempts only immediately before treatment with SSRIs or psychotherapy (Simon and Savarino, 2007), and, similar to the TADS, improved suicidal ideation after treatment was initiated.

How can we understand that there are increased rates of spontaneously reported serious adverse effects on drug versus placebo, but not any differences in suicidality on regularly assessed clinical measures? The clue may be in the term "spontaneous" and explanations of the association between drug and suicidality other than causality. One such alternative explanation is subjects on active drug have more side effects (e.g., headache), and, as a result, providers may have more opportunity/contact with subjects to hear about suicidal occurrences as opposed to these events being "caused" by antidepressants. Another alternative explanation is improvement from the antidepressant resulting in a subject talking about suicidal thoughts for the first time.

It is possible that, in a subgroup of patients treated with SSRIs, particularly those already agitated and/or suicidal, that treatment causes a disinhibition that leads to worsening of ideation and/or a greater tendency to make suicidal threats. Because this event usually leads to removal of the subject from the study and a change in treatment, analyses that look at the slope of suicidal ideation will not find an effect. In addition, suicidality as measured on rating scales is highly correlated with the severity of depression that is more likely to decline on drug than on placebo.

In conclusion, it appears that spontaneously reported events are more common in SSRI treatment. Nevertheless, given the greater number of patients who benefit from SSRIs than who experience these serious adverse effects, the lack of any completed suicides, and the decline in overall suicidality on rating scales, the risk/benefit ratio for SSRI use in pediatric depression appears to be favorable with careful monitoring.

Although the risk/benefit ratio favors the use of SSRIs, further work is required (Apter et al., 2006; Bridge et al., 2007; Emslie et al., 2006; March et al., 2006a,b). Also, it remains to be clarified whether certain factors such as sex; subject's history of suicidality; family history of suicidality; disorder (it appears that the effects are more obvious in depressed youths); severity of depressive symptoms at intake; doses, half-life, and type of antidepressants; time during treatment; withdrawal side effects (due to noncompliance or medication short half-life); induction of agitation, activation, or hypomania; and/or susceptibility to side effects (e.g., slow metabolizers or variations in genetic polymorphisms) are related to increased risk of suicidality (Apter et al., 2006; Brent, 2004; Bridge et al., 2007; Hammad et al., 2006; Safer and Zito, 2006).

Clinical Use. Except for lower initial doses to avoid unwanted effects, the doses of the antidepressants in children and adolescents are similar to those used for adult patients (Findling et al., 2002; Leonard et al., 1997). Some studies have reported that the half-lives of sertraline, citalopram, paroxetine, and bupropion SR are much shorter than reported in adults (Axelson et al., 2002, Daviss et al., 2005; Findling et al., 2006). Therefore, psychiatrists should be alert for the possibility of withdrawal side effects when these medications are prescribed once daily. Also, to avoid side effects and improve adherence to treatment, it is recommended to start with a low dose and increase it slowly until appropriate doses have been achieved. Patients should be treated with adequate and tolerable doses for at least 4 weeks. Clinical response should be assessed at 4-week intervals, and if the child has tolerated the antidepressant, the dose may be increased if a complete response has not been obtained

(Heiligenstein et al., 2006; Hughes et al., 2007). At each step, adequate time should be allowed for clinical response, and frequent, early dose adjustments should be avoided. However, patients who are showing minimal or no response after 8 weeks of treatment are likely to need alternative treatments. Furthermore, by about 12 weeks of treatment, the goal should be remission of symptoms, and in youths who are not remitted by that time, alternative treatment options may be warranted. Other strategies for nonresponders are described in Recommendation 15.

Given the small but statistically significant association between the antidepressants and suicidality, it is recommended that all of the patients receiving these medications be carefully monitored for suicidal thoughts and behavior as well as other side effects thought to be possibly associated with increased suicidality, such as akathisia, irritability, withdrawal effects, sleep disruption, increased agitation, and induction of mania or a mixed state, particularly during the first weeks of treatment. The FDA recommends that depressed youths should be seen every week for the first 4 weeks and biweekly thereafter, although it is not always possible to schedule weekly face-to-face appointments. In this case, evaluations should be briefly carried out by telephone, but it is important to emphasize that there are no data to suggest that the monitoring schedule proposed by the FDA or telephone calls have any impact on the risk of suicide. Monitoring is important for all patients, but patients at increased risk of suicide (e.g., those with current or prior suicidality, impulsivity, substance abuse, history of sexual abuse, family history of suicide) should be scrutinized particularly closely. Those with a family history of bipolar disorder should be carefully monitored for onset of mania or mixed state. After the continuation or maintenance phases are over, or when the antidepressants need to be discontinued, all antidepressants, except for fluoxetine, should be discontinued slowly. Fluoxetine, because of its long half-life, is the exception and can be stopped at once. Abrupt discontinuation of antidepressants may induce withdrawal symptoms, some of which may mimic a relapse or recurrence of a depressive episode (e.g., tiredness, irritability, severe somatic symptoms; Zajecka et al., 1997). Sometimes withdrawal symptoms can be accompanied by worsening or emergent suicidal symptoms. The withdrawal symptoms can appear after as soon as 6 to 8 weeks on the antidepressants and within 24 to 48 hours of discontinuation.

Careful attention to possible medication interactions is recommended because most antidepressants inhibit, to varying degrees, the metabolism of several medications that are metabolized by the diverse clusters of hepatic cytochrome P-450 isoenzymes. In addition, interactions of antidepressants with other serotonergic and/or noradrenergic medications, in particular, monoamine oxidase inhibitors, may induce the serotonergic syndrome, marked by agitation, confusion, and hyperthermia (Boyer and Shannon, 2005).

For further information regarding the management of medication, refer to the Practice Parameter for the Use of Psychotropic Medications in Children and Adolescents (American Academy of Child and Adolescent Psychiatry, submitted).

Recommendation 10. To Consolidate the Response to the Acute Treatment and Avoid Relapses, Treatment Should Always Be Continued for 6 to 12 Months [MS].

In naturalistic studies of depressed patients treated with either CBT or fluoxetine, the rate of relapse is high (Birmaher et al., 2000 [ut]; Emslie et al., 1998 [ut]; Kroll et al., 1996 [ut]), with the highest risk for relapse within 4 months of symptomatic improvement. After 12 weeks of open treatment with fluoxetine, a 6-month randomized, controlled fluoxetine discontinuation trial also showed that continued treatment with this SSRI was associated with a much lower rate of relapse (40%) compared to treatment with placebo (69%; Emslie et al., 2004 [ut]). The high relapse rate on fluoxetine was accounted for, at least in part, by the poor adherence to treatment. Residual depressive symptoms after the open trial were associated with higher rates of relapse during the discontinuation trial, indicating the need to seek remission and not only response to treatment. Monthly continuation therapy with CBT also resulted in a much lower relapse rate than that found in a historical control group that received acute treatment followed by no continuation treatment (Kroll et al., 1996 [ct]).

Until further research becomes available, continuation therapy for at least 6 to 12 months is recommended for all patients who have responded to the acute treatment. Often discontinuation can be tried during the summer, so that a relapse would be less disruptive to school function; however, it is important to

note that the treatment for depression can also be helping other disorders (e.g., anxiety) and discontinuation may accelerate the symptoms of these other conditions. During the continuation phase, patients typically are seen at least monthly, depending on clinical status, functioning, support systems, environmental stressors, motivation for treatment, and the presence of comorbid psychiatric or medical disorders. In this phase, psychotherapy consolidates the skills learned during the acute phase and helps patients cope with the psychosocial sequelae of the depression, but also addresses the antecedents, contextual factors, environmental stressors, and internal as well as external conflicts that may contribute to a relapse. Moreover, if the patient is taking antidepressants, follow-up sessions should continue to foster medication adherence, optimize the dose, and evaluate for the presence of side effects.

Recommendation 11. To Avoid Recurrences, Some Depressed Children and Adolescents Should Be Maintained in Treatment for Longer Periods of Time [CG].

As discussed in the Clinical Course section, MDD is a recurrent illness. Thus, once the child has been asymptomatic for approximately 6 to 12 months, the clinician must decide whether maintenance therapy is indicated and the type and duration of therapy. The main goal of the maintenance phase is to foster healthy growth and development and prevent recurrences. This phase may last 1 year or longer and is typically conducted with visits at a frequency of monthly to quarterly, depending on the patient's clinical status, functioning, support systems, environmental stressors, motivation for treatment, existence of comorbid psychiatric/medical disorders, and availability and skill of the clinician.

There are no treatment studies of youths to guide clinicians as to which patients require a longer period of continuation and maintenance treatment. In adults, those with at least three episodes of recurrent depression require longer periods of treatment (e.g., at least 3–5 years; Kupfer et al., 1992). One general rule of thumb is that the longer it takes for a patient to recover or the higher the number of recurrences, the longer the period of maintenance. Specifically, those patients with at least two episodes of depression or one severe episode or chronic episodes of depression should have maintenance treatment for longer than 1 year. Those with double depression (depression with comorbid DD) who have been depressed "as long as they can remember" may need treatment indefinitely, with an explanation to families that there is no hard-and-fast rule about this because of a lack of studies in this population. Moreover, other factors that are related to risk of a prolonged episode or recurrence should also make the clinician consider maintenance treatments. These factors include patient factors of comorbidity, psychosis, suicidality, number of prior episodes, environmental factors such as family disruption due to conditions external to the child (e.g., divorce, illness, job loss, homelessness), family psychopathology, and lack of community support.

Finally, it is important to treat the youths not only for a certain length of time but also to treat to achieve no or minimal residual symptoms because children and adolescents who have not recovered fully and still have subsyndromal depression are more vulnerable to recurrence (Brent et al., 2001; Lewinsohn et al., 1994; Pine et al., 1998).

Recommendation 12. Depressed Patients With Psychosis, Seasonal Depression, and Bipolar Disorder May Require Specific Somatic Treatments [CG].

Psychotic Depression. Although there are few studies in youths (Geller et al., 1985 [ct]), it appears that the combination of antidepressants with antipsychotics may be helpful for patients with psychotic depression. However, vague or mild psychotic symptoms in a depressed child may respond to antidepressants alone. Clinical consensus recommends the atypical antipsychotic medications combined with SSRIs as the treatment of choice for depressed psychotic youths. It is important to be aware of the short- and long-term side effects associated with the use of atypical antipsychotics and possible interactions with the antidepressants. How long these medications should be continued after the psychotic symptoms have improved is a question, but in general the recommendation is to slowly taper off these medications, with the eventual goal of keeping the child on monotherapy with an antidepressant.

In adults electroconvulsive therapy is particularly effective for this subtype of depression. Noncontrolled reports suggest that this treatment also may be useful for depressed psychotic adolescents (American Academy of Child and Adolescent Psychiatry, 2004).

SAD. A small RCT showed that bright light therapy is efficacious for youths with SAD (Swedo et al., 1997

[rct]). It appears that patients may respond better during the morning hours, but morning hours may be difficult on school days and for youths who refuse to wake up early in the morning. Bright light therapy has been associated with some side effects, such as headaches and eye strain. Some authors have recommended an ophthalmological evaluation before initiating light therapy, but this practice has been frequently questioned unless patients have a history of eye illness. Treatment with light may induce episodes of hypomania or mania in vulnerable patients.

Bipolar Disorder. The symptoms of unipolar and bipolar depression are similar; therefore, early in the course of illness, it is difficult to determine whether a patient needs only an antidepressant or would benefit from concomitant use of mood stabilizers. As noted under Differential Diagnosis, some specific symptoms may warn the clinician about the possibility that the child is at risk of the development of a manic or hypomanic episode. Sometimes the child experiences mild recurrent hypomanic symptoms that often are overlooked. If indicators of risk of bipolar disorder are present (see Differential Diagnosis section), then the clinician should discuss with the patient and family the pros and cons of initiating a prophylactic mood-stabilizing agent. Patients with a psychotic depression may be at greater risk of developing bipolar disorder (Geller et al., 1994; Strober and Carlson, 1982).

For mild to moderate unipolar depression in patients with a bipolar diathesis, it may be best to start with psychotherapy because the risk of manic conversion with the use of antidepressants is substantial (Martin et al., 2004). Also, if there is a strong suspicion that the child has bipolar disorder, a mood stabilizer, such as lithium carbonate, valproate, or lamotrigine may be indicated, particularly if the patient presents with a depressive disorder marked by mood lability (for further discussion of the treatment of bipolar depression, see Kowatch et al., 2005).

Recommendation 13. Treatment Should Include the Management of Comorbid Conditions [MS].

It is of prime importance to treat the comorbid conditions that frequently accompany MDD because these conditions may influence the initiation, maintenance, and recurrence of depression; reduce the probability of a complete treatment response; and increase the risk of suicide, other functional impairment in school, and problems with interpersonal relationships associated with MDD (Birmaher et al., 1996, 2002; Curry et al., 2006; Daviss et al., 2001 [ct]; Fombonne et al., 2001a,b; Hamilton and Bridge, 1999; Hughes et al., 1990, 2007). Likewise, depressive symptoms also may negatively influence the treatment of comorbid disorders. Although there are few studies (e.g., Daviss et al., 2001 [ct]) to guide the clinician in how to sequence the treatment of depression and other comorbid disorders, we suggest that the clinician make a determination of which condition is causing the greatest distress and functional impairment and begin treatment with that disorder. Also, if recovery from depression is unlikely until a comorbid condition is addressed (e.g., severe malnutrition in anorexia, severe substance dependence such as cocaine or intravenous drug dependence), then the comorbid condition must be addressed first.

Several psychosocial and pharmacological treatments used to treat depression also may be useful for the treatment of comorbid conditions, particularly anxiety disorders (Bridge et al., 2007). For depressed youths with comorbid substance abuse, it is important to treat both disorders because depressive symptomatology increases the risk of persistent substance abuse and vice versa; abuse worsens the prognosis of the depression, and depression comorbid with substance abuse is a potent set of risk factors for completed suicide (American Academy of Child and Adolescent Psychiatry, 2001; Gould et al., 1998). One RCT in adults as well as an open trial in adolescents with depression comorbid with alcohol abuse found that fluoxetine was superior to placebo in reduction of both depressive symptoms and alcohol use (Cornelius et al., 2001). However, additional studies regarding the use of psychosocial and pharmacological treatments for depressed youths with comorbid substance abuse are necessary.

There are few published studies examining the efficacy of psychopharmacological or psychotherapeutic treatments for depression in medically ill children and adolescents. Studies are necessary, however, because diagnosable depression may occur frequently in children and adolescents with medical diseases, and medical illness and its treatment may change the natural course of depression (Lewinsohn et al., 1996). Furthermore, the pharmacokinetics, pharmacodynamics, and side effects of the antidepressants may be affected by both the medical illnesses and medications used to treat these illnesses. Psychotherapy is useful not only for treating

depression in these children but also for helping these patients and their families cope with the medical illness (Kovacs et al., 1996; Szigethy et al., 2004 [ut]).

Recommendation 14. During All Treatment Phases, Clinicians Should Arrange Frequent Follow-up Contacts That Allow Sufficient Time to Monitor the Subject's Clinical Status, Environmental Conditions, and, If Appropriate, Medication Side Effects [MS].

Symptoms of depression, suicidal or homicidal ideation, mania or hypomania; development of new comorbid disorders; psychosocial and academic functioning; and environmental conditions should be reviewed frequently by interviewing the child, parents, and, if appropriate, other informants (e.g., teachers). Traditionally, treatment response has been determined by the absence of MDD criteria (e.g., no more than one *DSM* symptom; see Recommendation 6) or, more frequently, by a significant reduction (e.g., ≥50%) in symptom severity. However, using the latter criterion, patients deemed "responders" may still have considerable residual symptoms. Therefore, an absolute final score on the Beck Depression Inventory ≤9 (Beck and Steer, 1987) or Children's Depression Rating Scale (Poznanski and Mokros, 1995) ≤28 together with persistent improvement in patient's functioning for at least 2 weeks or longer may better reflect a satisfactory response. Overall improvement has also been measured using a score of 1 or 2 (very much or much improvement) in the Clinical Global Impression Scale, Improvement subscale (Guy, 1976).

Because the goal is to restore function and not just reduce symptoms, a lack of progress in functional status is an important clue that the depression is incompletely treated or that impaired functional status is due to a comorbid psychiatric or medical disorder or environmental factors. The functional improvement can be measured using several rating scales such as a score ≥70 on the Global Assessment of Functioning (*DSM-IV*; American Psychiatric Association, 2000b) or the Children's Global Assessment Scale (Shaffer et al., 1983).

If a patient is being treated with medications, then it is important to evaluate the adherence to medication treatment, presence of side effects, and youth and parent beliefs about the medication benefits and its side effects that may contribute to poor adherence or premature discontinuation of treatment. History of suicidality, homicidal ideation, and somatic symptoms should be evaluated before starting the pharmacological treatment, and during treatment they should be differentiated from symptoms of mood and other psychiatric or medical conditions.

Recommendation 15. During All Treatment Phases, for a Child or Adolescent Who Is Not Responding to Appropriate Pharmacological and/or Psychotherapeutic Treatments, Consider Factors Associated With Poor Response [MS].

When managing patients who are not responding to treatment, the following reasons for treatment failure should be considered: misdiagnosis, unrecognized or untreated comorbid psychiatric or medical disorders (e.g., anxiety, dysthymic, eating, substance use, personality, hypothyroidism), undetected bipolar disorder, inappropriate pharmacotherapy or psychotherapy, inadequate length of treatment or dose, lack of adherence to treatment, medication side effects, exposure to chronic or severe life events (e.g., sexual abuse, ongoing family conflicts), personal identity issues (e.g., concern about same-sex attraction), cultural/ethnic factors, and an inadequate fit with, or skill level of, the psychotherapist.

Preliminary results of the NIMH multicenter study, the Treatment of Resistant Depression in Adolescents (TORDIA), showed that in depressed adolescents who have failed to respond to an adequate trial with a SSRI, a switch to another antidepressant plus CBT resulted in a better response than a switch to another antidepressant without additional psychotherapy (Brent et al., 2007 [rct]).

Open small studies using lithium and MAOI augmentation have shown contradictory results (Ryan et al., 1988a [ut], b; Strober et al., 1992 [ut]). Adult studies suggest that augmentation with T3 is efficacious and well-tolerated, but such studies have not been conducted in younger populations (Cooper-Kazaz et al., 2007 [rct]). Sallee et al. (1997 [rct]) found that intravenous clomipramine was superior to placebo for adolescents with treatment-resistant depression. Finally, some reports have suggested that adolescents with treatment-resistant depression may respond to ECT (American Academy of Child and Adolescent Psychiatry, 2004), but further research in this area is needed.

Several psychopharmacological strategies have been recommended for adults with resistant depression that may be applicable to youths: optimization (extending the initial medication trial and/or adjusting the dose, addition of CBT or IPT), switching to another agent in the same or a different class of medications, augmentation, or

a combination (e.g., lithium, T_3; Hughes et al., 2007). Optimization and augmentation strategies are usually used when patients have shown a partial response to the current regimen, and switching is usually used when patients have not responded or cannot tolerate the medications, but no studies have validated these practices in children. In a landmark study of treatment-resistant depressed adults, after unsuccessful treatment with an SSRI, approximately one in four patients had a remission of symptoms after switching to another antidepressant (Rush et al., 2006 [rct], Trivedi et al., 2006 [rct]). In addition, a combination of medication plus CBT has been shown to be superior to medication management alone for the treatment of partial responders and for the prevention for relapse (Fava et al., 2004 [ut]; Keller et al., 2000 [rct]). A switch from one modality of treatment to another (medication to psychotherapy or vice versa) has been found to be helpful for some chronically depressed adults who have failed one monotherapy (Schatzberg et al., 2005 [ut]). Depressed adolescents and adults with a history of sexual abuse may show a lower likelihood for response to standard treatments and may need a psychotherapeutic approach that deals with interpersonal issues and the aftereffects of the trauma (Barbe et al., 2004b [rct]). Also, depressed adolescents randomized to CBT and fluoxetine showed the highest response when compared to those treated with monotherapy with CBT, fluoxetine, or placebo, although post hoc comparison between combination and fluoxetine alone was not significantly different, and, for more severe depressions, the combination was not superior to fluoxetine alone (Curry et al., 2006 [rct]). Finally, the use of somatic therapies that have not been well studied in children such as transcranial magnetic stimulation or more intensive somatic therapies for depressed teens such as electroconvulsive therapy should be considered.

Each of the above-noted strategies requires implementation in a systematic fashion, education of the patient and family, and support and education to reduce the potential for the patient to become hopeless.

PREVENTION

Recommendation 16. Children With Risk Factors Associated With Development of Depressive Disorders Should Have Access to Early Services Interventions [CG].

Several RCTs using psychoeducation, cognitive, coping and social skills, and family therapy have targeted children and adolescents deemed to be at risk of depression by virtue of having subsyndromal depressive symptoms, a previous episode of depression, and/or a family history of depression (Beardslee et al., 2003; Clarke et al., 1995, 2001, 2002 [rct]; Jaycox et al., 1994 [rct]; Weisz et al., 1997 [rct]).

A recent meta-analysis of the existing literature regarding the prevention of depressive symptoms in youth showed that programs that included populations at risk were more effective than those targeting general populations (universal studies), particularly for females and older subjects. However, the effects of these treatments were small to modest, both immediately post-intervention and at an average follow-up of 6 months (Horowitz and Garber, 2006).

Successful treatment of mothers with depression was associated with significantly fewer new psychiatric diagnoses and higher remission rates of existing disorders in their children (Weissman et al., 2006a). Maternal depression has also been associated with less response to CBT for depression (Brent et al., 1998). These findings support the importance of early identification and vigorous treatment for depressed mothers in primary care or psychiatric clinics.

Early-onset dysthymia is associated with an increased risk of MDD (Kovacs et al., 1994), indicating the need for early treatment. Also, there is evidence that anxiety disorder is a precursor of depression (Kovacs et al., 1989; Pine et al., 1998; Weissman et al., 2005), and treatment of this disorder may reduce the onset and recurrences of depression (Dadds et al., 1999; Hayward et al., 2000). Because SSRIs appear to have a much greater efficacy for anxiety than for depression, vigorous detection and treatment of anxiety disorders may reduce the risk of subsequent depression.

The strategies for the prevention of onset or of recurrence of depression should include the amelioration of risk factors associated with this disorder. In addition, prevention may also include lifestyle modifications: regular and adequate sleep, exercise, a coping plan for stress (e.g., meditation, yoga, exercise, social activities), pursuit of enjoyable and meaningful activities, and avoidance of situations that are predictably stressful and nonproductive. For those with recurrent depression, a proactive plan to avoid stressors and a plan for coping with anticipated difficulties may be helpful in relapse and recurrence prevention. Finally, it is

important to educate caregivers, school personnel, pediatricians, and youths about the warning signs of depressive disorder and appropriate sources of assessment and treatment.

PARAMETER LIMITATIONS

AACAP practice parameters are developed to assist clinicians in psychiatric decision making. These parameters are not intended to define the standard of care, nor should they be deemed inclusive of all of the proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources.

Disclosure: Dr. Birmaher participates or has participated in forums for Solvay Pharmaceuticals, Inc., and Abcomm, Inc., and receives royalties from Random House. Dr. Bukstein receives or has received research support, acted as a consultant to, and/or served on the speakers' bureaus of Cephalon, Forest, McNeil Pediatrics, Shire, Eli Lilly, and Novartis. Drs. Brent, Bernet and Walter have no financial relationships to disclose.

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Family-Centered Bedside Rounds: A New Approach to Patient Care and Teaching Stephen E. Muething, MD, Uma R. Kotagal, MBBS, MSc, Pamela J. Schoettker, MS, Javier Gonzalez del Rey, MD, Thomas G. DeWitt, MD

The importance of patient-centered care and the role of families in decision-making are becoming more recognized. Starting with a single acute care unit, a multidisciplinary improvement team at Cincinnati Children's Hospital developed and implemented a new process that allows families to decide if they want to be part of attending-physician rounds. Family involvement seems to improve communication, shares decision-making, and offers new learning for residents and students. Despite initial concerns of staff members, family-centered rounds has been widely accepted and spread throughout the institution. Here we report our experiences as a potential model to improve family-centered care and teaching. **Pediatrics** 2007;119:829–832.

PEDIATRICS®
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ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

SUBCOMMITTEE ON ATTENTION-DEFICIT/HYPERACTIVITY DISORDER, STEERING COMMITTEE ON QUALITY IMPROVEMENT AND MANAGEMENT

Pediatrics; originally published online October 16, 2011;
DOI: 10.1542/peds.2011-2654

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Guidance for the Clinician in Rendering Pediatric Care

CLINICAL PRACTICE GUIDELINE

ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

SUBCOMMITTEE ON ATTENTION-DEFICIT/HYPERACTIVITY DISORDER, STEERING COMMITTEE ON QUALITY IMPROVEMENT AND MANAGEMENT

KEY WORDS

attention-deficit/hyperactivity disorder, children, adolescents, preschool, behavioral therapy, medication

ABBREVIATIONS

AAP—American Academy of Pediatrics
ADHD—attention-deficit/hyperactivity disorder
DSM-PC—*Diagnostic and Statistical Manual for Primary Care*
CDC—Centers for Disease Control and Prevention
FDA—Food and Drug Administration
DSM-IV—*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*
MTA—Multimodal Therapy of ADHD

The recommendations in this report do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

www.pediatrics.org/cgi/doi/10.1542/peds.2011-2654

doi:10.1542/peds.2011-2654

All clinical practice guidelines from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

abstract

Attention-deficit/hyperactivity disorder (ADHD) is the most common neurobehavioral disorder of childhood and can profoundly affect the academic achievement, well-being, and social interactions of children; the American Academy of Pediatrics first published clinical recommendations for the diagnosis and evaluation of ADHD in children in 2000; recommendations for treatment followed in 2001. *Pediatrics* 2011;128:000

Summary of key action statements:

1. The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity (quality of evidence B/strong recommendation).
2. To make a diagnosis of ADHD, the primary care clinician should determine that *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria have been met (including documentation of impairment in more than 1 major setting); information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care. The primary care clinician should also rule out any alternative cause (quality of evidence B/strong recommendation).
3. In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD, including emotional or behavioral (eg, anxiety, depressive, oppositional defiant, and conduct disorders), developmental (eg, learning and language disorders or other neurodevelopmental disorders), and physical (eg, tics, sleep apnea) conditions (quality of evidence B/strong recommendation).
4. The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (quality of evidence B/strong recommendation).

5. Recommendations for treatment of children and youth with ADHD vary depending on the patient's age:
   a. For *preschool-aged children (4–5 years of age)*, the primary care clinician should prescribe evidence-based parent- and/or teacher-administered behavior therapy as the first line of treatment (quality of evidence A/strong recommendation) and may prescribe methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child's function. In areas where evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment (quality of evidence B/recommendation).
   b. For *elementary school–aged children (6–11 years of age)*, the primary care clinician should prescribe US Food and Drug Administration–approved medications for ADHD (quality of evidence A/strong recommendation) and/or evidence-based parent- and/or teacher-administered behavior therapy as treatment for ADHD, preferably both (quality of evidence B/strong recommendation). The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order) (quality of evidence A/strong recommendation). The school environment, program, or placement is a part of any treatment plan.
   c. For *adolescents (12–18 years of age)*, the primary care clinician should prescribe Food and Drug Administration–approved medications for ADHD with the assent of the adolescent (quality of evidence A/strong recommendation) and may prescribe behavior therapy as treatment for ADHD (quality of evidence C/recommendation), preferably both.
6. The primary care clinician should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects (quality of evidence B/strong recommendation).

INTRODUCTION

This document updates and replaces 2 previously published clinical guidelines from the American Academy of Pediatrics (AAP) on the diagnosis and treatment of attention-deficit/hyperactivity disorder (ADHD) in children: "Clinical Practice Guideline: Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity Disorder" (2000)[1] and "Clinical Practice Guideline: Treatment of the School-aged Child With Attention-Deficit/Hyperactivity Disorder" (2001).[2] Since these guidelines were published, new information and evidence regarding the diagnosis and treatment of ADHD has become available. Surveys conducted before and after the publication of the previous guidelines have also provided insight into pediatricians' attitudes and practices regarding ADHD. On the basis of an increased understanding regarding ADHD and the challenges it raises for children and families and as a source for clinicians seeking to diagnose and treat children, this guideline pays particular attention to a number of areas.

Expanded Age Range

The previous guidelines addressed diagnosis and treatment of ADHD in children 6 through 12 years of age. There is now emerging evidence to expand the age range of the recommendations to include preschool-aged children and adolescents. This guideline addresses the diagnosis and treatment of ADHD in children 4 through 18 years of age, and attention is brought to special circumstances or concerns in particular age groups when appropriate.

Expanded Scope

Behavioral interventions might help families of children with hyperactive/impulsive behaviors that do not meet full diagnostic criteria for ADHD. Guidance regarding the diagnosis of problem-level concerns in children based on the *Diagnostic and Statistical Manual for Primary Care* (DSM-PC), *Child and Adolescent Version*,[3] as well as suggestions for treatment and care of children and families with problem-level concerns, are provided here. The current DSM-PC was published in 1996 and, therefore, is not consistent with intervening changes to *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM). Although this version of the DSM-PC should not be used as a definitive source for diagnostic codes related to ADHD and comorbid conditions, it certainly may continue to be used as a resource for enriching the understanding of ADHD manifestations. The DSM-PC will be revised when both the DSM-V and ICD-10 are available for use.

A Process of Care for Diagnosis and Treatment

This guideline and process-of-care algorithm (see Supplemental Fig 2 and Supplemental Appendix) recognizes evaluation, diagnosis, and treatment as a continuous process and provides recommendations for both the guideline and the algorithm in this single publication. In addition to the formal recommendations for assessment, diagnosis, and treatment, this guideline

provides a single algorithm to guide the clinical process.

Integration With the Task Force on Mental Health

This guideline fits into the broader mission of the AAP Task Force on Mental Health and its efforts to provide a base from which primary care providers can develop alliances with families, work to prevent mental health conditions and identify them early, and collaborate with mental health clinicians.

The diagnosis and management of ADHD in children and youth has been particularly challenging for primary care clinicians because of the limited payment provided for what requires more time than most of the other conditions they typically address. The procedures recommended in this guideline necessitate spending more time with patients and families, developing a system of contacts with school and other personnel, and providing continuous, coordinated care, all of which is time demanding. In addition, relegating mental health conditions exclusively to mental health clinicians also is not a viable solution for many clinicians, because in many areas access to mental health clinicians to whom they can refer patients is limited. Access in many areas is also limited to psychologists when further assessment of cognitive issues is required and not available through the education system because of restrictions from third-party payers in paying for the evaluations on the basis of them being educational and not health related.

Cultural differences in the diagnosis and treatment of ADHD are an important issue, as they are for all pediatric conditions. Because the diagnosis and treatment of ADHD depends to a great extent on family and teacher perceptions, these issues might be even more prominent an issue for ADHD. Specific cultural issues are beyond the scope of this guideline but are important to consider.

METHODOLOGY

As with the 2 previously published clinical guidelines, the AAP collaborated with several organizations to develop a working subcommittee that represented a wide range of primary care and subspecialty groups. The subcommittee included primary care pediatricians, developmental-behavioral pediatricians, and representatives from the American Academy of Child and Adolescent Psychiatry, the Child Neurology Society, the Society for Pediatric Psychology, the National Association of School Psychologists, the Society for Developmental and Behavioral Pediatrics, the American Academy of Family Physicians, and Children and Adults With Attention-Deficit/Hyperactivity Disorder (CHADD), as well as an epidemiologist from the Centers for Disease Control and Prevention (CDC).

This group met over a 2-year period, during which it reviewed the changes in practice that have occurred and issues that have been identified since the previous guidelines were published. Delay in completing the process led to further conference calls and extended the years of literature reviewed in order to remain as current as possible. The AAP funded the development of this guideline; potential financial conflicts of the participants were identified and taken into consideration in the deliberations. The guideline will be reviewed and/or revised in 5 years unless new evidence emerges that warrants revision sooner.

The subcommittee developed a series of research questions to direct an extensive evidence-based review in partnership with the CDC and the University of Oklahoma Health Sciences Center. The diagnostic review was conducted by the CDC, and the evidence was evaluated in a combined effort of the AAP, CDC, and University of Oklahoma Health Sciences Center staff. The treatment-related evidence relied on a recent evidence review by the Agency for Healthcare Research and Quality and was supplemented by evidence identified through the CDC review.

The diagnostic issues were focused on 5 areas:

1. ADHD prevalence—specifically: (*a*) What percentage of the general US population aged 21 years or younger has ADHD? (*b*) What percentage of patients presenting at pediatricians' or family physicians' offices in the United States meet diagnostic criteria for ADHD?
2. Co-occurring mental disorders—of people with ADHD, what percentage has 1 or more of the following co-occurring conditions: sleep disorders, learning disabilities, depression, anxiety, conduct disorder, and oppositional defiant disorder?
3. What are the functional impairments of children and youth diagnosed with ADHD? Specifically, in what domains and to what degree do youth with ADHD demonstrate impairments in functional domains, including peer relations, academic performance, adaptive skills, and family functioning?
4. Do behavior rating scales remain the standard of care in assessing the diagnostic criteria for ADHD?
5. What is the prevalence of abnormal findings on selected medical screening tests commonly recommended as standard components of an evaluation of a child with suspected ADHD? How accurate are these tests in the diagnosis of ADHD compared with a reference standard (ie, what are the psychometric properties of these tests)?

The treatment issues were focused on 3 areas:

1. What new information is available

regarding the long-term efficacy and safety of medications approved by the US Food and Drug Administration (FDA) for the treatment of ADHD (stimulants and nonstimulants), and specifically, what information is available about the efficacy and safety of these medications in preschool-aged and adolescent patients?

2. What evidence is available about the long-term efficacy and safety of psychosocial interventions (behavioral modification) for the treatment of ADHD for children, and specifically, what information is available about the efficacy and safety of these interventions in preschool-aged and adolescent patients?
3. Are there any additional therapies that reach the level of consideration as evidence based?

Evidence-Review Process for Diagnosis

A multilevel, systematic approach was taken to identify the literature that built the evidence base for both diagnosis and treatment. To increase the likelihood that relevant articles were included in the final evidence base, the reviewers first conducted a scoping review of the literature by systematically searching literature using relevant key words and then summarized the primary findings of articles that met standard inclusion criteria. The reviewers then created evidence tables that were reviewed by content-area experts who were best able to identify articles that might have been missed through the scoping review. Articles that were missed were reviewed carefully to determine where the abstraction methodology failed, and adjustments to the search strategy were made as required (see technical report to be published). Finally, although published literature reviews did not contribute directly to the evidence base, the articles included in review articles were cross-referenced with the final evidence tables to ensure that all relevant articles were included in the final evidence tables.

For the scoping review, articles were abstracted in a stratified fashion from 3 article-retrieval systems that provided access to articles in the domains of medicine, psychology, and education: PubMed (www.ncbi.nlm.nih.gov/sites/entrez), PsycINFO (www.apa.org/pubs/databases/psycinfo/index.aspx), and ERIC (www.eric.ed.gov). English-language, peer-reviewed articles published between 1998 and 2009 were queried in the 3 search engines. Key words were selected with the intent of including all possible articles that might have been relevant to 1 or more of the questions of interest (see the technical report to be published). The primary abstraction included the following terms: "attention deficit hyperactivity disorder" or "attention deficit disorder" or "hyperkinesis" and "child." A second, independent abstraction was conducted to identify articles related to medical screening tests for ADHD. For this abstraction, the same search terms were used as in the previous procedure along with the additional condition term "behavioral problems" to allow for the inclusion of studies of youth that sought to diagnose ADHD by using medical screening tests. Abstractions were conducted in parallel fashion across each of the 3 databases; the results from each abstraction (complete reference, abstract, and key words) were exported and compiled into a common reference database using EndNote 10.0.[4] References were subsequently and systematically deduplicated by using the software's deduplication procedure. References for books, chapters, and theses were also deleted from the library. Once a deduplicated library was developed, the semifinal database of 8267 references was reviewed for inclusion on the basis of inclusion criteria listed in the technical report. Included articles were then pulled in their entirety, the inclusion criteria were reconfirmed, and then the study findings were summarized in evidence tables. The articles included in relevant review articles were revisited to ensure their inclusion in the final evidence base. The evidence tables were then presented to the committee for expert review.

Evidence-Review Process for Treatment

In addition to this systematic review, for treatment we used the review from the Agency for Healthcare Research and Quality (AHRQ) Effective Healthcare Program "Attention Deficit Hyperactivity Disorder: Effectiveness of Treatment in At-Risk Preschoolers; Long-term Effectiveness in All Ages; and Variability in Prevalence, Diagnosis, and Treatment."[5] This review addressed a number of key questions for the committee, including the efficacy of medications and behavioral interventions for preschoolers, children, and adolescents. Evidence identified through the systematic evidence review for diagnosis was also used as a secondary data source to supplement the evidence presented in the AHRQ report. The draft practice guidelines were developed by consensus of the committee regarding the evidence. It was decided to create 2 separate components. The guideline recommendations were based on clear characterization of the evidence. The second component is a practice-of-care algorithm (see Supplemental Fig 2) that provides considerably more detail about how to implement the guidelines but is, necessarily, based less on available evidence and more on consensus of the committee members. When data were lacking, particularly in the

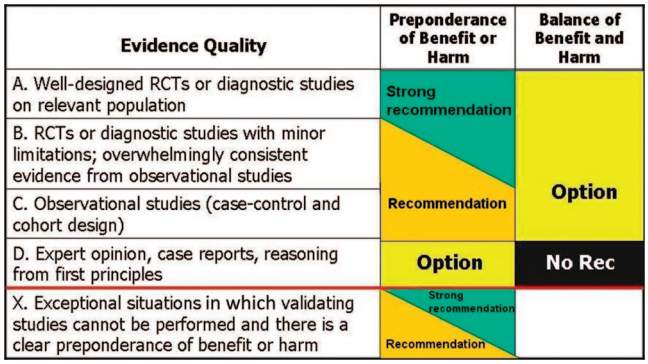

FIGURE 1

Integrating evidence-quality appraisal with an assessment of the anticipated balance between benefits and harms if a policy is conducted leads to designation of a policy as a strong recommendation, recommendation, option, or no recommendation. The evidence is discussed in more detail in a technical report that will follow in a later publication. RCT indicates randomized controlled trial; Rec, recommendation.

process-of-care algorithmic portion of the guidelines, a combination of evidence and expert consensus was used. Action statements labeled "strong recommendation" or "recommendation" were based on high- to moderate-quality scientific evidence and a preponderance of benefit over harm.[6] Option-level action statements were based on lesser-quality or limited data and expert consensus or high-quality evidence with a balance between benefits and harms. These clinical options are interventions that a reasonable health care provider might or might not wish to implement in his or her practice. The quality of evidence supporting each recommendation and the strength of each recommendation were assessed by the committee member most experienced in epidemiology and graded according to AAP policy (Fig 1).[6]

The guidelines and process-of-care algorithm underwent extensive peer review by committees, sections, councils, and task forces within the AAP; numerous outside organizations; and other individuals identified by the subcommittee. Liaisons to the subcommittee also were invited to distribute the draft to entities within their organizations. The resulting comments were compiled and reviewed by the chairperson, and relevant changes were incorporated into the draft, which was then reviewed by the full committee.

ABOUT THIS GUIDELINE

Key Action Statements

In light of the concerns highlighted previously and informed by the available evidence, the AAP has developed 6 action statements for the evaluation, diagnosis, and treatment of ADHD in children. These action statements provide for consistent and quality care for children and families with concerns about or symptoms that suggest attention disorders or problems.

Context

This guideline is intended to be integrated with the broader algorithms developed as part of the mission of the AAP Task Force on Mental Health.[7]

Implementation: A Process-of-Care Algorithm

The AAP recognizes the challenge of instituting practice changes and adopting new recommendations for care. To address the need, a process-of-care algorithm has been developed and has been used in the revision of the AAP ADHD toolkit.

Implementation: Preparing the Practice

Full implementation of the action statements described in this guideline and the process-of-care algorithm might require changes in office procedures and/or preparatory efforts to identify community resources. The section titled "Preparing the Practice" in the process-of-care algorithm and further information can be found in the supplement to the Task Force on Mental Health report.[7] It is important to document all aspects of the diagnostic and treatment procedures in the patients' records. Use of rating scales for the diagnosis of ADHD and assessment for comorbid conditions and as a method for monitoring treatment as described in the process algorithm (see Supplemental Fig 2), as well as information provided to parents such as management plans, can help facilitate a clinician's accurate documentation of his or her process.

Note

The AAP acknowledges that some primary care clinicians might not be confident of their ability to successfully diagnose and treat ADHD in a child because of the child's age, coexisting conditions, or other concerns. At any point at which a clinician feels that he or she is not adequately trained or is uncertain about making a diagnosis or continuing with treatment, a referral to a pediatric or mental health subspecialist should be made. If a diagnosis of ADHD or other condition is made by a subspecialist, the primary care clinician should develop a management strategy with the subspecialist that ensures that the child will continue to receive appropriate care consistent with a medical home model wherein the pediatrician part-

ners with parents so that both health and mental health needs are integrated.

KEY ACTION STATEMENTS FOR THE EVALUATION, DIAGNOSIS, TREATMENT, AND MONITORING OF ADHD IN CHILDREN AND ADOLESCENTS

Action statement 1: The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** In a considerable number of children, ADHD goes undiagnosed. Primary care clinicians' systematic identification of children with these problems will likely decrease the rate of undiagnosed and untreated ADHD in children.
- **Harms/risks/costs:** Children in whom ADHD is inappropriately diagnosed might be labeled inappropriately, or another condition might be missed, and they might receive treatments that will not benefit them.
- **Benefits-harms assessment:** The high prevalence of ADHD and limited mental health resources require primary care pediatricians to play a significant role in the care of their patients with ADHD so that children with this condition receive the appropriate diagnosis and treatment. Treatments available have shown good evidence of efficacy, and lack of treatment results in a risk for impaired outcomes.
- **Value judgments:** The committee considered the requirements for establishing the diagnosis, the prevalence of ADHD, and the efficacy and adverse effects of treatment as well as the long-term outcomes.
- **Role of patient preferences:** Success with treatment depends on patient and family preference, which has to be taken into account.
- **Exclusions:** None.
- **Intentional vagueness:** The limits between what can be handled by a primary care clinician and what should be referred to a subspecialist because of the varying degrees of skills among primary care clinicians.
- **Strength: strong recommendation.**

The basis for this recommendation is essentially unchanged from that in the previous guideline. ADHD is the most common neurobehavioral disorder in children and occurs in approximately 8% of children and youth[8–10]; the number of children with this condition is far greater than can be managed by the mental health system. There is now increased evidence that appropriate diagnosis can be provided for preschool-aged children[11] (4–5 years of age) and for adolescents.[12]

Action statement 2: To make a diagnosis of ADHD, the primary care clinician should determine that *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV-TR) criteria have been met (including documentation of impairment in more than 1 major setting), and information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care. The primary care clinician should also rule out any alternative cause (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** The use of DSM-IV criteria has lead to more uniform categorization of the condition across professional disciplines.
- **Harms/risks/costs:** The DSM-IV system does not specifically provide for developmental-level differences and might lead to some misdiagnoses.
- **Benefits-harms assessment:** The benefits far outweigh the harm.
- **Value judgments:** The committee took into consideration the importance of coordination between pediatric and mental health services.
- **Role of patient preferences:** Although there is some stigma associated with mental disorder diagnoses resulting in some families preferring other diagnoses, the need for better clarity in diagnoses was felt to outweigh this preference.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

As with the findings in the previous guideline, the DSM-IV criteria continue to be the criteria best supported by evidence and consensus. Developed through several iterations by the American Psychiatric Association, the DSM-IV criteria were created through use of consensus and an expanding research foundation.[13] The DSM-IV system is used by professionals in psychiatry, psychology, health care systems, and primary care. Use of DSM-IV criteria, in addition to having the best evidence to date for criteria for ADHD, also affords the best method for communication across clinicians and is established with third-party payers. The criteria are under review for the development of the DSM-V, but these changes will not be available until at least 1 year after the publication of this current guideline. The diagnostic criteria have not changed since the previous guideline and are presented in Supplemental Table 2. An anticipated change in the DSM-V is increasing the age limit for when ADHD needs to have first presented from 7 to 12 years.[14]

Special Circumstances: Preschool-aged Children (4–5 Years Old)

There is evidence that the diagnostic criteria for ADHD can be applied to preschool-aged children; however, the subtypes detailed in the DSM-IV might not be valid for this population.[15–21] A review of the literature, including the multisite study of the efficacy of methylphenidate in preschool-aged children, revealed that the criteria could appropriately identify children with the condition.[11] However, there are added challenges in determining the presence of key symptoms. Preschool-aged children are not likely to have a separate observer if they do not attend a preschool or child care program, and even if they do attend, staff in those programs might be less qualified than certified teachers to provide accurate observations. Here, too, focused checklists can help physicians in the diagnostic evaluation, although only the Conners Comprehensive Behavior Rating Scales and the ADHD Rating Scale IV are DSM-IV–based scales that have been validated in preschool-aged children.[22]

When there are concerns about the availability or quality of nonparent observations of a child's behavior, physicians may recommend that parents complete a parent-training program before confirming an ADHD diagnosis for preschool-aged children and consider placement in a qualified preschool program if they have not done so already. Information can be obtained from parents and teachers through the use of validated DSM-IV–based ADHD rating scales. The parent-training program must include helping parents develop age-appropriate developmental expectations and specific management skills for problem behaviors. The clinician may obtain reports from the parenting class instructor about the parents' ability to manage their children, and if the children are in programs in which they are directly observed, instructors can report information about the core symptoms and function of the child directly. Qualified preschool programs include programs such as Head Start or other public prekindergarten programs. Preschool-aged children who display significant emotional or behavioral concerns might also qualify for Early Childhood Special Education services through their local school districts, and the evaluators for these programs and/or Early Childhood Special Education teachers might be excellent reporters of core symptoms.

Special Circumstances: Adolescents

Obtaining teacher reports for adolescents might be more challenging, because many adolescents will have multiple teachers. Likewise, parents might have less opportunity to observe their adolescent's behaviors than they had when their children were younger. Adolescents' reports of their own behaviors often differ from those of other observers, because they tend to minimize their own problematic behaviors.[23–25] Adolescents are less likely to exhibit overt hyperactive behavior. Despite the difficulties, clinicians need to try to obtain (with agreement from the adolescent) information from at least 2 teachers as well as information from other sources such as coaches, school guidance counselors, or leaders of community activities in which the adolescent participates. In addition, it is unusual for adolescents with behavioral/attention problems not to have been previously given a diagnosis of ADHD. Therefore, it is important to establish the younger manifestations of the condition that were missed and to strongly consider substance use, depression, and anxiety as alternative or co-occurring diagnoses. Adolescents with ADHD, especially when untreated, are at greater risk of substance abuse.[26] In addition, the risks of mood and anxiety disorders and risky sexual behaviors increase during adolescence.[12]

Special Circumstances: Inattention or Hyperactivity/Impulsivity (Problem Level)

Teachers, parents, and child health professionals typically encounter children with behaviors relating to activity level, impulsivity, and inattention who might not fully meet DSM-IV criteria. The DSM-PC[3] provides a guide to the more common behaviors seen in pediatrics. The manual describes common variations in behavior as well as more problematic behaviors at levels of less impairment than those specified in the DSM-IV.

The behavioral descriptions of the DSM-PC have not yet been tested in community studies to determine the prevalence or severity of developmental variations and problems in the areas of inattention, hyperactivity, or impulsivity. They do, however, provide guidance to clinicians regarding elements of treatment for children with problems with mild-to-moderate inattention, hyperactivity, or impulsivity. The DSM-PC also considers environmental influences on a child's behavior and provides information on differential diagnosis with a developmental perspective.

Action statement 3: In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD, including emotional or behavioral (eg, anxiety, depressive, oppositional defiant, and conduct disorders), developmental (eg, learning and language disorders or other neurodevelopmental disorders), and physical (eg, tics, sleep apnea) conditions (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** Identifying coexisting conditions is important for developing the most appropriate treatment plan.
- **Harms/risks/costs:** The major risk is misdiagnosing the conditions and providing inappropriate care.
- **Benefits-harms assessment:** There is a preponderance of benefit over harm.
- **Value judgments:** The committee members took into consideration the common occurrence of coexisting conditions and the importance of addressing them in making this recommendation.
- **Role of patient preferences:** None.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

A variety of other behavioral, developmental, and physical conditions can coexist in children who are evaluated for ADHD. These conditions include, but are not limited to, learning problems, language disorder, disruptive behavior, anxiety, mood disorders, tic disorders, seizures, developmental coordination disorder, or sleep disorders.[23,24,27–38] In some cases, the presence of a coexisting condition will alter the treatment of ADHD. The primary care clinician might benefit from additional support and guidance or might need to refer a child with ADHD and coexisting conditions, such as severe mood or anxiety disorders, to subspecialists for assessment and management. The subspecialists could include child psychiatrists, developmental-behavioral pediatricians, neurodevelopmental disability physicians, child neurologists, or child or school psychologists.

Given the likelihood that another condition exists, primary care clinicians should conduct assessments that determine or at least identify the risk of coexisting conditions. Through its Task Force on Mental Health, the AAP has developed algorithms and a toolkit[39] for assessing and treating (or comanaging) the most common developmental disorders and mental health concerns in children. These resources might be useful in assessing children who are being evaluated for ADHD. Payment for evaluation and treatment must cover the fixed and variable costs of providing the services, as noted in the AAP policy statement "Scope of Health Care Benefits for Children From Birth Through Age 26.[40]

Special Circumstances: Adolescents

Clinicians should assess adolescent patients with newly diagnosed ADHD for symptoms and signs of substance abuse; when these signs and symptoms are found, evaluation and treatment for addiction should precede treatment for ADHD, if possible, or careful treatment for ADHD can begin if necessary.[25]

Action statement 4: The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** The recommendation describes the coordinated services most appropriate for managing the condition.
- **Harms/risks/costs:** Providing the services might be more costly.
- **Benefits-harms assessment:** There is a preponderance of benefit over harm.
- **Value judgments:** The committee members considered the value of medical home services when deciding to make this recommendation.
- **Role of patient preferences:** Family preference in how these services are provided is an important consideration.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

As in the previous guideline, this recommendation is based on the evidence that ADHD continues to cause symptoms and dysfunction in many children who have the condition over long periods of time, even into adulthood, and that the treatments available address symptoms and function but are usually not curative. Although the chronic illness model has not been specifically studied in children and youth with ADHD, it has been effective for other chronic conditions such as asthma,[23] and the medical home model has been accepted as the preferred standard of care.[41] The management process is also helped by encouraging strong family-school partnerships.[42]

Longitudinal studies have found that, frequently, treatments are not sustained despite the fact that long-term outcomes for children with ADHD indicate that they are at greater risk of significant problems if they discontinue treatment.[43] Because a number of parents of children with ADHD also have ADHD, extra support might be necessary to help those parents provide medication on a consistent basis and institute a consistent behavioral program. The medical home and chronic illness approach is provided in the process algorithm (Supplemental Fig 2). An important process in ongoing care is bidirectional communication with teachers and other school and mental health clinicians involved in the child's care as well as with parents and patients.

Special Circumstances: Inattention or Hyperactivity/Impulsivity (Problem Level)

Children with inattention or hyperactivity/impulsivity at the problem level (DSM-PC) and their families might also benefit from the same chronic illness and medical home principles.

Action statement 5: Recommendations for treatment of children and youth with ADHD vary depending on the patient's age.

Action statement 5a: For *preschool-aged children (4–5 years of age)*, the primary care clinician should prescribe evidence-based parent- and/or teacher-administered behavior therapy as the first line of treatment (quality of evidence A/strong recommendation) and may prescribe methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child's function. In areas in which evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment (quality of evidence B/recommendation).

Evidence Profile

- **Aggregate evidence quality:** A for behavior; B for methylphenidate.
- **Benefits:** Both behavior therapy and methylphenidate have been demonstrated to reduce behaviors associated with ADHD and improve function.
- **Harms/risks/costs:** Both therapies increase the cost of care, and behavior therapy requires a higher level of family involvement, whereas methylphenidate has some potential adverse effects.
- **Benefits-harms assessment:** Given the risks of untreated ADHD, the benefits outweigh the risks.
- **Value judgments:** The committee members included the effects of untreated ADHD when deciding to make this recommendation.
- **Role of patient preferences:** Family preference is essential in determining the treatment plan.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

Action statement 5b: For *elementary school-aged children (6–11 years of age)*, the primary care clinician should prescribe FDA-approved medications for ADHD (quality of evidence A/strong recommendation) and/or evidence-based parent- and/or teacher-administered behavior therapy as treatment for ADHD, preferably both (quality of evidence B/strong recommendation). The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order) (quality of evidence A/strong recommendation). The school environment, program, or placement is a part of any treatment plan.

Evidence Profile

- **Aggregate evidence quality:** A for treatment with FDA-approved medications; B for behavior therapy.
- **Benefits:** Both behavior therapy and FDA-approved medications have been demonstrated to reduce behaviors associated with ADHD and improve function.
- **Harms/risks/costs:** Both therapies increase the cost of care, and behavior therapy requires a higher level of family involvement, whereas FDA-approved medications have some potential adverse effects.
- **Benefits-harms assessment:** Given the risks of untreated ADHD, the benefits outweigh the risks.
- **Value judgments:** The committee members included the effects of untreated ADHD when deciding to make this recommendation.
- **Role of patient preferences:** Family preference, including patient preference, is essential in determining the treatment plan.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

Action statement 5c: For *adolescents (12–18 years of age)*, the primary care clinician should prescribe FDA-approved medications for ADHD with the assent of the adolescent (quality of evidence A/strong recommendation) and may prescribe behavior therapy as treatment for ADHD (quality of evidence C/recommendation), preferably both.

Evidence Profile

- **Aggregate evidence quality:** A for medications; C for behavior therapy.
- **Benefits:** Both behavior therapy and FDA-approved medications have been demonstrated to reduce behaviors associated with ADHD and improve function.
- **Harms/risks/costs:** Both therapies increase the cost of care, and behavior therapy requires a higher level of family involvement, whereas FDA-approved medications have some potential adverse effects.
- **Benefits-harms assessment:** Given the risks of untreated ADHD, the benefits outweigh the risks.
- **Value judgments:** The committee members included the effects of untreated ADHD when deciding to make this recommendation.
- **Role of patient preferences:** Family preference, including patient preference, is essential in determining the treatment plan.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation/ recommendation.**

Medication

Similar to the recommendations from the previous guideline, stimulant medications are highly effective for most children in reducing core symptoms of ADHD.[44] One selective norepinephrine-reuptake inhibitor (atomoxetine[45,46]) and 2 selective α_2-adrenergic agonists (extended-release guanfacine[47,48] and extended-release clonidine[49]) have also demonstrated efficacy in reducing core symptoms. Because norepinephrine-reuptake inhibitors and α_2-adrenergic agonists are newer, the evidence base that supports them—although adequate for FDA approval—is considerably smaller than that for stimulants. None of them have been approved for use in preschool-aged children. Compared with stimulant medications that have an effect size [effect size = (treatment mean − control mean)/control SD] of approximately 1.0,[50] the effects of the nonstimulants are slightly weaker; atomoxetine has an effect size of approximately 0.7, and extended-release guanfacine and extended-release clonidine also have effect sizes of approximately 0.7.

The accompanying process-of-care algorithm provides a list of the currently available FDA-approved medications for ADHD (Supplemental Table 3). Characteristics of each medication are provided to help guide the clinician's choice in prescribing medication.

As was identified in the previous guideline, the most common stimulant adverse effects are appetite loss, abdominal pain, headaches, and sleep disturbance. The results of the Multimodal Therapy of ADHD (MTA) study revealed a more persistent effect of stimulants on decreasing growth velocity than have most previous studies, particularly when children were on higher and more consistently administered doses. The effects diminished by the third year of treatment, but no compensatory rebound effects were found.[51] However, diminished growth was in the range of 1 to 2 cm. An uncommon additional significant adverse effect of stimulants is the occurrence of hallucinations and other psychotic symptoms.[52] Although concerns have been raised about the rare occurrence of sudden cardiac death among children using stimulant medications,[53] sudden death in children on stimulant medication is extremely rare, and evidence is conflicting as to whether stimulant medications increase the risk of sudden death.[54–56] It is important to expand the history to include specific cardiac symptoms, Wolf-Parkinson-White syndrome, sudden death in the family, hypertrophic cardiomyopathy, and long QT syndrome. Preschool-aged children might experience increased mood lability and dysphoria.[57] For the nonstimulant atomoxetine, the adverse effects include initial somnolence and gastrointestinal tract symptoms, particularly if the dosage is increased too rapidly; decrease in appetite; increase in suicidal thoughts (less common); and hepatitis (rare). For the nonstimulant α_2-adrenergic agonists extended-release guanfacine and extended-release clonidine, adverse effects include somnolence and dry mouth.

Only 2 medications have evidence to support their use as adjunctive therapy with stimulant medications sufficient to achieve FDA approval: extended-release guanfacine[26] and extended-release clonidine. Other medications have been used in combination off-label, but there is currently only anecdotal evidence for their safety or efficacy, so their use cannot be recommended at this time.

Special Circumstances: Preschool-aged Children

A number of special circumstances support the recommendation to initiate ADHD treatment in preschool-aged children (ages 4–5 years) with behavioral therapy alone first.[57] These circumstances include:

- The multisite study of methylphenidate[57] was limited to preschool-aged children who had moderate-to-severe dysfunction.
- The study also found that many children (ages 4–5 years) experience improvements in symptoms with behavior therapy alone, and the overall evidence for behavior therapy in preschool-aged children is strong.
- Behavioral programs for children 4 to 5 years of age typically run in the form of group parent-training programs and, although not always compensated by health insurance, have a lower cost. The process algorithm (see Supplemental pages s15-16) contains criteria for the clinician to use in assessing the quality of the behavioral therapy. In addition, programs such as Head Start and Children and Adults With Attention Deficit Hyperactivity Disorder (CHADD) (www.chadd.org) might provide some behavioral supports.

Many young children with ADHD might still require medication to achieve maximum improvement, and medication is not contraindicated for children 4 through 5 years of age. However, only 1 multisite study has carefully assessed medication use in preschool-aged children. Other considerations in the recommendation about treating children 4 to 5 years of age with stimulant medications include:

- The study was limited to preschool-aged children who had moderate-to-severe dysfunction.
- Research has found that a number of young children (4–5 years of age) experience improvements in symptoms with behavior therapy alone.
- There are concerns about the possi-

ble effects on growth during this rapid growth period of preschool-aged children.

- There has been limited information about and experience with the effects of stimulant medication in children between the ages of 4 and 5 years.

Here, the criteria for enrollment (and, therefore, medication use) included measures of severity that distinguished treated children from the larger group of preschool-aged children with ADHD. Thus, before initiating medications, the physician should assess the severity of the child's ADHD. Given current data, only those preschool-aged children with ADHD who have moderate-to-severe dysfunction should be considered for medication. Criteria for this level of severity, based on the multisite-study results,[57] are (1) symptoms that have persisted for at least 9 months, (2) dysfunction that is manifested in both the home and other settings such as preschool or child care, and (3) dysfunction that has not responded adequately to behavior therapy. The decision to consider initiating medication at this age depends in part on the clinician's assessment of the estimated developmental impairment, safety risks, or consequences for school or social participation that could ensue if medications are not initiated. It is often helpful to consult with a mental health specialist who has had specific experience with preschool-aged children if possible.

Dextroamphetamine is the only medication approved by the FDA for use in children younger than 6 years of age. This approval, however, was based on less stringent criteria in force when the medication was approved rather than on empirical evidence of its safety and efficacy in this age group. Most of the evidence for the safety and efficacy of treating preschool-aged children with stimulant medications has been from methylphenidate.[57] Methylphenidate evidence consists of 1 multisite study of 165 children and 10 other smaller single-site studies that included from 11 to 59 children (total of 269 children); 7 of the 10 single-site studies found significant efficacy. It must be noted that although there is moderate evidence that methylphenidate is safe and efficacious in preschool-aged children, its use in this age group remains off-label. Although the use of dextroamphetamine is on-label, the insufficient evidence for its safety and efficacy in this age group does not make it possible to recommend at this time.

If children do not experience adequate symptom improvement with behavior therapy, medication can be prescribed, as described previously. Evidence suggests that the rate of metabolizing stimulant medication is slower in children 4 through 5 years of age, so they should be given a lower dose to start, and the dose can be increased in smaller increments. Maximum doses have not been adequately studied.[57]

Special Circumstances: Adolescents

As noted previously, before beginning medication treatment for adolescents with newly diagnosed ADHD, clinicians should assess these patients for symptoms of substance abuse. When substance use is identified, assessment when off the abusive substances should precede treatment for ADHD (see the Task Force on Mental Health report[7]). Diversion of ADHD medication (use for other than its intended medical purposes) is also a special concern among adolescents[58]; clinicians should monitor symptoms and prescription-refill requests for signs of misuse or diversion of ADHD medication and consider prescribing medications with no abuse potential, such as atomoxetine (Strattera [Ely Lilly Co, Indianapolis, IN]) and extended-release guanfacine (Intuniv [Shire US Inc, Wayne, PA]) or extended-release clonidine (Kapvay [Shionogi Inc, Florham Park, NJ]) (which are not stimulants) or stimulant medications with less abuse potential, such as lisdexamfetamine (Vyvanse [Shire US Inc]), dermal methylphenidate (Daytrana [Noven Therapeutics, LLC, Miami, FL]), or OROS methylphenidate (Concerta [Janssen Pharmaceuticals, Inc, Titusville, NJ]). Because lisdexamfetamine is dextroamphetamine, which contains an additional lysine molecule, it is only activated after ingestion, when it is metabolized by erythrocyte cells to dexamphetamine. The other preparations make extraction of the stimulant medication more difficult.

Given the inherent risks of driving by adolescents with ADHD, special concern should be taken to provide medication coverage for symptom control while driving. Longer-acting or late-afternoon, short-acting medications might be helpful in this regard.[59]

Special Circumstances: Inattention or Hyperactivity/Impulsivity (Problem Level)

Medication is not appropriate for children whose symptoms do not meet DSM-IV criteria for diagnosis of ADHD, although behavior therapy does not require a specific diagnosis, and many of the efficacy studies have included children without specific mental behavioral disorders.

Behavior Therapy

Behavior therapy represents a broad set of specific interventions that have a common goal of modifying the physical and social environment to alter or change behavior. Behavior therapy usually is implemented by training parents in specific techniques that improve their abilities to modify and

TABLE 1 Evidence-Based Behavioral Treatments for ADHD

Intervention Type	Description	Typical Outcome(s)	Median Effect Size[a]
Behavioral parent training (BPT)	Behavior-modification principles provided to parents for implementation in home settings	Improved compliance with parental commands; improved parental understanding of behavioral principles; high levels of parental satisfaction with treatment	0.55
Behavioral classroom management	Behavior-modification principles provided to teachers for implementation in classroom settings	Improved attention to instruction; improved compliance with classroom rules; decreased disruptive behavior; improved work productivity	0.61
Behavioral peer interventions (BPI)[b]	Interventions focused on peer interactions/relationships; these are often group-based interventions provided weekly and include clinic-based social-skills training used either alone or concurrently with behavioral parent training and/or medication	Office-based interventions have produced minimal effects; interventions have been of questionable social validity; some studies of BPI combined with clinic-based BPT found positive effects on parent ratings of ADHD symptoms; no differences on social functioning or parent ratings of social behavior have been revealed	

[a] Effect size = (treatment median − control median)/control SD.

[b] The effect size for behavioral peer interventions is not reported, because the effect sizes for these studies represent outcomes associated with combined interventions. A lower effect size means that they have less of an effect. The effect sizes found are considered moderate.

Adapted from Pelham W, Fabiano GA. *J Clin Child Adolesc Psychol.* 2008;37(1):184–214.

shape their child's behavior and to improve the child's ability to regulate his or her own behavior. The training involves techniques to more effectively provide rewards when their child demonstrates the desired behavior (eg, positive reinforcement), learn what behaviors can be reduced or eliminated by using planned ignoring as an active strategy (or using praising and ignoring in combination), or provide appropriate consequences or punishments when their child fails to meet the goals (eg, punishment). There is a need to consistently apply rewards and consequences as tasks are achieved and then to gradually increase the expectations for each task as they are mastered to shape behaviors. Although behavior therapy shares a set of principles, individual programs introduce different techniques and strategies to achieve the same ends.

Table 1 lists the major behavioral intervention approaches that have been demonstrated to be evidence based for the management of ADHD in 3 different types of settings. The table is based on 22 studies, each completed between 1997 and 2006.

Evidence for the effectiveness of behavior therapy in children with ADHD is derived from a variety of studies[60–62] and an Agency for Healthcare Research and Quality review.[5] The diversity of interventions and outcome measures makes meta-analysis of the effects of behavior therapy alone or in association with medications challenging. The long-term positive effects of behavior therapy have yet to be determined. Ongoing adherence to a behavior program might be important; therefore, implementing a chronic care model for child health might contribute to the long-term effects.[63]

Study results have indicated positive effects of behavior therapy when combined with medications. Most studies that compared behavior therapy to stimulants found a much stronger effect on ADHD core symptoms from stimulants than from behavior therapy. The MTA study found that combined treatment (behavior therapy and stimulant medication) was not significantly more efficacious than treatment with medication alone for the core symptoms of ADHD after correction for multiple tests in the primary analysis.[64] However, a secondary analysis of a combined measure of parent and teacher ratings of ADHD symptoms revealed a significant advantage for the combination with a small effect size of $d = 0.26$.[65] However, the same study also found that the combined treatment compared with medication alone did offer greater improvements on academic and conduct measures when ADHD coexisted with anxiety and when children lived in low socioeconomic environments. In addition, parents and teachers of children who were receiving combined therapy were significantly more satisfied with the treatment plan. Finally, the combination of medication management and behavior therapy allowed for the use of lower dosages of stimulants, which possibly reduced the risk of adverse effects.[66]

School Programming and Supports

Behavior therapy programs coordinating efforts at school as well as home might enhance the effects. School programs can provide classroom adaptations, such as preferred seating, modified work assignments, and test modifications (to the location at which it is administered and time allotted for taking the test), as well as behavior plans as part of a 504 Rehabilitation Act Plan or special education Individualized Education Program (IEP) under the "other health impairment" designation as part of the Individuals With

Disability Education Act (IDEA).[67] It is helpful for clinicians to be aware of the eligibility criteria in their state and school district to advise families of their options. Youths documented to have ADHD can also get permission to take college-readiness tests in an untimed manner by following appropriate documentation guidelines.[68]

The effect of coexisting conditions on ADHD treatment is variable. In some cases, treatment of the ADHD resolves the coexisting condition. For example, treatment of ADHD might resolve oppositional defiant disorder or anxiety.[68] However, sometimes the co-occurring condition might require treatment that is in addition to the treatment for ADHD. Some coexisting conditions can be treated in the primary care setting, but others will require referral and comanagement with a subspecialist.

Action statement 6: Primary care clinicians should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects (quality of evidence B/strong recommendation).

Evidence Profile

- **Aggregate evidence quality:** B.
- **Benefits:** The optimal dose of medication is required to reduce core symptoms to or as close to the levels of children without ADHD.
- **Harms/risks/costs:** Higher levels of medication increase the chances of adverse effects.
- **Benefits-harms assessment:** The importance of adequately treating ADHD outweighs the risk of adverse effects.
- **Value judgments:** The committee members included the effects of untreated ADHD when deciding to make this recommendation.
- **Role of patient preferences:** The families' preferences and comfort need to be taken into consideration in developing a titration plan.
- **Exclusions:** None.
- **Intentional vagueness:** None.
- **Strength: strong recommendation.**

The findings from the MTA study suggested that more than 70% of children and youth with ADHD respond to one of the stimulant medications at an optimal dose when a systematic trial is used.[65] Children in the MTA who were treated in the community with care as usual from whomever they chose or to whom they had access received lower doses of stimulants with less frequent monitoring and had less optimal results.[65] Because stimulants might produce positive but suboptimal effects at a low dose in some children and youth, titration to maximum doses that control symptoms without adverse effects is recommended instead of titration strictly on a milligram-per-kilogram basis.

Education of parents is an important component in the chronic illness model to ensure their cooperation in efforts to reach appropriate titration (remembering that the parents themselves might be challenged significantly by ADHD).[69,70] The primary care clinician should alert parents and children that changing medication dose and occasionally changing a medication might be necessary for optimal medication management, that the process might require a few months to achieve optimal success, and that medication efficacy should be systematically monitored at regular intervals.

Because stimulant medication effects are seen immediately, trials of different doses of stimulants can be accomplished in a relatively short time period. Stimulant medications can be effectively titrated on a 3- to 7-day basis.[65]

It is important to note that by the 3-year follow-up of 14-month MTA interventions (optimal medications management, optimal behavioral management, the combination of the 2, or community treatment), all differences among the initial 4 groups were no longer present. After the initial 14-month intervention, the children no longer received the careful monthly monitoring provided by the study and went back to receiving care from their community providers. Their medications and doses varied, and a number of them were no longer taking medication. In children still on medication, the growth deceleration was only seen for the first 2 years and was in the range of 1 to 2 cm.

CONCLUSION

Evidence continues to be fairly clear with regard to the legitimacy of the diagnosis of ADHD and the appropriate diagnostic criteria and procedures required to establish a diagnosis, identify co-occurring conditions, and treat effectively with both behavioral and pharmacologic interventions. However, the steps required to sustain appropriate treatments and achieve successful long-term outcomes still remain a challenge. To provide more detailed information about how the recommendations of this guideline can be accomplished, a more detailed but less strongly evidence-based algorithm is provided as a companion article.

AREAS FOR FUTURE RESEARCH

Some specific research topics pertinent to the diagnosis and treatment of ADHD or developmental variations or problems in children and adolescents in primary care to be explored include:

- identification or development of reliable instruments suitable to use in primary care to assess the nature or degree of functional impairment in children/adolescents with ADHD and monitor improvement over time;
- study of medications and other therapies used clinically but not approved by the FDA for ADHD, such as

electroencephalographic biofeedback;

- determination of the optimal schedule for monitoring children/adolescents with ADHD, including factors for adjusting that schedule according to age, symptom severity, and progress reports;
- evaluation of the effectiveness of various school-based interventions;
- comparisons of medication use and effectiveness in different ages, including both harms and benefits;
- development of methods to involve parents and children/adolescents in their own care and improve adherence to both behavior and medication treatments;
- standardized and documented tools that will help primary care providers in identifying coexisting conditions;
- development and determination of effective electronic and Web-based systems to help gather information to diagnose and monitor children with ADHD;
- improved systems of communication with schools and mental health professionals, as well as other community agencies, to provide effective collaborative care;
- evidence for optimal monitoring by some aspects of severity, disability, or impairment; and
- long-term outcomes of children first identified with ADHD as preschool-aged children.

SUBCOMMITTEE ON ATTENTION DEFICIT HYPERACTIVITY DISORDER (OVERSIGHT BY THE STEERING COMMITTEE ON QUALITY IMPROVEMENT AND MANAGEMENT, 2005–2011)

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ACKNOWLEDGMENTS

This guideline was developed with support from the Partnership for Policy Implementation (PPI) initiative. Physicians trained in medical informatics were involved with formatting the algorithm and helping to keep the key action statements actionable, decidable, and executable.

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ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

SUBCOMMITTEE ON ATTENTION-DEFICIT/HYPERACTIVITY DISORDER, STEERING COMMITTEE ON QUALITY IMPROVEMENT AND MANAGEMENT

Pediatrics; originally published online October 16, 2011;
DOI: 10.1542/peds.2011-2654

PRACTICE GUIDELINE FOR THE
Treatment of Patients With Major Depressive Disorder
Second Edition

WORK GROUP ON MAJOR DEPRESSIVE DISORDER

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Originally published in April 2000. This guideline is more than 5 years old and has not yet been updated to ensure that it reflects current knowledge and practice. In accordance with national standards, including those of the Agency for Healthcare Research and Quality's National Guideline Clearinghouse (http://www.guideline.gov/), this guideline can no longer be assumed to be current. A third edition of this guideline is in development; publication is expected in December 2009. The September 2005 Guideline Watch associated with this guideline provides additional information that has become available since publication of the guideline, but it is not a formal update of the guideline.

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CONTENTS

STATEMENT OF INTENT

The American Psychiatric Association (APA) Practice Guidelines are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual patient and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome for every individual, nor should they be interpreted as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.

This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities some contributors, including work group members and reviewers, have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. Work group members are selected on the basis of their expertise and integrity. Any work group member or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work is asked to disclose this to the Steering Committee on Practice Guidelines and the work group. Iterative guideline drafts are reviewed by the Steering Committee, other experts, allied organizations, APA members, and the APA Assembly and Board of Trustees; substantial revisions address or integrate the comments of these multiple reviewers. The development of the APA practice guidelines is not financially supported by any commercial organization.

More detail about mechanisms in place to minimize bias is provided in a document available from the APA Department of Quality Improvement and Psychiatric Services, "APA Guideline Development Process."

This practice guideline was approved in January 2000 and published in April 2000.

GUIDE TO USING THIS PRACTICE GUIDELINE

This practice guideline uses available evidence to develop treatment recommendations for the care of adult patients with major depressive disorder. This guideline contains many sections, not all of which will be equally useful for all readers. The following guide is designed to help readers find the sections that will be most useful to them.

Part A contains the treatment recommendations for patients with major depressive disorder. Section I is the summary of treatment recommendations, which includes the main treatment recommendations, along with codes that indicate the degree of clinical confidence in each recommendation. Section II is a guide to the formulation and implementation of a treatment plan for the individual patient. This section includes all of the treatment recommendations. Section III, "Specific Clinical Features Influencing the Treatment Plan," discusses a range of clinical conditions that could alter the general recommendations discussed in Section II.

Part B, "Background Information and Review of Available Evidence," will be useful to understand, in detail, the evidence underlying the treatment recommendations of Part A. Section IV provides an overview of DSM-IV criteria, prevalence rates for major depressive disorder, and general information on its natural history and course. Section V is a structured review and synthesis of published literature regarding the available treatments for major depressive disorder.

Part C, "Future Research Needs," draws from the previous sections to summarize those areas in which better research data are needed to guide clinical decisions.

To share feedback on this or other published APA practice guidelines, a form is available at http://www.psych.org/psych_pract/pg/reviewform.cfm.

DEVELOPMENT PROCESS

This document is a practical guide to the management of major depressive disorder for adults over the age of 18 and represents a synthesis of current scientific knowledge and rational clinical practice. This guideline strives to be as free as possible of bias toward any theoretical posture, and it aims to represent a practical approach to treatment. Studies were identified through an extensive review of the literature by using MEDLARS for the period 1971–1999. The key words used were affective disorder, major depression, depressive disorder, seasonal affective disorder, melancholia, unipolar depression, endogenous depression, dysthymic disorder, dysthymia, postpartum depression, pseudodementia, antidepressant medications, tricyclic antidepressive agents, monoamine oxidase inhibitors, lithium, and electroconvulsive therapy and included the concepts of melancholia, neurotic depression, and major depression. In addition, the key words for the psychotherapy search were psychotherapy (not otherwise specified); behavior therapy, including aversive therapy, biofeedback (psychology), cognitive therapy, desensitization (psychologic), implosive therapy, and relaxation techniques (meditation); psychoanalytic therapy, including existentialism, free association, transactional analysis, psychotherapy (brief); and psychotherapy (group), including family therapy and marital therapy.

Major review articles and standard psychiatric texts were consulted. The Agency for Healthcare Policy Research *Evidence Report on Treatment of Depression—Newer Pharmacotherapies* (1) was reviewed in its entirety. Review articles and relevant clinical trials were reviewed in their entirety; other studies were selected for review on the basis of their relevance to the particular issues discussed in this guideline. Definitive standards are difficult to achieve, except in narrow circumstances in which multiple replicated studies and wide clinical opinion dictate certain forms of treatment. In other areas, the specific choice among two or more treatment options is left to the clinical judgment of the clinician.

The recommendations are based on the best available data and clinical consensus with regard to the particular clinical decision. The summary of treatment recommendations is keyed according to the level of confidence with which each recommendation is made. In addition, each reference is followed by a letter code in brackets that indicates the nature of the supporting evidence.

INTRODUCTION

This guideline seeks to summarize the specific forms of somatic, psychotherapeutic, psychosocial, and educational treatments that have been developed to deal with major depressive disorder. It begins at the point where the psychiatrist has diagnosed an adult patient as suffering from major depressive disorder, according to the criteria defined in DSM-IV, and has medically evaluated the patient to ascertain the presence of alcohol or substance use disorder or other somatic factors that may contribute to the disease process (e.g., hypothyroidism, pancreatic carcinoma) or complicate its treatment (e.g., cardiac disorders). The purpose of this guideline is to assist the physician faced with the task of implementing specific antidepressant treatment(s). It should be noted that many patients have coexisting conditions and their difficulties cannot be described with one DSM diagnostic category. The psychiatrist should consider, but not be limited to, the treatment guidelines for a single diagnosis. For patients found to have depressive symptoms within the context of bipolar disorder, the psychiatrist should refer to the *Practice Guideline for the Treatment of Patients With Bipolar Disorder* (2).

This document concerns patients 18 years of age and older. Some comments regarding the treatment of major depressive disorders in children and adolescents can be found in Section III.B.5., along with more definitive references.

PART A:
TREATMENT RECOMMENDATIONS FOR PATIENTS WITH MAJOR DEPRESSIVE DISORDER

I. SUMMARY OF TREATMENT RECOMMENDATIONS

Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation:

[I] Recommended with substantial clinical confidence.
[II] Recommended with moderate clinical confidence.
[III] May be recommended on the basis of individual circumstances.

Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient [I]. Treatment consists of an acute phase, during which remission is induced; a continuation phase, during which remission is preserved; and a maintenance phase, during which the susceptible patient is protected against the recurrence of subsequent major depressive episodes. Psychiatrists initiating treatment for major depressive disorder have at their disposal a number of medications, a variety of psychotherapeutic approaches, electroconvulsive therapy (ECT), and other treatment modalities (e.g., light therapy) that may be used alone or in combination. The psychiatrist must determine the setting that will most likely ensure the patient's safety as well as promote improvement in the patient's condition [I].

A. PSYCHIATRIC MANAGEMENT

Psychiatric management consists of a broad array of interventions and activities that should be instituted by psychiatrists for all patients with major depressive disorder [I]. Regardless of the specific treatment modalities selected, it is important to continue providing psychiatric management through all phases of treatment. The specific components of psychiatric management that must be addressed for all patients include performing a diagnostic evaluation, evaluating safety of the patient and others, evaluating the level of functional impairments, determining a treatment setting, establishing and maintaining a therapeutic alliance, monitoring the patient's psychiatric status and safety, providing education to patients and families, enhancing treatment adherence, and working with patients to address early signs of relapse.

B. ACUTE PHASE

1. Choice of an initial treatment modality

In the acute phase, in addition to psychiatric management, the psychiatrist may choose between several initial treatment modalities, including pharmacotherapy, psychotherapy, the combination of medications plus psychotherapy, or ECT [I]. Selection of an initial treatment modality should be influenced by both clinical (e.g., severity of symptoms) and other factors (e.g., patient preference) (Figure 1).

a) Antidepressant medications

If preferred by the patient, antidepressant medications may be provided as an initial primary treatment modality for mild major depressive disorder [I]. Antidepressant medications should be provided for moderate to severe major depressive disorder unless ECT is planned [I]. A combination of antipsychotic and antidepressant medications or ECT should be used for psychotic depression [I].

b) Psychotherapy

A specific, effective psychotherapy alone as an initial treatment modality may be considered for patients with mild to moderate major depressive disorder [II]. Patient preference for psychotherapeutic approaches is an important factor that should be considered in the decision. Clinical features that may suggest the use of psychotherapeutic interventions include the presence of significant psychosocial stressors, intrapsychic conflict, interpersonal difficulties, or a comorbid axis II disorder [I].

c) Psychotherapy plus antidepressant medications

The combination of a specific effective psychotherapy and medication may be a useful initial treatment choice for patients with psychosocial issues, interpersonal problems, or a comorbid axis II disorder together with moderate to severe major depressive disorder [I]. In addition, patients who have had a history of only partial response to adequate trials of single treatment modalities may benefit from combined treatment. Poor adherence with treatments may also warrant combined treatment modalities.

d) Electroconvulsive therapy

ECT should be considered for patients with major depressive disorder with a high degree of symptom severity and functional impairment or for cases in which psychotic symptoms or catatonia are present [I]. ECT may also be the treatment modality of choice for patients in whom there is an urgent need for response, such as patients who are suicidal or refusing food and nutritionally compromised [II].

2. Choice of specific pharmacologic treatment

Antidepressant medications that have been shown to be effective are listed in Table 1 [II]. The effectiveness of antidepressant medications is generally comparable between classes and within classes of medications. Therefore, the initial selection of an antidepressant medication will largely be based on the anticipated side effects, the safety or tolerability of these side effects for individual patients, patient preference, quantity and quality of clinical trial data regarding the medication, and its cost (see Section V.A.1) [I]. On the basis of these considerations, the following medications are likely to be optimal for most patients: selective serotonin reuptake inhibitors (SSRIs), desipramine, nortriptyline, bupropion, and venlafaxine. In general, monoamine oxidase inhibitors (MAOIs) should be restricted to patients who do not respond to other treatments because of their potential for serious side effects and the necessity of dietary restrictions. Patients with major depressive disorder with atypical features are one group for whom several studies sug-

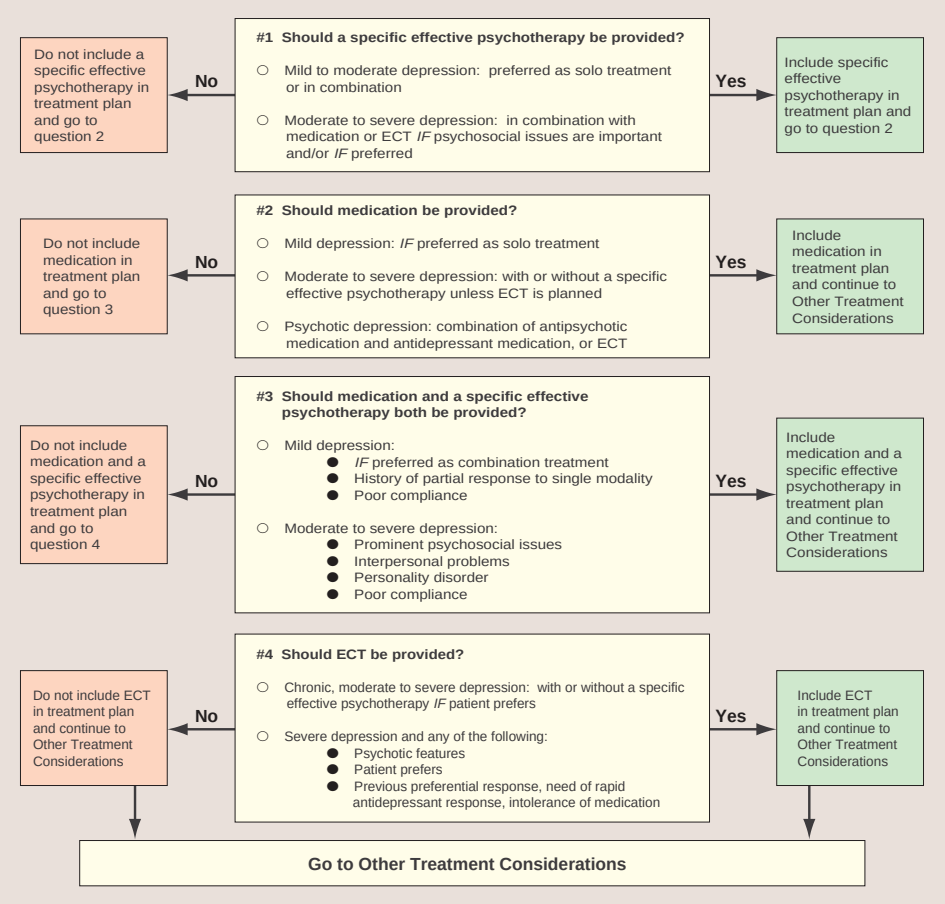

FIGURE 1. Choice of Treatment Modalities for Major Depressive Disorder.

gest MAOIs may be particularly effective; however, in clinical practice, many psychiatrists start with SSRIs in such patients because of the more favorable adverse effect profile.

a) Implementation

When pharmacotherapy is part of the treatment plan, it must be integrated with the psychiatric management and any other treatments that are being provided (e.g., psychotherapy) [I]. Once an antidepressant medication has been selected, it can be started at the dose levels suggested in Table 1 [I]. Titration to full therapeutic doses generally can be accomplished over the initial week(s) of treatment but may vary depending on the development of side effects, the patient's age, and the presence of comorbid illnesses. Patients who have started taking an antidepressant medication should be carefully monitored to assess their response to pharmacotherapy as well as the emergence of side effects, clinical condition, and safety [I] (see Figure 2). Factors to consider in determining the frequency of patient monitoring include the severity of illness, the patient's cooperation with treatment, the availability of social supports, and the presence of comorbid general medical problems. Visits should also be frequent enough to monitor and address suicidality and to promote treatment adherence. In practice, the frequency of monitoring during the acute phase of pharmacotherapy can vary from once a week in routine cases to multiple times per week in more complex cases.

TABLE 1. Commonly Used Antidepressant Medications (this list is representative, but not comprehensive)

Generic Name	Starting Dose (mg/day)[a]	Usual Dose (mg/day)
Tricyclics and tetracyclics		
Tertiary amine tricyclics		
Amitriptyline	25–50	100–300
Clomipramine	25	100–250
Doxepin	25–50	100–300
Imipramine	25–50	100–300
Trimipramine	25–50	100–300
Secondary amine tricyclics		
Desipramine[b]	25–50	100–300
Nortriptyline[b]	25	50–200
Protriptyline	10	15–60
Tetracyclics		
Amoxapine	50	100–400
Maprotiline	50	100–225
SSRIs[b]		
Citalopram	20	20–60[c]
Fluoxetine	20	20–60[c]
Fluvoxamine	50	50–300[c]
Paroxetine	20	20–60[c]
Sertraline	50	50–200[c]
Dopamine-norepinephrine reuptake inhibitors		
Bupropion[b]	150	300
Bupropion, sustained release[b]	150	300
Serotonin-norepinephrine reuptake inhibitors		
Venlafaxine[b]	37.5	75–225
Venlafaxine, extended release[b]	37.5	75–225
Serotonin modulators		
Nefazodone	50	150–300
Trazodone	50	75–300
Norepinephrine-serotonin modulator		
Mirtazapine	15	15–45
MAOIs		
Irreversible, nonselective		
Phenelzine	15	15–90
Tranylcypromine	10	30–60
Reversible MAOI-A		
Moclobemide	150	300–600
Selective noradrenaline reuptake inhibitor		
Reboxetine	—[d]	—[d]

[a]Lower starting doses are recommended for elderly patients and for patients with panic disorder, significant anxiety or hepatic disease, and general comorbidity.
[b]These medications are likely to be optimal medications in terms of the patient's acceptance of side effects, safety, and quantity and quality of clinical trial data.
[c]Dose varies with diagnosis; see text for specific guidelines.
[d]FDA approval is anticipated. When available, consult manufacturer's package insert or the Physician's Desk Reference for recommended starting and usual doses.

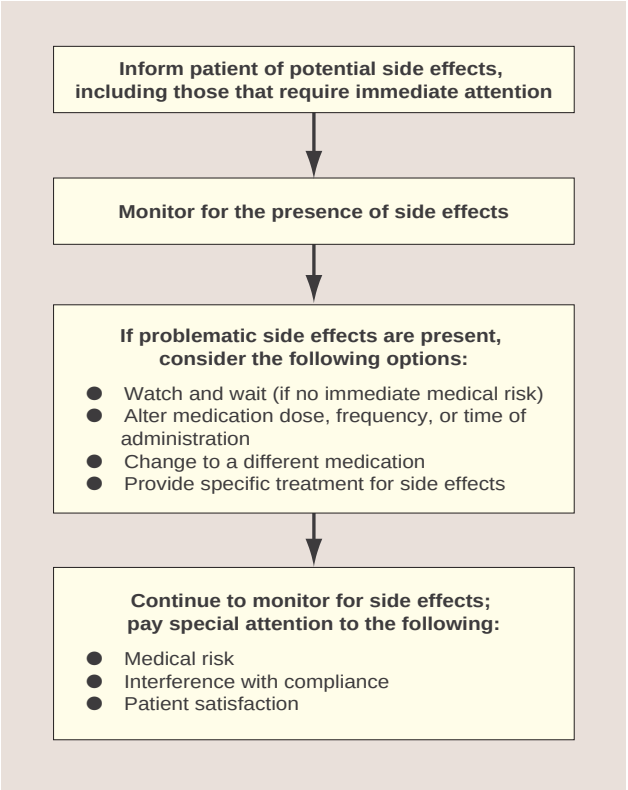

FIGURE 2. Management of Medication Side Effects.

b) Failure to respond

If at least moderate improvement is not observed following 6–8 weeks of pharmacotherapy, a reappraisal of the treatment regimen should be conducted [I]. Section II.B.2.b reviews options for adjusting the treatment regimen when necessary. Following any change in treatment, the patient should continue to be closely monitored. If there is not at least a moderate improvement in major depressive disorder symptoms after an additional 6–8 weeks of treatment, the psychiatrist should conduct another thorough review. An algorithm depicting the sequence of subsequent steps that can be taken for patients who fail to respond fully to treatment is provided in Figure 3.

3. Choice of specific psychotherapy

Cognitive behavioral therapy and interpersonal therapy are the psychotherapeutic approaches that have the best documented efficacy in the literature for the specific treatment of major depressive disorder, although rigorous studies evaluating the efficacy of psychodynamic psychotherapy have not been published [II]. When psychodynamic psychotherapy is used as a specific treatment, in addition to symptom relief, it is frequently associated with broader long-term goals. Patient preference and the availability of clinicians with appropriate training and expertise in the specific approach are also factors in the choice of a particular form of psychotherapy.

a) Implementation

When psychotherapy is part of the treatment plan, it must be integrated with the psychiatric management and any other treatments that are being provided (e.g., medication treatment) [I].

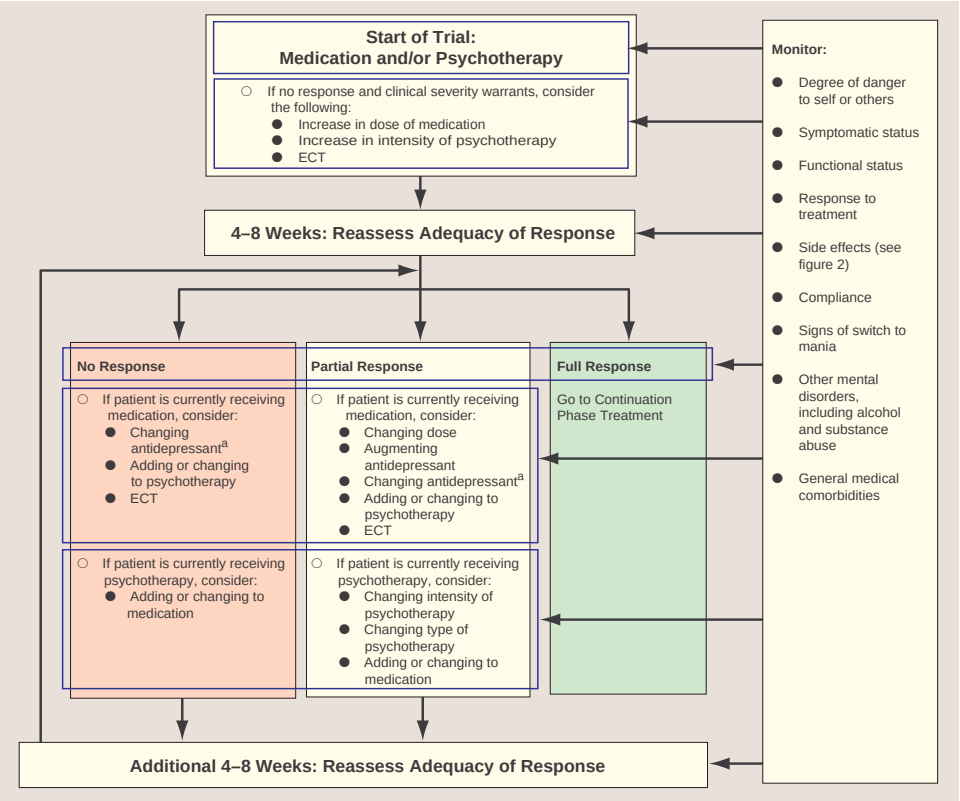

FIGURE 3. Acute Phase Treatment of Major Depressive Disorder.

[a]Choose either another antidepressant from the same class or, if two previous medication trials from the same class were ineffective, an antidepressant from a different class.

The optimal frequency of psychotherapy has not been rigorously studied in controlled trials. The psychiatrist should take into account multiple factors when determining the frequency for individual patients, including the specific type and goals of psychotherapy, the frequency necessary to create and maintain a therapeutic relationship, the frequency of visits required to ensure treatment adherence, and the frequency necessary to monitor and address suicidality. The frequency of outpatient visits during the acute phase generally varies from once a week in routine cases to as often as several times a week.

Regardless of the type of psychotherapy selected, the patient's response to treatment should be carefully monitored [I].

If more than one clinician is involved in providing the care, it is essential that all treating clinicians have sufficient ongoing contact with the patient and with each other to ensure that relevant information is available to guide treatment decisions [I].

b) Failure to respond

If after 4–8 weeks of treatment at least a moderate improvement is not observed, then a thorough review and reappraisal of the diagnosis, complicating conditions and issues, and treatment plan should be conducted [I]. Figure 3 and Section II.B.3.b review the options to consider.

TABLE 2. Considerations in the Decision to Use Maintenance Treatment

Factor	Component
Risk of recurrence	Number of prior episodes; presence of comorbid conditions; residual symptoms between episodes
Severity of episodes	Suicidality; psychotic features; severe functional impairments
Side effects experienced with continuous treatment	
Patient preferences	

4. Choice of medications plus psychotherapy

In general, the same issues that influence the specific choice of medication or psychotherapy when used alone should be considered when choosing treatments for patients receiving combined modalities [I].

5. Assessing the adequacy of response

It is not uncommon for patients to have a substantial but incomplete response in terms of symptom reduction or improvement in functioning during acute phase treatments. It is important not to conclude the acute phase of treatment for such patients, as a partial response is often associated with poor functional outcomes. When patients are found to have not fully responded to an acute phase treatment, a change in treatment should be considered as outlined in Figure 3 [II].

C. CONTINUATION PHASE

During the 16–20 weeks following remission, patients who have been treated with antidepressant medications in the acute phase should be maintained on these agents to prevent relapse [I]. In general, the dose used in the acute phase is also used in the continuation phase. Although there has been less study of the use of psychotherapy in the continuation phase to prevent relapse, there is growing evidence to support the use of a specific effective psychotherapy during the continuation phase [I]. Use of ECT in the continuation phase has received little formal study but may be useful in patients for whom medication or psychotherapy has not been effective in maintaining stability during the continuation phase [II]. The frequency of visits must be determined by the patient's clinical condition as well as the specific treatments being provided.

D. MAINTENANCE PHASE

Following the continuation phase, maintenance phase treatment should be considered for patients to prevent recurrences of major depressive disorder [I]. Factors to consider are discussed in Table 2 and in Section II.D.

In general, the treatment that was effective in the acute and continuation phases should be used in the maintenance phase [II]. In general, the same full antidepressant medication doses are employed as were used in prior phases of treatment; use of lower doses of antidepressant medication in the maintenance phase has not been well studied. For cognitive behavioral therapy and interpersonal therapy, maintenance phase treatments usually involve a decreased frequency of visits (e.g., once a month).

TABLE 3. Risk Factors for Recurrence of Major Depressive Disorder

- Prior history of multiple episodes of major depressive disorder
- Persistence of dysthymic symptoms after recovery from an episode of major depressive disorder
- Presence of an additional nonaffective psychiatric diagnosis
- Presence of a chronic general medical disorder

The frequency of visits in the maintenance phase must be determined by the patient's clinical condition as well as the specific treatments being provided. The frequency required could range from as low as once every 2–3 months for stable patients who require only psychiatric management and medication monitoring to as high as multiple times a week for those in whom psychodynamic psychotherapy is being conducted.

E. DISCONTINUATION OF ACTIVE TREATMENT

The decision to discontinue active treatment should be based on the same factors considered in the decision to initiate maintenance treatment, including the probability of recurrence, the frequency and severity of past episodes, the persistence of dysthymic symptoms after recovery, the presence of comorbid disorders, and patient preferences [I]. In addition to the factors listed in Table 2 and Table 3, patients and their psychiatrists should consider patient response, in terms of both beneficial and adverse effects, to maintenance treatments.

Specific clinical features that will influence the general treatment are discussed in Section III.

II. FORMULATION AND IMPLEMENTATION OF A TREATMENT PLAN

The following discussion regarding formulation and implementation of a treatment plan refers specifically to patients with major depressive disorder. For the treatment of patients found to have depressive symptoms within the context of bipolar disorder, readers should refer to the *Practice Guideline for the Treatment of Patients With Bipolar Disorder* (2). The treatment recommendations that follow may have some relevance for patients who have depressive symptoms on the basis of other syndromes, such as dysthymia, although this cannot be fully established with the existing scientific literature.

The successful treatment of patients with major depressive disorders is promoted by an initial thorough assessment of the patient. Treatment then consists of an acute phase lasting a minimum of 6–8 weeks, during which remission is induced. Remission is defined as a return to the patient's baseline level of symptom severity and functioning and should not be confused with substantial but incomplete improvement. After achieving remission, the patient enters the continuation phase, which usually lasts 16–20 weeks, during which time the remission is preserved and relapse is prevented. Relapse is generally defined as the reemergence of significant depressive symptoms or dysfunction following a remission. Patients who successfully complete the continuation phase without relapse then enter the maintenance phase of treatment. The goal during the maintenance phase is to protect susceptible patients against recurrence of subsequent major depressive episodes; the duration of the maintenance phase will vary depending on the frequency and severity of prior major depressive episodes.

Psychiatrists initiating treatment of an episode of major depressive disorder have at their disposal a number of medications, a variety of psychotherapeutic approaches, ECT, and other treatment modalities (e.g., light therapy). These various interventions may be used alone or in combination. The psychiatrist must determine the setting that will most likely ensure the patient's safety as well as promote improvement in the patient's condition.

A. PSYCHIATRIC MANAGEMENT

Psychiatric management consists of a broad array of interventions and activities that should be instituted by psychiatrists for all patients with major depressive disorder. The specific components of psychiatric management that must be addressed for all patients are described in more detail below.

1. Perform a diagnostic evaluation

Patients with major depressive disorder symptoms should receive a thorough diagnostic evaluation both to determine whether a diagnosis of depression is warranted and to reveal the presence of other psychiatric or general medical conditions. The general principles and components of a complete psychiatric evaluation have been outlined in the American Psychiatric Association's *Practice Guideline for Psychiatric Evaluation of Adults* (3). These should include a history of the present illness and current symptoms; a psychiatric history, including symptoms of mania as well as a treatment history that particularly notes current treatments and responses to previous treatments; a general medical history and history of substance use disorders; a personal history (e.g., psychological development, response to life transitions, and major life events); a social, occupational, and family history; a review of the patient's medications; a review of systems; a mental status examination; a physical examination; and diagnostic tests as indicated.

2. Evaluate the safety of patient and others

A careful assessment of the patient's risk for suicide is crucial. Some components of an evaluation for suicide risk are summarized in Table 4. An assessment of the presence of suicidal ideation is essential, including the degree to which the patient intends to act on any suicidal ideation and the extent to which the patient has made plans for or begun to prepare for suicide. The availability of means for suicide should be inquired about and a judgment made concerning the lethality of those means. Clinical factors that may increase the likelihood of a patient acting on suicidal ideation should be assessed, including the presence of psychotic symptoms, severe anxiety, panic attacks, and alcohol or substance use. Whether a patient has a history of making suicide attempts and the nature of those attempts should be evaluated. Patients should also be asked about suicide in their family history and recent exposure to suicide or suicide attempts by others. A complete assessment of suicide risk should be individualized to the particular circumstances of the patient and include an evaluation of the patient's strengths and motivation to seek help. Patients who are found to possess suicidal or homicidal ideation, intention, or plans require close monitoring. Measures such as hospitalization (involuntary when indicated) should be considered for those at significant risk. However, it should be kept in mind that the ability to predict suicide attempts and completed suicide is poor, with both many false positives (i.e., patients who appear more likely to make attempts or complete suicide but who do not) and false negatives (i.e., patients who appear less likely to make attempts or complete suicide but who do). For this reason, despite the best efforts of the psychiatrist, some patients may engage in self-harm or harm toward others.

TABLE 4. Components of an Evaluation for Suicide Risk

- Presence of suicidal or homicidal ideation, intent, or plans
- Access to means for suicide and the lethality of those means
- Presence of psychotic symptoms, command hallucinations, or severe anxiety
- Presence of alcohol or substance use
- History and seriousness of previous attempts
- Family history of or recent exposure to suicide

3. Evaluate functional impairments

Major depressive disorder is frequently associated with functional impairments, and the presence, type(s), and severity of dysfunction should be evaluated. Impairments can include deficits in interpersonal relationships, work, living conditions, and other medical or health-related needs. Identified impairments in functioning should be addressed; for example, some patients may require assistance in scheduling absences from work or other responsibilities, whereas others may require encouragement to not make any major life changes while in a major depressive disorder state. Patients should also be encouraged to set realistic, attainable goals for themselves in terms of desirable levels of functioning.

4. Determine a treatment setting

Treatment settings for patients with major depressive disorder include a continuum of possible levels of care, from involuntary hospitalizations to day programs to ambulatory settings. In general, patients should be treated in the setting that is most likely to prove safe and effective. The psychiatrist should choose an appropriate site of treatment after evaluating the patient's clinical condition, including symptom severity, comorbidity, suicidality, homicidality, level of functioning, and available support system. The determination of a treatment setting should also include consideration of patients' ability to adequately care for themselves, provide reliable feedback to the psychiatrist, and cooperate with treatment of their major depressive disorder.

Patients who exhibit suicidal or homicidal ideation, intention, or a plan require close monitoring. Hospitalization is usually indicated for patients who are considered to pose a serious threat of harm to themselves or others. If patients refuse, they can be hospitalized involuntarily if their condition meets criteria for involuntary admission of the local jurisdiction. Severely ill patients who lack adequate social support outside of a hospital setting should be considered for admission to a hospital or intensive day program. Additionally, those patients who also have complicating psychiatric or general medical conditions or who have not responded adequately to outpatient treatment may need to be hospitalized.

The optimal treatment setting and the patient's ability to benefit from a different level of care should be reevaluated on an ongoing basis throughout the course of treatment.

5. Establish and maintain a therapeutic alliance

Regardless of the treatment modalities ultimately selected for patients, it is important for the psychiatrist to establish a therapeutic alliance with the patient. Major depressive disorder is often a chronic condition that requires patients to actively participate and adhere to treatment plans for long periods. Unfortunately, features of major depressive disorder may include poor motivation, pessimism over the effectiveness of treatments, decrements in cognition such as attention or memory, decreased self-care, and possibly intentional self-harm. In addition, successful treatment may require patients to tolerate side effects. For these reasons, a strong treatment alliance between patient and psychiatrist is crucial. To establish and maintain a therapeutic alliance with patients, it is important for psychiatrists to pay attention to the concerns of patients

and their families as well as their wishes for treatment. Management of the therapeutic alliance should include awareness of transference and countertransference issues, even if these are not directly addressed in treatment.

6. Monitor the patient's psychiatric status and safety

As treatment progresses, different features and symptoms of the patient's illness may emerge or subside. Monitoring the patient's status for the emergence of changes in destructive impulses toward self or others is especially crucial; additional measures such as hospitalization or more intensive treatment should be considered for patients found to be at higher risk. The psychiatrist should be vigilant to changes in the patient's psychiatric status, including major depressive disorder symptoms as well as symptoms of other potential comorbid conditions. Significant changes in a patient's psychiatric status or the emergence of new symptoms may warrant a diagnostic reevaluation of the patient.

7. Provide education to the patient and, when appropriate, to the family

Education concerning major depressive disorder and its treatments should be provided to all patients. When appropriate, education should also be provided to involved family members. Specific educational elements may be especially helpful in some circumstances; for example, emphasizing that major depressive disorder is a real illness and that effective treatments are both necessary and available may be crucial for patients who attribute their illness to a moral defect or for family members who are convinced that there is nothing wrong with the patient. Education regarding available treatment options will help patients make informed decisions, anticipate side effects, and adhere to treatments.

8. Enhance treatment adherence

The successful treatment of major depressive disorder requires close adherence to treatment plans, in some cases for long or indefinite durations. Especially while symptomatic, patients with major depressive disorder may be poorly motivated, unduly pessimistic over their chances of recovery with treatment, suffering from deficits in memory, or taking less care of themselves. In addition, the side effects or requirements of treatments may lead to nonadherence. Particularly during the maintenance phase, euthymic patients may tend to undervalue the benefits of treatment and focus on the burdens of treatment. Psychiatrists should recognize these possibilities, encourage the patient to articulate any concerns regarding adherence, and emphasize the importance of adherence for successful treatment. Specific components of a message to patients that have been shown to improve adherence include emphasizing: 1) when and how often to take the medicine; 2) the need for at least 2–4 weeks before beneficial effects may be noticed; 3) the need to take medication even after feeling better; 4) the need to consult with the doctor before discontinuing medication; and 5) what to do if problems or questions arise (4). Some patients, particularly elderly patients, have been shown to have improved adherence when both the complexity of medication regimens and the costs of treatments are minimized. Severe or persistent problems of nonadherence may represent psychological conflicts or psychopathology for which psychotherapy should be considered. When family members are involved, they can also be encouraged to play a helpful role in improving adherence.

9. Work with the patient to address early signs of relapse

Given the chronic, episodic nature of major depressive disorder, exacerbations are common. Patients, as well as their families if appropriate, should be instructed about the significant risk of relapse. They should be educated to identify early signs and symptoms of new episodes. Patients should also be instructed to seek adequate treatment as early in the course of the new episode as possible to decrease the likelihood of a full-blown exacerbation or complications.

B. ACUTE PHASE

1. Choice of initial treatment modality

In the acute phase, in addition to psychiatric management, the psychiatrist may choose between several initial treatment modalities, including pharmacotherapy, psychotherapy, the combination of medications and psychotherapy, or ECT. A discussion of the potential role of other treatments (e.g., light therapy and St. John's wort) can be found in Section V. Selection of an initial treatment modality should be influenced by both clinical (e.g., severity of symptoms) and other factors (e.g., patient preference) (Figure 1).

a) Antidepressant medications

When pharmacotherapy is part of the treatment plan, it must be integrated with the psychiatric management and any other treatments that are being provided (e.g., psychotherapy). Antidepressant medications can be used as an initial treatment modality by patients with mild, moderate, or severe major depressive disorder. Clinical features that may suggest that medications are the preferred treatment modality include history of prior positive response to antidepressant medications, severity of symptoms, significant sleep and appetite disturbances or agitation, or anticipation of the need for maintenance therapy. Other issues that may be important considerations in the decision to use antidepressant medication include patient preference or the lack of available adequate alternative treatment modalities. Patients with major depressive disorder with psychotic features require either the combined use of antidepressant and antipsychotic medications or ECT.

b) Psychotherapy

A specific, effective psychotherapy alone may be considered as an initial treatment modality for patients with mild to moderate major depressive disorder. Clinical features that may suggest the use of a specific psychotherapy include the presence of significant psychosocial stressors, intrapsychic conflict, interpersonal difficulties, or axis II comorbidity. Patient preference for psychotherapeutic approaches is an important factor that should be considered in the decision to use psychotherapy as the initial treatment modality. Pregnancy, lactation, or the wish to become pregnant may also be an indication for psychotherapy as an initial treatment.

c) Psychotherapy plus antidepressant medications

The combination of a specific effective psychotherapy and medication may be a useful initial treatment choice for patients with psychosocial issues, intrapsychic conflict, interpersonal problems, or a comorbid axis II disorder together with moderate to severe major depressive disorder. In addition, patients who have had a history of only partial response to adequate trials of single treatment modalities may benefit from combined treatment. Poor adherence with treatments may also warrant combined treatment with pharmacotherapy and psychotherapeutic approaches that focus on treatment adherence.

d) Electroconvulsive therapy

ECT should be considered for patients with major depressive disorder with a high degree of symptom severity and functional impairment as well as in cases in which psychotic symptoms or catatonia are present. ECT may also be the treatment modality of choice for patients in whom there is an urgent need for response, such as patients who are suicidal or who are refusing food and are nutritionally compromised. The presence of comorbid general medical conditions that preclude the use of antidepressant medications, a prior history of positive response to ECT, and patient preference are other important considerations that may influence the psychiatrist's decision to select ECT as a treatment modality.

TABLE 5. Factors to Consider in Choosing a First-Line Antidepressant Medication

- Anticipated side effects and their safety or tolerability
- History of prior response in patient or family member
- Patient preference
- Cost
- Quantity and quality of clinical trial data
- MAOIs: generally reserve for patients who do not respond to other treatments
- SSRIs or MAOIs: consider for patients with atypical symptoms

2. Choice of specific pharmacologic treatment

Antidepressant medications that have been shown to be effective are listed in Table 1. The effectiveness of antidepressant medications is generally comparable between classes and within classes of medications. Therefore, the initial selection of an antidepressant medication will largely be based on the anticipated side effects, the safety or tolerability of these side effects for individual patients, patient preference, quantity and quality of clinical trial data regarding the medication, and its cost (Table 5). On the basis of these considerations, the following medications are likely to be optimal agents for most patients: SSRIs, desipramine, nortriptyline, bupropion, and venlafaxine. Additional considerations that may influence the choice of antidepressant medication include a history of prior response to a medication and the presence of comorbid psychiatric or general medical conditions. For example, secondary amine tricyclic antidepressant medications may not be optimal in patients with cardiovascular conditions, cardiac conduction defects, closed-angle glaucoma, urinary retention, or significant prostatic hypertrophy. SSRIs can carry a risk of sexual side effects and may be more expensive because of the lack of currently available generic preparations. Similarly, the specific side effect profiles and higher costs should be considerations in decisions regarding use of other newer antidepressant medications. In general, MAOIs should be restricted to patients who do not respond to other treatments because of their potential for serious side effects and the necessity of dietary restrictions. Patients with major depressive disorder with atypical features are one group for whom several studies suggest MAOIs may be particularly effective; however, in clinical practice, many psychiatrists start with SSRIs in such patients because of the more favorable adverse effect profile.

a) Implementation of pharmacotherapy

Once an antidepressant medication has been selected it can be started at doses suggested in Table 1. Titration of the dose to full therapeutic doses generally can be accomplished over the initial week(s) of treatment but may vary depending on the development of side effects, the patient's age, and the presence of comorbid conditions. In elderly or medically frail patients, the starting and therapeutic doses should be reduced, generally to half of the usual adult doses.

Patients who have started taking an antidepressant medication should be carefully monitored to assess the response to pharmacotherapy as well as the emergence of side effects, clinical condition, and safety (see Figure 2). There are limited clinical trial data to guide the decision regarding the frequency of monitoring patients during pharmacotherapy. Factors to consider when determining this frequency include the severity of illness, the patient's cooperation with treatment, the availability of social supports, and the presence of comorbid general medical problems. Visits should also be frequent enough to monitor and address suicidality and to promote treatment adherence. Experienced researchers have found that patients in clinical trials appear to benefit from monitoring once a week or more to enhance adherence rates and to avoid the demoralization that may occur before the onset of beneficial effects. In clinical practice, the frequency of monitoring during the acute phase of pharmacotherapy may vary from once a week in routine cases to multiple times per week in more complex cases. The method of monitoring may vary depending upon the clinical context (e.g., face-to-face visits, telephone contact, or contact with another clinician knowledgeable about the patient and the treatment modality).

TABLE 6. Required Washout Times Between Antidepressant Trials

Antidepressant Change	Minimum Washout Period
To MAOI from drug with long-half-life metabolites (e.g., fluoxetine)	5 weeks
To MAOI from drug without long-half-life metabolites (e.g., tricyclic antidepressant, paroxetine, fluvoxamine, venlafaxine) or other MAOI	2 weeks
To non-MAOI antidepressant from MAOI	2 weeks

Improvement with pharmacotherapy can be observed after 4–8 weeks of treatment. If at least a moderate improvement is not observed in this time period, reappraisal and adjustment of the pharmacotherapy should be considered.

b) Failure to respond

If at least moderate improvement is not observed following 4–8 weeks of pharmacotherapy, a reappraisal of the treatment regimen should be conducted. An algorithm depicting the sequence of subsequent steps that can be taken and possible outcomes for patients who do not respond fully to treatment is provided in Figure 3. It is important to keep in mind when employing such algorithms that they are based largely on clinical experience and only limited clinical trial data.

First, patient adherence and pharmacokinetic/pharmacodynamic factors affecting treatment should be investigated, in some cases through determination of serum antidepressant medication levels. Following this review, the treatment plan can be revised by implementing one of several therapeutic options, including maximizing the initial medication treatment, switching to another non-MAOI antidepressant medication (Table 1 and Table 6), augmenting antidepressant medications with other agents or psychotherapy, using an MAOI, or ECT (5).

Maximizing the initial treatment regimen is perhaps the most conservative strategy. For patients who have shown a partial response, particularly those with features of personality disorders, extending the antidepressant medication trial (e.g., by 2–4 weeks) may allow some patients to respond more fully (6). Use of higher antidepressant doses may be helpful for patients who have received only modest doses or for those who for pharmacodynamic reasons have low serum drug levels despite usual doses and adherence. Patients who have had their dose increased should be monitored for an increase in the severity of side effects.

Switching to a different non-MAOI antidepressant medication is a common strategy for treatment-refractory patients, especially those who have not shown at least partial response to the initial medication regimen. Patients can be switched to a non-MAOI antidepressant medication from the same pharmacologic class (e.g., from an SSRI to another SSRI) or to one from a different pharmacologic class (e.g., from an SSRI to a tricyclic antidepressant) (see Table 1 and Table 6) (5).

Augmentation of non-MAOI antidepressant medications may be helpful, particularly for patients who have had a partial response to antidepressant monotherapy. Options include adding a second non-MAOI antidepressant medication from a different pharmacologic class, taking care to avoid drug-drug interactions, or adding another adjunctive medication such as lithium, thyroid hormone, an anticonvulsant, or psychostimulants.

Adding, changing, or increasing the intensity of psychotherapy should be considered for patients with major depressive disorder who do not respond to medication treatment. Additional strategies for patients who do not respond adequately to treatment include switching to an MAOI after allowing sufficient time between medications to avoid hazardous interactions. ECT also remains perhaps the most effective therapy for treatment-resistant patients.

Following any change in treatment, the patient should continue to be closely monitored. If there is not at least a moderate improvement in major depressive disorder symptoms after an additional 4–8 weeks of treatment, the psychiatrist should conduct another thorough review. This reappraisal should include the following: verifying the patient's diagnosis and adherence; uncovering and addressing clinical factors that may be preventing improvement, such as the presence of comorbid general medical conditions or psychiatric conditions (e.g., alcohol or substance abuse); and uncovering and addressing psychosocial issues that may be impeding recovery. If no new information is uncovered to explain the patient's lack of adequate response, other treatment options should be considered, including obtaining a consultation and possibly ECT.

3. Choice of a specific psychotherapy

Cognitive behavioral therapy and interpersonal therapy have the best-documented effectiveness in the literature for the specific treatment of major depressive disorder. When psychodynamic psychotherapy is used as a specific treatment, in addition to symptom relief, it is frequently associated with broader long-term goals. Patient preference and the availability of clinicians with appropriate training and expertise in specific psychotherapeutic approaches are also factors in the choice of a particular form of psychotherapy. Other clinical factors influencing the type of psychotherapy employed are the stage and severity of the major depressive disorder episode. For example, although some data suggest that cognitive behavioral therapy alone may be effective for patients with moderate to severe major depressive disorder, most such patients will require medication. In general, the choice among psychotherapeutic approaches is dependent on patient preference, with particular regard to whether the goals are mainly symptomatic improvement versus broader psychosocial goals.

During the initial phases of treatment for patients with moderate to severe major depressive disorder, psychiatric management will have to include support and psychoeducation for the patient and the family, permission for the patient to excuse himself or herself from duties impossible to perform, and assistance regarding the making or postponing of major personal and business decisions. Some patients at this stage may not have the emotional energy or cognitive ability required for insight-oriented psychotherapy. If indicated, this may be initiated later in the course of recovery.

a) Implementation

When psychotherapy is part of the treatment plan, it must be integrated with the psychiatric management and any other treatments that are being provided (e.g., medication treatment). The optimal frequency of psychotherapy has not been rigorously studied in controlled trials. The psychiatrist should take into account multiple factors when determining the frequency for individual patients, including the specific type and goals of the psychotherapy, the frequency necessary to create and maintain a therapeutic relationship, the frequency of visits required to ensure treatment adherence, and the frequency necessary to monitor and address suicidality. Also affecting the frequency of psychotherapy visits are the severity of illness, the patient's cooperation with treatment, the availability of social supports, cost, geographic accessibility, and presence of comorbid general medical problems. The frequency of outpatient visits during the acute phase generally varies from once a week in routine cases to as often as several times a week. Transference-focused treatments tend to require more frequent and regular visits.

Regardless of the type of psychotherapy selected, the patient's response to treatment should be carefully monitored. If after 4–8 weeks of treatment at least a moderate improvement is not observed, then a thorough review and reappraisal of the treatment plan should be conducted.

There are no definitive studies to determine when it is preferable to have the psychiatrist provide all treatments (sometimes referred to as the "integrated" model) versus when it might be preferable to have a different clinician provide the psychotherapy, with the psychiatrist providing the psychiatric management and the medication (sometimes referred to as "split" treat-

ment). The expertise of the psychiatrist in providing the desired type of psychotherapy and the preferences of the patient are frequently factors in the decision. The integrated treatment model provides for better coordination of care. Lower costs have been used as a rationale in support of the split-treatment model. However, it is not clear that the costs of that model are actually lower than for the integrated model (7).

If the split model is used, it is essential that the psychiatrist who is providing the psychiatric management and the medication treatment meets with the patient frequently enough to monitor his or her care. It is also essential that the two (or more) treating clinicians have sufficient ongoing contact to ensure that relevant information is available to guide treatment decisions.

b) Failure to respond

The patient's condition and response to therapeutic interventions should be carefully monitored from the outset of psychotherapy. If the patient's condition fails to stabilize or is deteriorating, reassessment is indicated (8). If after 4–8 weeks of treatment at least a moderate improvement is not observed, then a thorough review and reappraisal of the diagnosis, complicating conditions and issues, and treatment plan should be conducted. In many cases, the treatment plan can be revised by the addition or substitution of pharmacotherapy (see Figure 3). Following any revision or refinement of treatment, the patient should continue to be closely monitored. If there continues to not be at least a moderate improvement in major depressive disorder symptoms after an additional 4–8 weeks of treatment, another thorough review, reappraisal, and revision of the treatment plan should be conducted.

4. Choice of medications plus psychotherapy

There are relatively few empirical data from clinical trials to help guide the selection of particular antidepressant medications and psychotherapeutic approaches for individuals who will receive the combination of both modalities. In general, the same issues that influence these decisions when choosing a monotherapy will apply, and the same doses of antidepressant medication and the same frequency and course of psychotherapy should be used for patients receiving combination modality treatments as those employed for patients receiving them as a monotherapy.

Patients receiving combined antidepressant medication and psychotherapy should also be monitored closely for treatment effect, side effects, clinical condition, and safety. If after 4–8 weeks there is not at least a moderate improvement, a thorough review should be conducted, including of the patient's adherence and pharmacokinetic/pharmacodynamic factors affecting treatment. The treatment plan can be revised by using many of the same therapeutic options described for patients who have not responded to treatment with either modality alone. Following any change in treatment, the patient should continue to be monitored, and if there is not at least a moderate improvement in major depressive disorder symptoms after an additional 4–8 weeks of treatment, another thorough review should be conducted. Other treatment options should be considered, including clinical consultation or possibly ECT.

5. Assessing the adequacy of treatment response

The goal of acute phase treatment for major depressive disorder is to return patients to their baseline levels of symptomatic and functional status. However, it is not uncommon for patients to have a substantial but incomplete response in terms of symptom reduction or improvement in functioning during acute phase treatment. It is important not to conclude the acute phase of treatment for such patients, as a partial response is often associated with poor functional outcomes.

Identifying patients who have not had a complete response to treatment and formally assessing the extent to which patients have returned to their baseline may be aided by the use of structured measures of depression symptom severity and functional status. When patients are found to have not fully responded to an acute phase treatment, a change in treatment should be considered, as outlined in Figure 3.

C. CONTINUATION PHASE

During the 16–20 weeks following remission, patients who have been treated with antidepressant medications in the acute phase should be maintained with these agents to prevent relapse. In general, the dose used in the acute phase is also used in the continuation phase. Some psychiatrists combine a decrease in the dose with careful monitoring in the continuation phase; however, there are no data to support the effectiveness of this approach. Although there has been less study of the use of psychotherapy in the continuation phase to prevent relapse, there is growing evidence to support the use of a specific effective psychotherapy during the continuation phase. Use of ECT in the continuation phase has received little formal study. The frequency of visits must be determined by the patient's clinical condition as well as the specific treatments being provided.

During the continuation phase, the frequency of visits may vary. For stable patients in whom the visits are for the purpose of providing psychiatric management, the frequency could be once every 2–3 months. For other patients, such as those in whom active psychotherapy is being conducted, the frequency required may be as high as multiple times a week. If maintenance phase treatment is not indicated for patients who remain stable following the continuation phase, patients may be considered for discontinuation of treatment. If treatment is discontinued, patients should be carefully monitored for relapse, and treatment should be promptly reinstituted if relapse occurs.

D. MAINTENANCE PHASE

On average, 50%–85% of patients with a single episode of major depressive disorder will have at least one more episode. Therefore, following the continuation phase, maintenance phase treatment should be considered for patients to prevent recurrences of major depressive episodes. Factors that should be considered when deciding whether to use maintenance treatment are summarized in Table 2.

In general, the treatment that was effective in the acute and continuation phases should be used in the maintenance phase. In general, the same full antidepressant medication doses are employed as were used in prior phases of treatment; use of lower doses of antidepressant medication in the maintenance phase has not been well studied. For cognitive behavioral therapy and interpersonal therapy, maintenance phase treatments usually involve a decrease in frequency of visits (e.g., once a month). Psychodynamic psychotherapy usually continues at the same frequency in the effort to explore the role of axis II disorders or other psychological factors in predisposing to depressive episodes.

Although the effectiveness of combinations of antidepressant medication and psychotherapy in the maintenance phase has not been well studied, such combinations may be an option for some patients. Patients who exhibit repeated episodes of moderate or severe major depressive disorder despite optimal pharmacologic treatment or patients who are medically ineligible for such treatment may be maintained with periodic ECT. There has been little formal study of other treatment modalities in the maintenance phase.

Similar to the continuation phase, the frequency of visits may vary in the maintenance phase. The frequency required could range from as low as once every several months for stable patients who require only psychiatric management and medication monitoring to as high as once or twice per week for those in whom psychodynamic psychotherapy is being conducted. Maintenance ECT is usually administered monthly; individuals for whom this is insufficient may find treatment at more frequent intervals to be beneficial. The optimal length of maintenance treatment is not known and may also vary depending on the frequency and severity of recurrences, tolerability of treatments, and patient preferences. For some patients, maintenance treatment may be required indefinitely.

E. DISCONTINUATION OF ACTIVE TREATMENT

The precise timing and method of discontinuing psychotherapy and pharmacotherapy for depression have not been systematically studied. The decision to discontinue maintenance treatment should be based on the same factors considered in the decision to initiate maintenance treatment, including the probability of recurrence, the frequency and severity of past episodes, the persistence of depressive symptoms after recovery, the presence of comorbid disorders, and patient preferences. In addition to the factors listed in Table 2 and Table 3, patients and their psychiatrists should consider patient response, in terms of both beneficial and adverse effects, to maintenance treatments.

When the decision is made to discontinue or terminate psychotherapy in the maintenance phase, the manner in which this is done should be individualized to the patient's needs and will depend on the type of psychotherapy, duration, and intensity of treatment. For example, maintenance treatment with cognitive behavioral therapy may have been of a preplanned length and not require extensive time for termination; on the other hand, a long-term psychodynamic psychotherapy may require greater time for and attention to the termination process.

When the decision is made to discontinue maintenance pharmacotherapy, it is best to taper the medication over the course of at least several weeks. Such tapering may allow for the detection of emerging symptoms or recurrences when patients are still partially treated and therefore more easily returned to full therapeutic intensity. In addition, such tapering can help minimize the risks of antidepressant medication discontinuation syndromes (9). Discontinuation syndromes are problematic because their symptoms include disturbances of mood, energy, sleep, and appetite and can be mistaken for or mask signs of relapse (10). Discontinuation syndromes have been found to be more frequent after discontinuation of medications with shorter half-lives, and patients maintained on short-acting agents should be given even longer, more gradual tapering (11).

After the discontinuation of active treatment, patients should be reminded of the potential for a depressive relapse. Early signs of major depressive disorder should be reviewed, and a plan for seeking treatment in the event of recurrence of symptoms should be established. Patients should continue to be monitored over the next several months to identify those in whom a relapse has occurred. If a patient suffers a relapse upon discontinuation of medication, treatment should be promptly reinitiated. In general, the previous treatment regimen to which the patient responded in the acute and continuation phases should be considered. Patients who relapse following discontinuation of antidepressant medication therapy should be considered to have suffered from another major depressive disorder episode and should receive another round of adequate acute phase treatment followed by continuation phase treatment and possibly maintenance phase treatment.

III. SPECIFIC CLINICAL FEATURES INFLUENCING THE TREATMENT PLAN

A. PSYCHIATRIC FEATURES

1. Suicide risk

Patients with major depressive disorder are at greater risk for suicide. Suicide risk should be assessed initially and over the course of treatment. If the patient has suicidal ideation, intention, or a plan, close surveillance is necessary. Factors to be considered in determining the nature and intensity of treatment include (but are not limited to) the nature of the doctor-patient alliance, the availability and adequacy of social supports, access to and lethality of suicide means, and

past history of suicidal behavior. The risk of suicide in some patients recovering from major depressive disorder increases transiently as they develop the energy and capacity to act on self-destructive plans made earlier in the course of their illness. Clinicians must be aware of the risk of suicide throughout the course of treatment. However, the prediction of suicide attempts or suicide completion for any given patient is extremely difficult, with both many false positives (patients who appear to be at greater risk of making attempts or completing suicide but who do not) and false negatives (patients who appear to be at decreased risk but who ultimately do make attempts or complete suicide). Therefore, even with the best possible care, a small proportion of patients with major depressive disorder are likely to die by suicide.

2. Psychotic features

Major depressive disorder with psychotic features carries a higher risk of suicide than does major depressive disorder uncomplicated by psychosis (12), and it constitutes a risk factor for recurrent major depressive disorder. Major depressive disorder with psychotic features responds better to treatment with a combination of an antipsychotic medication and an antidepressant medication than to treatment with either component alone (13). Lithium augmentation is helpful in some patients who have not responded to combined antidepressant-antipsychotic medication treatment (14). ECT is highly effective in major depressive disorder with psychotic features and may be considered a first-line treatment for this disorder (15).

3. Catatonic features

Catatonic features may occur in the context of mood disorders and are characterized by at least two of the following manifestations: motoric immobility, as evidenced by catalepsy or stupor; extreme agitation; extreme negativism; peculiarities of voluntary movement, as evidenced by posturing, stereotyped movements, mannerisms, or grimacing; and echolalia or echopraxia (16). Catatonia often dominates the presentation and may be so severe as to be life-threatening, compelling the consideration of urgent biological treatment. Immediate relief may often be obtained by the intravenous administration of benzodiazepines such as lorazepam or amobarbital. For patients who show some relief, continued oral administration of lorazepam, diazepam, or amobarbital may be helpful. Concurrent antidepressant medication treatments should be considered. When relief is not immediately obtained by administering barbiturates or benzodiazepines, the urgent provision of ECT should be considered. The efficacy of ECT, usually apparent after a few treatments, is well documented; ECT may initially be administered daily. After the catatonic manifestations are relieved, treatment may be continued with antidepressant medications, lithium, antipsychotics, or a combination of these compounds, as determined by the patient's condition.

4. Atypical features

Atypical major depressive disorder features include vegetative symptoms of reversed polarity (i.e., increased rather than decreased sleep, appetite, and weight), marked mood reactivity, sensitivity to emotional rejection, phobic symptoms, and a sense of severe fatigue that creates a sensation of leaden paralysis or extreme heaviness of the arms or legs (17). Patients need not have all of these features to be diagnosed as having atypical major depressive disorder (18). There is some overlap between patients with atypical major depressive disorder and patients with anergic bipolar major depressive disorder. Although tricyclic antidepressant medications yield response rates of only 35%–50% in patients with atypical major depressive disorder, several other antidepressant classes have been found to be more effective, yielding response rates of 55%–75% (comparable to the response rate of typical forms of major depressive disorder to tricyclic therapy) (19, 20). Results of several studies suggest that SSRIs, MAOIs, and possibly bupropion may be more effective treatments for atypical major depressive disorder (21–23). The presence and severity of specific symptoms as well as safety considerations should help

guide the choice of treatment for atypical major depressive disorder. For example, if a patient does not wish to, cannot, or is unlikely to adhere to the dietary and medication precautions associated with MAOI treatment, the use of an alternative antidepressant medication is indicated; on the other hand, bupropion may be anxiogenic and not preferred in cases where anxiety predominates.

5. Alcohol or substance abuse or dependence

Because of the frequent comorbidity of major depressive disorder and alcohol or other substance abuse, the psychiatrist should make every effort to obtain a detailed history of the patient's substance use. If there is suspicion that there is a problem in this area, the clinician should consider questioning a collateral for confirmation. If the patient is found to have a substance use disorder, a program to secure abstinence should be regarded as a principal priority in the treatment. A patient suffering from major depressive disorder with comorbid addiction is more likely to require hospitalization, more likely to attempt suicide, and less likely to comply with treatment than is a patient with major depressive disorder of similar severity not complicated by this factor. Some alcohol- and chemical-abusing patients reduce their consumption of these substances upon remediation of an underlying major depressive disorder, making the recognition and treatment of major depressive disorder doubly important for such individuals.

It is advisable, if other factors permit, to detoxify patients before initiating antidepressant medication therapy. Identifying the patients who should be started on a regimen of antidepressant medication therapy earlier, after initiation of abstinence, is difficult. A positive family history of major depressive disorder, a history of major depressive disorder preceding alcohol or other substance abuse, or a history of major depressive disorder during periods of sobriety raises the likelihood that the patient would benefit from antidepressant medication treatment, which may then be started earlier in treatment.

Concurrent drug abuse, especially with stimulant drugs, predisposes the patient to toxic interactions with MAOIs, although there have been few reports of such events (24). Benzodiazepines and other sedative-hypnotics carry the potential for abuse or dependence and should be used cautiously except as part of a detoxification regimen. Benzodiazepines have also been reported to contribute to major depressive disorder symptoms. Hepatic dysfunction and hepatic enzyme induction frequently complicate pharmacotherapy of patients with alcoholism and other substance abuse; these conditions may require careful monitoring of blood levels (if available), therapeutic effects, and side effects to avoid either psychotropic medication intoxication or inadequate treatment.

6. Comorbid panic or other anxiety disorder

Panic disorder complicates major depressive disorder in 15%–30% of the cases (25). Individuals with symptoms of both disorders manifest greater degrees of impairment than do patients with major depressive disorder only. In major depressive disorder with comorbid anxiety or panic disorder, both the major depressive disorder symptoms and anxiety symptoms have been shown to respond to antidepressant medication treatment (26). Although there is some evidence that MAOIs may be more effective than other classes for patients with major depressive disorder and anxiety symptoms (25), therapy should first be initiated with a non-MAOI agent because of the somewhat greater complications associated with MAOIs. Tricyclic antidepressant medications and SSRIs may initially worsen rather than alleviate anxiety and panic symptoms; these medications should therefore be introduced at a low dose and slowly increased when used to treat such patients. Bupropion has been reported as ineffective in the treatment of panic disorder (27). Alprazolam may sometimes be used with benefit in conjunction with antidepressant medications; in general, benzodiazepines should not be used as the primary pharmacologic agent for patients with major depressive disorder and anxiety symptoms, especially patients with more severe forms of major depressive disorder.

Obsessive-compulsive symptoms are also more common in patients with major depressive disorder episodes. Clomipramine and the SSRIs have demonstrated efficacy in the management of obsessive-compulsive symptoms in addition to also being effective antidepressant medications (28, 29). Such agents may be used to good effect when obsessive symptoms accompany an episode of major depressive disorder.

7. Major depressive disorder–related cognitive dysfunction (pseudodementia)

Major depressive disorder is routinely accompanied by signs and symptoms of cognitive inefficiency. Some patients have both major depressive disorder and dementia, while others have major depressive disorder that causes cognitive impairment (i.e., pseudodementia). In the latter case, the treatment of the major depressive disorder should reverse the signs and symptoms of cognitive dysfunction. Many patients complain that their thoughts are slowed and their capacity to process information is reduced; they also display diminished attention to their self-care and to their environment. Transient cognitive impairments, especially involving attention, concentration, and memory storage and retrieval, are demonstrable through neuropsychological testing (30). In extreme examples, especially in the elderly, these complaints and deficits are so prominent that patients may appear demented. Major depressive disorder–related cognitive dysfunction is a reversible condition that resolves with treatment of the underlying major depressive disorder. Several clinical features help differentiate major depressive disorder pseudodementia from true dementia. When performing cognitive tasks, pseudodemented patients generally exert relatively less effort but report more incapacity than do demented patients. The latter group, especially in more advanced stages, typically neither recognize nor complain of their cognitive failures, since insight is impaired; in comparison, pseudodemented patients characteristically complain bitterly that they cannot think or cannot remember. Major depressive disorder pseudodementia lacks the signs of cortical dysfunction (i.e., aphasia, apraxia, agnosia) encountered in degenerative dementia, such as Alzheimer's disease (31). It is vital that individuals with major depressive disorder–related cognitive disturbance not be misdiagnosed and thereby denied vigorous antidepressant medication treatment or ECT.

8. Dysthymia

Antidepressant medications have been found to be effective in the treatment of dysthymia and chronic major depressive disorder, including tricyclic antidepressants, SSRIs, other newer agents, and MAOIs; unfortunately, there is little evidence from clinical trials regarding the relative efficacies of particular agents (1, 32, 33). In general, the manner in which antidepressive agents are implemented for dysthymia is similar to that for episodes of major depressive disorder; responses to antidepressant medications by patients with dysthymia and chronic major depressive disorder have been shown to be comparable to the responses by patients with major depressive disorder episodes (34).

Psychotherapy, including interpersonal therapy, cognitive behavioral therapy, cognitive therapy, and behavior therapy, has also been shown to be effective in treating patients with dysthymia and chronic major depressive disorder, although responses have been somewhat smaller than when these modalities are used to treat patients with major depressive disorder (34, 35). Individuals with chronic major depressive disorder may also be considered for psychodynamic psychotherapy in order to examine psychological factors that may maintain the depressed disposition. The combination of psychotherapy and medication has been shown to be more effective than medication alone in patients with dysthymia (36–38).

Double depression is the term used to describe the common condition of a patient with chronic dysthymia who suffers the additional burden of a more severe and pervasive episode of major depressive disorder. Antidepressant medication treatment has been shown to reverse not only the acute major depressive disorder episode but also the underlying chronic dysthymia (39).

9. Comorbid personality disorders

People with any of a variety of personality disorders, including obsessive-compulsive, avoidant, dependent, and borderline disorders, are prone to episodes of major depressive disorder (40). Clinical experience indicates that patients with narcissistic personality disorder are also particularly vulnerable to episodes of major depressive disorder. Patients with major depressive disorder who meet criteria for borderline personality disorder frequently exhibit atypical features, including mood reactivity, and may be more likely to respond to MAOIs and SSRIs than to tricyclic antidepressants (41). Patients with virtually any form of personality disorder exhibit less satisfactory antidepressant medication treatment response, in terms of both social functioning and residual major depressive disorder symptoms, than do individuals without personality disorders (42). Psychodynamic psychotherapy, including psychoanalysis, may be beneficial in modifying the personality disorder in selected patients. Antisocial personality traits tend to interfere with treatment adherence and development of a psychotherapeutic relationship.

10. Seasonal major depressive disorder

Some individuals suffer annual episodes of major depressive disorder with onset in the fall or early winter, usually at the same time each year. Some of these patients suffer manic or hypomanic episodes as well. The major depressive disorder episodes frequently have atypical features such as hypersomnia and overeating. The entire range of treatments for major depressive disorder may also be used to treat seasonal affective disorder, either in combination with or as an alternative to light therapy. As a primary form of treatment, light therapy may be recommended as a time-limited trial (43), primarily in outpatients with clear seasonal patterns. In patients with more severe forms of seasonal major depressive disorder, its use is considered adjunctive to psychopharmacologic intervention.

B. DEMOGRAPHIC AND PSYCHOSOCIAL VARIABLES

1. Major psychosocial stressors

Major depressive disorder may follow a substantial adverse life event, especially one that involves the loss of an important human relationship or life role. Major depressive disorder episodes following life stresses are no less likely than other depressive episodes to either require or benefit from antidepressant medication treatment. Nonetheless, attention to the relationship of both prior and concurrent life events to the onset, exacerbation, or maintenance of major depressive disorder symptoms is an important aspect of the overall treatment approach. A close relationship between a life stressor and major depressive disorder suggests the potential utility of a psychotherapeutic intervention coupled, as indicated, with somatic treatment.

2. Bereavement

Bereavement is a particularly severe stressor and is commonly accompanied by the signs and symptoms of major depressive disorder. Historically, such depressive manifestations have been regarded as normative, and presentations otherwise diagnosable as major depressive disorder are therefore diagnosed in DSM-IV as uncomplicated bereavement when they begin within the first 3 months of the loss (44). Data indicate that almost one-quarter of bereaved individuals meet the criteria for major depressive disorder at 2 months and again at 7 months and that many of these people continue to do so at 13 months (45). Individuals with more prolonged major depressive disorder manifestations tend to be younger and to have a history of prior episodes of major depressive disorder. Antidepressant medications or psychotherapy should be used when the reaction to a loss is particularly prolonged and psychopathology and functional impairment persist.

3. Family distress

The recognition of a problem in the family setting is important in that such a situation constitutes an ongoing stressor that may hamper the patient's response to treatment. Ambivalent, abusive, rejecting, or highly dependent family relationships may particularly predispose an individual to major depressive disorder. Such families should be evaluated for family therapy, which may be used in conjunction with individual and pharmacologic therapies. Even for instances in which there is no apparent family dysfunction, it is important to provide the family with education about the nature of the illness and to enlist the family's support and cooperation.

4. Cultural factors

Specific cultural variables may hamper the accurate assessment of major depressive disorder symptoms. An appreciation by the therapist of cultural variables is critical in the accurate diagnosis of major depressive disorder and in the selection and conduct of psychotherapy and pharmacotherapy. There is evidence that the expression of major depressive disorder symptoms may vary among cultures, especially the tendency to manifest somatic and psychomotor symptoms (46). Ethnic groups may also differ in their pharmacotherapeutic responses to antidepressant medications (47, 48). The language barrier has also been shown to severely impede accurate psychiatric diagnosis and effective treatment (49, 50).

5. Children and adolescents

The clinical presentation of depression in children and adolescents can differ significantly from that of adults and will vary with the child's age. Younger children may exhibit behavioral problems such as social withdrawal, aggressive behavior, apathy, sleep disruption, and weight loss. Adolescents may present with somatic complaints, self-esteem problems, rebelliousness, poor performance in school, or a pattern of engaging in risky or aggressive behavior. A careful assessment of the risk of suicide is necessary and should include an evaluation of risk factors such as recent loss or termination of a relationship, especially by suicide, disciplinary action, or alcohol or other substance abuse. A variety of informants should be used in the evaluation, including parents and teachers.

While a review of medication treatment studies (1) and a number of treatment recommendations (51) for children and adolescents are available, the evidence base for guiding treatment decisions for youth with major depressive disorder is quite limited. As a result, treatment decisions are frequently based on clinical consensus and the extrapolation of data from adults. It is important to be aware, however, that the extrapolation of adult data to children and adolescents is fraught with problems. For example, medications shown to be effective in adults have not always been found to be effective in children, and medications shown to be safe in adults have raised some serious safety concerns in children.

6. Older age

Considerations that go into choosing among psychotherapy, pharmacotherapy, and ECT for the elderly are essentially the same as for younger patients (52). The elderly typically display more vegetative signs and cognitive disturbance and complain less of subjective dysphoria than do their younger counterparts; major depressive disorder may consequently be misattributed to physical illness, dementia, or the aging process itself. It is recognized, however, that major depressive disorder and general medical illness frequently coexist in this age group, and those undergoing their first major depressive disorder episode in old age should be regarded as possibly harboring an as yet undiagnosed neurological or other general medical disorder that is responsible for the major depressive disorder condition. Some medications commonly prescribed for the elderly (e.g., beta-blockers) are thought to be risk factors for the development of major depressive disorder. The clinician should carefully assess whether a given agent contributed to the

major depressive disorder before prematurely altering what may be a valuable medication regimen. Major depressive disorder is a common complication of cerebral infarction, especially in the anterior left hemisphere (53).

Although elderly patients typically require a lower oral dose than younger patients to yield a particular blood level and tolerate a given blood level less well, the blood levels at which antidepressant medications are maximally effective appear to be the same as for younger patients (54). Elderly patients are particularly prone to orthostatic hypotension and cholinergic blockade; for this reason, fluoxetine, sertraline, bupropion, desipramine, and nortriptyline are frequently chosen rather than amitriptyline, imipramine, and doxepin. Weight loss may be especially problematic in the elderly. When this is the case, it might be beneficial to use an antidepressant that causes weight gain (see Table 7). Although the role of stimulants for antidepressant monotherapy is very limited, these compounds have some role in apathetic major depressive disorder in elderly patients with complicating general medical conditions. ECT should be considered for many of these patients. A recent study has shown that antidepressant medication (nortriptyline) and interpersonal therapy are effective maintenance therapies for elderly patients with recurrent major depressive disorder; a trend toward superior response was observed for combined pharmacotherapy and psychotherapy compared to pharmacotherapy alone (52).

7. Gender and pregnancy

The risks of certain adverse effects from treatments may also differ by gender. Caution is advised in the prescription of trazodone to men because of the risk of priapism. Older men are at risk for prostatic hypertrophy, making them particularly sensitive to medication effects on the bladder outlet. While both men and women may experience decreased libido or anorgasmia while taking SSRIs, men may also experience ejaculatory dysfunction. Some women who are taking birth control pills require higher doses of tricyclic antidepressant medications because of the induction of the hepatic enzymes responsible for medication metabolism.

The diagnostic assessment for women, in particular, should include a detailed inquiry regarding reproductive life history, including menstruation, menopause, birth control, and abortions. History of experiences of sexual and physical abuse, posttraumatic stress disorder, and treatment, if any, should be obtained.

Major depressive disorder occurring during pregnancy is a difficult therapeutic problem. Women of childbearing potential in psychiatric treatment should be carefully counseled as to the risks of becoming pregnant while taking psychotropic medications. Whenever possible, a pregnancy should be planned in consultation with the psychiatrist so that medication may be discontinued before conception if feasible. Antidepressant medication treatment should be considered for pregnant women who have major depressive disorder, as well as for those women who are in remission from major depressive disorder, receiving maintenance medication, and deemed to be at high risk for a recurrence if the medication is discontinued. The risks of treatment with medications must be weighed against the risks of alternative treatments, as well as the risks to the woman if the major depressive disorder is not effectively treated. These risks have recently been reviewed (55).

Specific concerns about the risks of untreated major depressive disorder in pregnancy include the possibility of low birth weight secondary to poor maternal weight gain (or frank weight loss). Suicidality, as well as the potential for long-term hospitalization, marital discord, the inability to engage in appropriate obstetrical care, and difficulty caring for other children must also be considered.

The considerations for the use of psychotherapy during pregnancy are identical to those relevant to nonpregnant patients, with the caveat that the risks of a delay in effectiveness may need to be considered in the context of the mother's safety as well as the safety of her fetus.

TABLE 7. Potential Treatments for Side Effects of Antidepressant Medications

Side Effect	Antidepressant(s) Associated With Effect	Treatment
Cardiovascular		
Orthostatic hypotension	Tricyclic antidepressants; trazodone; nefazodone; MAOIs	Lower dose; discontinue medication; fludrocortisone; add salt to diet
Reduced cardiac output	Tricyclic antidepressants	Discontinue medication
Arrhythmias	Tricyclic antidepressants	Discontinue medication
Hypertension	Venlafaxine	Lower dose; discontinue medication
Hypertensive crisis	MAOIs	Discontinue medication; intravenous phentolamine
Increase in cholesterol	Mirtazapine	Lower dose; discontinue medication
Anticholinergic		
Dry mouth	Tricyclic antidepressants; reboxetine	Pilocarpine oral rinse; gum; candy
Constipation	Tricyclic antidepressants; reboxetine	Hydration; bulk laxatives
Urinary hesitancy	Tricyclic antidepressants; reboxetine	Bethanechol
Visual changes	Tricyclic antidepressants; reboxetine	Pilocarpine eye drops
Delirium	Tricyclic antidepressants	Discontinue medication; antipsychotic medication
Sedation	Tricyclic antidepressants; trazodone; nefazodone; mirtazapine	Bedtime dosing
Weight gain	Tricyclic antidepressants; mirtazapine; MAOIs	Lower dose; change to secondary amine (if tricyclic antidepressant required); discontinue medication
Nausea, vomiting	SSRIs; bupropion, sustained release; venlafaxine, extended release	Lower dose; discontinue medication
Insomnia	SSRIs; bupropion; reboxetine	Lower dose; discontinue medication; morning dosing; trazodone at bedtime
Activation	SSRIs; venlafaxine	Lower dose; discontinue medication
Neurological		
Myoclonus	Tricyclic antidepressants; MAOIs	Lower dose; discontinue medication; clonazepam
Extrapyramidal symptoms; tardive dyskinesia	Amoxapine; SSRIs	Lower dose; discontinue medication
Seizures	Bupropion; amoxapine	Lower dose; discontinue medication; antiepileptic medication
Headaches	SSRIs; bupropion	Lower dose; discontinue medication
Sexual side effects		
Arousal, erectile dysfunction	Paroxetine; venlafaxine	Lower dose; discontinue medication; sildenafil; yohimbine; ginkgo; methylphenidate; dextroamphetamine; pemoline
	Tricyclic antidepressants; SSRIs	Lower dose; discontinue medication; sildenafil; yohimbine; ginkgo; bethanechol; neostigmine

TABLE 7. Potential Treatments for Side Effects of Antidepressant Medications *(continued)*

Side Effect	Antidepressant(s) Associated With Effect	Treatment
Sexual side effects *(continued)*		
Orgasm dysfunction	SSRIs; venlafaxine	Lower dose; discontinue medication; granisetron; amantadine; cyproheptadine; sildenafil
	MAOIs; tricyclic antidepressants	Lower dose; discontinue medication; cyproheptadine; amantadine
Priapism	Trazodone	Discontinue medication; surgical correction
Serotonin syndrome	SSRIs; MAOIs; venlafaxine	Discontinue medication
Agranulocytosis	Mirtazapine	Discontinue medication; monitor white blood cell count, granulocyte colony–stimulating factor

Wisner et al. reviewed the risks associated with the use of antidepressant medications during pregnancy (55). Potential risks that should be considered include intrauterine death, morphologic teratogenicity, growth impairment, behavioral teratogenicity, and neonatal toxicity. Wisner et al. also reviewed the limitations of the available database and the basic principles to be used in treating pregnant women with antidepressants. In particular, dose requirements change during pregnancy because of changes in volume of distribution, hepatic metabolism, protein binding, and gastrointestinal absorption. Although clinicians need to keep abreast of new data as they become available, at this time there is no evidence that tricyclic antidepressants, fluoxetine, or newer SSRIs cause either intrauterine death or major birth defects. However, in one large study (56), three or more minor physical anomalies occurred more commonly in infants exposed to fluoxetine than in a comparison group. This study also demonstrated that fetuses exposed to fluoxetine after 25 weeks' gestation had lower birth weights, which were associated with lower maternal weight gain.

The area of behavioral teratogenicity remains the major area of concern when prescribing psychoactive medications to pregnant women. Both tricyclic antidepressants and fluoxetine have been studied, and the results provide no evidence for effects on cognitive function, temperament, or general behavior. However, replication studies, as well as data regarding other newer antidepressants, are needed.

Neonatal withdrawal syndromes have been reported in babies exposed, in utero, to tricyclic antidepressants, fluoxetine, and sertraline. Given these data, it is recommended that consideration be given to using either a tricyclic antidepressant or an SSRI that has been studied in pregnant women. If a tricyclic antidepressant is to be used, nortriptyline should be particularly considered because of its relatively low anticholinergic effects, long history of use, and well-studied relationship between plasma concentration and therapeutic effect (55). When antidepressants are used, maternal weight gain should be carefully monitored, and consideration should be given to gradually tapering the medication 10–14 days before the expected date of delivery. If this is done, and the woman is considered to be at risk from her major depressive disorder, the medication can be restarted following delivery, although the dose should be readjusted to that required before pregnancy. In selected cases not responding to or unsuitable for medication, for patients with major depressive disorder with psychotic features, or for individuals electing to use this modality as a matter of preference after having weighed the relative risks and benefits, ECT may be used as an alternative treatment; the current literature supports the safety for mother and fetus, as well as the efficacy of ECT during pregnancy (57).

Several major depressive disorder conditions may follow childbirth (58). The transient 7–10-day depressive condition referred to as postpartum blues typically is too mild to meet the criteria for major depressive disorder and does not require medication. It is optimally treated by

reassuring the patient of its brief nature and favorable outcome. Puerperal psychosis is a more severe disorder complicating 1–2 per 1,000 births; more than one-half of the episodes of this type meet the criteria for major depressive disorder (59), and many patients who have had episodes of this type ultimately prove to have bipolar disorder. Major depressive disorder, and especially major depressive disorder with psychotic features, can seriously interfere with the new mother's ability to provide physically and emotionally appropriate care for her baby. The woman's parenting skills for both the newborn baby and any other children in her care must be carefully assessed. Women with postpartum psychotic major depressive disorder may have homicidal impulses toward the newborn; for this reason, careful assessment of homicidal as well as suicidal ideation, intention, or plans is important. Women whose maintenance antidepressant medication treatment was discontinued during pregnancy appear to be particularly at risk for recurrence of major depressive disorder; such individuals should have their medications restored after delivery, in the absence of a contraindication.

Major depressive disorder in the postpartum period should be treated according to the same principles delineated for other types of major depressive disorder. However, when a woman decides to nurse, the potential benefits to the mother of using antidepressant medications should be balanced against the potential risks to the newborn inherent in the possibility of receiving some antidepressant in the breast milk; mothers should be counseled regarding the relative risks and benefits when making treatment decisions (60, 61).

8. Family history

The presence of a positive family history of recurrent major depressive disorder increases the chances that the patient's own illness will be recurrent and that the patient will not fully recover between episodes.

The presence in a depressed patient of a positive family history of bipolar disorder or acute psychosis probably increases the chances that the patient's own major depressive disorder is a manifestation of bipolar rather than unipolar disorder and that antidepressant medication therapy may incite a switch to mania (62). Patients with such a family history should be particularly closely questioned regarding a prior history of mania or hypomania, since lithium used alone or in conjunction with another antidepressant medication is particularly likely to exert a beneficial effect in patients with bipolar disorder who have a major depressive episode. Patients with major depressive disorder with a family history of bipolar disorder should be carefully observed for signs of a switch to mania during antidepressant medication treatment.

C. TREATMENT IMPLICATIONS OF CONCURRENT GENERAL MEDICAL DISORDERS

1. Asthma

Individuals with asthma who receive MAOIs should be cautioned regarding interactions with sympathomimetic bronchodilators, although other antiasthma agents appear to be safe. Other antidepressant medications may be used for patients with asthma without fear of interaction.

2. Cardiac disease

The presence of specific cardiac conditions complicates or contraindicates certain forms of antidepressant medication therapy, notably use of tricyclic agents; the cardiac history should therefore be carefully explored before the initiation of medication treatment. Although tricyclic antidepressants have been used effectively to treat major depressive disorder in patients with some forms of ischemic heart disease (63), psychiatrists should take particular care in using tricyclics for patients with a history of ventricular arrhythmia, subclinical sinus node dysfunction, conduction defects (including asymptomatic conduction defects), prolonged QT intervals, or a

recent history of myocardial infarction (64–70). SSRIs, bupropion, and ECT appear to be safer for patients with preexisting cardiac disease, although the latter may require consultation with a specialist and treatment modification before use (63, 71–77). MAOIs do not adversely affect cardiac conduction, rhythm, or contraction but may induce orthostatic hypotension and also run the risk of interacting adversely with other medications that may be taken by such patients. There is anecdotal evidence that trazodone may induce ventricular arrhythmias, but the agent appears to be safe for the overwhelming majority of patients.

A depressed patient with a history of any cardiac problem should be monitored for the emergence of cardiac symptoms, ECG changes, or orthostatic blood pressure decrements. Consultation with the patient's cardiologist before and during antidepressant medication treatment may be advisable and is especially advisable during any treatment for a patient who has recently had a myocardial infarction.

3. Dementia

Treatment of major depressive disorder in the cognitively impaired patient requires the involvement of clinicians in the patient's pharmacotherapy, supervision, and monitoring; this involvement may entail education of home health aides, nursing home providers, and others. Individuals with dementia are particularly susceptible to the toxic effects of muscarinic blockade on memory and attention. Therefore, individuals suffering from dementia generally do best when given antidepressant medications with the lowest possible degree of anticholinergic effect, e.g., bupropion, fluoxetine, sertraline, trazodone, and, of the tricyclic agents, desipramine or nortriptyline. Alternatively, some patients do well given stimulants in small doses. ECT is also effective in major depressive disorder superimposed on dementia, and it should be used if medications are contraindicated, not tolerated, or if immediate resolution of the major depressive disorder episode is medically indicated (such as when it interferes with the patient's acceptance of food). Practitioners should be aware that a transient worsening of the patient's cognitive status may occur in such cases (72, 75, 78).

4. Epilepsy

Although many antidepressant medications lower the seizure threshold and theoretically exert a dose-dependent adverse effect on seizure control in patients with major depressive disorder with epilepsy, major depressive disorder in patients with seizure disorders can usually be safely and effectively managed according to the same principles outlined for patients without seizures. Consideration should be given to concomitant prescription of an antiepileptic (or elevating the dose of an existing antiepileptic).

5. Glaucoma

Medications with anticholinergic potency may precipitate acute narrow-angle glaucoma in susceptible individuals (i.e., those with shallow anterior chambers) (79). Patients with glaucoma receiving local miotic therapy may be treated with antidepressant medications, including those possessing anticholinergic properties, provided that their intraocular pressure is monitored during antidepressant medication treatment. Agents lacking anticholinergic activity (bupropion, sertraline, fluoxetine, and trazodone) avoid this liability.

6. Hypertension

Antihypertensive agents and tricyclic antidepressant medications may interact to either intensify or counteract the effect of the antihypertensive therapy. The action of antihypertensive agents that block alpha receptors (e.g., prazosin) may be intensified by antidepressant medications that block these same receptors, notably the tricyclic antidepressants and trazodone. Tricyclic antidepressants may antagonize the therapeutic actions of guanethidine, clonidine, or α-methyldopa. Concurrent antihypertensive treatment, especially with diuretics, increases the likelihood that

tricyclic antidepressants, trazodone, or MAOIs will induce symptomatic orthostatic hypotension. Beta-blockers, especially propranolol, may be a cause of major depressive disorder in some patients; individuals who have become depressed after initiation of treatment with one of these medications should be changed to another antihypertensive regimen. Dose-dependent elevations in blood pressure with venlafaxine are usually mild, although more severe elevations have been observed (80), making this agent less preferable in patients with hypertension.

7. Obstructive uropathy

Prostatism and other forms of bladder outlet obstruction are relative contraindications to the use of antidepressant medication compounds with antimuscarinic effects. Benzodiazepines, trazodone, and MAOIs may also retard bladder emptying. The antidepressant medications with the least propensity to do this are SSRIs, bupropion, and desipramine.

8. Parkinson's disease

Amoxapine, an antidepressant medication with dopamine-receptor blocking properties, should be avoided for patients who have Parkinson's disease. Lithium may in some instances induce or exacerbate parkinsonian symptoms. Bupropion, in contrast, exerts a beneficial effect on the symptoms of Parkinson's disease in some patients but may also induce psychotic symptoms, perhaps because of its agonistic action in the dopaminergic system (81). MAOIs (other than selegiline, also known as L-deprenyl, a selective type B MAOI recommended in the treatment of Parkinson's disease) may adversely interact with L-dopa products (82). Selegiline loses its specificity for MAO-B in doses greater than 10 mg/day and may induce serotonin syndrome when given in higher doses in conjunction with serotonin-enhancing antidepressant medications. Major depressive disorder, which occurs to some degree in 40%–50% of patients with Parkinson's disease, may be related to the alterations of serotonergic and noradrenergic systems that occur in this disorder. There is no evidence favoring any particular antidepressant medication from the standpoint of therapeutic efficacy in patients with Parkinson's disease complicated by major depressive disorder. The theoretical benefits of the antimuscarinic effects of some of the tricyclic agents in the treatment of patients with major depressive disorder with Parkinson's disease are offset by the memory impairment that may result. ECT exerts a transient beneficial effect on the symptoms of idiopathic Parkinson's disease in many patients (83).

PART B:
BACKGROUND INFORMATION AND REVIEW OF AVAILABLE EVIDENCE

IV. DISEASE DEFINITION, EPIDEMIOLOGY, NATURAL HISTORY, AND COURSE

DSM-IV criteria for major depressive episode and major depressive disorder are listed in Table 8.

A. SPECIFIC FEATURES OF DIAGNOSIS

1. Severity

An episode of major depressive disorder may be classified as mild, moderate, or severe. Mild episodes are characterized by little in the way of symptoms beyond the minimum required to make the diagnosis and by minor functional impairment. Moderate episodes are characterized by the presence of symptoms in excess of the bare diagnostic requirements and by greater degrees of functional impairment. Severe episodes are characterized by the presence of several symptoms in excess of the minimum requirements and by the symptoms' marked interference with social and/or occupational functioning. In the extreme, afflicted individuals may be totally unable to function socially or occupationally or even to feed or clothe themselves or to maintain minimal personal hygiene. The nature of the symptoms, such as suicidal ideation and behavior, should also be considered in assessing severity.

2. Melancholia

The melancholic subtype is a severe form of major depressive disorder with characteristic somatic symptoms, and it is believed to be particularly responsive to pharmacotherapy and ECT.

3. Psychotic features

Major depressive disorder may be accompanied by hallucinations or delusions; these may be congruent or noncongruent with the depressive mood.

4. Dysthymia

The differential diagnosis of dysthymia and major depressive disorder is particularly difficult, since the two disorders share similar symptoms and differ primarily in duration and severity. Usually major depressive disorder consists of one or more discrete major depressive episodes that can be distinguished from the person's usual functioning, whereas dysthymia is characterized by a chronic mild depressive syndrome that has been present for at least 2 years. If the initial onset of what appears to be dysthymia directly follows a major depressive episode, the appropriate diagnosis is major depressive disorder in partial remission. The diagnosis of dysthymia can be made following major depressive disorder only if there has been a full remission of the major depressive episode that has lasted at least 6 months before the development of dysthymia.

People with dysthymia frequently have a superimposed major depressive disorder, and this condition is often referred to as double major depressive disorder. Patients with double major depressive disorder are less likely to have a complete recovery than are patients with major depressive disorder without dysthymia.

B. EPIDEMIOLOGY

The Epidemiologic Catchment Area study indicates that major depressive disorder has a 1-month prevalence of 2.2% and a lifetime prevalence of 5.8% in Americans 18 years and older (84). Other studies estimate the lifetime prevalence to be as high as 26% for women and 12% for men. The illness is 1.5 to 3 times as common among those with a first-degree biological relative affected with the disorder as among the general population. Major depressive disorder is frequently accompanied by comorbid conditions. For example, in one study of patients with major depressive disorder under the care of psychiatrists in the United States, 84% had at least one comorbid condition: 61% had a co-occurring axis I condition, 30% a comorbid axis II condition, and 58% a comorbid axis III condition (85). Frequently a major depressive episode follows a psychosocial stressor, particularly death of a loved one, marital separation, or the ending of an important relationship. Childbirth sometimes precipitates a major depressive episode. Pa-

TABLE 8. DSM-IV Criteria for Major Depressive Episode and Major Depressive Disorder

Diagnosis	Criterion/Symptom Description
Major depressive episode	A. At least five of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (do not include symptoms that are clearly due to general medical condition or mood-incongruent delusions or hallucinations) 1. Depressed mood most of the day, nearly every day, as indicated either by subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful) 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others) 3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day 4. Insomnia or hypersomnia nearly every day 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) 6. Fatigue or loss of energy nearly every day 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others) 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide 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
Major depressive disorder, single episode	A. Presence of a single major depressive episode B. The major depressive episode is not better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified C. There has never been a manic episode, a mixed episode, or a hypomanic episode

TABLE 8. DSM-IV Criteria for Major Depressive Episode and Major Depressive Disorder *(continued)*

Diagnosis	Criterion/Symptom Description
Major depressive disorder, recurrent	A. Presence of two or more major depressive episodes (each separated by at least 2 months in which criteria are not met for a major depressive episode) B. The major depressive episodes are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified C. There has never been a manic episode, a mixed episode, or a hypomanic episode

Source. Reprinted from *Diagnostic and Statistical Manual of Mental Disorders,* 4th Edition. Washington, DC, American Psychiatric Association, 1994. Copyright © 1994, American Psychiatric Association.

tients with major depressive disorder identified in psychiatric settings tend to have episodes of greater severity and to have recurrent forms of major depressive disorder and also are more likely to have other mental disorders than are subjects from the community and primary care settings.

C. NATURAL HISTORY AND COURSE

The average age at onset is the late 20s, but the disorder may begin at any age. The symptoms of major depressive disorder typically develop over days to weeks. Prodromal symptoms, including generalized anxiety, panic attacks, phobias, or depressive symptoms that do not meet the diagnostic threshold, may occur over the preceding several months. In some cases, however, a major depressive disorder may develop suddenly (e.g., when associated with severe psychosocial stress). The duration of a major depressive episode is also variable. Untreated, the episode typically lasts 6 months or longer. Some patients with major depressive disorder will eventually have a manic or hypomanic episode and will then be diagnosed as having bipolar disorder.

1. Recurrence

Although some people have only a single episode of major depressive disorder, with full return to premorbid functioning, it is estimated that from 50% to 85% of the people who have such an episode will eventually have another episode, at which time the illness will meet the criteria for recurrent major depressive disorder (86). People with major depressive disorder superimposed on dysthymia are at greater risk for having recurrent episodes of major depressive disorder than those without dysthymia.

The course of recurrent major depressive disorder is variable. Some people have episodes separated by many years of normal functioning, others have clusters of episodes, and still others have increasingly frequent episodes as they grow older.

2. Interepisode status

Functioning usually returns to the premorbid level between episodes. In 20%–35% of the cases, however, there are persistent residual symptoms and social or occupational impairment. Patients who continue to meet the criteria for a major depressive episode throughout the course of the disturbance are considered to have the chronic type, whereas those who remain symptomatic are considered to be in partial remission.

3. Seasonal pattern

A seasonal pattern of major depressive disorder is characterized by a regular temporal relationship between the onset and remission of symptoms and particular periods of the year (e.g., in

the northern hemisphere, regular appearance of symptoms between the beginning of October and the end of November and regular remission from mid-February to mid-April). Patients should not receive this diagnosis if there is an obvious effect of seasonally related psychosocial stressors, e.g., seasonal unemployment.

4. Complications

The most serious complications of a major depressive episode are suicide and other violent acts. Other complications include marital, parental, social, and vocational difficulties (87). The illness, especially in its recurrent and chronic forms, may cause distress for other individuals in the patient's social network, e.g., children, spouse, and significant others. If the patient is a parent, the disorder may affect his or her ability to fulfill parental role expectations (88). Major depressive disorder episodes are associated with occupational dysfunction, including unemployment, absenteeism, and decreased work productivity (89). Major depressive disorder may also complicate recovery from other medical illnesses. Major depressive disorder has been demonstrated to be a major risk factor in the post-myocardial-infarction period.

V. REVIEW AND SYNTHESIS OF AVAILABLE EVIDENCE

Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient's symptoms; past general medical and psychiatric history; psychological makeup and conflicts; life stressors; family, psychosocial, and cultural environment; and preference for specific treatments or approaches.

The psychiatrist's task is both to effect and to maintain improvement. Treatment consists of an acute phase, during which remission is induced; a continuation phase, during which remission is preserved; and a maintenance phase, during which the susceptible patient is protected against the recurrence of subsequent major depressive disorder episodes. Psychiatrists initiating treatment of a major depressive disorder episode have at their disposal a number of medications, a variety of psychosocial approaches, ECT, and light therapy. These various interventions may be used alone or in combination. Furthermore, the psychiatrist must decide whether to conduct treatment on an outpatient, partial hospitalization, or inpatient basis.

A. ACUTE PHASE SOMATIC TREATMENTS

1. Antidepressant medications

a) Goals

The goal of treatment with antidepressant medications in the acute phase is the remission of major depressive disorder symptoms. For cases of first-episode major depressive disorder uncomplicated by comorbid general medical illness or by special features such as atypical, psychotic, or bipolar symptoms, many antidepressant medications are available. Systematic data from clinical trials regarding the relative efficacy of different antidepressant medications are lacking. For most patients, antidepressant medications approved by the Food and Drug Administration (FDA) are generally considered equally effective, with response rates in clinical trials ranging from 50% to 75% of patients. However, among some subgroups of patients with major depressive disorder, ef-

ficacy may differ. Antidepressant medications also differ in their potential to cause particular side effects. Antidepressant medications have been grouped as follows: 1) tricyclic antidepressant medications, which for the purposes of this review also include the tetracyclic antidepressant medication maprotiline; 2) SSRIs, which include fluoxetine, sertraline, paroxetine, fluvoxamine, and citalopram; 3) other antidepressant medications, including bupropion, nefazodone, trazodone, venlafaxine, mirtazapine, and reboxetine (for which FDA approval is anticipated); and 4) MAOIs, which include phenelzine, tranylcypromine, and isocarboxazid.

b) Efficacy

Quantitative reviews of the efficacy of antidepressant medications for major depressive disorder have been performed, including the recent *Evidence Report on Treatment of Depression—Newer Pharmacotherapies* (1). This study examined 315 trials, lasting 6 weeks or longer, of newer pharmacotherapies for patients with depressive disorders. Additional details concerning the evidence of antidepressant medication efficacy that may be beyond the scope of this guideline can be obtained from such reviews.

Interpreting data from clinical trials on the efficacy of pharmacotherapy for major depressive disorder can be complicated by several issues. First, it is important to consider whether and what type of comparison group was used (e.g., placebo or active agent). In trials of antidepressant medication treatments, high placebo response rates could explain observed treatment effects in poorly controlled trials as well as make detection of true treatment effects difficult in well-controlled trials. It is also important to consider both whether trials were blinded and whether in "blinded" trials, medication side effects could reveal the identity of active agents. Issues related to the outcomes measured in trials are important as well. A variety of different outcome measures are employed, and a report of "efficacy" could refer to symptom reduction (e.g., reduction in the frequency or severity of major depressive disorder symptoms), response (e.g., reduction in major depressive disorder symptoms below a threshold), or prevention of relapse. Data often come from short-term (6- to 12-week) efficacy trials that may not reveal whether treatments are effective over the medium and long term. Lastly, it is important to consider whether publication bias against reporting of negative studies could affect the perception of overall treatment effectiveness.

(1) Tricyclic antidepressants

Since the first trial in which a tricyclic compound (imipramine) was shown to improve major depressive disorder symptoms (90), hundreds of subsequent randomized controlled trials have demonstrated the efficacy of this class as a treatment for major depressive disorder (1). Heterocyclic antidepressant medications, including tricyclics and tetracyclics, have been found to be statistically significantly superior to placebo in approximately 75% of studies (91); several reviews suggest that approximately 50%–75% of patients with major depressive disorder treated with heterocyclic antidepressant medications respond compared to 25%–33% treated with placebo (92–95). The efficacy of individual agents and subclasses of tricyclics (e.g., secondary amines or tertiary amines) appears to be comparable.

Results of some investigations have suggested that tricyclic antidepressants may possess superior efficacy among subgroups of patients with severe major depressive disorder symptoms (91, 96–99). Some studies have also suggested that in major depressive disorder marked by melancholic features, tricyclic antidepressants may be additionally effective (100, 101) as well as superior to SSRIs (102, 103); however, not all research supports these findings (104).

(2) Selective serotonin reuptake inhibitors

SSRIs currently available include fluoxetine, sertraline, paroxetine, fluvoxamine, and citalopram. A large body of literature containing approximately 50 randomized, placebo-controlled trials supports the premise that SSRIs are superior to placebo in the treatment of major depressive dis-

order. In over 50 investigations the effectiveness of SSRIs has been compared to that of other antidepressant medications, mainly tricyclic antidepressants; in these trials, SSRIs have generally had comparable efficacy to antidepressant medications from other classes (1, 105, 106). In general, significant differences in efficacy between individual SSRIs have not been observed.

There is some evidence that SSRIs may be more effective than tricyclic antidepressants for subgroups of patients with atypical symptoms of major depressive disorder (e.g., mood reactivity, hypersomnia, hyperphagia, and hypersensitivity to rejections) (23). SSRIs have also been shown to be helpful for some patients who have not responded to tricyclic antidepressants (107).

(3) Other antidepressant medications

Several other antidepressant medications are available that differ structurally or in their pharmacologic action from medications in the categories just described. Trazodone is the medication from this group for which the most data on efficacy exists. In most trials, trazodone has had superior efficacy relative to placebo; however, its efficacy relative to other antidepressant medications remains controversial. Although data from some controlled trials suggest comparable efficacy to tricyclic antidepressants (108, 109), other investigations suggest trazodone may possess inferior efficacy relative to other antidepressant medications (1, 110, 111), particularly in subgroups with severe major depressive disorder symptoms or prominent psychomotor retardation (112, 113).

Nefazodone has an analogous structure to trazodone but somewhat different pharmacologic properties. In controlled trials, nefazodone has had superior efficacy to placebo; in five trials, nefazodone has been found to have comparable efficacy to tricyclic antidepressants (1, 114, 115). Some studies suggest that nefazodone may have an optimal therapeutic dose range corresponding to approximately 300–600 mg/day (115, 116).

Bupropion appears to inhibit the reuptake of both norepinephrine and dopamine, although its mechanism of action remains unclear. Trial data have shown that bupropion is superior to placebo (117) and generally comparable in efficacy to both tricyclic antidepressants (1, 118–121) and SSRIs (122).

Venlafaxine and mirtazapine appear to act through inhibition of reuptake of both norepinephrine and serotonin. Both have been demonstrated to be superior to placebo; venlafaxine and mirtazapine have each been shown in four trials to possess generally comparable efficacy to tricyclic antidepressants (1, 110, 123–128). Results from one trial suggest a positive relationship between the effective dose of venlafaxine and the severity of major depressive disorder—favorable responses were achieved with lower doses in milder major depressive disorders, whereas higher doses were more efficacious in severe major depressive disorder (129).

Reboxetine is a new selective noradrenaline reuptake inhibitor for which approval from the FDA is expected. In four trials, reboxetine has been shown to be more effective than placebo; in 6 trials against active treatment, reboxetine has been found to possess at least comparable effectiveness as tricyclic antidepressants and SSRIs (1, 130).

(4) Monoamine oxidase inhibitors

MAOIs that have been used as antidepressant medications include phenelzine, tranylcypromine, and isocarboxazid. MAOIs have also been shown in multiple trials to be effective treatments for major depressive disorder. Although some earlier comparisons employing lower doses of MAOIs found tricyclic antidepressants to be superior, MAOIs are now considered to have comparable efficacy to tricyclic antidepressants for typical cases of major depressive disorder (131–136). There are no significant differences in efficacy among the MAOIs.

Results of several investigations suggest that MAOIs may be particularly effective in treating subgroups of patients with major depressive disorder with atypical features such as reactive moods, reversed neurovegetative symptoms, and sensitivity to rejection (19, 137, 138). MAOIs have also been shown to be effective treatments for some patients who have failed other antidepressant medication trials (132, 136, 139, 140).

c) Side effects

The severity of side effects from antidepressant medications in clinical trials has been assessed both through the frequency of reported side effects and through the frequency of treatment dropout. The likelihood of different side effects varies between classes of antidepressant medications, between subclasses, and between individual agents. Prominent and clinically relevant side effects associated with particular classes, subclasses, and individual medications are reviewed in Table 7.

(1) Tricyclic antidepressants

i. Cardiovascular effects

Tricyclic antidepressants can cause a number of cardiovascular side effects through α-adrenergic blockade, including tachycardia or orthostatic hypotension. Side effects such as orthostatic hypotension may in turn lead to events such as dizziness, falls, or fractures. Secondary amines such as nortriptyline or desipramine cause less α-adrenergic blockade and may offer advantages over tertiary amines (69). Salt depletion, whether voluntary or a result of diuretic treatment, may contribute to orthostatic hypotension. If there is no medical contraindication, patients with symptomatic orthostatic hypotension should be cautioned against extreme dietary salt restriction.

Tricyclic antidepressant medications act similarly to class I antiarrhythmic agents such as quinidine, disopyramide, and procainamide by prolonging cardiac repolarization and depressing fast sodium ion channels (141). Both secondary and tertiary amines have been documented to suppress ventricular premature depolarizations (64, 67). Combinations of tricyclic antidepressants with other class I antiarrhythmic agents can exert additive toxic effects on cardiac conduction; patients with ventricular arrhythmias taking another class I antiarrhythmic agent who require tricyclic medication therapy should be under careful medical supervision. Tricyclic antidepressants may also provoke arrhythmias in patients with subclinical sinus node dysfunction; for example, in patients with tachyarrhythmias, treatment with tricyclic antidepressants may on occasion provoke bradyarrhythmias (65). Among patients with preexisting but asymptomatic conduction defects, such as interventricular conduction delay and bundle-branch block, tricyclic antidepressants may induce symptomatic conduction defects and symptomatic orthostatic hypotension (69). Individuals with prolonged QT intervals, whether preexistent or medication-induced, are predisposed to the development of ventricular tachycardia (70). It has also been reported that patients with normal pretreatment ECG results may develop atrioventricular block that reverts to normal after discontinuation of antidepressant medication treatment (69).

For most patients, tricyclic antidepressants exert no appreciable effect on ventricular ejection fraction (142); rarely (and usually in patients with marked baseline disturbances of myocardial function), tricyclic antidepressants may exert a deleterious effect on ejection fraction (66, 68).

ii. Anticholinergic side effects

All tricyclic antidepressant medications have some degree of antimuscarinic action; tertiary amine tricyclic antidepressants produce the most anticholinergic side effects, whereas the newer secondary amines, desipramine and nortriptyline, have less antimuscarinic activity. The most common undesirable consequences of muscarinic blockade are dry mouth, impaired ability to focus at close range, constipation, urinary hesitation, tachycardia, and sexual dysfunction. Although patients can develop some degree of tolerance to anticholinergic side effects, these symptoms may require treatment if they cause substantial dysfunction or interfere with adherence. Impaired visual accommodation may be counteracted through the use of pilocarpine eye drops. Urinary hesitation may be treated by prescribing bethanechol, 200 mg/day (in divided doses to avoid symptoms of cholinergic excess, principally abdominal cramps, nausea, and diarrhea). Dry mouth may be counteracted by advising the patient to use sugarless gum or candy

or by prescribing an oral rinse of 1% pilocarpine used three or four times daily; oral bethanecol may also be effective. Constipation is best dealt with through adequate hydration and the use of bulk laxatives. Antidepressant medications with anticholinergic side effects should be avoided in patients with cognitive impairment, narrow-angle glaucoma, or prostatic hypertrophy. Tricyclic antidepressants may also precipitate anticholinergic delirium, particularly in patients who are elderly or medically compromised.

iii. Sedation

Tricyclic antidepressants also have affinity for histaminergic receptors and produce varying degrees of sedation. In general, tertiary amines cause greater sedation, whereas secondary amines cause less. Sedation often attenuates in the first weeks of treatment, and patients experiencing only minor difficulty from this side effect should be encouraged to allow some time to pass before changing antidepressant medications. Patients with major depressive disorder with insomnia may benefit from sedation when their medication is given as a single dose before bedtime.

iv. Weight gain

Tricyclic antidepressants have the capacity to induce weight gain, possibly through their histaminergic properties. The degree of weight gain appears to vary by agent (e.g., greater weight gain with amitriptyline and less with desipramine), be dose dependent, and be reversible with cessation of tricyclic antidepressant therapy.

v. Neurological effects

Tricyclic antidepressants can induce mild myoclonus (143). Since this may be a sign of toxicity, the clinician may wish to check the blood level (if available) to ensure that it is not excessive. If the level is nontoxic and the myoclonus is not symptomatic, the agent may be continued without a change in dose. If the myoclonus is symptomatic and the blood level is within the recommended range, the patient may be treated with clonazepam at a dose of 0.25 mg t.i.d. Alternatively, the antidepressant medication may be changed. A toxic confusional state has been identified in some patients with high blood levels of tricyclic antidepressant medications, and it responds to simply lowering the dose (144). Amoxapine, a tricyclic antidepressant with antipsychotic properties, can also cause extrapyramidal side effects and tardive dyskinesia. In overdoses, tricyclic antidepressants can precipitate seizures.

vi. Medication interactions

Medications that induce hepatic microsomal enzymes, such as carbamazepine or barbiturates, will cause a decrease in serum tricyclic antidepressant level. On the other hand, drugs such as antipsychotic medications or SSRIs can reduce the metabolism and clearance of tricyclic antidepressants and raise tricyclic antidepressant levels. Tricyclic antidepressants can also alter the pharmacokinetics or pharmacodynamics of other medications; for example, tricyclic antidepressants can cause a lowering of valproate levels and reduce the activity of clonidine. Therefore, adjustments in medication doses may be necessary when tricyclic antidepressants are administered concomitantly with other drugs for which there is an interaction. Potentially dangerous interactions, including hypertensive crises, can develop when tricyclic antidepressants are administered with MAOIs, norepinephrine, or epinephrine.

(2) Selective serotonin reuptake inhibitors

i. Gastrointestinal

SSRIs cause nausea, vomiting, and diarrhea to a greater extent than tricyclic antidepressant medications (145). These adverse events are generally dose dependent and tend to dissipate over the first few weeks of treatment.

ii. Activation/insomnia

In some patients, SSRIs may precipitate or exacerbate restlessness, agitation, and sleep disturbances. These side effects often attenuate with time. Anxiety may be minimized by introducing the agent at a low dose; insomnia may be effectively treated by the addition of trazodone, up to 100 mg at bedtime.

iii. Sexual side effects

Although loss of erectile or ejaculatory function in men and loss of libido and anorgasmia in both sexes may be complications of virtually any antidepressant medication, these side effects appear to be more common with SSRIs. The psychiatrist should ascertain whether the sexual dysfunction is a result of the antidepressant medication or the underlying major depressive disorder. If sexual dysfunction is determined to be a side effect of the antidepressant medication, a variety of strategies are available, including continuing treatment to assess whether the dysfunction will disappear with time, lowering the dose, discontinuing the antidepressant, or substituting another antidepressant such as bupropion (Table 7) (146). Specific pharmacologic treatments that can be added for arousal or erectile dysfunction include sildenafil, yohimbine, or neostigmine; specific medications that can be added for orgasm dysfunction include sildenafil, cyproheptadine, or amantadine (147).

iv. Neurological effects

SSRIs can initially exacerbate both migraine headaches and tension headaches. These effects tend to be transient and improve within the first few weeks of treatment. There is some suggestion that with continued treatment SSRIs may then actually help prevent and treat migraine headaches (148, 149). SSRIs have also been associated with extrapyramidal reactions, including akathisia, dystonia, parkinsonism, and tardive dyskinesia (150, 151). The occurrence of such extrapyramidal symptoms is generally very low but may be higher in older patients, especially those with Parkinson's disease.

v. Effects on weight

Fluoxetine has been shown to cause an initial reduction in weight but this tends to be gained back subsequently (152). The literature differs as to whether patients taking SSRIs beyond the acute phase do (153) or do not (154) experience weight gain as a medication side effect.

vi. Serotonin syndrome

SSRI use has been associated with the rare development of a syndrome due to an excess of serotonergic activity. Features of serotonin syndrome include abdominal pain, diarrhea, flushing, sweating, hyperthermia, lethargy, mental status changes, tremor and myoclonus, rhabdomyolysis, renal failure, cardiovascular shock, and possibly death (155, 156). Although serotonin syndrome can occur with the use of SSRIs alone, it is usually associated with the simultaneous use of multiple serotonergic agents such as SSRIs together with MAOIs, fenfluramine, or dexfenfluramine.

vii. Drug interactions

As previously described, there can be a potentially lethal interaction between SSRIs and MAOIs: serotonin syndrome. It has been suggested that at least five half-lives elapse between the time an SSRI is stopped and an MAOI is started; for fluoxetine discontinuation, this corresponds to waiting approximately 5 weeks before starting an MAOI, whereas for discontinuation of other SSRIs it corresponds to waiting approximately 1 week before starting an MAOI (157). A 2-week waiting period has been suggested after discontinuing an MAOI before starting an SSRI.

SSRIs can also have variable effects on hepatic microsomal enzymes and therefore cause both increases and decreases in the blood levels of other medications.

(3) Other antidepressant medications

i. Trazodone

The most common side effect with trazodone is sedation; this side effect may allow trazodone to be used to advantage in patients with initial insomnia. Trazodone can also cause cardiovascular side effects including orthostasis. Although trazodone does not prolong cardiac conduction, there have been case reports of cardiac arrhythmias developing during trazodone treatment (158, 159). Trazodone can cause sexual side effects, including erectile dysfunction in men; in rare instances, this may lead to irreversible priapism requiring surgical correction (160).

ii. Nefazodone

Side effects observed with nefazodone treatment include dry mouth, nausea, and constipation. Although nefazodone lacks anticholinergic properties, blurred vision has been noted. Nefazodone may also cause sedation and orthostasis but not as severe as that observed with trazodone. Nefazodone is known to inhibit hepatic microsomal enzymes and can raise levels of concurrently administered medications such as certain antihistamines, benzodiazepines, and digoxin.

iii. Bupropion

Neurological side effects have been observed with bupropion treatment including headaches, tremors, and seizures. Risks of seizures can be reduced by avoiding high doses (e.g., using less than 450 mg/day), using divided dosing schedules (e.g., three times a day), and avoiding bupropion use in patients with risk factors for seizures. Bupropion also possesses dopaminergic activity and has been associated with the development of psychotic symptoms, including delusions and hallucinations. For these reasons, bupropion should be used cautiously in patients with psychotic disorders. Other side effects observed with bupropion treatment include insomnia and gastrointestinal upset.

iv. Venlafaxine

The side effects of venlafaxine have been likened to those seen with SSRIs, including nausea and vomiting, sexual dysfunction, and activation; like the side effects seen with SSRIs, those with venlafaxine can attenuate with continued use. Venlafaxine can also cause an increase in blood pressure. Because this increase is dose related, venlafaxine-induced hypertension may respond to dose reduction.

v. Mirtazapine

The most common side effects from mirtazapine include sedation, dry mouth, and weight gain. These tend to occur early and may attenuate with continued treatment. Mirtazapine has also been shown to increase serum cholesterol levels in some patients (161). Although agranulocytosis has been observed to occur in patients taking mirtazapine, its occurrence has been very rare. Routine monitoring of a patient's WBC count is not needed, although checking may be advisable in patients with signs or symptoms of infection.

vi. Reboxetine

The most frequently reported side effects in trials of reboxetine have been dry mouth, constipation, increased sweating, insomnia, urinary hesitancy/retention, impotence, tachycardia, and vertigo (162). In clinical trials done to date, few serious adverse events have been reported among patients treated with reboxetine.

(4) Monoamine oxidase inhibitors

i. Hypertensive crises

A hypertensive crisis can occur when a patient taking an MAOI ingests large amounts of tyramine or other pressor amines in foods or medications. This reaction is characterized by the acute onset of severe headache, nausea, neck stiffness, palpitations, profuse perspiration, and

confusion, possibly leading to stroke and death (163). Dietary restrictions include avoiding such foods as aged cheeses or meats, fermented products, yeast extracts, fava or broad beans, and overripe or spoiled foods. The list of medications that must be avoided includes all sympathomimetic and stimulant drugs as well as over-the-counter decongestants and cold remedies.

Some clinicians have recommended that patients carry nifedipine and, at the outset of a possible hypertensive crisis, take an oral dose of 10 mg before proceeding to the hospital (164); this practice has not been approved by the FDA, and further study of the safety and efficacy of this strategy is needed (165). Definitive treatment of hypertensive crises usually involves intravenous administration of phentolamine in an emergency room setting.

ii. Serotonin syndrome

This syndrome most commonly occurs when MAOIs are taken in close proximity to other serotonergic agents (166). When patients are being switched from an SSRI with a short half-life to an MAOI, a waiting period of at least 2 weeks is needed between the discontinuation of one medication and the initiation of the other. When switching from fluoxetine to an MAOI, a waiting period of at least 5 weeks is needed before the MAOI is started. The serotonin syndrome may also occur when venlafaxine is administered soon after an MAOI (167).

iii. Cardiovascular effects

Orthostatic hypotension is commonly seen during MAOI treatment. Possible treatments for this side effect include the addition of salt to increase intravascular volume or use of the steroid fludrocortisone. MAOI use can also be associated with the development of peripheral edema, which may be helped by the use of support stockings.

iv. Weight gain

Weight gain is also commonly seen in patients treated with MAOIs. The likelihood of this side effect appears to vary with the agent used, with most weight gain seen with tranylcypromine and the least with phenelzine.

v. Sexual side effects

Sexual side effects seen with MAOI therapy include anorgasmia, decreased libido, and erectile or ejaculatory dysfunction. Sexual side effects may diminish over time or with reductions in MAOI doses.

vi. Neurological effects

MAOI treatment can also be accompanied by headaches and insomnia; these side effects may diminish over time with continued use. Other neurological effects seen with MAOI use include sedation, myoclonic jerks, paresthesias, and, rarely, peripheral neuropathy.

d) Implementation

Typical starting doses and typical effective adult dose ranges that have been used in short-term efficacy trials of antidepressant medications appear in Table 1. Initial doses should be incrementally raised as tolerated until a presumably therapeutic dose is reached. For some antidepressant medications, the exact relationships between doses and major depressive disorder symptom response have not been rigorously investigated with fixed-dose studies, and minimum effective doses have not been clearly established; for other antidepressant medications, studies have failed to show dose-response relationships (168–170). Therefore, the initial doses and usual adult doses in Table 1 are intended to serve as general guidelines, and actual doses may vary from individual to individual. In general, older patients, medically frail patients, or patients with decreased ability to metabolize and clear antidepressant medications will require lower doses; in such patients, reduction of initial and therapeutic doses to 50% of usual adult doses is often recommended. Doses will also be affected by the side effect profile of medications and the patient's ability to tolerate these.

In short-term efficacy trials, all antidepressant medications appear to require 4–6 weeks to achieve their maximum therapeutic effects (171, 172) (although some patients may show partial improvement by as soon as the end of the first week [173]). Therefore, adequacy of response cannot be judged until after this period of time. Patients should be alerted to this and instructed to continue taking their antidepressant medications throughout this initial period.

For some medications, particularly the tricyclic antidepressants nortriptyline, desipramine, and imipramine, blood drug levels have been shown to correlate with both efficacy and side effects. Although in most cases monitoring of serum antidepressant medication levels is not necessary, in some circumstances this can be very useful. These circumstances can include when patients have not responded to adequate doses of an antidepressant medication given for adequate durations; when patients are particularly vulnerable to the toxic effects of a medication and require the lowest possible effective dose; when there are concerns about patient adherence; and when there is concern that drug-drug interactions are adversely affecting antidepressant medication levels.

Some antidepressant medications, especially tricyclics, can be associated with significant morbidity and potentially mortality in overdose. Ingestion of a 10-day supply of a tricyclic agent administered at a dose of 200 mg/day is often lethal. Early on in treatment, it is prudent to dispense only small quantities of such antidepressant medications and keep in mind the possibility that patients can hoard medications over time. Alternatively, in patients who are suicidal it may be preferable to employ agents that are safer in overdose such as the SSRIs, trazodone, nefazodone, bupropion, venlafaxine, or mirtazapine.

2. Failure to respond to pharmacotherapy in the acute phase

Adequate treatment with an antidepressant medication for at least 4–8 weeks is necessary before concluding that a patient is not responsive or only partially responsive to a particular medication (172). Initial treatment with antidepressant medication fails to achieve a satisfactory response in approximately 20%–30% of patients with major depressive disorder; poor treatment response has been found to be not just the result of inadequate treatment but also a consequence of inappropriate diagnoses; failure to appreciate and remedy coexisting general medical conditions, psychiatric disorders, or complicating psychosocial factors; and nonadherence (174). For these reasons a first step in the care of a patient who has not responded to medication should be a review and reappraisal of the diagnosis, adherence, and neglected contributing factors, including general medical problems, alcohol or substance abuse or dependence, other psychiatric disorders, and general psychosocial issues impeding recovery. In cases where nonadherence or complicating psychosocial stressors are prominent, the addition of psychotherapy may be effective in enhancing response (152).

For patients whose treatment failure is not readily attributable to inappropriate diagnoses, poor adherence, or complicating conditions, a variety of therapeutic options are available, including maximizing the initial treatment, switching to another non-MAOI agent, augmenting antidepressant medications with other medications or psychotherapy, using an MAOI, and ECT (5). Empirical data concerning the relative efficacies of these strategies are limited.

a) Maximizing initial treatments

There is little evidence to support extending antidepressant medication trials beyond 6 weeks in patients who have shown no response. However, for patients who have shown a partial response, particularly those with features of personality disorders and prominent psychosocial stressors, extending the antidepressant medication trial (e.g., by 2–4 weeks) may allow up to one-third of patients to respond more fully (6).

Use of higher antidepressant medication doses is another strategy to maximize an initial treatment regimen, especially for patients who have received only modest doses or those who for pharmacodynamic reasons have low serum drug levels despite adequate doses and adherence.

Unfortunately, with the exception of nortriptyline, therapeutic windows for serum drug levels of most antidepressant medications are unknown. In addition, the strategy of increasing doses is often limited by the occurrence of more frequent and severe side effects.

b) Switching to a different non-MAOI agent

With the introduction of many newer antidepressant medications, switching to a different non-MAOI antidepressant medication has been a common strategy for patients who have failed a trial of pharmacotherapy. A few trials have been conducted in which patients who failed an initial antidepressant medication were switched to a non-MAOI antidepressant medication from the same pharmacologic class (e.g., from one tricyclic antidepressant to another) or to one from a different pharmacologic class (e.g., from a tricyclic antidepressant to an SSRI). Although results from these trials have been variable, up to 50% of patients have been found to respond to a second non-MAOI antidepressant medication trial (5). Data regarding the types of treatment-refractory patients who are most likely to benefit from particular switching strategies are limited. Although their use in this context has not been extensively evaluated, mood stabilizers such as carbamazepine and valproic acid have demonstrated some benefit in the treatment of medication-resistant major depressive disorder (175, 176).

c) Augmenting antidepressant medications with other treatments

Antidepressant medication augmentation strategies often consist of the use of multiple non-MAOI antidepressant medications. An SSRI in combination with a tricyclic agent, such as desipramine, has been reported to induce a rapid antidepressant medication response (50). However, SSRIs added to a tricyclic antidepressant medication may cause an increased blood level and delayed elimination of the tricyclic medication, predisposing the patient to tricyclic medication toxicity unless the dose of the tricyclic is reduced (177).

Lithium is another medication commonly used as an adjunct; other agents in use are thyroid hormone and stimulants. Lithium is felt by many experienced clinicians to be the most effective adjunct; it is reported to be useful in up to 50% of antidepressant medication nonresponders and is usually well tolerated (178). The interval before full response to adjunctive lithium is said to be in the range of several days to 3 weeks. The blood level required in this context has not yet been determined. If effective and well tolerated, lithium should be continued for the duration of treatment of the acute episode. Lithium may also increase the antidepressant medication effectiveness of carbamazepine (179). Thyroid hormone supplementation, even in euthyroid patients, may increase the effectiveness of antidepressant medication treatment (180). The dose proposed for this purpose is 25 μg/day of triiodothyronine, increased to 50 μg/day in a week or so in the event of continued nonresponse. The duration of treatment required has not been well studied. Case reports suggest that stimulant medications may be effective adjuncts to antidepressant medication therapy (181, 182). There are no clear guidelines regarding the length of time stimulants should be coadministered.

A rarely used strategy is the combined use of a tricyclic antidepressant medication and an MAOI. This combination has been shown to be effective in alleviating some severe medication-resistant major depressive disorders; however, the risk of toxic interactions necessitates careful monitoring (183, 184). The combined use of MAOIs and other antidepressant medications has in some circumstances led to serious untoward reactions characterized by delirium, hyperthermia, hyperreflexia, myoclonus, and death; the reaction is sometimes referred to as the serotonin syndrome and is thought to be the result of overly enhanced serotonergic transmission. Use of an MAOI in combination with a tricyclic antidepressant should probably not be considered until all other strategies for treatment-refractory patients have been exhausted; psychiatrists and patients choosing to use an MAOI and a tricyclic antidepressant should be well acquainted with the potential hazards and carefully weigh the relative risks and benefits of such a strategy.

Data indicating the relative efficacies of the various adjunctive treatments are generally lacking.

d) Using a monoamine oxidase inhibitor

The role of MAOIs in major depressive disorder has largely become that of a treatment for patients who have failed other pharmacotherapies. Studies have demonstrated the effectiveness of MAOIs in patients who have failed to respond to other antidepressant medications, particularly tricyclic antidepressants (185). However, the effectiveness of MAOIs relative to other strategies for treatment-resistant patients remains unclear. Great care must be taken when switching patients from another antidepressant medication to an MAOI and from an MAOI to other antidepressant medications because of the persistence of the effects of discontinued medications and their metabolites and the potential for toxic interactions. For example, if the clinician chooses to discontinue a monoamine uptake blocking antidepressant medication and substitute an MAOI, toxic interactions can best be avoided by allowing a 1- to 2-week washout period between medication trials. The long half-life of the SSRI fluoxetine and its metabolites necessitates a 5-week washout period before the use of an MAOI.

e) Using electroconvulsive therapy

ECT has the highest rate of response of any form of antidepressant treatment and should be considered in virtually all cases of moderate or severe major depressive disorder not responsive to pharmacologic intervention. Even medication-resistant patients may show at least a 50% likelihood of a satisfactory response to ECT (186). ECT may also be the strategy of choice for patients with major depressive disorder with psychotic symptoms who have not responded to an antidepressant medication plus antipsychotic medication. ECT is generally considered to be safer than many forms of combination antidepressant medication treatment, although data to support this are lacking. There is growing use of ECT combined with antidepressant medication to potentiate response, although only a small amount of data supporting this practice presently exists (72, 187–191). The safety of combining lithium and ECT has been questioned, although there are conflicting data (72, 192–195).

3. Electroconvulsive therapy

a) Efficacy

ECT has been shown in controlled clinical trials to have efficacy that is superior to placebo, simulated ECT, and antidepressant medication therapy (196). The proportion of patients with major depressive disorder who respond to ECT is high, with 80%–90% of those treated showing improvement (197). Results of several studies indicate that ECT can be effective in over half of patients with major depressive disorder who have failed antidepressant medication therapy (198–200).

The report of the APA Task Force on Electroconvulsive Therapy identified patient populations for whom ECT may be particularly beneficial and indicated (72, 201). ECT should be considered as the treatment choice for severe major depressive disorder when it is coupled with psychotic features, catatonic stupor, severe suicidality, or food refusal leading to nutritional compromise, as well as in other situations (such as pregnancy or when a particularly rapid antidepressant response is required). ECT is also indicated as a first-line treatment for patients who have previously shown a positive response to this treatment modality or who prefer it. It should be considered for all patients with functional impairment whose illness has not responded to medication or who have a medical condition that precludes the use of an antidepressant medication.

b) Side effects

ECT is generally a very safe treatment. However, although risks of morbidity and mortality in general do not exceed those associated with anesthesia alone, some types of serious medical conditions may have an increased risk with ECT as well as with other treatment modalities (72, 202–204). The chief side effects of ECT are cognitive. Treatment is associated with a transient postictal

confusional state and with a longer period of anterograde and retrograde memory interference. The anterograde memory impairment, which has been difficult to disentangle from the memory deficits accompanying major depressive disorder itself, typically resolves in a few weeks after cessation of treatment (205). Some degree of retrograde amnesia, particularly for recent memories, may continue, at least for patients receiving bilateral ECT (72, 206–209). Rarely, patients report more pervasive and persistent cognitive disruption, the basis of which is uncertain (210).

ECT may have cardiovascular side effects, mediated by changes on the autonomic nervous system. ECT can cause a transient rise in heart rate, cardiac workload, and blood pressure, which may have deleterious effects on patients with cardiovascular disease, including recent myocardial infarction, congestive heart failure, and cardiac arrhythmias (211). The presence of significant cardiovascular disease in candidates for ECT is an indication for caution and general medical or cardiology consultation.

ECT has also been associated with a transient rise in intracranial pressure and blood-brain barrier permeability (212). For these reasons, patients with evidence of increased intracranial pressure or cerebrovascular fragility are at substantially greater risk and should only receive ECT after careful general medical, neurological, or neurosurgical evaluation (72, 78).

c) Implementation

The evaluation preceding ECT should consist of a psychiatric history and examination to verify the indication for this treatment, a general medical evaluation to define risk factors (including medical history and physical examination with cognitive assessment, vital signs, and any specifically indicated laboratory tests), anesthesia evaluation addressing the nature and extent of anesthetic risk and the need for modification of medications or anesthetic technique, the obtaining of informed consent, and, finally, an evaluation that summarizes treatment indications and risks and suggests any indicated additional evaluative procedures, alterations in treatment, or modifications in ECT technique (72). In assessing cases with indications for caution (e.g., recent myocardial infarction, cardiac arrhythmias, and intracranial-space-occupying lesions), the relative risks and benefits should be carefully weighed in collaboration with an anesthesiologist and a general medical physician, cardiologist, or neurologist, as the case requires.

ECT may be administered either bilaterally or unilaterally. Compared to bilateral treatment, unilateral placement induces less cognitive interference in most patients, but in some cases it is also less effective (213). When unilateral treatment is used, stimuli that are only marginally above seizure threshold exhibit a less satisfactory antidepressant medication effect than those of higher intensity, although this effect must be balanced against the cognitive interference evoked by grossly suprathreshold stimulation. In the event that unilateral treatment is initiated and the patient does not respond satisfactorily to the initial six treatments, bilateral treatment should be considered. Stimulus parameters vary from patient to patient but should be titrated to induce an adequate generalized seizure, which is typically at least 15–25 seconds in duration (72, 214, 215).

The total course of treatment should be such that maximal remission of symptoms is achieved (i.e., the patient fully recovers or reaches a plateau); typically this involves 6 to 12 treatments and generally does not exceed 20 treatments (72, 216). ECT is typically administered every other day; less frequent administration has been associated with less cognitive impairment but also a prolonged period until onset of action (217).

Patients should be maintained on antidepressant medication therapy or lithium following acute response to ECT (218). Patients who do not respond to such maintenance medication therapies may require maintenance ECT treatment (219).

4. Light therapy

Although several trials conducted during the 1980s demonstrated that bright light therapy was more effective than a dim-light control condition, some questions have been raised concerning the adequacy of the study designs (220). However, recent trials with more adequate control

conditions have also demonstrated the effectiveness of bright light therapy over nonlight control conditions (221–223). On the basis of limited trial data, bright light therapy has been suggested as a first-line treatment in subsyndromal winter "blues" and as an adjunct in chronic major depressive disorder or dysthymia with seasonal exacerbations. Patients with a history of reactivity to ambient light, hypersomnia, atypical negative symptoms, and overeating of sweet food in the afternoon have also been considered candidates for favorable response to light treatment. On the other hand, studies of the role of light therapy in premenstrual dysphoria or in older patients with nonseasonal major depressive disorder with advanced sleep phase disorder yielded equivocal results.

Side effects of light therapy include headache, eye strain, irritability, insomnia, and occasionally hypomania, which declines by decrease of exposure time and/or distance to light. Although patients with retinal diseases or ordinary photosensitivity, systemic lupus erythematosus, and history of skin cancer are vulnerable, none of these conditions is an absolute contraindication for light therapy. Each condition would require the attention and consultative supervision of the appropriate specialist if the light therapy is to be conducted.

A 10,000-lux intensity light box slanted toward the patient's face for 30 minutes/day either once or in two divided times is the preferred short-term treatment procedure. Timing may be designed to secure adherence. The late-night application is discouraged as it may cause insomnia. Duration of treatment is titrated according to the patient's reaction. Patients usually show improvement within 1 week, but at times the full response manifests over several weeks.

Patients who are responsive may be given light therapy at each episode of recurrence, presumably without any diminished efficacy. Prophylactic use of light therapy administered in the late fall and early winter is being explored. Combining light therapy with an antidepressant medication may potentiate the effectiveness of each agent. Such an approach may be useful if either or both therapies cannot be used in full therapeutic doses. The potential photosensitizing effect of antidepressant medications should be considered, and patients receiving both treatments should be advised to take appropriate precautions.

5. St. John's wort

St. John's wort is a whole plant product with antidepressant medication properties. Since it is not regulated as a drug by the FDA, preparations lack standardization regarding their contained ingredients and composition as well as potency.

A recent review of 14 short-term, double-blind (although the distinctive taste of St. John's wort extract may have caused some unblinding) trials conducted in outpatients with mild to moderate major depressive disorder symptoms demonstrated that St. John's wort had efficacy superior to placebo and generally comparable to low-dose tricyclic treatment (e.g., amitriptyline, 30–150 mg/day) (1). The proportion experiencing any side effect was lower among those taking St. John's wort than tricyclics (25% versus 40%) (1).

Although the doses of St. John's wort used in trials ranged between 300 and 1,800 mg/day, differences in extract preparations make dose comparisons and the identification of optimal doses difficult. The combined use of St. John's wort with MAOIs is contraindicated. The safety and efficacy of the combined use of St. John's wort with other antidepressant medications is not known.

B. ACUTE PHASE PSYCHOSOCIAL INTERVENTIONS

1. Goals

A range of psychosocial interventions may be useful in the acute treatment of major depressive disorder. Although various therapeutic approaches are discussed here and in the literature as

distinct entities, such separate categorizations are primarily useful for heuristic or research purposes. In practice, psychiatrists use a combination or synthesis of various approaches and strategies; these in turn are determined by and individually tailored to each patient on the basis of that person's particular conditions and coping capacities. In actual application the techniques and the therapist-patient relationship are powerfully intertwined.

2. Efficacy

Evaluating the efficacy of psychotherapeutic approaches for major depressive disorder can be complicated by several problems. For some types of psychotherapeutic interventions, few or no clinical trials have been conducted. Those that have been conducted have compared psychotherapy to a variety of control conditions such as waiting lists, other forms of psychotherapy, medications, placebos, or no control group, making comparisons of the observed treatment effect sizes between trials difficult. Some trials have not examined the effects of psychotherapy exclusively among patients with major depressive disorder and may not have examined or adequately assessed, specifically, improvement in major depressive disorder as an outcome. In other trials, the nature of the psychotherapeutic intervention has involved a poor protocol or has been poorly described, thereby making generalization of the study results to psychotherapeutic approaches used in practice difficult.

a) Cognitive behavioral therapy

Cognitive behavioral therapy (also considered to include cognitive psychotherapy) maintains that irrational beliefs and distorted attitudes toward the self, the environment, and the future perpetuate depressive affects. The goal of cognitive behavioral therapy is to reduce depressive symptoms by challenging and reversing these beliefs and attitudes (224).

In the two decades since it was first evaluated as a treatment for major depressive disorder, cognitive behavioral therapy has been extensively studied in over 80 controlled trials. Based on different subsets of these trials, several meta-analytic studies have quantified the efficacy of cognitive behavioral therapy. Effect sizes for cognitive behavioral therapy compared to no treatment or minimal treatment have been fairly robust (generally near or above 1 standard deviation in the outcome measure) (53, 225–228). However, estimates from meta-analyses of the effectiveness of cognitive behavioral therapy relative to other treatments have been more inconsistent, probably because of differences in the criteria that were used to include or exclude trials (e.g., characteristics of study populations, interventions or control conditions, or outcome measures used). For example, some meta-analyses have concluded that effect sizes for cognitive behavioral therapy are larger than for pharmacotherapy (225–231), whereas others suggest they are equally effective (232). Effect sizes for cognitive behavioral therapy have generally been at least as large as, and in some cases larger than, for other forms of psychotherapy such as behavior therapy, interpersonal therapy, or brief dynamic psychotherapy (231).

There have been suggestions on the basis of individual clinical trials that the efficacy of cognitive behavioral therapy may differ on the basis of the severity of major depressive disorder. In subanalyses of the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program study, cognitive behavioral therapy was observed to be less effective than imipramine plus clinical management among individuals with severe depression (defined as scores $\geq$20 on the Hamilton Rating Scale for Depression or $\leq$50 on the Global Assessment of Functioning); there was also a trend for cognitive behavioral therapy to be less effective than interpersonal therapy (233). No differences were observed between cognitive behavioral therapy, interpersonal therapy, imipramine plus clinical management, or placebo plus clinical management among less severely depressed subjects. Other trials have failed to show differential responses to treatments on the basis of initial symptom severity, possibly because of lack of statistical power (230, 234).

Several studies have used clinical trial data to identify other characteristics of patients that may be associated with differential response to cognitive behavioral therapy. Factors suggested as being associated with poor response to cognitive behavioral therapy include unemployment, male gender, comorbidity, dysfunctional attitudes, and several laboratory test values (e.g., abnormal sleep EEG results, increased hypothalamic-pituitary-adrenocortical activity, and increased T_4; 235–238). On the other hand, results from several analyses have suggested that cognitive behavioral therapy may be more effective than other treatments for depressed individuals with personality disorders (42, 239).

b) Behavior therapy

Behavior therapy of major depressive disorder is based on theoretical models drawn from behavior theory (240) and social learning theory (241). Specific behavior therapy techniques include activity scheduling (155, 242), self-control therapy (243), social skills training (244), and problem solving (245).

Although the efficacy of behavior therapy has been examined in a substantial number of trials, relatively few have employed random assignments and adequate control arms. Two meta-analyses that covered 10 of these trials have concluded that behavior therapy is superior to wait listing (observed in seven of eight trials) (92, 231). Results of individual clinical trials have suggested that behavior therapy may be superior in efficacy to brief dynamic psychotherapy (246, 247) and generally comparable in efficacy to cognitive therapy (248–251) or pharmacotherapy (252).

One post hoc examination of clinical trial data found that response to behavior therapy may be more likely in patients with less initial severity of major depressive disorder symptoms (253), whereas other studies have not (254–256). Among depressed adolescents, parental involvement has been found to predict response to behavior therapy (257).

c) Interpersonal therapy

Interpersonal therapy focuses on losses, role disputes and transitions, social isolation, deficits in social skills, and other interpersonal factors that may impact the development of depression (258). Interpersonal therapy attempts to intervene by facilitating mourning and promoting recognition of related affects, resolving role disputes and transitions, and overcoming deficits in social skills to permit the acquisition of social supports.

In one trial conducted among depressed psychiatric patients, interpersonal therapy was found to be superior to nonscheduled controls and comparable to other active treatments, including cognitive therapy or antidepressant medication (231). In the NIMH Treatment of Depression Collaborative Research Program study, interpersonal therapy was also reported to be more effective than placebo plus clinical management and comparable to cognitive behavioral therapy or imipramine plus clinical management (42). However, in subanalyses, interpersonal therapy, cognitive behavioral therapy, and imipramine plus clinical management were no different from placebo plus clinical management among those with mild depression severity (defined as scores of <20 on the Hamilton depression rating scale or >50 on the Global Assessment of Functioning); among those with more severe major depressive disorder, both interpersonal therapy and imipramine plus clinical management were more effective than either cognitive behavioral therapy or placebo plus clinical management (233, 259). A controlled trial of interpersonal therapy has also been conducted demonstrating the effectiveness of interpersonal therapy among depressed primary care patients (260). After 8 months, the proportions of patients treated with interpersonal therapy, nortriptyline, or usual care that achieved remission were 46%, 48%, and 18%, respectively.

Some recent studies have also suggested possible subgroups in whom interpersonal therapy may show differential efficacy. In one trial conducted among HIV-positive patients with major depressive disorder, significantly greater improvement was observed following interpersonal therapy than supportive therapy (261). In a subsequent study among depressed HIV-positive

patients, greater improvements were observed after interpersonal therapy or interpersonal therapy plus imipramine than supportive psychotherapy or cognitive behavioral therapy (262). On the other hand, post hoc analyses of clinical trial data suggest that there may be an interaction between type of psychotherapy and dimensions of personality. Two such analyses have found that patients with major depressive disorder with personality disorders, particularly avoidant personality pathology, may be less responsive to interpersonal therapy than cognitive therapy (42, 263). Conversely, interpersonal therapy has been proposed to be more effective than cognitive therapy for patients with major depressive disorder with obsessive personality traits and for patients who are single and noncohabitating (264).

d) Psychodynamic psychotherapy

The term "psychodynamic psychotherapy" encompasses a number of psychotherapeutic interventions that may be brief or long-term in duration (265–267). These interventions share a basis in psychodynamic theories regarding the etiologic nature of psychological vulnerability, personality development, and symptom formation as shaped by developmental deficit and conflict occurring during the life cycle from earliest childhood forward (268–272). Some of these theories focus predominantly on conflicts related to guilt, shame, interpersonal relationships, the management of anxiety, and repressed or unacceptable impulses. Others are more focused on developmental psychological deficits produced by inadequacies or problems in the relationship between the child and emotional caretakers, resulting in problems of self-esteem, a sense of psychological cohesiveness, and emotional self-regulation (271, 273–277).

Psychodynamic psychotherapy is most often of longer-term duration than other psychotherapies and is usually associated with goals beyond that of immediate symptom relief. These goals are usually associated with an attempt to modify the underlying psychological conflicts and deficits that increase the patient's vulnerability to major depressive affect and the development of major depressive disorder. Psychodynamic psychotherapy is therefore much broader than most other psychotherapies, encompassing both current and past problems in interpersonal relationships, self-esteem, and developmental conflicts associated with anxiety, guilt, or shame. Time-limited, structured psychodynamic psychotherapy may focus more on understanding the psychological basis of the presenting symptoms or on a selected underlying conflict. It is often combined with psychopharmacologic intervention to reduce the major depressive disorder episode, which is consistent with the common belief that major depressive disorder is a biopsychosocial phenomenon. Sometimes a goal of psychodynamic psychotherapy, brief or extended, may be to help the patient accept or adhere to necessary pharmacotherapy (8).

Determining the efficacy of psychodynamic psychotherapy as a single modality in the treatment of major depressive disorder is complicated by two problems. First, many trials of psychodynamic psychotherapy for depression have included patients with conditions that would not meet DSM-IV criteria for major depressive disorder. Second, variations of psychodynamic psychotherapy have served in many studies as a nonspecific comparison treatment to other psychotherapeutic interventions; as a result, details of the psychodynamic psychotherapy employed have been poorly defined. Results of two meta-analyses suggest that brief psychodynamic psychotherapy for the treatment of major depressive disorder is more effective than a waiting list control condition but probably less effective than other forms of psychotherapy (92, 231). In one of these meta-analyses involving six trials (92), the proportions of patients considered to be responders to brief psychodynamic psychotherapy, cognitive therapy, interpersonal therapy, and behavioral therapy were 35%, 47%, 52%, and 55%, respectively. Research on the efficacy of combined pharmacotherapy and brief psychodynamic psychotherapy (278, 279) is also limited and inconclusive.

Although psychodynamic psychotherapy appears to be used widely in clinical practice, the efficacy of long-term psychodynamic psychotherapy in the acute phase of major depressive disorder has not been adequately studied in controlled trials.

e) Marital therapy and family therapy

Marital and family problems are common in the course of mood disorders, and comprehensive treatment often demands that these problems be assessed and addressed. Marital and family problems may be a consequence of major depressive disorder but may also increase vulnerability to major depressive disorder and in some instances retard recovery (280, 281). Techniques for using marital/family approaches for the treatment of major depressive disorder have been developed, including behavioral approaches (280), a psychoeducational approach, and a strategic marital therapy approach (9). Family therapy has also been used in the inpatient treatment of patients with major depressive disorder (282).

Studies of the efficacy of marital or family therapy, either as a primary or adjunctive treatment, have been conducted among patients with depressive symptoms and not among patients with, specifically, major depressive disorder. Based on data from 17 clinical trials of marital therapy, two reviews have concluded that it is an effective means for reducing major depressive disorder symptoms and risk of relapse (283, 284). Results from individual studies suggest that the efficacy of marital therapy and its effectiveness relative to other psychotherapies may depend on whether marital distress is present. In one study, a greater proportion of depressed subjects with marital distress responded to marital therapy than cognitive therapy (88% versus 71%); on the other hand, among depressed subjects without marital distress, a greater proportion responded to cognitive therapy than marital therapy (85% versus 55%) (285). In another study conducted among depressed subjects with marital discord, marital therapy and cognitive behavioral therapy were both equally effective and more effective than a wait list condition (286).

f) Group therapy

Specific types of psychotherapy for which there are some data to support that they may be effective in the treatment of depression when administered in a group format include cognitive behavioral therapy (287–289) and interpersonal therapy (290–291). Although there have been meta-analyses of the relative effectiveness of psychotherapeutic approaches conducted in a group format versus an individual format, these have not specifically involved studies of patients with rigorously defined major depressive disorder (292–295).

On the basis of very limited controlled studies, supportive group therapy has also been suggested to be useful in the treatment of major depressive disorder. For example, one recent study conducted among depressed outpatients found that a mutual support group and cognitive behavioral therapy in a group format were equally effective in reducing depressive symptoms among depressed outpatients (287). In another study of patients with mild to moderate major depressive disorder who were also HIV positive, treatment with structured supportive group therapy plus placebo yielded similar decreases in depressive symptoms as structured group therapy plus fluoxetine (296). Individuals experiencing bereavement or such common stressors as chronic illness may particularly benefit from the example of others who have successfully dealt with the same or similar challenges. Survivors are offered the opportunity to gain enhanced self-esteem by making themselves models for others, and they offer newer patients successful role models.

Medication maintenance support groups may also offer benefits, although data from controlled trials among patients with major depressive disorder are lacking. Such groups provide information to the patient and to family members regarding prognosis and medication issues, thereby providing a psychoeducational forum that makes a chronic mental illness understandable in the context of a medical model.

The efficacy of self-help groups led by lay members (297) in the treatment of major depressive disorder has not been well studied. However, one recent investigation of group therapies found that a higher proportion of depressed outpatients had remitted following treatment in groups led by professionals than in groups led by nonprofessionals (287). The possibility that self-help support groups comprising individuals with major depressive disorder may serve a

useful role by enhancing the support network and self-esteem of participating patients and their families requires future study.

3. Side effects

In general, psychotherapeutic treatments are relatively safe and well-tolerated interventions. Psychotherapeutic approaches that may employ exposure to unpleasant situations (e.g., behavior therapy, cognitive behavioral therapy) may initially increase distress in patients. Psychotherapy that requires considerable time or patience to practice frequent exercises may be poorly tolerated.

One imperfect measure of the relative side effects and tolerability of psychotherapy can be obtained from the dropout rates in clinical trials; however, many other factors can also affect these rates (e.g., other burdens of the research trial, specific features of the clinical management provided). In the NIMH Treatment of Depression Collaborative Research Program, dropout rates during 16 weeks of treatment with interpersonal therapy, cognitive behavioral therapy, imipramine plus clinical management, or placebo plus clinical management were 23%, 32%, 33%, and 40%, respectively (259).

4. Implementation

There can be a variety of methods for conducting psychotherapeutic interventions, both between and within specific types of psychotherapy.

Clinical considerations and other patient factors should be considered in determinations of the nature and intensity of psychosocial interventions. Generally, dynamic psychotherapy is conducted in a less directive manner than behavioral psychotherapy; transference considerations and the patient's freedom to associate into unexpected material are taken into account. More behaviorally oriented psychotherapy, on the other hand, may be conducted in a more structured manner and require patients to be instructed in practice exercises and monitoring techniques.

There are little data available on optimal length of psychosocial interventions. In many trials, cognitive behavioral therapy has been delivered in approximately 12 weekly sessions and interpersonal therapy has been delivered in 16–20 weekly sessions. In a subanalysis of one clinical trial, cognitive behavioral therapy delivered in 16 weeks was more effective than cognitive behavioral therapy delivered in 8 weeks among those with severe major depressive disorder (298).

C. PSYCHOTHERAPY COMBINED WITH PHARMACOTHERAPY

Several reviews of trials of the combination of psychotherapy and pharmacotherapy for patients with mild to moderate major depressive disorder have failed to find the combination to be superior to either treatment modality alone (92, 299). On the other hand, among patients with severe or recurrent major depressive disorder, the combination of psychotherapy (including interpersonal therapy, cognitive behavioral therapy, behavior therapy, or brief dynamic therapy) and pharmacotherapy has been found to be superior to treatment with a single modality in individual studies (38, 300–304) and a meta-analysis (305).

Results from a series of recent studies provide indirect evidence that for patients who have had only a partial response to pharmacotherapy, adding a course of cognitive behavioral therapy may be an effective strategy for preventing relapse (306–309).

D. CONTINUATION TREATMENT

The continuation phase of treatment is generally considered to be the 16–20 weeks after achieving full remission. The goal of continuation treatment is to prevent relapse in the vulner-

able period immediately following symptomatic recovery. Several studies have shown that if antidepressant medications are discontinued following recovery, approximately 25% of patients will relapse within 2 months (92, 310, 311). There is evidence that patients who do not completely recover during acute treatment have a significantly higher risk of relapse than those who have no residual symptoms and are especially in need of treatment in later phases (312).

Although randomized controlled trials of antidepressant medications in the continuation phase are limited, the available data indicate that patients treated for a first episode of uncomplicated major depressive disorder who exhibit a satisfactory response to an antidepressant medication should continue to receive a full therapeutic dose of that agent for at least 16–20 weeks after achieving and maintaining full remission (1, 313, 314).

There is some evidence that patients who are given cognitive behavioral therapy in the acute phase have a lower rate of relapse than those who receive and then discontinue antidepressant medications in the acute phase and an equivalent relapse rate to those who take antidepressant medication in the continuation phase (234). There have also been a few recent studies of treatment with psychotherapeutic interventions administered in the continuation phase. One study found that among patients who responded to acute treatment with cognitive therapy, those who continued this treatment over 2 years had lower relapse rates than those who did not have continuation treatment (315). Results from a series of studies (307, 309, 316) suggest that cognitive behavioral therapy may be an effective continuation treatment following antidepressant medication therapy for preventing relapse (306).

When treatments are ultimately tapered and discontinued after the continuation phase, patients should be carefully monitored during and immediately after discontinuation to ensure that remission is stable. Patients who have had multiple prior episodes of major depressive disorder should be considered for maintenance medication treatment.

E. MAINTENANCE TREATMENT

Major depressive disorder is, for many, a recurrent disorder. Among those suffering from an episode of major depressive disorder, between 50% and 85% will go on to have at least one lifetime recurrence, usually within 2 or 3 years (310). Factors that have been found to be associated with a higher risk of recurrence appear in Table 2. Factors that have been found to be associated with increased severity of subsequent episodes include a history of a prior episode complicated by serious suicide attempts, psychotic features, or severe functional impairment.

Among the therapeutic options available for maintenance treatment, antidepressant medications have received the most study. There have been over 20 trials of pharmacotherapy in the maintenance phase, and results from these have generally demonstrated the effectiveness of antidepressant medication for relapse prevention (317); these trials have mainly been of tricyclic antidepressant medications (318, 319), although six trials involved newer antidepressant medications (1). Information to assist in the full range of clinical decisions regarding medication use in the maintenance phase is more limited. Results from one study suggest that full doses are superior to lower doses in the maintenance phase, despite the fact that lower doses are less likely to produce side effects (320).

There have been fewer investigations of the effectiveness of psychotherapy in the maintenance phase. In one study, maintenance cognitive therapy delivered over 2 years was as effective as maintenance medication for recurrent major depressive disorder (228). Another report suggests that interpersonal psychotherapy during the maintenance phase may be effective in lengthening the interepisode interval in some less severely ill patients not receiving medication (318).

The combined use of psychotherapy, such as cognitive behavioral therapy, cognitive therapy, or interpersonal therapy, and pharmacotherapy in the maintenance phase has also been considered by investigators, and some results suggest that the combination of antidepressant medica-

tions plus psychotherapy may be additionally effective in preventing relapse over treatment with single modalities (307, 318, 319, 321, 322).

ECT has also been used in the maintenance phase, although evidence for its benefits comes largely from case reports (197, 219, 323, 324). The optimal frequency and duration of maintenance phase ECT treatments has not been well studied.

The timing and method of discontinuing maintenance treatment has not been systematically studied. However, the risk of cholinergic rebound observed with abrupt discontinuation of some antidepressant medications together with concerns about major depressive disorder recurrences after the discontinuation of any antidepressant medication argue in favor of gradual tapering (325).

PART C: FUTURE RESEARCH NEEDS

Notable progress has been made in our understanding of major depressive disorder and its treatment, including the introduction of a variety of therapeutic agents and treatment modalities. However, many issues remain regarding how to optimally use these treatments to achieve the best health outcomes for patients with major depressive disorder. The following are a few of the types of research questions that require future study.

VI. ANTIDEPRESSANT MEDICATIONS

In terms of the use of antidepressant medications during the acute, continuation, and maintenance phases of treatment, many important questions remain.

1. What are the specific clinical indications for the use of particular antidepressant medications?
2. What are the relative efficacies of different antidepressant medications?
3. What are the relationships between antidepressant blood levels and response?
4. What are the relative risks of toxicities (e.g., cardiotoxicity) and adverse effects for different antidepressant medications?
5. What should the duration of treatment be before a patient is considered medication-resistant, and does this duration vary among agents?
6. Does the combination of antidepressants from different pharmacologic classes (e.g., SSRIs and tricyclic antidepressants) offer greater efficacy than administration of single agents?
7. What are the comparative efficacies of different antidepressant medications in the continuation and maintenance phases?
8. What are the long-term side effects of chronic use of specific antidepressant medications?
9. What is the required duration of maintenance treatment with antidepressants?
10. What are indications for a trial of discontinuation of maintenance treatment?

VII. PSYCHOTHERAPY

Many issues concerning the use of psychotherapy in the treatment of major depressive disorder during the acute, continuation, and maintenance phases also require clarification. The disparity between the widespread use of psychodynamic psychotherapy in practice and the complete lack of rigorous studies of its efficacy must be addressed. In particular, there is a critical need to design and implement rigorous, controlled studies to evaluate the efficacy and effectiveness of psychodynamic psychotherapy for the treatment of patients with major depressive disorder.

In addition, the following are critical issues:

1. What are the relative efficacies of different psychotherapeutic approaches in the acute phase of treatment?
2. What components or aspects of specific psychotherapeutic approaches are responsible for efficacy? What common elements of all effective psychotherapeutic approaches are responsible for efficacy?
3. What are the indications (e.g., subtypes of depressive disorders) for use of various forms of psychotherapy?
4. What are the efficacies of particular psychotherapeutic approaches in the continuation and maintenance phases of treatment?
5. Is the use of multiple forms of psychotherapy, either concurrently or sequentially, effective?
6. What are the optimal frequencies of psychotherapeutic contact for the various forms of psychotherapy in the acute, continuation, and maintenance phases?

VIII. ELECTROCONVULSIVE THERAPY

Regarding ECT, additional research is needed to clarify several important issues.

1. What are indications for initial treatment with bilateral electrode placement?
2. After how many unilateral treatments without satisfactory response should a switch from unilateral to bilateral electrode placement be made?
3. Can the efficacy or tolerability of ECT be increased with adjunctive antidepressant and antipsychotic agents?
4. What are the indications and best methods for providing maintenance ECT?

IX. OTHER TREATMENT MODALITIES

In addition to research on the treatments covered above, additional rigorous investigation is needed to answer questions concerning other therapeutic modalities.

1. What are the indications, relative efficacies, and safety of specific treatments such as lithium or thyroid hormone as adjuncts to antidepressant medications for nonresponders?
2. Is light therapy effective as an adjunct in nonseasonal major depressive disorder or as a primary treatment for seasonal major depressive disorder in the maintenance phase?

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American Academy of Psychoanalysis
American Association of Community Psychiatrists
American College of Emergency Physicians
American Dietetic Association
American Society of Clinical Psychopharmacology, Inc.
Black Psychiatrists of America
Royal Australian & New Zealand College of Psychiatrics
Society for Adolescent Medicine

XI. REFERENCES

The following coding system is used to indicate the nature of the supporting evidence in the references:

[A] *Randomized clinical trial.* A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are blind to the assignments.

[B] *Clinical trial.* A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet standards for a randomized clinical trial.

[C] *Cohort or longitudinal study.* A study in which subjects are prospectively followed over time without any specific intervention.

[D] *Case-control study.* A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.

[E] *Review with secondary analysis.* A structured analytic review of existing data (e.g., a meta-analysis or a decision analysis).

[F] *Review.* A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.

[G] *Other.* Textbooks, expert opinion, case reports, and other reports not included above.

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Behavioral Health in Medi-Cal in 2014

PPG/PCP

Target Population: Children and adults in Managed Care Plans who meet medical necessity or EPSDT for Mental Health Services

Outpatient Services by PCP (Within the scope of practice)

- ✓ Routine Screening for Emotional Health and substance misuse
- ✓ Outpatient Medication Treatment and Monitoring
- ✓ Brief Counseling/Support/Education
- ✓ Screening, Brief Intervention and Referral for Treatment (SBIRT) for Alcohol, new service by primary care setting

LA Care/Beacon 877-344-2858

Target Population: Children and adults in Managed Care Plans who meet medical necessity or EPSDT for Mental Health Services

Newly expanded Carved-in effective 1/1/14

- ✓ Individual/group mental health evaluation and treatment (psychotherapy)
- ✓ Psychological testing when clinically indicated to evaluate a mental health condition
- ✓ Psychiatric consultation
- ✓ Outpatient services for the purposes of monitoring medication treatment
- ✓ Outpatient laboratory, supplies and supplements

LA County DMH 800-854-7771

Target Population: Children and adults who meet medical necessity or EPSDT criteria for Medi-Cal Specialty Mental health Services

Outpatient Services

- ✓ Mental Health Services (assessments plan development, therapy, rehabilitation and collateral)
- ✓ Medication Support
- ✓ Day Treatment Services and Day Rehabilitation
- ✓ Crises Intervention and Crises Stabilization
- ✓ Targeted Case Management
- ✓ Therapeutic Behavior Services

Residential Services

- ✓ Adult Residential Treatment Services
- ✓ Crises Residential Treatment Services

Inpatient Services

- ✓ Acute Psychiatric Inpatient Hospital Services
- ✓ Psychiatric Inpatient Hospital Professional Services
- ✓ Psychiatric Health Facility services

LA County DPH 888-742-7900

Target Population: Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal Substance Use Disorder Services

Outpatient Services

- ✓ Outpatient Drug Free
- ✓ Intensive Outpatient (newly expanded to all populations)
- ✓ Narcotic Treatment Program
- ✓ Naltrexone

Residential Services pregnant and postpartum women (possibly expanded to all populations)

Inpatient Services

- ✓ Voluntary Inpatient Detoxification Services (newly expanded with NO restriction of physical medical necessity)

L.A. Care HEALTH PLAN®

Updated 06/02/14

L.A. Care HEALTH PLAN®

L.A. Care's Mental Health and Substance Abuse Hotline

Beacon Health Strategies

Beacon can assist you with behavioral health management for L.A. Care members. Here's how:

Beacon

Who Can Use the Service?	Members in the L.A. Care direct lines of business: • Healthy Kids • LA Care Covered • Medi-Cal • Medicare Advantage (HMO SNP) • PASC-SEIU Homecare Workers Health Plan (PASC-SEIU Plan)
Service Provided	• Specialty mental health care • Triage, Linkages and Referrals

LA0780 01/14

Beacon

1-877-344-2858 (TTY/TDD 1-800-735-2929)

www.beaconhs.com

Available 24 hours a day, 7 days a week

Community Resource:

Department of Mental Health

1-800-854-7771 www.dmh.ca.gov

Department of Public Health/Substance Abuse Prevention & Control

1-800-564-6600 www.publichealth.lacounty.gov/sapc/

Available 24 hours a day, 7 days a week

BEHAVIORAL HEALTH SERVICE FAQ's

Q. What are the new Behavioral Health Benefits under Medi-Cal Expansion?

A. Medi-Cal expansion has added new health plan outpatient behavioral health benefits for all Medi-Cal members. These new benefits include individual and group therapy, psychiatric consultation, outpatient psychiatric services, psychological testing when clinically indicated to evaluate a mental health condition, and outpatient laboratory/medications/supplies and supplements.

Q. Who is providing these new benefits?

A. LA Care has contracted with Beacon Health Strategies Provider Network for this set of new benefits. Beacon, a Managed Behavioral Health Organization, also provides behavioral health services for L.A. Care's other lines of business.

Q. What Behavioral Health Services are in the scope of a PCP's practice?

A. A PCP will continue to be responsible for routine screening for emotional health; medication treatment and monitoring for mild to moderate common conditions such as depression, anxiety, ADHD, other stabled mental health conditions (for on-going medication), etc; and, brief counseling/support/education. Moreover, you will also be responsible for the new SBIRT services for alcohol misuse.

Q. What is SBIRT?

A. SBIRT stands for screening, brief intervention, and referral to treatment. Besides routine health education on alcohol and drug uses, PCP will now be required to conduct screening for individuals who answer positive to the single alcohol screening question included in the Staying Healthy Assessment or any time you identify someone with a potential alcohol misuse problem.

Q. What is included in the SBIRT services?

A. All SBIRT services must be provided by a PCP or an SBIRT trained non-licensed staff under the PCP/NP/PA/Psychologist supervision. The services include one screening session and up to three brief intervention sessions of 15-minute each in-person or via phone. PCPs are required to have a minimum of four hours of SBIRT training.

Q. Where can I get the SBIRT training?

A. Information on SBIRT training and resources can be found on the California Department of Health Care Services at http://www.dhcs.ca.gov

Q. Are there any changes to county mental health services?

A. LA County Department of Mental Health (DMH) will continue to provide the specialty mental health services. And, the LA County Department of Public Health/Substance Abuse Prevention & Control (DPH) will continue to be responsible for Drug Medi-Cal services.

Q. How do I know when and where to refer patient for behavioral health services when it is beyond my scope of practices?

A. When treatment for a mental health condition is beyond your scope of practices or when patient did not response to the SBIRT services you should refer the patient to the next appropriate level of care. To assist you with this process we have developed a screening tool. This screening tool, with step-by-step instruction, can be found **here** or on the Useful tools section. However, you may refer a patient directly to Beacon if you are not able to determine if the patient should be referred to DMH, Beacon or DPH. No Prior Authorization for Behavioral Health services are required.

Q. How do I contact Beacon Health Strategies?

A. You can contact Beacon at any time by calling 1-877-344-2858.

Q. If I am not a Beacon contracted Behavioral Health Provider, how do I proceed with providing continuity of care to an LA Care member?

A. You will need to contact Beacon Health Strategies to arrange for continuity of care with your practice. You may consider participating in Beacons Network. Beacon will work with you to assure continuity of care for an L.A. Care member.

Q. How do I become part of Beacons Network?

A. Call Beacon at 1-877-344-2858. Someone will assist you right away and begin the process.

URGENT Behavioral Health Screening Form to Obtain Specialty Mental Health Assessment
Please complete and follow algorithm

*****If this is an emergency, please call 911**

Referral Date: _____

MEMBER INFO

Patient Name: _____ Date of Birth: ____/____/____ ☐M ☐ F
(Last) (First)

Medi-Cal # (CIN): _____ Current Eligibility: _____ Language/cultural requirements: _____

Address: _____ City: _____ Zip: _____ Phone: (_____) _____

Caregiver/Guardian: _____ Phone: (_____) _____

Referring Clinician: _____ Phone: (_____) _____

Primary Care Provider _____Phone: (_____) _____Health Plan: _____

Behavioral Health Diagnoses (1) _____ (2) _____ (3) _____

Documents Included with Referral: ☐**Required consent completed** ☐MD notes ☐H&P ☐Assessment ☐Other: _____

Desired/Existing behavioral health clinician/provider/program, if any:_____

List A (check all that apply):

- ☐Homelessness
- ☐Still symptomatic after 2 standard psychiatric med trials
- ☐History of bipolar disorder or manic episode
- ☐Excessive truancy or failing school
- ☐Substance and/or EtOH addiction and failed SBI
- ☐Behavior problems (aggressive/self-destructive/assaultive)
- ☐Paranoid, hearing voices, seeing things, delusional
- ☐Excessive emergency room visits or hospitalization
- ☐Significant functional impairment in key roles (e.g. work, home, self-care)

List B (check all that apply):

- ☐>2 psychiatric hospitalizations in the past 12 months
- ☐Suicidal/Homicidal preoccupation or behaviors in past 12 months
- ☐>2 incarcerations in past 12 months
- ☐Diagnostic Uncertainty

Referral algorithm based on checked boxes:

☐ 1-2 in list A and none in list B: **Call Beacon Behavioral Health line for consult (use eConsult when available) 877-344-2858**

☐ 3 or more in list A and none in list B **OR** one in both lists: **Fax form to Beacon at 866-422-3413 then call 877-344-2858**

☐ 2 or more in list A and one in list B **OR** 2 or more in list B: **Email form to DMH screener@dmh.lacounty.gov then call 855-425-8141**

☐ Substance and/or EtOH addiction and failed SBI alone: **Fax form to SAPC at 626-458-7637 then call 888-742-7900**

Pertinent Current/Past Information

Current symptoms and impairments: _____

_____

Brief MH/SUD history: _____

Brief medical history: _____

Current Medication(s) & Dosage: _____

For Receiving Clinician Use ONLY

Assigned Case Manager/MD/Therapist Name: _____ Phone: (_____) _____

Date communicated assessment outcome with referral source: _____

Instruction for the Screener

If this is an emergency situation, please call 911

Abbreviation:

H&P: History and Physical exam

EtOH: Alcohol

MH/SUD: Mental Health and Substance use disorder

SBI: Screening and Brief Intervention

Explanation:

- '*Current Eligibility'*: other insurances, ie Medicare, private, etc
- *'Caregiver/Guardian'*: parents (for minor), conservator, etc
- *'Required consent completed'*: written consent (Authorization to Exchange Protected Health Information) or verbal consent (when screen over the phone) is required prior to release information to mental health and/or substance use disorder evaluator/receiving clinician (please clearly document)
- *'Desired/Existing behavioral health clinician/provider/program'*: if member/client or referral source prefers a specific program, clinician, or provider that would meet member's individual needs. If member/client is currently receiving services from a mental health program, clinician, or provider, please indicate name and contact info
- *'Excessive ER visit or 911 calls'*: In comparison to expected numbers of visits or calls that could be reasonably expected as a result of the patient's general physical and behavioral health conditions
- *'Diagnostic uncertainty'*: apply only when it is effecting behavioral health care planning

Referral clinician:

- If the Member/Client has an existing behavioral health clinician/provider or an open/active case in a program, please refer him/her directly to that treating source and send the written consent (or documentation for a verbal consent via phone) with the screen form to the treating source.
- For referrals to Beacon, please send the written consent (or documentation for a verbal consent via phone) with the screen form to the receiving clinician via encrypted email to Medi-CalReferral@beaconhs.com or eFax at **866-422-3413**, and then call the Beacon line at **877-344-2858**.
- For referrals to DMH, please send the written consent (or documentation for a verbal consent via phone) with the screen form to the provider referral center via encrypted email to screener@dmh.lacounty.gov or eFax at **562-863-3971** and then call the DMH line at **855-425-8141**.
- For referrals to County Substance Abuse Prevention & Control (DPH/SAPC), please send the written consent (or documentation for a verbal consent via phone) with the screen form to the provider referral fax at **626-458-7637**, and then call the SAPC line at **888-742-7900**.

Receiving clinician:

- Please make sure to communicate with the referral source regarding the assessment outcome and/or disposition. The completed "Authorization to Exchange PHI" accompanying the Behavioral Health Screening Form permits a response to the referral source without further authorization.
- Receiving clinician at Beacon, DMH, and DPH/SAPC will be required to track and send quarterly report to **Vilma Diaz**, vdiaz@lacare.org, at LA Care as part of the MOU/contract.
- After a full assessment and it is determined that the individual's treatment need is better met at a different system of care/level of care, please refer and send the complete assessment document to the appropriate system of care/level of care.
    - If the care is determined to be appropriately provided by PCP, contact Beacon to coordinate placement.
    - In the event of a disagreement as to the appropriate system of care/level of care, please forward the case to the appropriate identified individual responsible for dispute resolution within your system of care and continue with treatment while decision is pending.
- If the Member/Client has requested for services by self without any referral, please make sure to communicate with the identified primary care physician regarding the assessment outcome and/or disposition.

Access to Medi-Cal Specialty Mental Health Services

Level of Need	Indicators	Disposition	Who to Call
Emergency	• Acutely suicidal or homicidal • At risk of immediate harm	911 response • PMRT response • Urgent Care Center Referral	911 800-854-7771 (24/7 access)
Urgent Need for Assessment	Meet DMH threshold criteria on screener (Ψ)	Outpatient specialty mental health appointment scheduled	855-425-8141
Routine Appointments	Meet <u>all</u> below: • Medi-Cal Specialty Mental Health Included Diagnosis (*) • Significant functional impairment in key roles (e.g. work, home, self-care) • Expectation that proposed interventions can impact patient's condition • Condition will not be responsive to physical health care based treatments		Options: • Health Neighborhood Partner (Attachment A) • Service Area Navigator (Attachment B) • ACCESS: 1-800-854-7771 • Individual calls or walks in to specialty mental health providers (**)
	If does <u>not</u> meet all above		• Applicable Managed Care Plan (Behavioral Health line on Member's ID card)

ΨScreener: Urgent Behavioral Health Screening Form to Obtain Specialty Mental Health Assessment

Attachment A: Health Neighborhood Provider Partnership Listing (in development)
Attachment B: DMH Service Area Navigator Roster

*Included Diagnosis: Pervasive Developmental Disorders except Autistic Disorder, Attention Deficit & Disruptive Behavior Disorders, Feeding & Eating Disorders of Infancy or Early Childhood, Elimination Disorders, Other Disorders of Infancy, Childhood or Adolescence, Schizophrenia & other Psychotic Disorders, Mood Disorders, Anxiety Disorders, Somatoform Disorders, Factitious Disorders, Dissociative Disorders, Paraphilias, Gender Identity Disorders, Eating Disorders, Impulse-control Disorders not elsewhere classified, Adjustment Disorders, Personality Disorders excluding Antisocial Personality Disorders, Medication - Included Movement Disorders

**Info on http://dmh.lacounty.gov/wps/portal/dmh/for_providers

PHYSICAL AND BEHAVIORAL HEALTHCARE
INFORMATION EXCHANGE FORM- FAQs FOR PRIMARY CARE PRACTITIONERS

Frequently Asked Questions (FAQs) for **Primary Care Physicians** about obtaining a Behavioral Health consult or information for a beneficiary enrolled in MediCal Managed Care by using the Information Exchange Form:

Q1. What is the Physical and Behavioral Healthcare Exchange of Information Form?

This Form is to be utilized by physical and behavioral health care practitioners for the purpose of exchanging provider and beneficiary treatment information. The use of this form will enhance coordination of care for Medi-Cal Managed Care beneficiaries.

Q2. How do I use this form to obtain a consult or information from Behavioral Health Practitioners?

The Primary Care Physician(PCP) completes the Initiating a query or Coordination of care section of the Form with pertinent information including the issues the Primary Care Practitioner needs to have addressed by the Behavioral Health Care Practitioner (BHP). The Form may be transmitted as follows:

1. *Beneficiary is instructed to take Form back to their Behavioral Health Practitioner.*
2. *Primary Care Physician may call the Behavioral Health Practitioner and fax the form.*

Q3. What happens after Form is transmitted to the Behavioral Health Practitioner?

*The BHP reviews the questions or issues raised by the P CP and then fills out the section: - "**BEHAVIORAL HEALTH PROVIDER – RESPONDING TO REQUEST".** Alternatively the BHP may call the PCP, fax, or use other agreed to means of communication to transmit the Form back to the PCP.*

Q4. Is the PCP the first provider to fill out the Form or the BHP or does it matter?

Similar to the PCP initiating a request for information or coordination a BHP may initiate a request on a similar and specific Form that the BHP may use.

Q5. What should I do with the completed Form once it is returned to me?

Incorporate the information obtained into your treatment approach and include this Form into the beneficiaries' permanent medical record.

Q6. What about the issue of confidentiality?

Please explain this exchange of information between health providers to the beneficiaries. The Information Exchange Forms were jointly developed by the County Department of Mental Health and L.A. Care Health Plan for purposes of exchanging beneficiary treatment information and are compliant with HIPAA requirements.

Q7. Behavioral Health Practitioners use a similar form to obtain pertinent information from Primary Care Providers. What do I do with a similar form that has been given to me by a Behavioral Health Practitioner to complete?

Review the reason for the request in the "Initiating query or coordination of care" section and determine that you can respond to the query within your scope of practice. Next, complete the "Responding to request" section. Make a copy of the form for your beneficiary's medical record. and return the form to the beneficiary. Alternatively, you may fax, but not email, the form to the behavioral health practitioner.

PRIMARY HEALTH CARE EXCHANGE OF INFORMATION REQUEST
Medi-Cal Managed Care Program

This form is used for the purpose of exchanging practitioner and beneficiary information to enhance care coordination for Medi-Cal Managed Care beneficiaries.

BENEFICIARY INFORMATION

Name: _____ **DOB:** _____

Address: _____ **City:** _____ **Zip:** _____ **Telephone:** _____

SSN: _____ ☐ **Medi-Cal #:** _____

PRIMARY CARE PRACTITIONER (PCP) *– INITIATING QUERY OR COORDINATION OF CARE*

Practitioner's Name: _____ **Telephone:** _____ **FAX:** _____

Email: _____ **Date of Last Visit:** _____

Physical Diagnosis(es): _____

Current Medications: _____

Reason(s) for Request:

☐ Depression or anxiety symptoms not responding to therapy ☐ Suspected Pediatric ADHD ☐ Suspected Psychosis
☐ Suspected Mood Disorder ☐ Coordination of Care ☐ Suspected Substance Abuse
☐ Other _____

_____

Practitioner's Signature: _____ **Date:** _____

Ask the beneficiary to sign the Agreement for Information Exchange at the bottom of the form. After making a copy of the form for your records, give the original to the beneficiary to take to the Behavioral Health Practitioner (BHP) who will complete the response portion and return the form to you. Send results of CBC, LFTs, TFTs, U/A, EKG, and any relevant consults, procedure results, or information with your request.

BEHAVIORAL HEALTH PRACTITIONER RESPONDING TO REQUEST

The PCP initiating this form is requesting behavioral health information for the above named person. Please complete and return this form via the beneficiary or by faxing to the PCP.

BHP Name: _____ **Telephone:** _____ **FAX:** _____

Diagnosis(es): _____ **Date of Last Visit:** _____ **Email:** _____

Current Medications: _____

_____

Recommendations or Response to the Request (attach information if necessary): _____

_____

Practitioner's Signature: _____ **Date:** _____

BEHAVIORAL HEALTH CARE EXCHANGE OF INFORMATION REQUEST
Medi-Cal Managed Care Programs

This form is used for the purpose of exchanging practitioner and beneficiary information to enhance care coordination for Medi-Cal Managed Care beneficiaries.

BENEFICIARY INFORMATION

Name: _____ **DOB:** _____

Address: _____ **City:** _____ **Zip:** _____ **Telephone:** _____

SSN: _____ ☐ **Medi-Cal #:** _____

BEHAVIORAL HEALTH PRACTITIONER – INITIATING QUERY OR COORDINATION OF CARE

Practitioner's Name: _____ **Telephone:** _____ **FAX:** _____

Email: _____ **Date of Last Visit:** _____

Behavioral Health Diagnosis(es): _____

Current Medications: _____

Reason(s) for Request:

☐ Coordination of Care ☐ Identify Current Medications ☐ Medical Evaluation Results ☐ EKG Results

☐ Neurological Assessment ☐ Laboratory/Imaging Results: _____

☐ Other _____

_____

Practitioner's Signature: _____ **Date:** _____

Ask the beneficiary to sign the Agreement for Information Exchange at the bottom of the form. After making a copy of the form for your records, give the original to the beneficiary to take to the Primary Care Practitioner (PCP) who will complete the response portion and return the form to you for filing in the client's medical record. Send additional pertinent information as you feel necessary.

PRIMARY CARE PRACTITIONER RESPONDING TO REQUEST

The behavioral health practitioner initiating this form is requesting information about the above named person. Please complete and return this form via the beneficiary or by faxing to the behavioral health practitioner.

PCP Name: _____ **Telephone:** _____ **FAX:** _____

Diagnosis(es): _____ **Date of Last Visit:** _____ **Email:** _____

Current Medications: _____

_____

Recommendations or Response to the Request (attach information if necessary): _____

_____

Practitioner's Signature: _____ **Date:** _____

Original – Given to PCP , Copy – Retained by Mental Health

CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION

I, _____authorize
(Name of patient)

_____,
(Name or general designation of alcohol/drug program making disclosure)

to disclose to _____,
(Name of person or organization to which disclosure is to be made)

the following information:

_____
(Nature and amount of information to be disclosed, as limited as possible)

_____

The purpose of the disclosure authorized in this consent is to:

_____
(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form. Dated: _____

_____ _____
Signature of patient Signature of person signing form if not patient

Describe authority to sign on behalf of patient _____

The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the World Health Organization, is a simple way to screen and identify people at risk of alcohol problems.

1. How often do you have a drink containing alcohol?

(0) Never (Skip to Questions 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Add up the points associated with answers. A total score of 8 or more indicates harmful drinking behavior.

Based on WHO's recommendation -
Score 1-7: Alcohol education
Score 8-15: Simple Advice
Score 16-19: Brief Intervention
Score 20-40: Referral to Treatment

Updated

Helping Patients Who Drink Too Much

A CLINICIAN'S GUIDE

Updated 2005 Edition

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
National Institutes of Health
National Institute on Alcohol Abuse and Alcoholism

New Supporting Materials

2005 Edition

Table of Contents

Appendix

. . . men who drink more than 4 standard drinks in a day (or more than 14 per week) and women who drink more than 3 in a day (or more than 7 per week) are at increased risk for alcohol-related problems.

Introduction

This *Guide* is written for primary care and mental health clinicians. It has been produced by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), a component of the National Institutes of Health, with guidance from physicians, nurses, advanced practice nurses, physician assistants, and clinical researchers.

How much is "too much"?

Drinking becomes too much when it causes or elevates the risk for alcohol-related problems or complicates the management of other health problems. According to epidemiologic research, **men who drink more than 4 standard drinks in a day (or more than 14 per week) and women who drink more than 3 in a day (or more than 7 per week) are at increased risk for alcohol-related problems**.[1]

Individual responses to alcohol vary, however. Drinking at lower levels may be problematic depending on many factors, such as age, coexisting conditions, and use of medication. Because it isn't known whether any amount of alcohol is safe during pregnancy, the Surgeon General urges abstinence for women who are or may become pregnant.[2]

Why screen for heavy drinking?

- **At-risk drinking and alcohol problems are common.** About 3 in 10 U.S. adults drink at levels that elevate their risk for physical, mental health, and social problems.[3] Of these heavy drinkers, about 1 in 4 currently has alcohol abuse or dependence.[3] All heavy drinkers have a greater risk of hypertension, gastrointestinal bleeding, sleep disorders, major depression, hemorrhagic stroke, cirrhosis of the liver, and several cancers.[4]
- **Heavy drinking often goes undetected.** In a recent study of primary care practices, for example, patients with alcohol dependence received the recommended quality of care, including assessment and referral to treatment, only about 10 percent of the time.[5]
- **Patients are likely to be more receptive, open, and ready to change than you expect.** Most patients don't object to being screened for alcohol use by clinicians and are open to hearing advice afterward.[6] In addition, most primary care patients who screen positive for heavy drinking or alcohol use disorders show some motivational readiness to change, with those who have the most severe symptoms being the most ready.[7]
- **You're in a prime position to make a difference.** Clinical trials have demonstrated that brief interventions can promote significant, lasting reductions in drinking levels in at-risk drinkers who aren't alcohol dependent.[8] Some drinkers who are dependent will accept referral to addiction treatment programs. Even for patients who don't accept a referral, repeated alcohol-focused visits with a health care provider can lead to significant improvement.[9,10]

If you're not already doing so, we encourage you to incorporate alcohol screening and intervention into your practice. **With this *Guide*, you have what you need to begin.**

What's the Same, What's New in This Update

Same approach to screening and intervention

The approach to alcohol screening and intervention presented in the original *2005 Guide* remains unchanged. That edition established a number of new directions compared with earlier versions, including a simplified, single-question screening question; more guidance for managing alcohol-dependent patients; and an expanded target audience that includes mental health practitioners, since their patients are more likely to have alcohol problems than patients in the general population.[11,12]

In the "how-to" section, two small revisions are noteworthy. Feedback from *Guide* users told us that some patients do not consider beer to be an alcoholic beverage, so the prescreening question on page 4 now reads, "Do you sometimes drink *beer, wine, or other* alcoholic beverages?" And on page 5, the assessment criteria remain the same, but the sequence now better reflects a likely progression of symptoms in alcohol use disorders.

Updated and new supporting materials

- **Updated medications section.** The section on prescribing medications (pages 13–16) contains added information about treatment strategies and options. It describes a newly approved, extended-release injectable drug to treat alcohol dependence that joins three previously approved oral medications.

- **Medication management support.** Patients taking medications for alcohol dependence require some behavioral support, but this doesn't need to be specialized alcohol counseling. For clinicians in general medicine and mental health settings, the *Guide* now outlines a brief, effective program of behavioral support that was developed for patients who received pharmacotherapy in a recent clinical trial (pages 17–22).

- **Specialized alcohol counseling resource.** For mental health clinicians who wish to provide specialized counseling for alcohol dependence, we've added information about a state-of-the-art behavioral intervention also developed for a recent clinical trial (page 31).

- **Online resources.** A new page on the NIAAA Web site is devoted to the *Guide* and related resources (*www.niaaa.nih.gov/guide*). See page 27 for a sampling of available forms, publications, and training resources.

- **New patient education handout.** "Strategies for Cutting Down" provides concise guidance for patients who are ready to cut back or quit. The handout may be photocopied from page 26 or downloaded from *www.niaaa.nih.gov/guide*, where it is also available in Spanish.

- **Transferred sections.** Two appendix resources from the preceding edition (the sample questions for assessment and the preformatted progress notes for baseline and followup visits) are now available online at *www.niaaa.nih.gov/guide*. The previous "Materials from NIAAA" section is now part of the "Online Materials for Clinicians and Patients" on page 27.

Before You Begin...

Decide on a screening method

The *Guide* provides two methods for screening: a single question (about heavy drinking days) to use during a clinical interview and a written self-report instrument (the AUDIT—see page 11). The single interview question can be used at any time, either in conjunction with the AUDIT or alone. Some practices may prefer to have patients fill out the AUDIT before they see the clinician. It takes less than 5 minutes to complete and can be copied or incorporated into a health history.

Think about clinical indications for screening

Key opportunities include

- As part of a **routine examination**
- Before **prescribing a medication** that interacts with alcohol (see box on page 29)
- In the **emergency department** or urgent care center
- When seeing patients who
  - are **pregnant** or trying to conceive
  - are **likely to drink heavily,** such as smokers, adolescents, and young adults
  - have **health problems that might be alcohol induced,** such as

cardiac arrhythmia	dyspepsia	liver disease
depression or anxiety	insomnia	trauma

  - have a chronic **illness that isn't responding to treatment as expected,** such as

chronic pain	diabetes	gastrointestinal disorders
depression	heart disease	hypertension

Set up your practice to simplify the process

- Decide who will conduct the screening (you, other clinical personnel, the receptionist who hands out the AUDIT)
- Use preformatted progress notes (see "Online Materials" on page 27)
- Use computer reminders (if using electronic medical records)
- Keep copies of the pocket guide (provided) and referral information in your examination rooms
- Monitor your performance through practice audits

How to Help Patients Who Drink Too Much: A Clinical Approach

STEP 1 Ask About Alcohol Use

Prescreen: Do you sometimes drink beer, wine, or other alcoholic beverages?

NO → Screening complete.

YES → **Ask the screening question about heavy drinking days:**

How many times in the past year have you had . . .

5 or more drinks in a day? *(for men)*

4 or more drinks in a day? *(for women)*

☐

One standard drink is equivalent to 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits—see chart on page 24.

If the patient used a written self-report (such as the AUDIT, p. 11), START HERE

Is the screening positive?

- 1 or more heavy drinking days or
- AUDIT score of ≥ 8 for men or ≥ 4 for women

NO

- **Advise staying within these limits:**

Maximum Drinking Limits

For healthy **men up to age 65**—

- no more than **4** drinks in a **day** AND
- no more than **14** drinks in a **week**

For healthy **women** (and healthy **men over age 65**)—

- no more than **3** drinks in a **day** AND
- no more than **7** drinks in a **week**

- **Recommend lower limits or abstinence** as medically indicated: for example, for patients who
  - take **medications** that interact with alcohol
  - have a **health condition** exacerbated by alcohol
  - are **pregnant** (advise abstinence)
- **Express openness to talking** about alcohol use and any concerns it may raise
- **Rescreen** annually

YES

- Your patient is an at-risk drinker. For a more complete picture of the drinking pattern, **determine the weekly average:**
  - On average, how many **days** a week do you have an alcoholic drink? ☐
  - On a typical drinking day, how many **drinks** do you have? ☐

  X

  Weekly average ☐
- **Record heavy drinking days in the past year and the weekly average** in the patient's chart (see page 27 for a downloadable baseline progress note).

GO TO STEP 2

STEP 2 Assess for Alcohol Use Disorders

Next, determine whether there is a *maladaptive pattern of alcohol use*, causing *clinically significant impairment* or *distress*. It is important to assess the severity and extent of all alcohol-related symptoms to inform your decisions about management. The following list of symptoms is adapted from the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), Revised.* Sample assessment questions are available online at *www.niaaa.nih.gov/guide.*

Determine whether, in the past 12 months, your patient's drinking has **repeatedly** caused or contributed to

- ☐ **risk** of bodily harm (drinking and driving, operating machinery, swimming)
- ☐ **relationship** trouble (family or friends)
- ☐ **role failure** (interference with home, work, or school obligations)
- ☐ **run-ins** with the law (arrests or other legal problems)

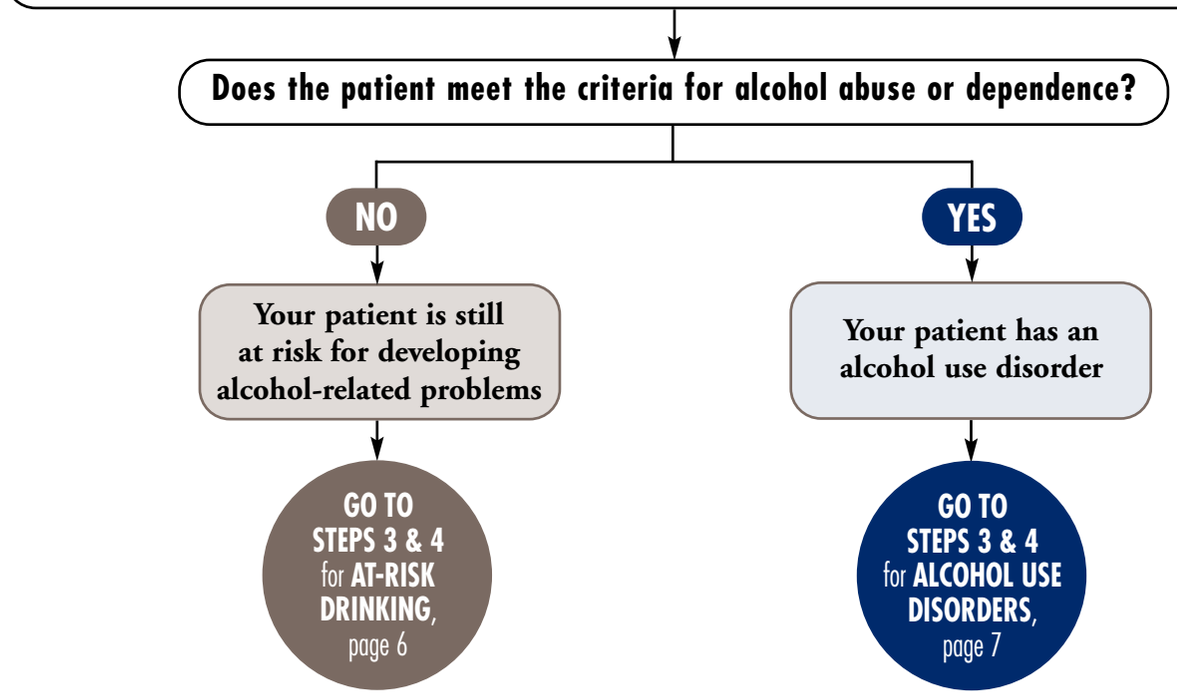
If yes to **one or more** → your patient has **alcohol abuse.**

In either case, proceed to assess for dependence symptoms.

Determine whether, in the past 12 months, your patient has

- ☐ **not been able to stick to drinking limits** (repeatedly gone over them)
- ☐ **not been able to cut down or stop** (repeated failed attempts)
- ☐ **shown tolerance** (needed to drink a lot more to get the same effect)
- ☐ **shown signs of withdrawal** (tremors, sweating, nausea, or insomnia when trying to quit or cut down)
- ☐ **kept drinking despite problems** (recurrent physical or psychological problems)
- ☐ **spent a lot of time drinking** (or anticipating or recovering from drinking)
- ☐ **spent less time on other matters** (activities that had been important or pleasurable)

If yes to **three or more** → your patient has **alcohol dependence.**



AT-RISK DRINKING (no abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

- **State your conclusion and recommendation clearly:**
  - "You're drinking more than is medically safe." Relate to the patient's concerns and medical findings, if present. (Consider using the chart on page 25 to show increased risk.)
  - "I strongly recommend that you cut down (or quit) and I'm willling to help." (See page 29 for advice considerations.)
- **Gauge readiness to change drinking habits:**
  "Are you willing to consider making changes in your drinking?"

Is the patient ready to commit to change at this time?

NO

Don't be discouraged—ambivalence is common. Your advice has likely prompted a change in your patient's thinking, a positive change in itself. With continued reinforcement, your patient may decide to take action. For now,

- **Restate your concern** about his or her health.
- **Encourage reflection** by asking patients to weigh what they like about drinking versus their reasons for cutting down. What are the major barriers to change?
- **Reaffirm your willingness to help** when he or she is ready.

YES

- **Help set a goal** to cut down to within maximum limits (see Step 1) or abstain for a time.
- **Agree on a plan,** including
  - what specific steps the patient will take (e.g., not go to a bar after work, measure all drinks at home, alternate alcoholic and nonalcoholic beverages).
  - how drinking will be tracked (diary, kitchen calendar).
  - how the patient will manage high-risk situations.
  - who might be willing to help, such as significant others or nondrinking friends.
- **Provide educational materials.** See page 26 for "Strategies for Cutting Down" and page 27 for other materials available from NIAAA.

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes).

Was the patient able to meet and sustain the drinking goal?

NO

- **Acknowledge that change is difficult.**
- **Support any positive change** and address barriers to reaching the goal.
- **Renegotiate the goal and plan;** consider a trial of abstinence.
- **Consider engaging significant others.**
- **Reassess the diagnosis** if the patient is unable to either cut down or abstain. (Go to Step 2.)

YES

- **Reinforce and support continued adherence** to recommendations.
- **Renegotiate drinking goals** as indicated (e.g., if the medical condition changes or if an abstaining patient wishes to resume drinking).
- **Encourage the patient to return** if unable to maintain adherence.
- **Rescreen** at least annually.

ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3 Advise and Assist (Brief Intervention)

- **State your conclusion and recommendation clearly:**
  - "I believe that you have an alcohol use disorder. I strongly recommend that you quit drinking and I'm willing to help."
  - Relate to the patient's concerns and medical findings if present.
- **Negotiate a drinking goal:**
  - Abstaining is the safest course for most patients with alcohol use disorders.
  - Patients who have milder forms of abuse or dependence and are unwilling to abstain may be successful at cutting down. (See Step 3 for At-Risk Drinking.)
- **Consider** referring for additional **evaluation by an addiction specialist,** especially if the patient is dependent. (See page 23 for tips on finding treatment resources.)
- **Consider** recommending a **mutual help group.**
- For patients who have dependence, **consider**
  - the need for **medically managed withdrawal** (detoxification) and treat accordingly (see page 31).
  - prescribing a **medication** for alcohol dependence for those who endorse abstinence as a goal (see page 13).
- **Arrange followup** appointments, including medication management support if needed (see page 17).

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit (see page 27 for downloadable progress notes). If the patient is receiving a medication for alcohol dependence, medication management support should be provided (see page 17).

Was the patient able to meet and sustain the drinking goal?

NO

- **Acknowledge that change is difficult.**
- **Support efforts** to cut down or abstain, while making it clear that your recommendation is to abstain.
- **Relate drinking to problems** (medical, psychological, and social) as appropriate.
- If the following measures aren't already being taken, **consider**
  - referring to an **addiction specialist** or consulting with one.
  - recommending a **mutual help group.**
  - engaging **significant others.**
  - prescribing a **medication** for alcohol-dependent patients who endorse abstinence as a goal.
- **Address coexisting disorders**—medical and psychiatric—as needed.

YES

- **Reinforce and support continued adherence** to recommendations.
- **Coordinate care** with a specialist if the patient has accepted referral.
- **Maintain medications** for alcohol dependence for at least 3 months and as clinically indicated thereafter.
- **Treat coexisting nicotine dependence** for 6 to 12 months after reaching the drinking goal.
- **Address coexisting disorders**—medical and psychiatric—as needed.

Appendix

Screening Instrument: The Alcohol Use Disorders Identification Test (AUDIT)

Your practice may choose to have patients fill out a written screening instrument before they see a clinician. In this *Guide*, the AUDIT is provided in both English and Spanish for this purpose. It takes only about 5 minutes to complete, has been tested internationally in primary care settings, and has high levels of validity and reliability.[13] You may photocopy these pages or download them from *www.niaaa.nih.gov/guide.*

Scoring the AUDIT

Record the score for each response in the blank box at the end of each line, then total these numbers. The maximum possible total is 40.

Total scores of 8 or more for men up to age 60 or 4 or more for women, adolescents, and men over 60 are considered positive screens.[14,15,16] For patients with totals near the cut-points, clinicians may wish to examine individual responses to questions and clarify them during the clinical examination.

Note: The AUDIT's sensitivity and specificity for detecting heavy drinking and alcohol use disorders varies across different populations. Lowering the cut-points increases sensitivity (the proportion of "true positive" cases) while increasing the number of false positives. Thus, it may be easier to use a cut-point of 4 for all patients, recognizing that more false positives may be identified among men.

Continuing with screening and assessment

After the AUDIT is completed, continue with Step 1, page 4.

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at *www.who.org*.

PACIENTE: Debido a que el uso del alcohol puede afectar su salud e interferir con ciertos medicamentos y tratamientos, es importante que le hagamos algunas preguntas sobre su uso del alcohol. Sus respuestas serán confidenciales, así que sea honesto por favor.

Marque una X en el cuadro que mejor describa su respuesta a cada pregunta.

Preguntas	0	1	2	3	4	
1. ¿Con qué frecuencia consume alguna bebida alcohólica?	Nunca	Una o menos veces al mes	De 2 a 4 veces al mes	De 2 a 3 más veces a la semana	4 o más veces a la semana	
2. ¿Cuantas consumiciones de bebidas alcohólicas suele realizar en un día de consumo normal?	1 o 2	3 o 4	5 o 6	De 7 a 9	10 o más	
3. ¿Con qué frecuencia toma 5 o más bebidas alcohólicas en un solo día?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
4. ¿Con qué frecuencia en el curso del último año ha sido incapaz de parar de beber una vez había empezado?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
5. ¿Con qué frecuencia en el curso del último año no pudo hacer lo que se esperaba de usted porque había bebido?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
6. ¿Con qué frecuencia en el curso del último año ha necesitado beber en ayunas para recuperarse después de haber bebido mucho el día anterior?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
7. ¿Con qué frecuencia en el curso del último año ha tenido remor-dimientos o sentimientos de culpa después de haber bebido?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
8. ¿Con qué frecuencia en el curso del último año no ha podido recordar lo que sucedió la noche anterior porque había estado bebiendo?	Nunca	Menos de una vez al mes	Mensualmente	Semanalmente	A diario o casi a diario	
9. ¿Usted o alguna otra persona ha resultado herido porque usted había bebido?	No		Sí, pero no en el curso del último año		Sí, el último año	
10. ¿Algún familiar, amigo, médico o profesional sanitario ha mostrado preocupación por un consumo de bebidas alcohólicas o le ha sugerido que deje de beber?	No		Sí, pero no en el curso del último año		Sí, el último año	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization and the Generalitat Valenciana Conselleria De Benestar Social. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at *www.who.org*.

Prescribing Medications for Alcohol Dependence

Three oral medications (naltrexone, acamprosate, and disulfiram) and one injectable medication (extended-release injectable naltrexone) are currently approved for treating alcohol dependence. They have been shown to help patients reduce drinking, avoid relapse to heavy drinking, achieve and maintain abstinence, or gain a combination of these effects. As is true in treating any chronic illness, addressing patient adherence systematically will maximize the effectiveness of these medications (see "Supporting Patients Who Take Medications for Alcohol Dependence," page 17).

When should medications be considered for treating an alcohol use disorder?

All approved drugs have been shown to be effective adjuncts to the treatment of alcohol dependence. Thus, consider adding medication whenever you're treating someone with active alcohol dependence or someone who has stopped drinking in the past few months but is experiencing problems such as craving or slips. Patients who have previously failed to respond to psychosocial approaches alone are particularly strong candidates.

Must patients agree to abstain?

No matter which alcohol dependence medication is used, patients who have a goal of abstinence, or who can abstain even for a few days prior to starting the medication, are likely to have better outcomes. Still, it's best to determine individual goals with each patient. Some patients may not be willing to endorse abstinence as a goal, especially at first. If a patient with alcohol dependence agrees to reduce drinking substantially, it's best to engage him or her in that goal while continuing to note that abstinence remains the optimal outcome.

A patient's willingness to abstain has important implications for the choice of medication. Most studies on effectiveness have required patients to abstain before starting treatment. A study of oral naltrexone, however, demonstrated a modest reduction in the risk of heavy drinking in people with mild dependence who chose to cut down rather than abstain.[17] A study of injectable naltrexone suggests that it, too, may reduce heavy drinking in dependent patients who are not yet abstinent, although it had a more robust effect in those who abstained for 7 days before starting treatment[18] and is only approved for use in those who can abstain in an outpatient setting before treatment begins. Acamprosate, too, is only approved for use in patients who are abstinent at the start of treatment. And disulfiram is contraindicated in patients who wish to continue to drink, because a disulfiram-alcohol reaction occurs with any alcohol intake at all.

Which of the medications should be prescribed?

Which medication to use will depend on clinical judgment and patient preference. Each has a different mechanism of action. Some patients may respond better to one type of medication than another.

Naltrexone

Mechanism: Naltrexone blocks opioid receptors that are involved in the rewarding effects of drinking alcohol and the craving for alcohol. It's available in two forms: oral (Depade®, ReVia®), with once daily dosing, and extended-release injectable (Vivitrol®), given as once monthly injections.

Efficacy: Oral naltrexone reduces relapse to heavy drinking, defined as 4 or more drinks per day for women and 5 or more for men.[19,20] It cuts the relapse risk during the first 3 months by about 36 percent (about 28 percent of patients taking naltrexone relapse versus about 43 percent of those taking a placebo).[20] Thus, it is especially helpful for curbing consumption in patients who have drinking "slips." It is less effective in maintenance of abstinence.[19,20] In the single study available when this *Guide* update was published, extended-release injectable naltrexone resulted in a 25 percent reduction in the proportion of heavy drinking days compared with a placebo, with a higher rate of response in males and those with lead-in abstinence.[18]

Acamprosate

Mechanism: Acamprosate (Campral®) acts on the GABA and glutamate neurotransmitter systems and is thought to reduce symptoms of protracted abstinence such as insomnia, anxiety, restlessness, and dysphoria. It's available in oral form (three times daily dosing).

Efficacy: Acamprosate increases the proportion of dependent drinkers who maintain abstinence for several weeks to months, a result demonstrated in multiple European studies and confirmed by a meta-analysis of 17 clinical trials.[21] The meta-analysis reported that 36 percent of patients taking acamprosate were continuously abstinent at 6 months, compared with 23 percent of those taking a placebo.

More recently, two large U.S. trials failed to confirm the efficacy of acamprosate,[22,23] although secondary analyses in one of the studies suggested possible efficacy in patients who had a baseline goal of abstinence.[23] A reason for the discrepancy between European and U.S. findings may be that patients in European trials had more severe dependence than patients in U.S. trials,[21,22] a factor consistent with preclinical studies showing that acamprosate has a greater effect in animals with a prolonged history of dependence.[24] In addition, before starting medication, most patients in European trials had been abstinent longer than patients in U.S. trials.[25]

Disulfiram

Mechanism: Disulfiram (Antabuse®) interferes with degradation of alcohol, resulting in accumulation of acetaldehyde which, in turn, produces a very unpleasant reaction including flushing, nausea, and palpitations if the patient drinks alcohol. It's available in oral form (once daily dosing).

Efficacy: The utility and effectiveness of disulfiram are considered limited because compliance is generally poor when patients are given it to take at their own discretion.[26] It is most effective when given in a monitored fashion, such as in a clinic or by a spouse.[27] (If a spouse or other family member is the monitor, instruct both monitor and patient that the monitor should simply observe the patient taking the medication and call you if the patient stops taking the medication for 2 days.) Some patients will respond to self-administered disulfiram, however, especially if they're highly motivated to abstain. Others may use it episodically for high-risk situations, such as social occasions where alcohol is present.

How long should medications be maintained?

The risk for relapse to alcohol dependence is very high in the first 6 to 12 months after initiating abstinence and gradually diminishes over several years. Therefore, a minimum initial period of 3 months of pharmacotherapy is recommended. Although an optimal treatment duration hasn't been established, it isn't unreasonable to continue treatment for a year or longer if the patient responds to medication during this time when the risk of relapse is highest. After patients discontinue medications, they may need to be followed more closely and have pharmacotherapy reinstated if relapse occurs.

If one medication doesn't work, should another be prescribed?

If there's no response to the first medication selected, you may wish to consider a second. This sequential approach appears to be common clinical practice, but currently there are no published studies examining its effectiveness. Similarly, there is not yet enough evidence to recommend a specific ordering of medications.

Is there any benefit to combining medications?

A large U.S. trial found no benefit to combining acamprosate and naltrexone.[22] More broadly, there is no evidence that combining any of the medications to treat alcohol dependence improves outcomes over using any one medication alone.

Should patients receiving medications also receive specialized alcohol counseling or a referral to mutual help groups?

Offering the full range of effective treatments will maximize patient choice and outcomes, since no single approach is universally successful or appealing to patients. The different approaches—medications for alcohol dependence, professional counseling, and mutual help groups—are complementary. They share the same goals while addressing different aspects of alcohol dependence: neurobiological, psychological, and social. The medications aren't prone to abuse, so they don't pose a conflict with other support strategies that emphasize abstinence.

Almost all studies of medications for alcohol dependence have included some type of counseling, and it's recommended that all patients taking these medications receive at least brief medical counseling. In a recent large trial, the combination of oral naltrexone and brief medical counseling sessions delivered by a nurse or physician was effective without additional behavioral treatment by a specialist.[22] Patients were also encouraged to attend support groups to increase social encouragement for abstinence. For more information, see "Supporting Patients Who Take Medications for Alcohol Dependence" on page 17 and "Should I recommend any particular behavioral therapy for patients with alcohol use disorders?" on page 31.

Medications for Treating Alcohol Dependence

	Naltrexone (Depade®, ReVia®)	**Extended-Release Injectable Naltrexone** (Vivitrol®)	**Acamprosate** (Campral®)	**Disulfiram** (Antabuse®)
Action	Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking.	Same as oral naltrexone; 30-day duration.	Affects glutamate and GABA neurotransmitter systems, but its alcohol-related action is unclear.	Inhibits intermediate metabolism of alcohol, causing a buildup of acetaldehyde and a reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol.
Contraindications	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure.	Same as oral naltrexone, plus inadequate muscle mass for deep intramuscular injection; rash or infection at the injection site.	Severe renal impairment (CrCl ≤ 30 mL/min).	Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease; hypersensitivity to rubber (thiuram) derivatives.
Precautions	Other hepatic disease; renal impairment; history of suicide attempts or depression. If opioid analgesia is needed, larger doses may be required and respiratory depression may be deeper and more prolonged. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see *www.niaaa.nih.gov/guide.*	Same as oral naltrexone, plus hemophilia or other bleeding problems.	Moderate renal impairment (dose adjustment for CrCl between 30 and 50 mL/min); depression or suicidal ideation and behavior. Pregnancy Category C.	Hepatic cirrhosis or insufficiency; cerebrovascular disease or cerebral damage; psychoses (current or history); diabetes mellitus; epilepsy; hypothyroidism; renal impairment. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see *www.niaaa.nih.gov/guide*.
Serious adverse reactions	Will precipitate severe withdrawal if the patient is dependent on opioids; hepatotoxicity (although does not appear to be a hepatotoxin at the recommended doses).	Same as oral naltrexone, plus infection at the injection site; depression; and rare events including allergic pneumonia and suicidal ideation and behavior.	Rare events include suicidal ideation and behavior.	Disulfiram-alcohol reaction, hepatotoxicity, optic neuritis, peripheral neuropathy, psychotic reactions.
Common side effects	Nausea, vomiting, decreased appetite, headache, dizziness, fatigue, somnolence, anxiety.	Same as oral naltrexone, plus a reaction at the injection site; joint pain; muscle aches or cramps.	Diarrhea, somnolence.	Metallic after-taste, dermatitis, transient mild drowsiness.
Examples of drug interactions	Opioid medications (blocks action).	Same as oral naltrexone.	No clinically relevant interactions known.	Anticoagulants such as warfarin; isoniazid; metronidazole; phenytoin; any nonprescription drug containing alcohol.
Usual adult dosage	*Oral dose:* 50 mg daily. *Before prescribing:* Patients must be opioid-free for a minimum of 7 to 10 days before starting. If you feel that there's a risk of precipitating an opioid withdrawal reaction, administer a naloxone challenge test. Evaluate liver function. *Laboratory followup:* Monitor liver function.	*IM dose:* 380 mg given as a deep intramuscular gluteal injection, once monthly. *Before prescribing:* Same as oral naltrexone, plus examine the injection site for adequate muscle mass and skin condition. *Laboratory followup:* Monitor liver function.	*Oral dose:* 666 mg (two 333-mg tablets) three times daily; *or* for patients with moderate renal impairment (CrCl 30 to 50 mL/min), reduce to 333 mg (one tablet) three times daily. *Before prescribing:* Evaluate renal function. Establish abstinence.	*Oral dose:* 250 mg daily (range 125 mg to 500 mg). *Before prescribing:* Evaluate liver function. Warn the patient (1) not to take disulfiram for at least 12 hours after drinking and that a disulfiram-alcohol reaction can occur up to 2 weeks after the last dose and (2) to avoid alcohol in the diet (e.g., sauces and vinegars), over-the-counter medications (e.g., cough syrups), and toiletries (e.g., cologne, mouthwash). *Laboratory followup:* Monitor liver function.

Note: This chart highlights some of the properties of each medication. It does ***not*** provide complete information and is ***not*** meant to be a substitute for the package inserts or other drug reference sources used by clinicians. For patient information about these and other drugs, the National Library of Medicine provides MedlinePlus (*http://medlineplus.gov*). Whether or not a medication should be prescribed and in what amount is a matter between individuals and their health care providers. The prescribing information provided here is ***not*** a substitute for a provider's judgment in an individual circumstance, and the NIH accepts no liability or responsibility for use of the information with regard to particular patients.

The information in this chart was drawn primarily from package inserts and references 18, 20, 22, and 26 (see pages 33–34).
January 2007

Supporting Patients Who Take Medications for Alcohol Dependence

Pharmacotherapy for alcohol dependence is most effective when combined with some behavioral support, but this doesn't need to be specialized, intensive alcohol counseling. Nurses and physicians in general medical and mental health settings, as well as counselors, can offer brief but effective behavioral support that promotes recovery. Applying this medication management approach in such settings would greatly expand access to effective treatment, given that many patients with alcohol dependence either don't have access to specialty treatment or refuse a referral.

How can general medical and mental health clinicians support patients who take medication for alcohol dependence?

Managing the care of patients who take medication for alcohol dependence is similar to other disease management strategies such as initiating insulin therapy in patients with diabetes mellitus. In the recent Combining Medications and Behavioral Interventions (COMBINE) clinical trial, physicians, nurses, and other health care professionals in outpatient settings delivered a series of brief behavioral support sessions for patients taking medications for alcohol dependence.[22] The sessions promoted recovery by increasing adherence to medication and supporting abstinence through education and referral to support groups.[22] This *Guide* offers a set of how-to templates outlining this program (see pages 19–22). It was designed for easy implementation in nonspecialty settings, in keeping with the national trend toward integrating the treatment of substance use disorders into medical practice.

What are the components of medication management support?

Medication management support consists of brief, structured outpatient sessions conducted by a health care professional. The initial session starts by reviewing the medical evaluation results with the patient as well as the negative consequences from drinking. This information frames a discussion about the diagnosis of alcohol dependence, the recommendation for abstinence, and the rationale for medication. The clinician then provides information on the medication itself and adherence strategies, and encourages participation in a mutual support group such as Alcoholics Anonymous (AA).

In subsequent visits, the clinician assesses the patient's drinking, overall functioning, medication adherence, and any side effects from the medication. Session structure varies according to the patient's drinking status and treatment compliance, as outlined on page 22. When a patient doesn't adhere to the medication regimen, it's important to evaluate the reasons and help the patient devise plans to address them. A helpful summary of strategies for handling nonadherence is provided in the "Medical Management Treatment Manual" from Project COMBINE, available online at *www.niaaa.nih.gov/guide.*

As conducted in the COMBINE trial, the program consisted of an initial session of about 45 minutes followed by eight 20-minute sessions during weeks 1, 2, 4, 6, 8, 10, 12, and 16. General medical or mental health practices may not follow this particular schedule, but it's offered along with the templates as a starting point for developing a program that works for your practice and your patients.

Can medication management support be used with patients who don't endorse a goal of abstinence?

This medication management program has been tested only in patients for whom abstinence was recommended, as is true with most pharmacotherapy studies. It's not known whether it would also work if the patient's goal is to cut back instead of abstain. Even when patients do endorse abstinence as a goal, they often cut back without quitting. You're encouraged to continue working with those patients who are working toward recovery but haven't yet met the optimal goals of abstinence or reduced drinking with full remission of dependence symptoms. You may also find many of the techniques used in medication management support—such as linking symptoms and laboratory results with heavy alcohol use—to be helpful for managing alcohol-dependent patients in general.

Initial Session Template

Medication Management Support for Alcohol Dependence

This template outlines the first in a series of appointments designed to support patients diagnosed with alcohol dependence who are starting a course of medication to help them maintain abstinence.

Date: _____ Time spent: _____

Patient name: _____

Pertinent history: _____

Observations: _____

Before counseling:

Record from the patient's chart:

☐ Alcohol-dependence medication prescribed:
☐ naltrexone PO ☐ XR-naltrexone injectable ☐ acamprosate ☐ disulfiram ☐ other: _____
dose and schedule: _____

☐ Lab results and other patient information (fill in the left column of the chart below, to the degree possible)

Gather:

☐ Patient information on the medication (available, for example, from *www.medlineplus.gov*)
☐ Wallet emergency card for naltrexone or disulfiram (see *www.niaaa.nih.gov/guide*)
☐ Listing of local mutual help groups. For AA, see *www.aa.org;* for other groups, see the National Clearinghouse for Alcohol and Drug Information Web site at *www.ncadi.samhsa.gov* under "Resources."

Patient information— from the chart or patient report, this forms the basis for counseling	**Counseling—** delivered in a nonjudgmental way, this enhances patient motivation and provides the rationale for medication
1 Review lab results and medical adverse consequences of heavy drinking:	**Tie results and symptoms to heavy alcohol use:**
Liver function test results: AST (SGOT): _____ ALT (SGPT): _____ GGT (GGTP): _____ Total Bilirubin: _____ Albumin: _____	→ **Describe normal liver function and adverse effects of heavy drinking, then discuss results of liver function tests:** *If normal range:* "This is a positive sign that your liver has avoided harm so far, and that now you have the opportunity to keep it that way by changing your drinking habits. Having a healthy liver will also help you make a quicker, more complete recovery." *If abnormal:* "The test results are most likely a sign of unhealthy changes in your liver from heavy alcohol use. The longer you continue to drink, the harder it is to reverse the damage. But if you stop drinking, you may be able to get your liver function back to normal."
Blood pressure: ____/____ **Pulse:** ____	→ **If blood pressure is elevated, describe relationship between high blood pressure and heavy drinking.**
Other medical conditions affected by drinking and relevant lab results: ☐ diabetes ☐ heart disease ☐ GI: _____ ☐ insomnia ☐ depression ☐ anxiety ☐ pain ☐ other: _____ ☐ other relevant lab results (e.g., MCV): _____	→ **Describe relationship between condition(s) and heavy drinking, including relevant lab results.**

2 Review amount of drinking and nonmedical adverse consequences of heavy drinking:

Amount of drinking: When was last drink?_____

In the past 30 days,
—how many drinking days (*any* alcohol): _____ days
—how many *heavy* drinking days (5+ drinks/day for men, 4+ drinks/day for women): _____ days

Nonmedical adverse consequences:

☐ interpersonal ☐ employment/school ☐ legal

specify: _____

→ **Focus more on the consequences of drinking than on the quantity:**

"I see that when you drink, you drink heavily, and that you've reported some problems related to that, such as (x). We see these as (additional) signs that drinking is harmful for you."

3 Confirm diagnosis of alcohol dependence.

→ **Recommend abstinence and provide rationale for medications:**

"You have a diagnosis of alcohol dependence." (Provide patient materials if available.) "We strongly recommend that you stop drinking altogether. For someone with alcohol dependence, this is the safest choice. It's also best for your health. Quitting is hard, which is why a medication has been prescribed that may help you abstain."

4 Review the patient's decision on abstinence:

Is the patient willing to abstain? ☐ yes ☐ no

Comment: _____

_____

→ **If the patient is unwilling or unable to commit to abstinence, offer a trial period:**

"If you're thinking that lifelong abstinence is too difficult a goal to commit to right now, you could try a brief period of, say, a month to find out what it's like to live without alcohol. Would you be willing to try this out?"

If a trial of abstinence isn't accepted, reconsider whether medication is still appropriate with a modified goal.

5 Provide medication counseling, focusing on

☐ **Mechanism of action and time course of effects.** Describe how the medication works and how long it may take to be effective.

☐ **Potential side effects.** Discuss the likelihood of side effects (see the package insert) and ways to cope with adverse events such as nausea or diarrhea. Advise the patient to contact you if concerned about side effects.

☐ **Dosing and adherence.** Review the dosing regimen, remind the patient to take the medication consistently for effectiveness, and explain what to do if a dose is skipped.

☐ **Adherence strategies.** Discuss the patient's history of pill-taking practices, then strategies to promote adherence, such as taking pills at the same time each day, using weekly pill containers, and enlisting others' support.

☐ **Emergency cards.** For naltrexone, educate the patient about potential complications with opioid use and analgesics. For disulfiram, educate the patient about the alcohol-disulfiram reaction and avoiding alcohol in food and medicines. Give the patient wallet emergency cards: _____ _____ (initials and date)

6 Encourage participation in a mutual support group:

☐ **Provide list of local options and describe the benefits of attendance.** Note that attending AA or another mutual support group is a way to acquire a network of friends who have found ways to live without alcohol. Tell the patient that medication is time limited and that the importance of mutual support groups increases when medications are stopped.

☐ **Address barriers to attendance:**

- If the patient is reluctant to attend: "Would you be willing to try just one meeting before our next session?"
- If the patient has attended a meeting before and wasn't comfortable: "Not all groups are alike. It's likely that you'll need to try several before finding one that feels right."
- If the patient is concerned about members disapproving of his or her medication: "The medication is a tool you'll use in an effort not to drink. It has been shown to help others stop drinking. Also, it's not addicting. And the official policy of AA supports people taking nonaddicting medicines prescribed by a doctor."

7 Wrap up:

☐ Summarize the diagnosis and recommendation for abstinence

☐ Summarize dosage regimen

☐ Ask about remaining questions or concerns

☐ Schedule the next visit

☐ Other followup: _____

_____

_____

8 Next appointment date: _____

Followup Session Template

Medication Management Support for Alcohol Dependence

Date: _____ Time spent: _____

Patient name: _____

Vital signs (if taken): BP: _____/_____ P: _____ Weight: _____

Laboratory data (if available): GGT: _____ AST: _____ ALT: _____ Other: _____

General progress and patient concerns since the last visit: _____

_____

Observations of patient cognition: _____ Mood: _____

Physical signs: _____ Other: _____

Drinking status

- **How long since the last drink?** _____ days/weeks/months
- **In the past 30 days (or since the last visit if less than 30 days):**
  - — how many drinking days (*any* alcohol): _____ days in the past _____ days
  - — how many *heavy* drinking days (5+ drinks/day for men, 4+ drinks/day for women): _____ days in the past _____ days
- **Other:** _____

Alcohol pharmacotherapy

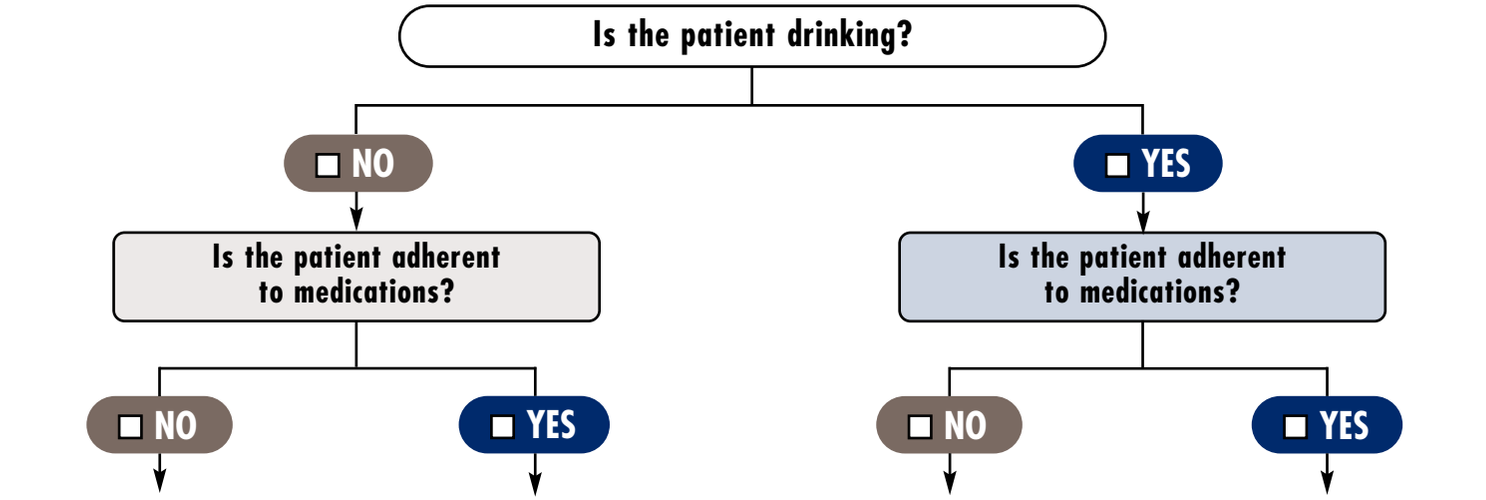
- **Medications prescribed:** ☐ none ☐ naltrexone PO ☐ XR-naltrexone injectable ☐ acamprosate ☐ disulfiram ☐ other: _____
- **In the past 30 days (or since the last visit if less than 30 days), how many days has the patient taken medication?** _____ days in the past _____ days
- **Side effects:** ☐ none ☐ nausea ☐ vomiting ☐ diarrhea ☐ headache ☐ injection site reaction ☐ other: _____
- **Patient's perception of the medication's effectiveness:** ☐ helpful ☐ not helpful ☐ not sure ☐ specify: _____

Other treatment received

Since your last visit, have you:

Yes	*No*	
☐	☐	Started any new medications? (specify) _____
☐	☐	Attended mutual support groups? If yes, how often? _____
☐	☐	Received alcohol or addiction counseling? (specify) _____
☐	☐	Received other counseling? (specify) _____
☐	☐	Entered a treatment program? ☐ residential ☐ intensive outpatient ☐ other (specify) _____
☐	☐	Been hospitalized for alcohol or drug use? (specify) _____
☐	☐	Been treated for withdrawal (shakes)? (specify) _____

Counseling provided (check the dialogue used)



- ☐ Congratulate the patient for not drinking
- ☐ Review the benefits of pharmacotherapy
- ☐ Ask why the medications are not taken regularly
- ☐ Explore possible remedies to correct nonadherence
- ☐ Set the next appointment

- ☐ Reinforce the patient's ability to follow advice and stick to the plan
- ☐ Ask what the patient has done to achieve this outcome
- ☐ Encourage the patient to stick with the plan—"Keep up the good work!"
- ☐ Review the benefits of abstinence
- ☐ Set the next appointment

- ☐ Review the initial reasons for seeking treatment (i.e., negative consequences of drinking)
- ☐ Review the benefits of abstinence and pharmacotherapy
- ☐ Review the reasons for medication nonadherence
- ☐ Create a new adherence plan, addressing barriers to treatment and providing suggestions on minimizing drinking cues
- ☐ Encourage the patient to "give treatment a chance"
- ☐ Set the next appointment

- ☐ Praise any small steps toward abstinence (e.g., fewer heavy drinking days)
- ☐ Review the benefits of abstinence
- ☐ Review the benefits of mutual support group meetings
- ☐ Remind the patient that medications take time to work
- ☐ Set the next appointment

Other recommendations (e.g., side effects management, new adherence plan): _____

_____

Followup:
- ☐ Continue the current treatment plan
- ☐ Change the treatment plan as follows: _____

_____

- ☐ (for nurses): Refer to physician for medical evaluation

Next appointment date: _____

Referral Resources

When making referrals, involve your patient in the decisions and schedule a referral appointment while he or she is in your office.

Finding evaluation and treatment options

- For patients with insurance, contact a behavioral health case manager at the insurance company for a referral.
- For patients who are uninsured or underinsured, contact your local health department about addiction services.
- For patients who are employed, ask whether they have access to an Employee Assistance Program with addiction counseling.
- To locate treatment options in your area:
  - Call local hospitals to see which ones offer addiction services.
  - Call the National Drug and Alcohol Treatment Referral Routing Service (1-800-662-HELP) or visit the Substance Abuse Facility Treatment Locator Web site at *http://findtreatment.samhsa.gov.*

Finding support groups

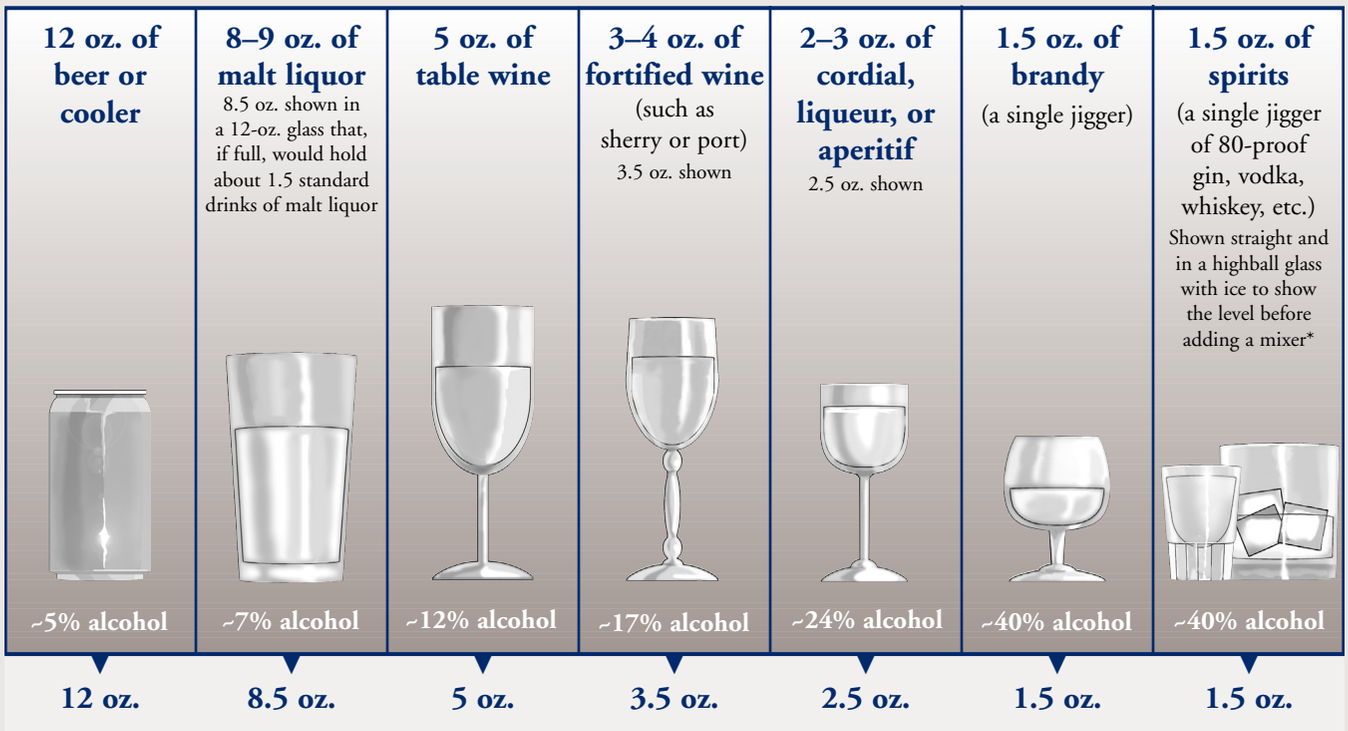
- Alcoholics Anonymous (AA) offers free, widely available groups of volunteers in recovery from alcohol dependence. Volunteers are often willing to work with professionals who refer patients. For contact information for your region, visit *www.aa.org.*
- Other mutual help organizations that offer secular approaches, groups for women only, or support for family members can be found on the National Clearinghouse for Alcohol and Drug Information Web site (*www.ncadi.samhsa.gov*) under "Resources."

Local resources

Use the space below for contact information for resources in your area (treatment centers, mutual support groups such as AA, local government services, the closest Veterans Affairs medical center, shelters, churches).

What's a Standard Drink?

A standard drink in the United States is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are U.S. standard drink equivalents. These are approximate, since different brands and types of beverages vary in their actual alcohol content.



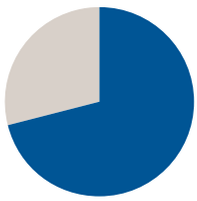
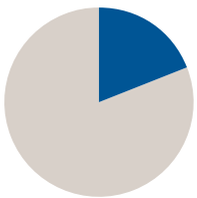
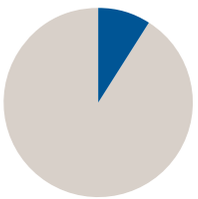
Many people don't know what counts as a standard drink and so they don't realize how many standard drinks are in the containers in which these drinks are often sold. Some examples:

- For **beer,** the approximate number of standard drinks in
  - 12 oz. = 1
  - 16 oz. = 1.3
  - 22 oz. = 2
  - 40 oz. = 3.3
- For **malt liquor,** the approximate number of standard drinks in
  - 12 oz. = 1.5
  - 16 oz. = 2
  - 22 oz. = 2.5
  - 40 oz. = 4.5
- For **table wine,** the approximate number of standard drinks in
  - a standard 750-mL (25-oz.) bottle = 5
- For **80-proof spirits,** or "hard liquor," the approximate number of standard drinks in
  - a mixed drink = 1 or more*
  - a pint (16 oz.) = 11
  - a fifth (25 oz.) = 17
  - 1.75 L (59 oz.) = 39

****Note:*** It can be difficult to estimate the number of standard drinks in a single mixed drink made with hard liquor. Depending on factors such as the type of spirits and the recipe, a mixed drink can contain from one to three or more standard drinks.

U.S. Adult Drinking Patterns

Nearly 3 in 10 U.S. adults engage in at-risk drinking patterns[3] and thus would benefit from advice to cut down or a referral for further evaluation. During a brief intervention, you can use this chart to show that (1) most people abstain or drink within the recommended limits and (2) the prevalence of alcohol use disorders rises with heavier drinking. Though a wise first step, cutting to within the limits is not risk free, since motor vehicle crashes and other problems can occur at lower drinking levels.

WHAT'S YOUR DRINKING PATTERN?	HOW COMMON IS THIS PATTERN?	HOW COMMON ARE ALCOHOL DISORDERS IN DRINKERS WITH THIS PATTERN?
Based on the following limits—number of drinks: On any **DAY**—Never more than **4** (men) or **3** (women) **– and –** In a typical **WEEK**—No more than **14** (men) or **7** (women)	**Percentage of U.S. adults aged 18 or older***	**Combined prevalence of alcohol abuse and dependence****
Never exceed the daily or weekly limits (2 out of 3 people in this group abstain or drink fewer than 12 drinks a year)	 **72%**	fewer than **1 in 100**
Exceed only the daily limit (More than 8 out of 10 in this group exceed the daily limit *less than once a week*)	 **16%**	**1 in 5**
Exceed both daily and weekly limits (8 out of 10 in this group exceed the daily limit *once a week or more*)	 **10%**	almost **1 in 2**

* Not included in the chart, for simplicity, are the 2 percent of U.S. adults who exceed *only* the weekly limits. The combined prevalence of alcohol use disorders in this group is 8 percent.

** See page 5 for the diagnostic criteria for alcohol disorders.

Strategies for Cutting Down

Small changes can make a big difference in reducing your chances of having alcohol-related problems. Here are some strategies to try. Check off some to try the first week, and add some others the next.

☐ Keeping track

Keep track of how much you drink. Find a way that works for you, such as a 3x5" card in your wallet, check marks on a kitchen calendar, or a personal digital assistant. If you make note of each drink before you drink it, this will help you slow down when needed.

☐ Counting and measuring

Know the standard drink sizes so you can count your drinks accurately. One standard drink is 12 ounces of regular beer, 8 to 9 ounces of malt liquor, 5 ounces of table wine, or 1.5 ounces of 80-proof spirits. Measure drinks at home. Away from home, it can be hard to know the number of standard drinks in mixed drinks. To keep track, you may need to ask the server or bartender about the recipe.

☐ Setting goals

Decide how many days a week you want to drink and how many drinks you'll have on those days. You can reduce your risk of alcohol dependence and related problems by drinking within the limits in the box to the right. It's a good idea to have some days when you don't drink.

☐ Pacing and spacing

When you do drink, pace yourself. Sip slowly. Have no more than one drink with alcohol per hour. Alternate "drink spacers"—nonalcoholic drinks such as water, soda, or juice—with drinks containing alcohol.

☐ Including food

Don't drink on an empty stomach. Have some food so the alcohol will be absorbed more slowly into your system.

☐ Avoiding "triggers"

What triggers your urge to drink? If certain people or places make you drink even when you don't want to, try to avoid them. If certain activities, times of day, or feelings trigger the urge, plan what you'll do instead of drinking. If drinking at home is a problem, keep little or no alcohol there.

☐ Planning to handle urges

When an urge hits, consider these options: Remind yourself of your reasons for changing. Or talk it through with someone you trust. Or get involved with a healthy, distracting activity. Or "urge surf"—instead of fighting the feeling, accept it and ride it out, knowing that it will soon crest like a wave and pass.

☐ Knowing your "no"

You're likely to be offered a drink at times when you don't want one. Have a polite, convincing "no, thanks" ready. The faster you can say no to these offers, the less likely you are to give in. If you hesitate, it allows you time to think of excuses to go along.

MAXIMUM DRINKING LIMITS FOR HEALTHY ADULTS*

For healthy **men up to age 65—**

- no more than **4** drinks in a **day** AND
- no more than **14** drinks in a **week**

For healthy **women** (and healthy **men over age 65**)—

- no more than **3** drinks in a **day** AND
- no more than **7** drinks in a **week**

* Depending on your health status, your doctor may advise you to drink less or abstain.

Additional tips for quitting

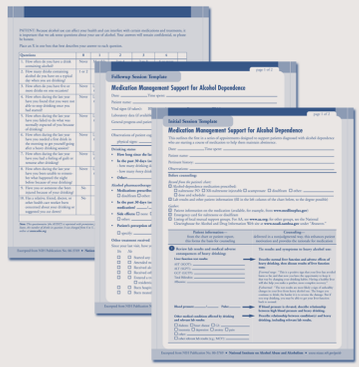
If you want to quit drinking altogether, the last three strategies can help. In addition, you may wish to ask for support from people who might be willing to help, such as a significant other or nondrinking friends. Joining Alcoholics Anonymous or another mutual support group is a way to acquire a network of friends who have found ways to live without alcohol. If you're dependent on alcohol and decide to stop drinking completely, don't go it alone. Sudden withdrawal from heavy drinking can cause dangerous side effects such as seizures. See a doctor to plan a safe recovery.

Online Materials for Clinicians and Patients

Visit the NIAAA Web site at *www.niaaa.nih.gov/guide* for these and other materials to support you in alcohol screening, brief interventions, and followup patient care. NIAAA continually develops and updates materials for practitioners and patients; please check the Web site for new offerings. You may also order materials by writing to the NIAAA Publications Distribution Center, P.O. Box 10686, Rockville, MD 20849-0686 or calling 301–443–3860.

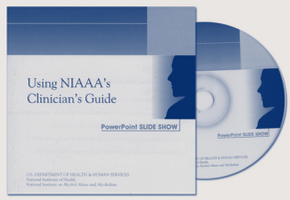
Clinician support and training

Forms for downloading



- Screening instrument: The Alcohol Use Disorders Identification Test (AUDIT) in English and Spanish
- Assessment support: Sample questions for assessment of alcohol use disorders
- Preformatted progress notes and templates
  - Baseline and followup progress notes
  - Medication management support templates
- Medication wallet card form

Animated slide show



- This 80-slide PowerPoint™ show helps instructors present the content of the *Guide* to students and professionals in the general medicine and mental health fields.

Online training

- Coming in spring 2007: Online training in screening and brief intervention for Continuing Medical Education credit.

Publications for professionals

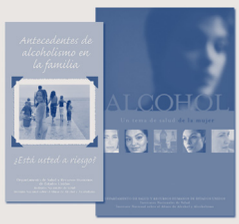
- *Alcohol Alerts:* These 4-page bulletins provide timely information on alcohol research and treatment.
- *Alcohol Research & Health:* Each issue of this quarterly peer-reviewed journal contains review articles on a central topic related to alcohol research.
- *A Pocket Guide for Alcohol Screening and Brief Intervention:* This is a condensed, portable version of this publication.
- Spanish edition of the *Guide: Ayudando a Pacientes Que Beben en Exceso—Guia Para Profesionales de la Salud.*

Patient education

Handouts for downloading

- In English and Spanish: *Strategies for Cutting Down; U.S. Adult Drinking Patterns; What's a Standard Drink?*

Publications for the public



- In English and Spanish: *Alcohol: A Women's Health Issue; Frequently Asked Questions about Alcoholism and Alcohol Abuse; A Family History of Alcoholism: Are You at Risk?* and more

Frequently Asked Questions

About alcohol screening and brief interventions

How effective is screening for heavy drinking?

Studies have demonstrated that screening is sensitive and that patients are willing to give honest information about their drinking to health care practitioners when appropriate methods are used.[6,15] Several methods have been shown to work, including quantity-frequency interview questions and questionnaires such as the CAGE, the AUDIT, the shorter AUDIT-C, the TWEAK (for pregnant women), and others.[28,29] In this *Guide*, the single screening question about heavy drinking days was chosen for its simplicity and because almost all people with alcohol use disorders report drinking 5 or more drinks in a day (for men) or 4 or more (for women) at least occasionally. This *Guide* also recommends the AUDIT (provided on page 11) as a self-administered screening tool because of its high levels of validity and reliability.[15]

With the single interview question, screening is positive with just one heavy drinking day in the past year. Isn't that casting a very broad net?

A common reaction to the screening question is, "Everybody's going to meet this, at least occasionally." A large national survey by NIAAA, however, showed that nearly three-fourths of U.S. adults never exceed the limits in the screening question.[3] Even if patients report that they only drink heavily on rare occasions, screening provides an opportunity to educate them about safe drinking limits so that heavy drinking doesn't become more frequent. The risk for alcohol-related problems rises with the number of heavy drinking days,[1] and some problems, such as driving while intoxicated or trauma, can occur with a single occasion.

How effective are brief interventions?

Randomized, controlled clinical trials in a variety of populations and settings have shown that brief interventions can decrease alcohol use significantly among people who drink above the recommended limits but aren't dependent. In several intervention trials with multiple brief contacts, for example, heavy drinkers cut an average of three to nine drinks per week, for a 13 to 34 percent net reduction in consumption.[30] Even relatively modest reductions in drinking can have important health benefits when spread across a large number of people. Brief intervention trials have also reported significant decreases in blood pressure readings, levels of gamma-glutamyl transferase (GGT), psychosocial problems, hospital days, and hospital readmissions for alcohol-related trauma.[8] Followup periods typically range from 6 to 24 months, although one recent study reported sustained reductions in alcohol use over 48 months.[8] A cost-benefit analysis in this study showed that each dollar invested in brief physician intervention could reap more than fourfold savings in future health care costs. Other research shows that for alcohol-dependent patients with an alcohol-related medical illness, repeated brief interventions at approximately monthly intervals for 1 to 2 years can lead to significant reductions in or cessation of drinking.[9,10]

What can I do to encourage my patients to give honest and accurate answers to the screening questions?

It's often best to ask about alcohol consumption at the same time as other health behaviors such as smoking, diet, and exercise. Using an empathic, nonconfrontational approach can help put patients at ease. Some clinicians have found that prefacing the alcohol questions with a nonthreatening opener such as "Do you enjoy a drink now and then?" can encourage reserved patients to talk. Patients may feel that a written or computerized self-report version of the AUDIT is less confrontational as well. To improve the accuracy of estimated drinking quantities, you could ask patients to look at the "What's a Standard Drink?" chart on page 24. Many people are surprised to learn what counts as a single standard drink, especially for beverages with a higher alcohol content such as malt liquors, fortified wines, and spirits. The chart also lists the number of standard drinks in commonly purchased beverage containers. In some situations, you may consider adding the questions "How often do you buy alcohol?" and "How much do you buy?" to help build an accurate estimate.

How can a clinic- or office-based screening system be implemented?

The best studied method, which is both easy and efficient, is to ask patients to fill out the 10-item AUDIT before seeing the doctor. This form (provided on page 11) can be added to others that patients fill out. The full AUDIT or the 3-item AUDIT-C can also be incorporated into a larger health history form. The AUDIT-C consists of the first three consumption-related items of the AUDIT; a score of 6 or more for men and 4 or more for women[31] indicates a positive screen. Alternatively, the single-item screen in Step 1 of this *Guide* could be incorporated into a health history form. Screening can also be done in person by a nurse during patient check-in. (See also "Set Up Your Practice to Simplify the Process" on page 3.)

Are there any specific considerations for implementing screening in mental health settings?

Studies have demonstrated a strong relationship between alcohol use disorders and other mental disorders.[32] Heavy drinking can cause psychiatric symptoms such as depression, anxiety, insomnia, cognitive dysfunction, and interpersonal conflict. For patients who have an independent psychiatric disorder, heavy drinking may compromise the treatment response. Thus, it is important that all mental health clinicians conduct routine screening for heavy drinking.

Less is known about the performance of screening methods or brief interventions in mental health settings than in primary care settings. Still, the single-question screener in this *Guide* is likely to work reasonably well, since almost everyone with an alcohol use disorder reports drinking above the recommended daily limits at least occasionally.

Mental health clinicians may need to conduct a more thorough assessment to determine whether an alcohol use disorder is present and how it might be interacting with other mental or substance use disorders. The recommended limits for drinking may need to be lowered depending on coexisting problems and prescribed medications.

Similarly, a more extended behavioral intervention may be needed to address coexisting alcohol use disorders, either delivered as part of mental health treatment or through referral to an addiction specialist.

About drinking levels and advice

When should I recommend abstaining versus cutting down?

Certain conditions warrant advice to abstain as opposed to cutting down. These include when drinkers:

- are or may become pregnant
- are taking a contraindicated medication (see box below)
- have a medical or psychiatric disorder caused by or exacerbated by drinking
- have an alcohol use disorder

If patients with alcohol use disorders are unwilling to commit to abstinence, they may be willing to cut down on their drinking. This should be encouraged while noting that abstinence, the safest strategy, has a greater chance of long-term success.

For heavy drinkers who don't have an alcohol use disorder, use professional judgment to determine whether cutting down or abstaining is more appropriate, based on factors such as these:

℞ Interactions Between Alcohol and Medications

Alcohol can interact negatively with medications either by interfering with the metabolism of the medication (generally in the liver) or by enhancing the effects of the medication (particularly in the central nervous system). Many classes of prescription medicines can interact with alcohol, including antibiotics, antidepressants, antihistamines, barbiturates, benzodiazepines, histamine H2 receptor agonists, muscle relaxants, nonopioid pain medications and anti-inflammatory agents, opioids, and warfarin. In addition, many over-the-counter medications and herbal preparations can cause negative side effects when taken with alcohol.

- a family history of alcohol problems
- advanced age
- injuries related to drinking
- symptoms such as sleep disorders or sexual dysfunction

It may be useful to discuss different options, such as cutting down to recommended limits or abstaining completely for perhaps a month or two, then reconsidering future drinking. If cutting down is the initial strategy but the patient is unable to stay within limits, recommend abstinence.

How do I factor the potential benefits of moderate drinking into my advice to patients who drink rarely or not at all?

Moderate consumption of alcohol (defined by U.S. Dietary Guidelines as up to two drinks a day for men and one for women) has been associated with a reduced risk of coronary heart disease.[33] Achieving a balance between the risks and benefits of alcohol consumption remains difficult, however, because each person has a different susceptibility to diseases potentially caused or prevented by alcohol. The advice you would give to a young person with a family history of alcoholism, for example, would differ from the advice you would give to a middle-aged patient with a family history of premature heart disease. Most experts don't recommend advising nondrinking patients to begin drinking to reduce their cardiovascular risk. However, if a patient is considering this, discuss safe drinking limits and ways to avoid alcohol-induced harm.

Why are the recommended drinking limits lower for some patients?

The limits are lower for women because they have proportionally less body water than men do and thus achieve higher blood alcohol concentrations after drinking the same amount of alcohol. Older adults also have less lean body mass and greater sensitivity to alcohol's effects. In addition, there are many clinical situations where abstinence or lower limits are indicated, because of a greater risk of harm associated with drinking. Examples include women who are or may become pregnant, patients taking medications that may interact with alcohol, young people with a family history of alcohol dependence, and patients with physical or psychiatric conditions that are caused by or exacerbated by alcohol.

Some of my patients who drink heavily believe that this is normal. What percentage of people drink at, above, or below moderate levels?

About 7 in 10 adults abstain, drink rarely, or drink within the daily and weekly limits noted in Step 1.[3] The rest exceed the daily limits, the weekly limits, or both. The "U.S. Adult Drinking Patterns" chart on page 25 shows the percentage of drinkers in each category, as well as the prevalence of alcohol use disorders in each group. Because heavy drinkers often believe that most people drink as much and as often as they do, providing normative data about U.S. drinking patterns and related risks can provide a helpful reality check. In particular, those who believe that it's fine to drink moderately during the week and heavily on the weekends need to know that they have a higher chance not only of immediate alcohol-related injuries, but also of developing alcohol use disorders and other alcohol-related medical and psychiatric disorders.

Some of my patients who are pregnant don't see any harm in having an occasional drink. What's the latest advice?

Some pregnant women may not be aware of the risks involved with drinking, while others may drink before they realize they're pregnant. A recent survey estimates that 1 in 10 pregnant women in the United States drinks alcohol.[34] In addition, among sexually active women who aren't using birth control, more than half drink and 12.4 percent report binge drinking, placing them at particularly high risk for an alcohol-exposed pregnancy.[34]

Each year, an estimated 2,000 to 8,000 infants are born with fetal alcohol syndrome in the United States, and many thousands more are born with some degree of alcohol-related effects.[35] These problems range from mild learning and behavioral problems to growth deficiencies to severe mental and physical impairment. Together, these adverse effects comprise fetal alcohol spectrum disorders.

Because it isn't known whether any amount of alcohol is safe during pregnancy, the Surgeon General recently reissued an advisory that urges women who are or may become pregnant to abstain from drinking alcohol.[2] The advisory also recommends that pregnant women who have already consumed alcohol stop to minimize further

risks and that health care professionals inquire routinely about alcohol consumption by women of childbearing age.

About diagnosing and helping patients with alcohol use disorders

What if a patient reports some symptoms of an alcohol use disorder but not enough to qualify for a diagnosis?

Alcohol use disorders are similar to other medical disorders such as hypertension, diabetes, or depression in having "gray zones" of diagnosis. For example, a patient might report a single arrest for driving while intoxicated and no other symptoms. Since a diagnosis of alcohol abuse requires repetitive problems, that diagnosis couldn't be made. Similarly, a patient might report one or two symptoms of alcohol dependence, but three are needed to qualify for a diagnosis.

Any symptom of abuse or dependence is a cause for concern and should be addressed, since an alcohol use disorder may be present or developing. These patients may be more successful with abstaining as opposed to cutting down to recommended limits. Closer followup is indicated, as well as reconsidering the diagnosis as more information becomes available.

Should I recommend any particular behavioral therapy for patients with alcohol use disorders?

Several types of behavioral therapy are used to treat alcohol use disorders. Cognitive-behavioral therapy, motivational enhancement, and 12-step facilitation (e.g., the Minnesota Model) have all been shown to be effective.[36] A combination of approaches has been shown to be effective as well (see the next question). Getting help in itself appears to be more important than the particular approach used, provided it avoids heavy confrontation and incorporates the basic elements of empathy, motivational support, and an explicit focus on changing drinking behavior. For patients receiving medications for alcohol dependence, brief medical counseling sessions delivered by a nurse or physician have been shown to be effective without additional behavioral treatment by a specialist[22] (see page 17).

In addition to more formal treatment approaches, mutual help groups such as Alcoholics Anonymous (AA) appear to be very beneficial for people who stick with them. AA is widely available, free, and requires no commitment other than a desire to stop drinking. If you've never attended a meeting, consider doing so as an observer and supporter. To learn more, visit *www.aa.org*. Other self-help organizations that offer secular approaches, groups for women only, or support for family members can be found on the National Clearinghouse for Alcohol and Drug Information Web site (*www.ncadi.samhsa.gov*) under "Resources."

As a mental health clinician, how can I learn more about specialized alcohol counseling?

For a recent major clinical trial, NIAAA grantees designed state-of-the-art individual outpatient psychotherapy for alcohol dependence. Called a combined behavioral intervention (CBI), it integrates cognitive-behavioral therapy, motivational enhancement, 12-step approaches, couples therapy, and community reinforcement—all treatments shown in earlier studies to be beneficial. Behavioral specialists deliver CBI in up to 20 sessions of 50 minutes (the median in the trial was 10 sessions). The treatment has four phases: building motivation for change, developing an individual plan for treatment and change, completing individualized skill-training modules, and performing maintenance checkups. Findings from the trial show that this specialized alcohol counseling or the medication naltrexone was effective, when coupled with structured medical management.[22] The CBI strategy and supporting materials are provided in the 328-page *Combined Behavioral Intervention Manual* from Project COMBINE; to order for a small fee, visit *www.niaaa.nih.gov/guide*.

How should alcohol withdrawal be managed?

Alcohol withdrawal results when a person who is alcohol dependent suddenly stops drinking. Symptoms usually start within a few hours and consist of tremors, sweating, elevated pulse and blood pressure, nausea, insomnia, and anxiety. Generalized seizures may also occur. A second syndrome, alcohol withdrawal delirium, sometimes follows. Beginning after 1 to 3 days and lasting

2 to 10 days, it consists of an altered sensorium, disorientation, poor short-term memory, altered sleep-wake cycle, and hallucinations. Management typically consists of administering thiamine and benzodiazepines, sometimes together with anticonvulsants, beta adrenergic blockers, or antipsychotics as indicated. Mild withdrawal can be managed successfully in the outpatient setting, but more complicated or severe cases require hospitalization. (Consult references 37 and 38 on page 34 for additional information.)

Are laboratory tests available to screen for or monitor alcohol problems?

For screening purposes in primary care settings, interviews and questionnaires have greater sensitivity and specificity than blood tests for biochemical markers, which identify only about 10 to 30 percent of heavy drinkers.[39,40] Nevertheless, biochemical markers may be useful when heavy drinking is suspected but the patient denies it. The most sensitive and widely available test for this purpose is the serum gamma-glutamyl transferase (GGT) assay. It isn't very specific, however, so reasons for GGT elevation other than excessive alcohol use need to be eliminated. If elevated at baseline, GGT and other transaminases may also be helpful in monitoring progress and identifying relapse, and serial values can provide valuable feedback to patients after an intervention. Other blood tests include the mean corpuscular volume (MCV) of red blood cells, which is often elevated in people with alcohol dependence, and the carbohydrate-deficient transferrin (CDT) assay. The CDT assay is about as sensitive as the GGT and has the advantage of not being affected by liver disease.[41]

If I refer a patient for alcohol treatment, what are the chances for recovery?

A review of seven large studies of alcoholism treatment found that about one-third of patients either were abstinent or drank moderately without negative consequences or dependence in the year following treatment.[42] Although the other two-thirds had some periods of heavy drinking, on average they reduced consumption and alcohol-related problems by more than half. These reductions appear to last at least 3 years.[36] This substantial improvement in patients who do not attain complete abstinence or problem-free reduced drinking is often overlooked. These patients may require further treatment, and their chances of benefiting the next time don't appear to be influenced significantly by having had prior treatments.[42] As is true for other medical disorders, some patients have more severe forms of alcohol dependence that may require long-term management.

What can I do to help patients who struggle to remain abstinent or who relapse?

Changing drinking behavior is a challenge, especially for those who are alcohol dependent. The first 12 months of abstinence are especially difficult, and relapse is most common during this time. If patients do relapse, recognize that they have a chronic disorder that requires continuing care, just like asthma, hypertension, or diabetes. Recurrence of symptoms is common and similar across each of these disorders,[43] perhaps because they require the patient to change health behaviors to maintain gains. The most important principle is to stay engaged with the patient and to maintain optimism about eventual improvement. Most people with alcohol dependence who continue to work at recovery eventually achieve partial to full remission of symptoms, and often do so without specialized behavioral treatment.[44] For patients who struggle to abstain or who relapse:

- If the patient is not taking medication for alcohol dependence, consider prescribing one and following up with medication management (see pages 13–22).
- Treat depression or anxiety disorders if they are present more than 2 to 4 weeks after abstinence is established.
- Assess and address other possible triggers for struggle or relapse, including stressful events, interpersonal conflict, insomnia, chronic pain, craving, or high-temptation situations such as a wedding or convention.
- If the patient is not attending a mutual help group or is not receiving behavioral therapy, consider recommending these support measures.
- Encourage those who have relapsed by noting that relapse is common and pointing out the value of the recovery that was achieved.
- Provide followup care and advise patients to contact you if they are concerned about relapse.

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NIAAA
National Institute on Alcohol
Abuse and Alcoholism

NIH Publication No. 07–3769
Reprinted May 2007

CONTROLLED SUBSTANCE REFILL PROGRAM: PATIENT AGREEMENT FORM

Treatment Agreement for Chronic Opioids

We want to ensure that patients and caregivers have clear communication and safe, effective procedures when patients use opioids.

EFFECTIVENESS: For most patients and pain conditions, opioids are effective pain-relieving medications. However, it is possible opioids will not work well for you and your pain.

SAFETY: Most people can take these drugs safely, but some people do experience side effects. (See below.)

SIDE EFFECTS: Most patients do not have serious side effects or drug interactions. Unfortunately, some do experience side effects and must stop the medication(s). Common side effects include constipation, itching, nausea, vomiting, sedation or lightheadedness. Uncommon reactions include swelling in the legs, water on the lungs, trouble breathing (especially if you have emphysema/COPD or are on other narcotics), mental slowing and loss of coordination, lowering of sex drive, decreased testosterone (male sex hormone) and addiction. Note: Pregnant women using opioids could make their newborn child dependent upon opioids. If you are pregnant, you need to alert your health care provider.

DEPENDENCE: Dependence is not the same as addiction. Many people who take opioids daily will become dependent on them. Dependence is when your body adapts to the medication and then experiences withdrawal if the medication is stopped or lowered too quickly. Withdrawal symptoms include moodiness, aches and pains, sweating, diarrhea, abdominal pain and even seizures.

ADDICTION: Addiction is not the same as dependence. While many people become dependent on daily opioids, only a small percentage of these people will become addicted. Addiction is characterized by behaviors such as loss of control of drug use, compulsive use and craving, and continued use despite harm or risk to the person. When people are addicted, they are not taking opioids simply to treat the pain.

GOALS: The goals of chronic pain management are to:

1. Improve your ability to function in your daily life,
2. Lower your pain.

TREATMENT OPTIONS :

1. Medications,
2. Counseling, relaxation training, hypnosis and meditation,
3. Chiropractic care, massage, acupuncture and physical therapy,
4. Surgery and injections.

WHAT YOU NEED TO DO :

1. Realize that opioid therapy is only one part of treatment.
2. Remain active every day and try to increase activity a little bit at a time.
3. Use your medications ONLY as directed by your provider.
4. Work with your provider and follow treatment recommendations in addition to taking prescribed medications.

Dr. _____ and staff have explained the risks and benefits of chronic opioid therapy for my pain.

I, _____, understand that I must comply with the following rules or I will not be given opioids.

I will fill the prescription at one and only one pharmacy.

Pharmacy name _____ Phone _____

I will take the medication, _____, as it was prescribed and only in that way.

continued ➤

I will not increase the dose or stop the medication unless asked to do so by my provider or my provider's partner.

I will report any worrisome side effect soon after it begins.

I will follow through on appointments that may help me with chronic pain and functioning. These may include physical and occupational therapy, counseling and other mental health practices, neurosurgery, neurology and orthopedics. Consistent failure to keep these appointments and therapies may result in the stopping of the opioid medications.

If prescribed, I will use medications other than opioids to control pain.

I will accept opioids for chronic pain from my provider only.

I will not share, exchange or sell my opioids, as the law prohibits those actions. I understand that my provider will report serious concerns of drug misuse to any and all authorities for investigation.

I will not use illegal/street drugs (this includes marijuana). I will not use narcotic medications unless provided to me from my provider.

I agree to provide samples for random drug testing when asked. If I fail to provide the sample when asked or if the results are unsatisfactory, I may forfeit the right to continue receiving the medication.

If my provider is concerned that I might have a substance abuse problem, I must agree to an evaluation by a specialist in abuse/addiction. If the evaluation suggests I have a drug abuse problem, my provider may stop my medication in a way that does not cause withdrawal symptoms.

I will not get early refills unless something has dramatically changed and then only if my provider agrees.

I recognize that opioids by themselves, in combination with alcohol or in combination with other medications can result in unclear thinking and loss of coordination. I agree to contact my provider if these symptoms arise. I should not drive or operate equipment if I have these side effects.

It is my responsibility to keep my medications safe. If opioids are lost, damaged or stolen, the medication may or may not be refilled early. Each case will be looked at individually. If the medication is stolen, I must file a police report and submit the number for verification to my provider's office. Again, stolen medications may or may not be refilled. If a refill is given, it will be given only once.

If a new condition develops that causes acute pain, I have the right to expect appropriate treatment for that new condition from the provider treating me for the new condition. I should not be required to increase the use of my chronic pain medication for a serious and new pain.

I understand that if my provider does not feel I am following through adequately with the treatment plan, my provider may lower or stop the opioid altogether.

I understand that my provider may decide to stop the opioid if after increasing it adequately, my pain and function have not responded positively.

By signing this form, I authorize my provider's office to contact any and all groups and organizations involved with my care and involved with the investigation of medication and drug abuse. I give permission to my provider to discuss my care with past caregivers, all pharmacies and policing agencies. This also gives these caregivers and pharmacies permission to share with my provider information about my past treatments and care.

PATIENT SIGNATURE DATE

HEALTH CARE PROVIDER DATE

Family Practice Management®

MoodCheck

Part A. Please place a check after the statements below that *accurately describe you*.

During times when I am not using drugs or alcohol:	
I notice that my mood and/or energy levels shift drastically from time to time.	
At times, I am moody and/or energy level is very low, and at other times, and very high.	
During my "low" phases, I often feel a lack of energy, a need to stay in bed or get extra sleep, and little or no motivation to do things I need to do.	
I often put on weight during these periods.	
During my low phases, I often feel "blue," sad all the time, or depressed.	
Sometimes, during the low phases, I feel helpless or even suicidal.	
During the low phases, my ability to function at work or socially is impaired.	
Typically, the low phases last for a few weeks, but sometimes they last only a few days.	
I also experience a period of "normal" mood in between mood swings, during which my mood and energy level feels "right" and my ability to function is not disturbed.	
I then notice a marked shift or "switch" in the way I feel.	
My energy increases above what is normal for me, and I often get many things done I would not ordinarily be able to do.	
Sometimes during those "high" periods, I feel as if I have too much energy or feel "hyper".	
During these high periods, I may feel irritable, "on edge," or aggressive.	
During the high periods, I may take on too many activities at once.	
During the high periods, I may spend money in ways that cause me trouble.	
I may be more talkative, outgoing or sexual during these periods.	
Sometimes, my behavior during the high periods seems strange or annoying to others.	
Sometimes, I get into difficulty with co-workers or police during these high periods.	
Sometimes, I increase my alcohol or nonprescription drug use during the high periods.	
Total	

Part B. The statements in Part A (not just those checked) describe me (circle one of the answers below):

Not at all (0)	A little (2)	Fairly well (4)	Very well (6)

Add the number in parentheses in Part B to your checkmark total from Part A. _____

Part C.

Please indicate whether any of your (blood) relatives have had any of these concerns:

	Grandparents	Parents	Aunts/Uncles	Brothers/Sisters	Children
Suicide	☐	☐	☐	☐	☐
Alcohol/Drug Problems	☐	☐	☐	☐	☐
Mental Hospital	☐	☐	☐	☐	☐
Depression Problems	☐	☐	☐	☐	☐
Manic or Bipolar	☐	☐	☐	☐	☐

Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	Yes	No
Have you ever attempted suicide?	Yes	No

(Please continue with part D, over)

MoodCheck

Part D.

How old were you when you first were depressed? (*circle one*)	As long as I can remember	Grade school	Middle school	High school	18-24	> 24
How many episodes of depression have you had?	One	2-4	5-6	>10		
Have antidepressants ever caused: (*circle all that apply)*	Excessive energy	Severe insomnia	Agitation	Irritability	Racing thoughts	Talking a lot
How many antidepressants have you tried, if any?	None	1	2	3	>3	
Has an antidepressant you took worked at first, and then stopped working?	No	Yes				
Do your episodes *start* gradually, or suddenly?	Gradually	Can't say	Suddenly			
Do your episodes *stop* gradually, or suddenly?	Gradually	Can't say	Suddenly			
Did you have an episode after giving birth?	No	Within 6 months	Within 2 months	Within 2 weeks		
Are your moods much different at different times of year?	No effect of time of year	Yes, seasonal shifts				
When you are depressed, do you sleep differently?	No	Sleep less	Sleep more			
When you are depressed, do you eat differently?	No	Eat less	Eat more			
When you are depressed, what happens to your energy?	Nothing	It varies a lot	Very low	Extremely low, can hardly move		
In episodes, have you lost contact with reality? (delusions, voices, people thought you were odd)	No	Yes				

If your total score from Parts A and B is **greater than 16**; or if you have **lots of circles** in shaded boxes on this page, you may need to learn more about "mood swings without mania". Use the Internet and search *Bipolar II* **.** This is something to learn about, not necessarily about *you*.

If your total score from Parts A and B is **less than 10**, and you have **few circles** in shaded boxes on this page, antidepressants are probably okay, if you and your doctor choose to use them. They can occasionally cause: unusual thoughts, including violent and suicidal ones; irritability; too much energy; and severe sleep problems. Contact your doctor if you think any of these might be happening to you.

Your Name_____ Date _____

Understanding ICD-10-CM and DSM-5:
A Quick Guide for Psychiatrists and Other Mental Health Clinicians

Among the most noticeable revisions to the Fifth Edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) is the inclusion of dual codes for every mental disorder to account for the currently used ICD-9-CM codes as well as new ICD-10-CM codes, which will be activated in October 2014. Since DSM-5 was released in May 2013, there have been questions about the need for additional clinician training related to the use of the ICD-10-CM codes. Because of the listing of the ICD-10-CM codes in the DSM-5, training that is focused solely on the ICD-10-CM is not necessary for clinicians to learn the appropriate codes for submitting insurance claims for DSM-5 mental disorder diagnoses. In the same manner that most mental health clinicians used the ICD-9-CM codes embedded in DSM-III, DSM-III-R, DSM-IV or DSM-IV-TR for submitting insurance claims, and never purchased a separate ICD-9-CM, it will also be possible to use the embedded ICD-10-CM codes in DSM-5 without the need for additional training. Please note that ICD-10-CM does not include diagnostic criteria, and the presence of documented DSM-5 diagnostic criteria in patient medical records is used by CMS and private insurance contractors for medical chart quality assessment, audit, and fraud/abuse determinations. However, it may be of benefit for clinicians to experience ICD-10-CM training in order to better understand the coding of *other medical disorders*—particularly in settings where general medical and mental health services are treated in an integrated setting. The APA will be posting a compendium of ICD-10-CM codes for frequently encountered non-mental health disorders that can be used as a reference for psychiatrists when reporting patient's comorbid medical diagnoses.

The following bullet points were developed to quickly clarify the key points of ICD-10-CM coding and implementation most relevant to mental health clinicians. We encourage all clinicians to review and ensure their familiarity with these important concepts.

Darrel A. Regier, M.D., M.P.H.
Vice-Chair, DSM-5 Task Force

William E. Narrow, M.D., M.P.H.
Research Director, DSM-5 Task Force

- On October 1, 2014, the entire health care system in the U.S. will change its diagnostic codes from ICD-9-CM to ICD-10-CM. Everyone is now using ICD-9-CM codes; mental health practitioners know these codes from using the DSM-IV-TR (they are also included in the DSM-5).

- **DSM-5 contains all of the information needed to assign HIPAA-compliant, valid ICD-10-CM codes to the psychiatric diagnoses that you make for your patients.**

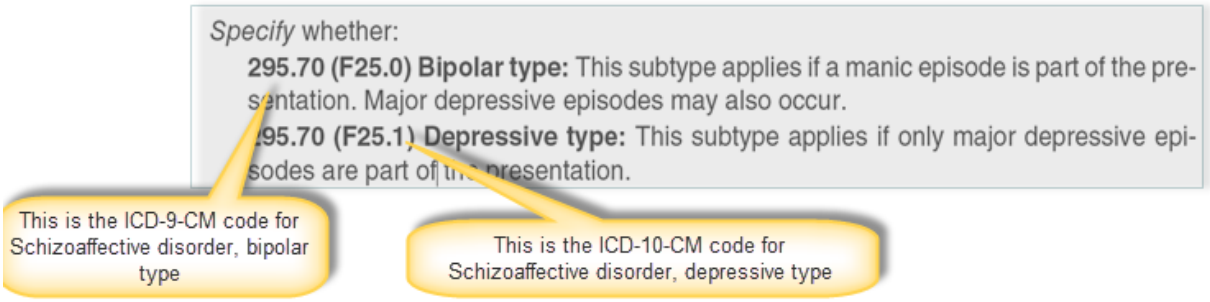
    - DSM-5 training can be helpful to clinicians. Training dedicated solely to ICD-10-CM is usually aimed at administrators, information technology specialists, and coding professionals.

- The ICD-10-CM codes are alpha-numeric. In DSM-5, they can be found ***in parentheses*** within the diagnostic criteria box for each disorder.

  - If there is only one ICD-10-CM assigned to a disorder, it can be found at the top of the criteria set. For example, Schizophrenia has an ICD-10-CM code of F20.9

  - When you look at a disorder in DSM-5, it will appear as below. Note that the ICD-9-CM code and the ICD-10-CM code have already been listed for you:

  - If more than one code can be assigned to a disorder, the codes can be found at the bottom of the diagnostic criteria box. This is the case when subtypes are coded. For example, for schizoaffective disorder, the bipolar type is coded F25.0 and the depressive type is coded F25.1. This will appear in the DSM-5 criteria as below:



  - For disorders with more complex coding, coding notes and coding tables are provided at the bottom of the criteria box. The substance/medication-induced disorders, for example, have complex coding.

- Clinicians should always check the bottom of the diagnostic criteria box for coding notes, which provide additional guidance. For example, in Schizoaffective disorder, if catatonia is present, an additional code for catatonia should be used, and will be provided in the coding note:

Specify if:
With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119–120, for definition).
Coding note: Use additional code 293.89 (F06.1) catatonia associated with schizoaffective disorder to indicate the presence of the comorbid catatonia.

- A section of text called “Recording Procedures” sometimes follows the diagnostic criteria box and provides even more guidance for documenting your diagnoses.

- For quick reference, ICD-10-CM codes can also be found in the “DSM-5 Classification” in the front of the manual, and as alphabetical and numerical listings in the appendices.

- For further information on the implementation of DSM-5, including ICD-10-CM coding updates, and to submit questions to DSM staff at the APA, please visit www.dsm5.org

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
550 S. VERMONT AVE., LOS ANGELES, CA 90020 HTTP://DMH.LACOUNTY.GOV

MARVIN J. SOUTHARD, D.S.W.
Director
ROBIN KAY, Ph.D.
Chief Deputy Director
RODERICK SHANER, M.D.
Medical Director

January 3, 2014

Dear Health Plan Provider:

As the New Year begins and many thousand more Los Angeles County (LAC) residents become Health Plan beneficiaries through Medi-Cal expansion, as the local Medi-Cal Mental Health Plan for Specialty Mental Health Carved-out Services, the LAC Department of Mental Health (DMH) welcomes the opportunity to provide your patients with high quality mental health services. We've worked closely with the Health Plans to make it as simple as possible for you to connect your patients to our clinicians, and we know that you'll be receiving materials from the Plans that will expedite this. Meanwhile, we want to introduce ourselves to you and provide a page of some quick answers to questions that we anticipate you may have. And, of course, we'll be available to answer other questions that might arise.

On behalf of all of the employees, contractors, and mental health clinicians at the LAC DMH, we want to express our excitement, enthusiasm, and commitment to working together with you to provide effective, integrated, and satisfying services to the beneficiaries in our system who have entrusted their care to all of us.

Sincerely,

Marvin J. Southard, D.S.W.
Director

Robin Kay, Ph.D.
Chief Deputy Director

Roderick Shaner, M.D.
Medical Director

MJS:RK:RS:lw

Questions and Answers about Los Angeles County Department of Mental Health Services

What is Specialty Mental Health?

Specialty Mental Health consists of mental health services for individuals that need more intensive specialized services than can be provided directly by the health plans. In general, such services focus on individuals with treatable certain mental health conditions that cause significant impairment and cannot be better addressed through the Primary Care Physician (PCP) and the Health Plan's Mental Health Provider Network.

How do I decide if my patient needs Specialty Mental Health Services?

Here are the usual ways. The Health Plan will provide you with more detailed info.

- Most commonly, you can call the Health Plan, via lines that they provide, to obtain advice or additional assessment regarding mental health service needs. If the Health Plan determines that assessment for Specialty Mental Health services is indicated, they can directly refer your patient to LAC DMH programs.
- You can also directly call neighborhood DMH programs, or suggest that your patient does so. Our programs can be found on our website, or you can call our ACCESS Line (800) 854-7771 for suggestions and help with finding navigations. Or, you can consult our neighborhood navigator listings, which will be supplied to you by the Health Plans.
- If you think that your patient is having a mental health emergency that could be dangerous, you can call 911 or the LAC DMH Access Line (800) 854-7771 for immediate intervention, depending on the nature of the emergency.
- If you think that an urgent appointment is necessary before your patient leaves your office, you can complete a special screening form, email it to screener@dmh.lacounty.gov and then call the LAC DMH urgent appointment line (855) 425-8141 to immediately obtain an appointment.

How will I know what care my patient is getting in Specialty Mental Health?

Specialty Mental Health providers are instructed to notify you of your patient's care and, if the patient gives permission, send relevant clinical information back to you and/or the Health Plan.

Who can I call with other questions about Specialty Mental Health Services?

The 24/7 LAC DMH ACCESS number (800) 854-7771 can direct you to the proper office within DMH to answer specific questions about Specialty Mental Health services and benefits.

DEPARTMENT OF MENTAL HEALTH-EMERGENCY OUTREACH BUREAU PSYCHIATRIC CRISIS SERVICES

ACCESS Center - (800) 854-7771

Services include deployment of crisis evaluation teams, information and referrals, gatekeeping of acute inpatient psychiatric beds, interpreter services and patient transport. This service is open 24/7.

Psychiatric Mobile Response Teams (PMRT) – (800) 854-7771

Psychiatric Mobile Response Teams (PMRT) consist of DMH clinicians designated per Welfare and Institutions Code 5150/ 5585 to perform evaluations for involuntary detention of individuals determined to be at risk of harming themselves or others or who are unable to provide food, clothing, or shelter as a result of a mental disorder.

Law Enforcement Teams (LET) - To make referrals to this programs call 911

This co-response model pairs a DMH clinician with a law enforcement officer. The primary mission is to respond to 911 or patrol officer requests for assistance on calls involving mentally ill, homeless, or high risk individuals. LET and PMRT support one another as resources permit. Current programs:

- Alhambra Police Department Mental Evaluation Team (AMET)
- Santa Monica Police Department Homeless Liaison Program (HLP)
- Burbank Police Department Mental Health Evaluation Team (BMHET)
- Los Angeles County Sheriff's Department Mental Evaluation Team (MET)
- Long Beach Police Department Mental Evaluation Team (Long Beach MET)
- Los Angeles County Metropolitan Transit Authority Crisis Response Unit (CRU)
- Pasadena Police Department Homeless Outreach Psychiatric Evaluations (HOPE)
- Los Angeles Police Department Case Assessment and Management Program (CAMP)
- Los Angeles Police Department Systemwide Mental Assessment Response Team (SMART)

School Threat Assessment Response Team (START) – (213) 739-5565

START provides training and consultation, assessment and intervention, and case management and monitoring to students at risk for targeted school violence. START collaborates with educational institutions, law enforcement agencies, mental health providers, and parents to mitigate or eliminate threats.

Homeless Outreach Mobile Engagement (HOME)- (213) 480-3480

HOME provides countywide field based outreach and engagement services and intensive case management to under-served or disengaged homeless persons who are mentally ill, living in homeless encampments, or frequenting locations where outreach is not readily available or provided in a focused manner.

Homeless Outreach Teams (HOT)- (800) 854-7771

Homeless Outreach Teams (HOT) are comprised of PMRT staff providing outreach and engagement to mentally ill homeless persons. HOT increases the likelihood of effective outcomes for this population in situations when they are at risk of involuntary hospitalization.

Psychiatric Emergency Teams (PET)

Psychiatric Emergency Teams (PET) are mobile teams operated by psychiatric hospitals approved by the Department of Mental Health to provide 5150 and 5585 evaluations. Team members are licensed mental health clinicians. PET operates similar to PMRT and provides additional resources in specific geographical regions. For contact information on PET, call (800) 854-7771.

Suicide Prevention Hotline - (877) 727-4747 or Suicide Prevention Center in Los Angeles (310) 391-1253

Provides a 24-hour suicide prevention crisis line and uses community volunteers in providing hotline service. The hotline counselors can refer the caller to a therapist in the community.

COUNTY OF LOS ANGELES
Public Health

JONATHAN E. FIELDING, M.D., M.P.H.
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Building A-9 East, Third Floor
Alhambra, CA 91803
TEL (626) 299-4193 • FAX (626) 458-7637

www.publichealth.lacounty.gov

January 6, 2014

Dear Health Plan Provider:

The County of Los Angeles Department of Public Health, Substance Abuse Prevention and Control (SAPC) welcomes the opportunity to work with you to assist your patients needing substance use disorder (SUD) services. In preparation for Medi-Cal expansion and the enhanced services offered under the Drug Medi-Cal program, we have been working closely with the Health Plans to make sure that you will be able to assist your patients to get the SUD services they may need. Attached is a page of quick answers on how to access SUD services through the Health Plans and the SAPC network. We are also available to answer other questions you may have as they arise.

We look forward to working with you and hope you will let us know any ways SAPC can strengthen its partnership with you and the Health Plans to improve the health of our shared patients.

Very truly yours,

John Viernes, Jr., Director
Substance Abuse Prevention and Control

JV:wks
lacareletter010614

Attachment

c: Jonathan E. Fielding, M.D., M.P.H.
Cynthia A. Harding, M.P.H.

QUESTIONS AND ANSWERS:
ACCESSING SUBSTANCE USE DISORDER SERVICES FOR HEALTH PLAN MEMBERS

What are Substance Use Disorder (SUD) Services?

SUD services offered through the SAPC service network under the Drug Medi-Cal benefit include outpatient counseling, intensive outpatient treatment, methadone maintenance, and residential treatment. In-patient detoxification services are provided through the general Medi-Cal program and accessible through the Health Plans.

How do I decide if my patient needs SUD Services?

Here are the usual ways. The Health Plans will provide you with more detailed information during the orientation and training sessions:

- Initially, you will have conducted an alcohol problem use screening as part of an annual health risk assessment. At that time, if a potential alcohol use problem is identified, you will then conduct up to three intervention sessions. If this intervention is unsuccessful or you otherwise determine that more intensive SUD services are indicated for your patient, please contact LA Care/Beacon or Health Net/MHN. They can assist you in determining the appropriate level of SUD services for your patient.

- A patient can also go directly to SAPC-contracted Drug Medi-Cal providers in the community and request admission without pre-authorization. The patient can access services through the SAPC toll-free assistance line at 1-800-564-6600 to the closest Community Assessment Service Center to the caller's residence for an assessment appointment and referral assistance. If a patient is already receiving SUD services through a SAPC-contracted provider, the provider will notify you and, with patient permission, send you relevant clinical information for care coordination.

- If a patient needs in-patient detoxification services, contact LA Care/Beacon or Health Net/MHN for authorization and placement assistance.

How will I know what SUD services my patient is getting?

SAPC contracted providers are instructed to notify you of your patient's care and, with patient permission, to send relevant clinical information back to you and/or the Health Plan.

Who can I call with other questions about SUD services through the SAPC network?

Please call the SAPC toll-free number at 1-888-742-7900 during regular office hours and inform staff that you are calling as a LA Care/Beacon or Health Net/MHN provider. Staff will assist you with your questions on SUD services for your patients.

An In-depth Look: State of California's Role in Serving Adults with Autism

In California, the Lanterman Developmental Disabilities Services Act and related laws define the obligations of the state and the California Department of Developmental Services (DDS) to provide services and supports to persons with developmental disabilities. Individuals with autism are eligible to receive services over a person's lifetime.

Regional Center Services

Regional centers are the primary source of care coordination and services for adult with autism. Other state and local entities provide health, vocational, and social services. Each consumer served by the Regional Centers has an individual program plan (IPP) that guides the purchase of services. Services may include care coordination, residential services, vocational services, day programs, respite, transportation, advocacy, and other services that support activities of daily living over a person's lifetime. With some limited exceptions where there is a family share of cost for certain services, services are provided at no charge using federal and state funds. Regional Centers are required to pursue generic resources provided by other public agencies and health insurance coverage when they are available and to provide services in the most cost efficient manner.

Residential Services

Adults with autism are less likely than children with autism to live in their family's homes. Adults with autism may access independent and supported living services to help them live in homes they own or lease in the community. They may also live in 24-hour nonmedical community care facilities licensed by the state Department of Social Services (DSS), DDS-operated developmental centers, and 24-hour intermediate care facilities that are health facilities licensed by the state Department of Health Services (DHS). Increased needs for housing and service providers to operate facilities are anticipated.

Employment Services

Regional centers fund habilitation services for adults with developmental disabilities that are no longer in school, have chosen paid work, are not capable of competitive employment, and would not benefit from vocational rehabilitation services offered to persons with disabilities through the state Department of Rehabilitation (DOR) because the person's disability is too severe.

Habilitation Services

Habilitation services funded through regional centers include Work Activity Programs (WAP) and Supported Employment Programs (SEP). WAP services are provided at work activity centers and persons are paid according to productive capacity. WAP services are intended to promote development of physical capacities, psychomotor skills, work habits, health and safety practices, and other work-related skills. SEP services are specialized services provided in an integrated work setting, such as direct supervision and training (or job coaching) and ongoing post-employment services, in order to help the person attain and retain community integrated employment.

Autism Speaks™
FAMILY SERVICES
COMMUNITY CONNECTIONS

Glossary of Adult Service Terms

Advocacy Services
Organizations provide protection and advocacy for the rights of individuals with disabilities. Information and referrals are available to identify services and supports for individuals with disabilities.

Day Programs
Day programs are attended by individuals with disabilities five days a week during work hours and provide opportunities to work, socialize, and participate in skills training. Day programs may include work services for a portion of the day, sheltered workshops, medical assistance, and supported employment services.

Employment Services
Vocational and employment services are designed to advance knowledge and job skills for gainful and competitive employment. Vocational and employment services can vary from intensive support to as-needed support.

General Assistance
General assistance refers to financial aid managed by a county or state to support individuals with disabilities. Resources include a state's Health Insurance and other services regardless of the person's income.

Habilitation
Habilitation Services are provided to maintain an individual at their highest level of vocational functioning, services are work related, includes paid work and other supports. Services are non-time limited.

Legal Services
Legal services refer to assistance in retaining an attorney and/or legal advice for individuals with disabilities. Services, counseling, or information are available at low-cost or free to people with disabilities.

Medical and Dental Care
Medical services relate to all aspects of healthcare. Supports include hospitals, medical day programs, medical assistance, intense psychiatric care, home care and rehabilitative services. Dental services provide dental care to the disability community for free or low-cost dental care.

Post Secondary Education
Post secondary education refers to study beyond the level of secondary education (e.g., high school). This includes colleges and universities, professional schools, adult vocational and GED programs, community colleges, and institutes of technology.

Recreation Programs
Recreational activities are designed for relaxation and leisure goals. They may include sports, hobbies, and provide opportunities to socialize.

Residential Services
Residential options are designed to provide living opportunities that support the individual's goals. Residences can vary from maximum independence to individuals who need assistance in everyday tasks.

Respite Care
Respite care refers to a qualified individual providing a time limited break to the primary caretakers. Respite care can be provided in or out of the individual's home.

Family Support
Family support services can provide assistance to caregivers and/or the individual with a disability. Services can focus on maximizing independence in the family unit.

Transportation
Transportation is offered to individuals with disabilities who travel to and from work, recreation, and other community destinations. Transportation options can be public or private.

* Information for this article was gathered by reviewing websites, agencies and providers for adults with autism. We encourage you to contact your state agencies to locate specific programs in your area.

Department of Rehabilitation Services
Adults with autism may receive services through the state Department of Rehabilitation (DOR). DOR is responsible for assisting Californians with disabilities to obtain and retain employment and maximize their ability to live independently in their communities. DOR provides vocational rehabilitation services to Californians with all types of disabilities through over 100 offices statewide. Services include employment counseling training and education, mobility and transportation aids, and job search and placement assistance. Consumers of the regional centers may receive DOR services rather than habilitation services through the regional center if DOR services are determined to be appropriate for the individual.

DOR also administers an independent living program that provides technical assistance and financial support for 29 independent living centers (ILCs) and the State Independent Living Council (SILC). SILC prepares a state plan for independent living which sets the policy and funding levels for the ILCs and services. ILCs are community-based, nonprofit agencies designed and operated by individuals with disabilities. All ILCs provide peer counseling, independent living skills training, housing assistance, information and referral, advocacy, and assistive technology. Other services may be provided by individual centers.

Other Services
Californians with autism may also receive services provided by other state and local entities and programs. Some of the major services are identified below.

• Medi-Cal, California's Medicaid program provides health care coverage for eligible low-income individuals, including persons with developmental disabilities. Pursuant to a federal Medicaid waiver for home and community-based services, Medi-Cal services may be provided to Californians with developmental disabilities who would otherwise require care in an institution regardless of the parents' or the spouse's income level.

• The In-Home Supportive Services (IHSS) program, a component of Medi-Cal, provides personal assistance services for eligible individuals, including persons with developmental disabilities so they can remain living in their homes.

• The Supplemental Security Income (SSI) program is a federal program that provides cash assistance to citizens who are age 65 and older, blind, or disabled. The State Supplementary Payment program (SSP) is a state program that provides additional cash assistance to SSI recipients.

• Community colleges, trade schools, and other colleges and universities in California may provide education and vocational training to persons with developmental disabilities.

• Intensive, one-on-one job services are available to persons with disabilities and others requiring special assistance through local job centers overseen by the Employment Development Department (EDD). Some persons with disabilities may receive additional specialized job search, assessment, education and training, placement, and retention services through the Jobs for All (JFA) program which is a collaborative effort between EDD and DOR.

Source: California Legislative Blue Ribbon Commission on Autism
http://senweb03.senate.ca.gov/autism/index.html

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Provider Resources:

Beacon Health Strategies (1-877-344-2858)

www.beaconhs.com

Los Angeles County Department of Mental Health (1-888-742-7900)

http://dmh.lacounty.gov/wps/portal/dmh/

Substance Abuse Prevention Control (1-800-564-6600)

http://publichealth.lacounty.gov/sapc/

Screening, Brief Interventions, and Referral to Treatment (SBIRT)

http://www.dhcs.ca.gov/services/medi-cal/Pages/SBIRT.aspx

Drug Interaction Checker

http://www.drugs.com/drug_interactions.html

Improving Pain Treatment Through Education

https://www.painedu.org/index.asp

Primary Care PTSD Scree (PC-PTSD)

http://www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf

Patient Health Questionnaire (PHQ) Screeners

http://phqscreeners.com/

Instructions: http://www.psycheducation.org/PCP/launch/downloadMoodCheck.htm

Suicide Assessment Five-step Evaluation and Triage (SAFE-T)

http://www.integration.samhsa.gov/images/res/SAFE_T.pdf

L.A. Care HEALTH PLAN

Treating Bipolar Disorder

Bipolar disorder results in extreme mood swings that can greatly disrupt your life. These symptoms may cause you distress. But with treatment, you can lead a more normal life.

Medications

Bipolar disorder is often treated with medications that stabilize moods. They help you feel better by keeping your moods more even, and help prevent future mood swings. Sometimes you may also be prescribed medications that treat depression. All medications can have side effects. If you're troubled by side effects, tell your doctor. Changing the dose or type of your medication may help. But don't stop taking medications until your doctor tells you. If you do, your symptoms will likely come back.

Talk Therapy (Psychotherapy)

Talking to a therapist or counselor may be part of your treatment. Having bipolar disorder can make it hard to hold a job or go to school. It can create stress for both you and your loved ones. A therapist can teach you how to cope with bipolar disorder. This can help you lessen manic or depressive episodes, or even prevent them. Your therapist can help you work out problems and heal relationships. He or she can also provide support when you need it most.

For accommodation of persons with special needs, call **1-888-439-5123** or TTY **1-866-522-2731**.

Friends and Family
Those closest to you may also need support. There are many groups for families of people with bipolar disorder. Learning more about this disorder can help your loved ones cope. It can also help them take an active role in your care.

Looking Ahead
Much research is being done on bipolar disorder. This research may lead to improved treatments and hope for a better future.

Resources

- National Institute of Mental Health
  866-615-6464 www.nimh.nih.gov

- National Alliance on Mental Illness
  800-950-6264 www.nami.org

- Mental Health America
  800-969-6642 www.nmha.org

L.A. Care HEALTH PLAN

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Depression: Tips to Help Yourself

As your doctors help treat your depression, you can also help yourself. Keep in mind that depression affects both your mind and body. Getting better will take time. Take care of your body and your soul. Be kind to yourself as you get better.

Be With Others

Don't keep to yourself. This might make you feel worse. Try to be with others. Take part in fun activities when you can. Go to a movie. See a ballgame. Talk with people you can trust. Accept help when it's offered.

Keep Your Perspective

- Depression can cloud your judgment. Wait until you feel better before making big decisions.
- This illness is not your fault. Don't blame yourself.
- Getting better is a process. Don't give up if it takes some time.
- Depression saps your energy and concentration. You may not be able to do all the things you used to do. Set small goals and do what you can.

Take Care of Your Body

People with depression may lose the desire to take care of themselves. This can make things worse. During and after treatment, make a point to:

- Exercise. It's a great way to take care of your body. Exercise also helps fight depression.
- Do not use drugs or alcohol. These may ease the pain in the short term. But they'll only make your problems worse in the long run.
- Lower your stress when you can. Ask your doctor for tips to help you do this.
- Eat right. A balanced diet helps keep your body healthy.

85448

Stress Relief: Activities

When you're feeling stressed, some simple exercises can provide relief right away. These exercises are not the kind you need sweatpants for. You can do them almost anytime and anywhere. They will help you feel more relaxed.

Walking

Taking a walk is a great way to fight stress. Walking offers a chance to take a break from a stressful situation. It can also give you a few minutes to think things through. Even a short walk can help you feel better. That's because walking is a positive action that you control.

Stretching

Muscle tension is a common response to stress. Stretching is a simple way to loosen up. Try these:

- **Neck stretch.** Sit up straight and tuck in your chin. Place your left hand on the right side of your head. Gently pull your head to the left and hold for 10 seconds. Switch sides and repeat the exercise.
- **Shoulder and arm stretch.** Put your hands together and lock your fingers. Then raise your hands above your head, palms upward. Hold for 15 seconds and relax. Repeat 3 times.

Deep Breathing

Deep breathing is a simple method for relieving tension. Use 3 deep breaths each time you do this exercise.

- **Inhale.** Breathe in slowly and deeply through your nose. Take in as much air as possible. Hold for 3 seconds.
- **Exhale.** Breathe out slowly through your mouth. Try pursing your lips as if you were going to whistle. This helps control how fast you exhale.

Las claves para manejar el estrés

Hay varias claves para manejar el estrés. En primer lugar, aprenda a reconocer cuándo se encuentra bajo estrés y los factores que se lo provocan; luego, encuentre maneras positivas de responder a estos factores. Asegúrese de cuidar bien de su salud y de tomarse el tiempo de relajarse. Siga leyendo para aprender más sobre las claves para manejar el estrés.

Cómo reconocer el estrés

Aprenda a reconocer su estrés y averigüe qué se lo provoca, tratando de estar consciente de cómo se siente cada día. Si siente que le dan palpitaciones o se le tensan los músculos, es porque su cuerpo podría estar respondiendo al estrés. Pregúntese por qué, luego anote su respuesta. Para seguir con el proceso, haga una lista de todas las cosas que le provocan sentimientos estresantes.

Lleve una vida sana

Si usted se mantiene saludable, podrá sobrellevar mejor el estrés. Esto implica dormir lo suficiente, alimentarse bien y hacer ejercicios, así como saber lo que más le importa en la vida y reservar tiempo para usted. Lleve un registro diario de salud para ver si usted hace estas cosas, y léalo una vez por semana. Si no se cuida bien a sí mismo, podría llegar a sentirse más estresado.

Responda mejor al estrés

La vida está llena de estresores que usted no puede controlar; sin embargo, sí puede aprender maneras más positivas de responder a ellos. Esto le ayudará a sentir que controla mejor la situación. Para comenzar, ponga en práctica este consejo: piense en el empeño que desea poner para enfrentarse a cierto estresor. ¿Realmente necesita encargarse de ello? Si es así, determine la mejor manera de hacerlo y cambie lo que puede. Pero si el estresor no es importante o si está fuera de su control, ¿para qué va a preocuparse?

Relájese para aflojar la marcha

La relajación puede ayudarle a prevenir o aliviar sentimientos estresantes. También podría ayudarle este consejo: cuando se enfrenta a un estresor, haga una breve pausa, respire hondo y luego espire lentamente mientras cuenta hasta 10. Esto le ayudará a despejar la mente para poder responder mejor al estrés.

L.A. Care HEALTH PLAN

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Keys to Managing Stress

There are several keys to managing stress. First, learn to recognize when you're under stress and what triggers it. Next, find positive ways of responding to your triggers. Be sure to take good care of your health and make time to relax. Read on to learn more about the keys to managing stress.

Recognizing Stress

Learn to recognize your stress and find out what triggers it. To do this, try to be aware of how you feel each day. If you notice your heart racing or your muscles tightening, your body may be responding to stress. Ask yourself why. Then write down your answer. To keep the process going, make a list of all the things that trigger stressful feelings.

Living a Healthy Life

Keeping yourself healthy helps you deal better with stress. This means getting enough sleep, eating right, and exercising. It also means knowing what you value most in life, and making time for yourself. Keep a daily health journal to see if you're doing these things. Then, read your journal each week. If you don't take good care of yourself, you may feel more stressed.

Responding Better to Stress

Life is full of stressors that you can't control. But you can learn more positive ways of responding to them. This will help you feel more in control. To begin, try this tip: Think about how much effort you want to put into dealing with a certain stressor. Do you really need to handle that stressor? If so, decide on the best way to do this. Change what you can. But if the stressor isn't important, or if it's out of your control, then why worry about it?

Relaxing to Slow Down

Relaxing can help you prevent or relieve stressful feelings. This tip may also help: When you're facing a stressor, pause for a moment. Then take a deep breath and slowly breathe out as you count to 10. This will help clear your mind so you can respond to stress better.

L.A. Care HEALTH PLAN

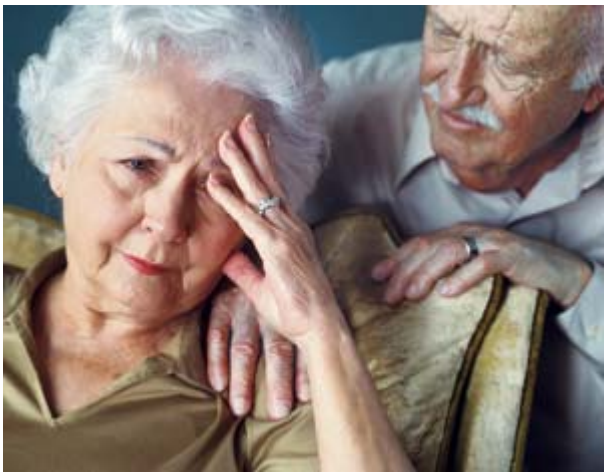
Know the Signs and Symptoms of Depression

Everyone feels down at times. The blues are part of life. But being sad for more than two weeks may be a sign of **depression.** Depression is a serious disease. It can be treated. Get help if you or someone you know is depressed.

Signs of Depression

People who are depressed may:

- Feel sad, blue, or down every day.
- Feel helpless, hopeless, or worthless.
- Lose interest in friends and things that used to make them happy.
- Not sleep well or sleep too much.
- Gain or lose weight.
- Feel tired all the time.
- Have body aches and pains.



Warning Signs

Warning signs for suicide include:

- Threats or talk of suicide (killing oneself).
- Giving away their things or making a will.
- Buying a gun.
- Sudden, unexplained cheerfulness or calm after a time of depression.

Getting Help

People who are depressed can get better. Talk to your doctor. Medication may be needed. L.A. Care members can get mental health counseling through Beacon Health Strategies. Learn more by calling 1-877-344-2862 for Medicare Advantage (HMO SNP) or 1-877-344-2858 (TTY/TDD 1-800-735-2929) for Healthy Kids, Healthy Families and PASC-SEIU Plan. You can also call the Department of Mental Health at 1-800-854-7771

For accommodation of persons with special needs, call **1-888-439-5123** or TTY **1-866-522-2731**.

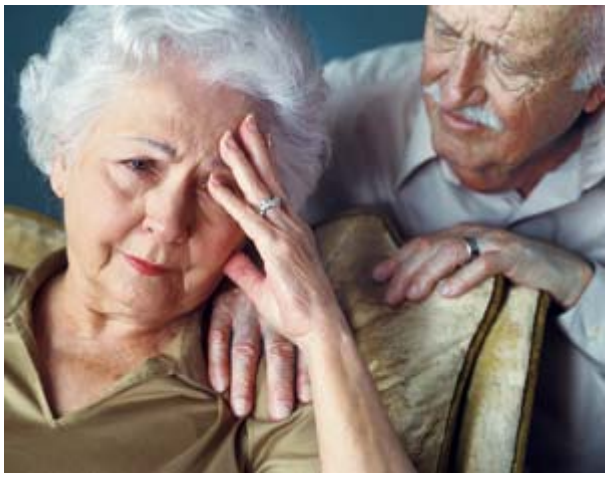
Conozca los signos y los síntomas de la depresión

Todos nos sentimos caídos en algún momento. Estar desanimado forma parte de la vida. Pero sentirse triste durante más de dos semanas puede ser un signo de **depresión.** La depresión es una enfermedad grave, pero puede tratarse. Pida ayuda si está deprimido o conoce a alguien que lo esté.

Signos de depresión

Las personas deprimidas pueden:

- Sentirse tristes, desanimadas o caídas todos los días.
- Sentirse inútiles, desesperanzadas o muy poco valiosas.
- Perder interés en los amigos y las cosas que solían hacerlas felices.
- No dormir bien o dormir demasiado.
- Subir o bajar de peso.
- Sentirse cansadas en todo momento.
- Sentir molestias o dolores en el cuerpo.



Señales de advertencia

Las señales de advertencia de suicidio incluyen:

- Amenazar con suicidarse (matarse) o hablar sobre el suicidio.
- Regalar sus pertenencias o redactar un testamento.
- Comprar un arma.
- Alegría o calma inesperadas e inexplicables después de un período de depresión.

Cómo obtener ayuda

Las personas deprimidas pueden sentirse mejor. Hable con su médico. Es posible que necesite tomar un medicamento. Los miembros de L.A. Care pueden recibir asesoría de salud mental a través de Beacon Health Strategies. Para obtener más información, llame al 1-877-344-2862 para Medicare Advantage (HMO SNP) o al 1-877-344-2858 (TTY/TDD 1-800-735-2929) para Healthy Kids, Healthy Families y el Plan PASC-SEIU. También puede llamar al Departamento de Salud Mental al 1-800-854-7771.

Si desea arreglos específicos para personas con necesidades especiales, llame al **1-888-439-5123** o a la línea TTY **1-866-522-2731**.

People with anxiety may have another illness, such as depression. Depression is feeling sad or unhappy. Most of us feel this way at one time or another. If you feel this way for two weeks or longer, it is time to seek help.

Many people think they are born worriers or that they can "handle it." However, anxiety is real. Some people may need to talk to a health care professional. Some people may need medicine.

L.A. Care Family Resource Centers

Your Centers for Health and Wellness

The Centers offer FREE health education and physical fitness classes for children and adults. Free child care provided while adult is in class.

For a location near you call **1-877-287-6290**.

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SAN FERNANDO VALLEY
Opening Soon

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For a Healthy Life

LA0777 08/12

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Getting Help for Anxiety

Anxiety is a word to describe the feeling of worry, tension, or even fear. **Anxiety is normal**. We all worry at times about things such as money, family, or our health. Anxiety can also come from good things such as getting married, a new job, or moving.

What are some signs of anxiety?

In your body:

- Headaches or muscle tension
- Heart beating fast (palpitations)
- Tiredness
- Trouble sleeping
- Trouble swallowing
- Nausea or vomiting

In your mind:

- Having trouble focusing
- Feeling impatient or irritable
- Worry or fear

What are some causes of anxiety?

- Stress from change
- Problems with school, family, or your health
- Car accidents or not having a car
- Loss of a job or loved one

When does anxiety become a problem?

If your worrying does not go away or interferes with your life, you may have an illness. Ask your doctor for help. He or she can refer you to an expert. You can get better.

What can I do about anxiety?

- Exercise on most days of the week
- Eat healthy foods
- Talk about issues with people you care about and trust
- Think positively
- Pray or meditate (think deeply or spiritually)

Talk with your doctor. Ask questions about your thoughts, feelings, and symptoms. Your doctor can refer you to a health care professional. It is important to find the right one. Let your doctor know if you have preferences based on gender, age, language, or culture.

As an L.A. Care Health Plan member you can talk to a nurse for **free** 24 hours a day, 7 days a week. Call **1-800-249-3619** TTY/TDD **1-866-522-2731**.

Las personas con ansiedad pueden tener otras enfermedades, como depresión. La depresión es sentirse triste o infeliz. La mayoría de nosotros se siente así de vez en cuando. Si se siente así durante dos semanas o más, es hora de buscar ayuda.

Muchas personas creen que han nacido con una personalidad preocupona o que pueden "arreglárselas". Sin embargo, la ansiedad es real. Es posible que algunas personas necesiten hablar con un profesional del cuidado de la salud. Otras tal vez necesiten medicamentos.

Centros de Recursos Familiares de L.A. Care

Sus Centros de salud y bienestar

Estos centros ofrecen clases gratuitas de educación de la salud y de ejercicio físico para niños y adultos. Se ofrece el servicio de guardería infantil gratis mientras el adulto está en clase.

Para encontrar un centro cerca de usted llame al **1-877-287-6290**.

INGLEWOOD
Esquina de Century y Crenshaw

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En Plaza México

VALLE DE SAN FERNANDO
Próxima apertura

L.A. Care HEALTH PLAN®

Por Una **Vida Sana**

Esta hoja informativa fue desarrollada por L.A. Care Health Plan junto con nuestros socios contratados por el plan de salud. Ellos son Care1st Health Plan y Kaiser Permanente. Conjuntamente brindamos servicios de atención médica administrados por Medi-Cal en el Condado de Los Angeles. **Anxiety** RHE586 (12/11) LA0777 08/12 SP

L.A. Care HEALTH PLAN®

Obteniendo Ayuda para la Ansiedad

La palabra ansiedad describe una sensación de preocupación, tensión o incluso miedo. **Es normal sentir ansiedad**. Todos nos preocupamos de vez en cuando por cosas como el dinero, la familia o nuestra salud. Las cosas buenas como el casarse, un nuevo trabajo o una nueva casa también puede causar ansiedad.

¿Cuáles son algunas causas de ansiedad?

En el cuerpo:

- dolor de cabeza o tensión muscular
- laatídos acelerados del corazón (palpitaciones)
- cansancio
- problemas para dormir
- problemas para tragar
- náuseas o vómitos

En la mente:

- problemas para concentrarse
- sentirse impaciente o irritable
- preocupación o miedo

¿Cuáles son algunas causas de ansiedad?

- estrés debido al cambio
- problemas con la escuela, la familia o la salud
- accidente de auto o no tener un auto
- pérdida de un trabajo o de un ser querido

¿Qué puedo hacer para sobrellevar la ansiedad?

- hacer ejercicio la mayoría de los días de la semana
- comer alimentos saludables
- hablar sobre lo que le preocupe con personas que le importen y en quienes confíe
- pensar positivamente
- rezar o meditar (pensar profunda o espiritualmente)

¿Cuándo se vuelve un problema la ansiedad?

Si su preocupación no desparece o si interfiere con su vida, es posible que tenga una enfermedad. Pida ayuda a su médico. Él o ella puede referirlo a un especialista. Usted puede mejorarse.

Hable con su médico. Pregúntele sobre sus pensamientos, sentimientos y síntomas. Su médico puede referirlo a un profesional del cuidado de la salud. Es importante que encuentre al profesional adecuado. Informe a su médico si tiene preferencias del sexo, edad, idioma o cultura.

Como miembro de L.A. Care Health Plan, puede hablar con una enfermera titulada de forma **gratuita** las 24 horas del día los 7 días de la semana. Llame al **1-800-249-3619**. TTY/TDD **1-866-522-2731**.

Tratamiento del trastorno bipolar

El trastorno bipolar resulta en fluctuaciones extremas del humor que pueden alterar profundamente su vida y producirle gran angustia. Pero sus síntomas pueden tratarse, y usted puede llevar una vida más normal.

Medicamentos

El trastorno bipolar suele tratarse con medicamentos que estabilizan el estado de ánimo. Estos medicamentos lo ayudan a sentirse mejor regularizando su humor y previniendo futuras fluctuaciones. A veces podrían recetarle también medicamentos para tratar la depresión. Todos los medicamentos pueden tener efectos secundarios. Si siente algún efecto molesto, hable con su médico; tal vez baste con que le cambien la dosis o el tipo de medicamento. Pero no deje de tomar sus medicamentos hasta que su médico le dé permiso de hacerlo ya que, si los suspende, es probable que le vuelvan los síntomas.

Terapia verbal (psicoterapia)

Hablar con un terapeuta o consejero puede ser parte de su tratamiento. El trastorno bipolar puede dificultar que usted conserve un empleo o pueda estudiar, creando tensiones tanto para usted como a sus seres queridos. Un terapeuta puede enseñarle cómo afrontar el trastorno bipolar. Esto puede ayudarle a disminuir el número de episodios maníacos o depresivos, o aun hasta prevenirlos. El terapeuta puede ayudarle a afrontar los problemas y a restaurar sus relaciones personales, y brindarle apoyo cuando usted más lo necesita.

Si desea arreglos específicos para personas con necesidades especiales, llame al **1-888-439-5123** o a la línea TTY **1-866-522-2731**.

Amigos y familiares
Las personas más allegadas a usted también podrían necesitar apoyo. Hay muchos grupos para familiares de personas con trastorno bipolar. Aprender más sobre este trastorno puede ayudar a sus seres queridos a sobrellevar la situación y a participar activamente en su atención médica.

Un futuro prometedor
Actualmente se están llevando muchas investigaciones sobre el trastorno bipolar, con miras a mejorar los tratamientos y brindar esperanzas para un mejor futuro.

Recursos

- National Institute of Mental Health
  866-615-6464 www.nimh.nih.gov

- National Alliance on Mental Illness
  800-950-6264 www.nami.org

- Mental Health America
  800-969-6642 www.nmha.org

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Depresión: sugerencias para que se ayude a sí mismo

Mientras los médicos le ayudan a tratar la depresión, usted también puede ayudarse. Recuerde que la depresión afecta tanto el cuerpo como la mente. Mejorar llevará tiempo. Cuide de su cuerpo y su alma. No se mortifique mientras mejora.

Procure estar con otras personas

No se aísle porque esa actitud lo hará sentirse peor. Intente estar con otras personas. Cuando pueda, participe en actividades divertidas. Vaya al cine, asista a un partido de béisbol, hable con personas en quienes confíe y acepte la ayuda cuando se la ofrezcan.

Mantenga su perspectiva

- La depresión puede interferir con su capacidad de analizar situaciones. Espere hasta que se sienta mejor antes de tomar decisiones importantes.
- Usted no es culpable de padecer esta enfermedad. No se culpe.
- Mejorar es un proceso. No se dé por vencido si demora más de lo pensado.
- La depresión debilita su energía y la concentración. Es probable que no pueda hacer todas las cosas que hacía habitualmente.
- Establezca objetivos pequeños y haga lo que pueda.

Cuide de su cuerpo

Las personas que padecen depresión pueden perder el deseo de cuidarse a sí mismos. Esto puede empeorar el proceso. Durante y después del tratamiento, propóngase hacer lo siguiente:

- Realizar ejercicio físico. Es una excelente manera de cuidar de su cuerpo. La actividad física también ayuda a combatir la depresión.
- No consumir drogas ni bebidas alcohólicas. Estas sustancias pueden aliviar el dolor temporalmente, pero solo lograrán empeorar sus problemas a largo plazo.
- Disminuir el estrés cuando pueda. Pida a su médico que le haga sugerencias para lograrlo.
- Alimentarse de forma correcta. Una dieta equilibrada ayuda a mantener su cuerpo saludable.

Alivio del estrés: Actividades

Cuando se sienta estresado, existen algunos ejercicios sencillos que pueden proporcionarle un alivio inmediato. Para este tipo de ejercicios no necesita ponerse ropa de gimnasia. De hecho, puede hacerlos prácticamente en cualquier momento y en cualquier lugar. Estos ejercicios le ayudarán a sentirse más relajado.

Camine

Salir a caminar es una excelente manera de combatir el estrés. Caminar le permite hacer un alto en una situación estresante. También le proporciona algunos minutos para reflexionar. Incluso un pequeño paseo puede ayudarle a sentirse mejor ya que caminar es una acción positiva que usted puede controlar.

Estire los músculos

La tensión muscular es una respuesta común al estrés. Hacer ejercicios de estiramiento es una forma sencilla de relajarse. Practique lo siguiente:

- **Estiramiento del cuello.** Siéntese derecho y meta la barbilla. Ponga su mano izquierda en el lado derecho de su cabeza. Hale suavemente su cabeza hacia la izquierda y sostenga esta posición durante diez segundos. Cambie de lado y repita el ejercicio.
- **Estiramiento de los hombros y brazos.** Junte sus manos y cruce los dedos. Luego suba las manos por encima de su cabeza con la palma de las manos hacia arriba. Sostenga esta posición durante 15 segundos y luego relájese. Repita este ejercicio tres veces.

Respire profundo

La respiración profunda es un método sencillo de aliviar la tensión. Tome tres respiraciones profundas cada vez que haga este ejercicio.

- **Inhale.** Tome una respiración lenta y profunda por la nariz. Inhale la mayor cantidad de aire que pueda. Contenga el aire durante tres segundos.
- **Exhale.** Bote el aire lentamente por la boca. Intente fruncir sus labios como si fuera a silbar. Esto le ayudará al controlar la velocidad de exhalación.

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Stress Relief: Relaxation

Alivio del estrés: Relajación

Fijar la mente ayuda a aliviar el estrés. Tomarse de cinco a diez minutos cada día para practicar la relajación le hará sentirse más reanimado. Los siguientes ejercicios pueden hacerse prácticamente en cualquier lugar. Haga uno o más de dichos ejercicios hasta que determine cuáles son los que le brindan mejores resultados.

Relaje su mente

Encuentre un lugar tranquilo donde nada ni nadie lo perturbe. Luego trate de hacer lo siguiente:

- Siéntese cómodamente. Quítese los zapatos. Apague su teléfono celular y su buscapersonas. Tome varias respiraciones profundas.
- Concentre su mente en un pensamiento, imagen o palabra que le inspire paz. Intente mantener su mente centrada en ese pensamiento durante cinco minutos.
- Cuando otros pensamientos le invadan la mente, relájese y vuelva a concentrarse. Deje que los pensamientos invasores se desvanezcan.
- Cuando termine, póngase de pie lentamente y estire los brazos por encima de su cabeza. Con la práctica, este ejercicio le ayudará a sentirse recuperado.

Relaje su cuerpo

Con la práctica, usted podrá utilizar claves mentales para indicarle a su cuerpo cómo debe sentirse.

- Siéntese cómodamente y despeje su mente. Algunas respiraciones profundas le ayudarán.
- Concentre su mente en su mano izquierda y repita lo siguiente: "Mi mano izquierda se siente caliente y pesada". Continúe repitiéndose esto hasta que su mano se sienta más pesada y más caliente.
- Repita este ejercicio utilizando su mano derecha. Luego concéntrese en sus brazos, piernas y pies hasta que todo su cuerpo se sienta relajado.
- Cuando termine, póngase de pie lentamente y estire los brazos por encima de su cabeza.

Haga visualizaciones

La visualización es como una vacación mental. Visualizar le permite liberar su mente mientras su cuerpo permanece en estado de reposo. Para empezar, visualícese en un estado cálido y relajado. Elija un entorno pacífico que le agrade y agregue los detalles. Por ejemplo, si se imagina una playa tropical, escuche el sonido de las olas en la playa. Sienta el calor del sol sobre su cara. Meta los dedos de los pies en la arena. Utilizando el poder de su mente, usted puede hacer un paréntesis de relajación cada vez que lo necesite.

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Stress Relief: Relaxation

Focusing the mind helps provide stress relief. Taking 5 to 10 minutes to practice relaxation each day helps you feel more refreshed. The following exercises can be done almost anywhere. Try one or more until you find what works best for you.

Calm Your Mind

Find a quiet place where you won't be disturbed. Then try the following:

- Sit comfortably. Take off your shoes. Turn off your cell phone and pager. Take a few deep breaths.
- Focus your mind on one peaceful thought, image, or word. Then try to hold that thought for 5 minutes.
- When other thoughts enter your mind, relax and refocus. Let the invading thoughts fall away.
- When you're done, stand up slowly and stretch your arms over your head. With practice, this exercise can help you feel restored.

Calm Your Body

With practice, you can use mental cues to tell your body how to feel.

- Sit comfortably and clear your mind. A few deep breaths will help.
- Mentally focus on your left hand and repeat to yourself, "My left hand feels warm and heavy." Keep doing this until your hand does feel heavier and warmer.
- Repeat the exercise using your right hand. Then focus on your arms, legs, and feet until your whole body feels relaxed.
- When you're done, stand up slowly and stretch your arms overhead.

Visualization

Visualization is like taking a mental vacation. It frees your mind while keeping your body in a calm state. To get started, picture yourself feeling warm and relaxed. Choose a peaceful setting that appeals to you and fill in the details. If you imagine a tropical beach, listen to the waves on the shore. Feel the sun on your face. Dig your toes in the sand. By using the power of your mind, you can take a soothing break when you need to.

not intended as a substitute for professional medical care. Always follow your healthcare professional's instructions.

L.A. Care HEALTH PLAN

Understanding Anxiety Disorder

Almost everyone gets nervous now and then. It is normal to have knots in your stomach before a test, or for your heart to race on a first date. But an anxiety disorder is much more than a case of nerves. In fact, its symptoms may be overwhelming. But treatment can relieve many of these symptoms. Talking to your doctor is the first step.

What Are Anxiety Disorders?

An anxiety disorder causes intense feelings of panic and fear. These feelings may arise for no apparent reason. And they tend to recur again and again. They may prevent you from coping with life and cause you great distress. As a result, you may avoid anything that triggers your fear. In extreme cases, you may never leave the house. Anxiety disorders may cause other symptoms, such as:

- Obsessive thoughts you can't control
- Constant nightmares or painful thoughts of the past
- Nausea, sweating, and muscle tension
- Difficulty sleeping or concentrating

What Causes Anxiety Disorders?

Anxiety disorders tend to run in families. For some people, childhood abuse or neglect may play a role. For others, stressful like events or trauma may trigger anxiety disorders. Anxiety can trigger low self-esteem and poor coping skills.

Getting Better

You may believe that nothing can help you. Or, you might fear what others may think. But most anxiety symptoms can be eased. Having an anxiety disorder is nothing to be ashamed of. Most people do best with treatment that combines medication and therapy. Although these aren't cures, they can help you live a healthier life.

Common Anxiety Disorders

- **Panic Disorder:** This causes intense fear of being in danger.
- **Phobias:** These are extreme fears of certain objects, places, or events.
- **Obsessive-compulsive disorder:** This causes you to have unwanted thoughts. You also may perform certain actions over and over.
- **Posttraumatic stress disorder:** This occurs in people who have survived a terrible ordeal. It can cause nightmares and flashbacks about the event.
- **Generalized anxiety disorder:** This causes constant worry that can greatly disrupt your life.

For accommodation of persons with special needs, call **1-888-439-5123** or TTY **1-866-522-2731**

L.A. Care HEALTH PLAN

Los trastornos de ansiedad

Casi todo el mundo siente nerviosismo de vez en cuando. Es normal tener un nudo en el estómago antes de un examen, o el pulso acelerado la primera vez que uno sale con alguien. Pero un trastorno de ansiedad es mucho más que un ataque de nervios; de hecho, sus síntomas pueden resultar abrumadores. Afortunadamente, muchos de estos síntomas pueden aliviarse con un tratamiento; empiece por hablar con su médico.

¿Qué son los trastornos de ansiedad?

Las personas con trastornos de ansiedad sienten pánico y miedo intensos. Estos sentimientos pueden surgir sin motivo aparente y tienden a recurrir una y otra vez, al punto de interferir en la vida cotidiana y causar gran angustia. Su temor podría inducirle a evitar cualquier factor que lo desencadena, en casos extremos, tal vez usted deje de salir de su casa. Los trastornos de ansiedad pueden producir otros síntomas, entre ellos:

- Pensamientos obsesivos que no se pueden controlar
- Pesadillas constantes o recuerdos dolorosos del pasado
- Náuseas, transpiración y tensión muscular
- Dificultad para dormir o para concentrarse

¿Qué causa los trastornos de ansiedad?

Los trastornos de ansiedad tienden a afectar a varios miembros de la misma familia; en algunas personas podrían deberse a maltrato o negligencia en la infancia, mientras que en otras a eventos estresantes o traumáticos en su vida. La ansiedad puede deteriorar la autoestima y las habilidades para enfrentarse a situaciones.

Para mejorar

Tal vez usted piense que nada puede ayudarlo o tema lo que dirán los demás. Pero muchos de los síntomas de ansiedad pueden aliviarse. No hay por qué avergonzarse de tener un trastorno de ansiedad; la mayoría de las personas obtienen los mejores resultados con un tratamiento que combina medicamentos y terapia. Aunque no es una cura, este tipo de tratamiento puede ayudarle a tener una vida más sana.

Trastornos de ansiedad frecuentes

Trastorno de pánico: Causa un miedo intenso de encontrarse en peligro.

Fobias: Miedos extremos a ciertos objetos, lugares o eventos.

Trastorno obsesivo-compulsivo: Causa pensamientos indeseables y a veces, la necesidad de realizar ciertas acciones una y otra vez.

Trastorno por estrés postraumático: Sucede en personas que han sobrevivido experiencias terribles; puede causar pesadillas y flashbacks sobre el evento.

Si desea arreglos específicos para personas con necesidades especiales, llame al **1-888-439-5123** o a la línea TTY **1-866-522-2731**

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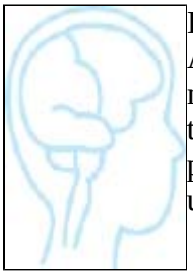
What Is ADHD?



Does your child have trouble sitting still or paying attention? You may have been told that ADHD (Attention Deficit Hyperactivity Disorder) may be the cause. A child with ADHD might have a hard time staying focused (attention deficit). He or she may also have trouble controlling impulses (hyperactivity disorder). A child with one or both of these problems struggles daily to perform and behave well. ADHD is no one's fault. But if left untreated, ADHD can deprive a child of self-esteem and limit success.

Which of the Following Describe Your Child?

A partial list of symptoms common to attention deficit and hyperactivity disorder appears below. Your child may show traits from one or both groups.

Attention Deficit

- Lacks mental focus
- Performs inconsistently
- Is distracted easily
- Has trouble shifting between tasks or settings
- Is messy, or loses things
- Forgets

Hyperactive/Impulsive

- Has trouble controlling impulses; might talk too much, interrupt, or have a hard time taking turns
- Is easy to upset or anger
- Is always moving (sometimes without purpose)
- Does not learn from mistakes

What Happens in the Brain?

The brain controls your body, thoughts, and feelings. It does so with the help of **neurotransmitters.** These chemicals help the brain send and receive messages. With ADHD, the level of these chemicals often varies. This may cause signs of ADHD to come and go.

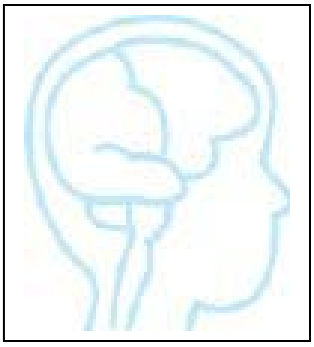
Remember Your Child's Strengths

Children with ADHD can be challenging to raise. Because of this, it's easy to overlook their good traits. What's special about your child? Do your best to value and support your child's unique talents, strengths, and interests.

When Messages Are Not Received

With ADHD, chemicals in certain parts of the brain can be in short supply. Because of this, some messages do not travel between nerve cells. Messages that signal a person to control behavior or pay attention aren't passed along. As a result, traits common to ADHD may occur.

¿Qué es ADHD?



A su hijo, ¿le cuesta estarse quieto o prestar atención? Tal vez le hayan dicho que su conducta se debe al déficit de atención y trastorno por hiperactividad, abreviado ADHD. Un niño con ADHD puede tener dificultades para concentrarse (déficit de atención) o controlar sus impulsos (trastorno por hiperactividad). Para los niños que tienen uno de estos problemas (o ambos), desempeñarse y portarse bien representa un gran esfuerzo. El ADHD no es culpa de nadie; pero si se deja sin tratar, puede privar a un niño de la confianza en sí mismo y limitar sus posibilidades de éxito.

¿Cuáles de estos rasgos describen a su hijo?

A continuación verá una lista parcial de síntomas propios del déficit de atención y trastorno de hiperactividad; su hijo podría presentar rasgos de uno o los dos grupos.

Déficit de atención

- Carece de concentración
- Su rendimiento en la escuela es irregular
- Se distrae fácilmente
- Le cuesta cambiar de tarea o de ambiente
- Es desordenado o se le pierden las cosas
- Es olvidadizo
-

Hiperactivedad/Impulsividad

- Le cuesta controlar los impulsos; quizás hable demasiado, interrumpa o le cueste esperar su turno en juegos o conversaciones
- Se altera o enoja fácilmente
- Siempre se está moviendo (a veces sin razón)
- No aprende de sus errores

¿Qué sucede en el cerebro?

El cerebro controla el cuerpo, las ideas y las emociones con ayuda de los **neurotransmisores,** unas sustancias químicas que lo ayudan a enviar y recibir mensajes. En el ADHD, los niveles de los neurotransmisores suelen variar; estas fluctuaciones pueden hacer que los signos de ADHD aparezcan y desaparezcan.

Recuerde los puntos Fuertes de su hijo

Criar niños con ADHD puede ser una experiencia difícil, ya que su comportamiento tiende a enmascarar sus cualidades y virtudes. ¿En qué se distingue su hijo? Haga lo que pueda para apreciar y apoyar los talentos, puntos fuertes e intereses únicos de su hijo.

Cuando no se reciben los mensajes

En el ADHD, las sustancias químicas de ciertas partes del cerebro pueden escasear, impidiendo la comunicación de ciertos mensajes entre las células nerviosas. Si no se transmiten los mensajes que ordenan a una persona que controle su comportamiento o que preste atención, pueden observarse los rasgos propios del ADHD.

Si desea arreglos específicos para personas con necesidades especiales, llame al **1-888-439-5123** o a la línea TTY **1-866-522-2731**

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Problems Linked to ADHD

Any child can suffer from depression, anxiety, or learning problems. These problems can exist along with ADHD or by themselves. Only through careful diagnosis can the true cause of a child's symptoms be found.

Depression

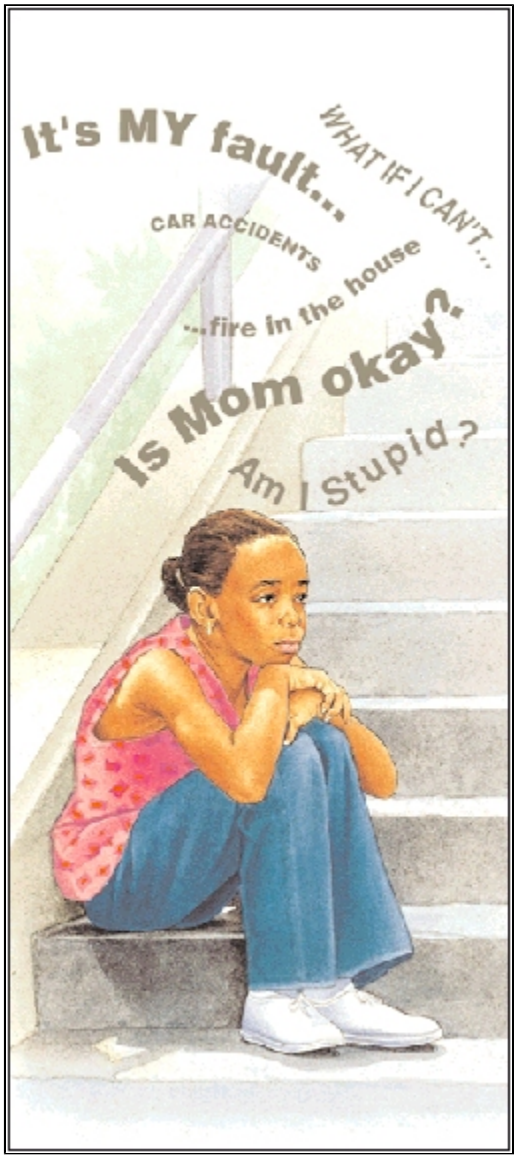
A depressed child may feel sad most of the time. He or she may have low self-esteem and show little interest in life. The child may eat or sleep more or less than in the past. He or she may withdraw from the rest of the world.

Anxiety

It is normal for children to have fears. But extreme anxiety can make a child scared and too sensitive. He or she may be obsessed with upsetting thoughts. The child may be restless, overactive, or withdrawn.

Learning Problems

A child with a learning problem may not fully process certain types of information. Some have trouble with what they see. Others have problems with what they hear. For instance, even if a teacher gives clear oral instructions, the message may not register in the child's mind. As a result, the child may struggle with one or more school subjects.



Problemas relacionados con ADHD

Cualquier niño puede sufrir depresión, ansiedad o dificultades del aprendizaje; estos problemas pueden existir ya sea con o sin el ADHD. Sólo un diagnóstico minucioso puede revelar la verdadera causa de los síntomas de un niño.

Depresión

Un niño deprimido puede sentirse triste la mayor parte del tiempo, tener poca autoestima y mostrar falta de interés en la vida. El niño puede dormir o comer más o menos que en el pasado; también puede encerrarse en sí mismo y aislarse del resto del mundo.

Ansiedad

Es normal que los niños sientan temor, pero la ansiedad excesiva puede volverlos asustadizos e hipersensibles. Los niños ansiosos pueden obsesionarse con pensamientos perturbadores, o actuar con intranquilidad, hiperactividad o retraimiento.

Dificultades del aprendizaje

Un niño con problemas del aprendizaje podría no ser capaz de procesar por completo ciertos tipos de información. Algunos niños tienen dificultades para captar lo que ven; a otros les cuesta procesar la información auditiva. Por ejemplo, aunque el maestro dé instrucciones orales muy claras, es posible que el mensaje no quede grabado en la mente del niño. En consecuencia, el niño podría pasar apuros con una o más asignaturas en la escuela.

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Treating ADHD: Learning New Behaviors

A child with ADHD often acts up and tunes out. But you can show your child new ways to react to the world. This process takes time and practice. Working with a counselor may help.

Coping Skills

What things upset your child? Perhaps having to do chores or share toys sparks poor behavior. Try to work with your child each day. Assign a simple task. Or talk with your child about the tips below. Show your child how to respond to frustration and anger in useful ways. This can help him or her learn self-control.

Reinforcing Success

Children with ADHD have trouble learning from past events. Positive feedback helps make lessons stick. Offer praise when a job is well done. This helps your child mark the moment in his or her mind. Place a sticker on a reward chart to celebrate each success.

Parent's Role

Here are some ways you can help:

- Teach coping skills after your child has taken a dose of medication. Learning is more likely to occur at such times.
- Praise your child's success. Offer a smile and a hug, a positive comment, or a small reward.
- Set clear rules. Explain what will be taken away if those rules are not followed. Then, follow through.
- Try to stick to a routine. Prepare your child for any change in that routine.
- Help your child stay focused. For instance, avoid crowded, noisy places if they bother your child. Also, limit choices.

Child's Role

Here are some hints for your child:

- Try out new ways of dealing with people and places that bother you. When you are upset, you might talk, draw, write, throw a ball, or spend some time alone.
- Act like a STAR: Stop, Think, Act, and then Review.

Tratamiento del ADHD: Aprender nuevas conductas

Los niños con ADHD suelen portarse mal y no prestar atención. Pero usted puede enseñar a su hijo nuevas formas de enfrentarse al mundo; este proceso de enseñanza requiere paciencia y práctica, y tal vez se facilite con la ayuda de un consejero profesional.

Técnicas para reaccionar

¿En qué circunstancias se altera su hijo? Tal vez se porte mal cuando tiene que hacer mandados o compartir juguetes. Trate de trabajar con su hijo todos los días, asignándole una tarea sencilla o mencionándole los consejos de esta hoja. Enséñele maneras productivas de reaccionar cuando está frustrado o enojado; esto puede ayudarlo a dominar sus impulsos.

Refuerce sus logros

Los niños con ADHD tienen dificultades para aprender de sucesos pasados. Los comentarios constructivos le ayudan a retener las lecciones. Elógielo cuando haga un buen trabajo; esto ayuda a que el niño grabe el momento en su mente. Ponga una calcomanía en un cuadro de premios por buena conducta para celebrar cada logro.

El papel de los padres

He aquí algunas maneras en que puede ayudar a su hijo:

- Enseñe las técnicas para reaccionar después de que el niño haya tomado una dosis de su medicamento; ése es el momento más propicio para el aprendizaje.
- Elogie los éxitos de su hijo con sonrisas y abrazos, haciendo comentarios positivos o dándole un pequeño premio.
- Establezca reglas claras y explique al niño lo que le va a quitar si no las obedece. Cuando venga al caso, cumpla sus promesas.
- Trate de seguir una rutina; si esa rutina va a cambiar por alguna razón, prepare al niño de antemano.
- Ayude a su hijo a mantener la concentración; por ejemplo, no lo lleve a lugares concurridos y bulliciosos si esto altera al niño. Además, limite el número de opciones que le ofrece.

El papel del niño

He aquí algunos consejos para su hijo:

- Cuando estés con personas o en lugares que te molestan, trata de hacer nuevas actividades para ponerte de buen humor. Si no te sientes bien, prueba a hablar, dibujar, escribir, lanzar la pelota o pasar un rato solo.
- Compórtate siempre de esta forma: detente, piensa, actúa y repasa los hechos.

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ADHD and Your Family

Taking care of a child with ADHD might cause other relationships in the household to suffer. This doesn't have to happen. Each member of the family can help build lasting bonds. That way, life can get better for everyone.

How You May Feel

If you have a child with ADHD, you may feel guilty, worried, and tired. Try to get enough rest and do some things you enjoy. Ask family and friends for support.

You and Your Partner

It's easy to blame each other. You may not agree on the child's diagnosis, treatment, or discipline. Finding answers isn't easy, but make an effort to talk each day. Now is the time to build new trust within your relationship.

Nurturing Your Other Children

You may devote a lot of time and effort to the child with ADHD. As a result, your other children may feel left out. Do your best to spend time with your other children, too. Instead of using up your energy, you may find that these moments help build your reserves.

Parent's Role

- **For yourself:** Recharge and relax. Free up some time by finding a caregiver who understands ADHD. Ask a counselor or your support group about people who might be able to supervise your child.
- **For your marriage:** Try to respect any differing opinions. Also, spend time alone as a couple. Talk about things other than your child and coping with ADHD.
- **For your other children:** Do things with them. Ask about their hobbies, desires, and fears. Let them know they matter to you. Then help them relate to the child with ADHD.
- Reward everyone's efforts to act like a family.
- Counseling may help you manage your stress. It can also help strengthen your marriage and resolve family conflicts.

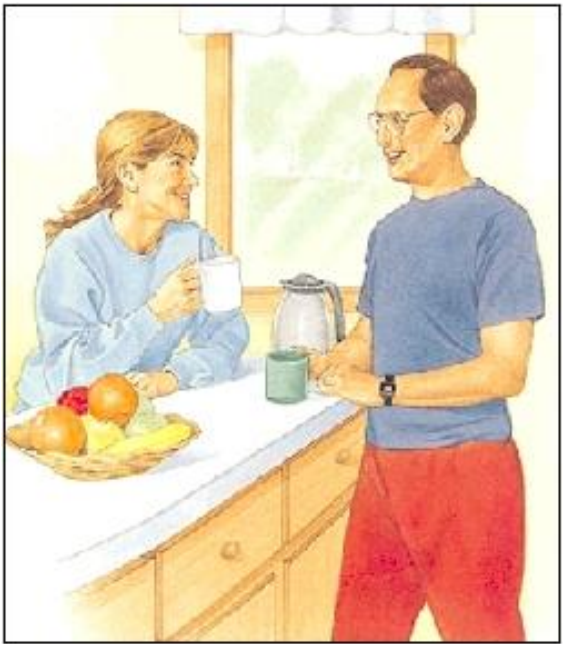
The Future Holds Promise

Your child's ADHD symptoms are likely to change and evolve as he or she matures. But with time and ongoing guidance, your child can learn to manage his or her traits. Many adults with ADHD are happy and successful.

El ADHD y su familia

Cuidar de un niño con ADHD puede causar discordia entre los demás familiares. Pero esto no tiene por qué pasar; cada miembro de la familia puede poner de su parte para establecer nexos duraderos y facilitarle la vida a todos.

Lo que usted podría sentir



Si tiene un hijo con ADHD, tal vez sienta culpabilidad, preocupación y agotamiento. Trate de descansar lo suficiente y hacer actividades que le agradan; consiga el apoyo de sus familiares y amigos.

Usted y su pareja

Es fácil echarse la culpa mutuamente. A veces la pareja no está de acuerdo con el diagnóstico, el tratamiento o la manera de disciplinar al niño. Aunque es difícil encontrar respuestas, haga el esfuerzo por comunicarse todos los días; éste es el momento ideal para fortalecer los lazos de confianza con su pareja.

No descuide a sus demás hijos

Tal vez tenga que dedicar mucho tiempo y esfuerzos al niño con ADHD, al punto de llegar a excluir a sus demás hijos. Haga lo que pueda para pasar tiempo también con ellos. En vez de agotarle las energías, tal vez encuentre que estos momentos le renuevan las reservas.

El papel de los padres

- **Para usted:** Recárguese y relájese. Para darse unas horas de descanso, contrate a alguien que tenga experiencia con el ADHD para que cuide a su hijo; pregunte a un consejero o a su grupo de apoyo si conocen a alguien que esté en capacidad de supervisar a su hijo.

Un futuro promisorio

Es probable que los síntomas de ADHD de su hijo cambien y evolucionen a medida que madura. Con el tiempo y una guía constante, su hijo puede aprender a controlar su problema; muchos adultos con ADHD son personas felices que tienen éxito en la vida.

- **Para su matrimonio:** Trate de respetar las diferencias de opinión. Además, pase más tiempo a solas con su pareja, y hable de temas que no tengan que ver ni con el niño ni con el manejo del ADHD.
- **Para sus demás hijos:** Haga actividades con ellos; pregúnteles sobre sus pasatiempos, deseos y temores. Hágales saber que usted los quiere, luego ayúdelos a interactuar con el niño que tiene ADHD.
- Premie todos los esfuerzos que se hagan para actuar como una familia.
- Un consejero profesional podría ayudarle a manejar el estrés, fortalecer su matrimonio y resolver los conflictos familiares.

Si desea arreglos específicos para personas con necesidades especiales, llame al **1-888-439-5123** o a la línea TTY **1-866-522-2731**

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Problems Linked to ADHD

Any child can suffer from depression, anxiety, or learning problems. These problems can exist along with ADHD or by themselves. Only through careful diagnosis can the true cause of a child's symptoms be found.

Depression

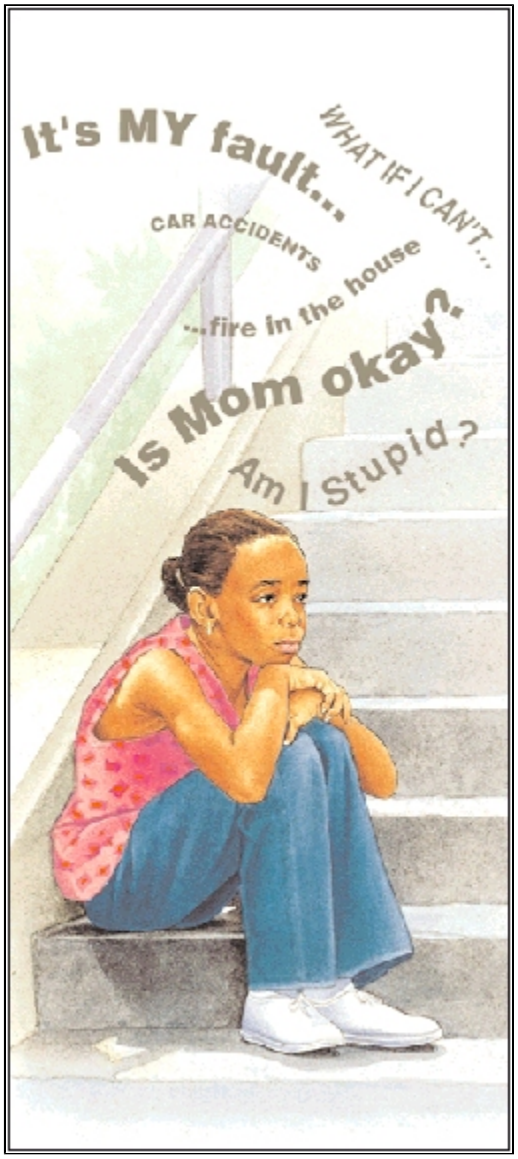
A depressed child may feel sad most of the time. He or she may have low self-esteem and show little interest in life. The child may eat or sleep more or less than in the past. He or she may withdraw from the rest of the world.

Anxiety

It is normal for children to have fears. But extreme anxiety can make a child scared and too sensitive. He or she may be obsessed with upsetting thoughts. The child may be restless, overactive, or withdrawn.

Learning Problems

A child with a learning problem may not fully process certain types of information. Some have trouble with what they see. Others have problems with what they hear. For instance, even if a teacher gives clear oral instructions, the message may not register in the child's mind. As a result, the child may struggle with one or more school subjects.



Problemas relacionados con ADHD

Cualquier niño puede sufrir depresión, ansiedad o dificultades del aprendizaje; estos problemas pueden existir ya sea con o sin el ADHD. Sólo un diagnóstico minucioso puede revelar la verdadera causa de los síntomas de un niño.

Depresión

Un niño deprimido puede sentirse triste la mayor parte del tiempo, tener poca autoestima y mostrar falta de interés en la vida. El niño puede dormir o comer más o menos que en el pasado; también puede encerrarse en sí mismo y aislarse del resto del mundo.

Ansiedad

Es normal que los niños sientan temor, pero la ansiedad excesiva puede volverlos asustadizos e hipersensibles. Los niños ansiosos pueden obsesionarse con pensamientos perturbadores, o actuar con intranquilidad, hiperactividad o retraimiento.

Dificultades del aprendizaje

Un niño con problemas del aprendizaje podría no ser capaz de procesar por completo ciertos tipos de información. Algunos niños tienen dificultades para captar lo que ven; a otros les cuesta procesar la información auditiva. Por ejemplo, aunque el maestro dé instrucciones orales muy claras, es posible que el mensaje no quede grabado en la mente del niño. En consecuencia, el niño podría pasar apuros con una o más asignaturas en la escuela.

L.A. Care HEALTH PLAN

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Understanding Autism

Most infants and young children love to be held and cuddled. This helps them form close bonds with their parents and other caregivers. But children with autism may resist being touched. And they may often seem remote and withdrawn. Some may never learn to talk. Although there is no cure for autism, many children with the disorder can be greatly helped.

What Is Autism?

Autism is not a mental illness. Autism is a disorder in which a child's brain doesn't develop normally. Symptoms often appear before age 3 and persist throughout the child's lifetime. These symptoms can vary widely and may be mild or severe. Most people with autism have trouble talking and relating to others. They often seem to be in a world of their own. Some children with the disorder may not respond to smiles or eye contact. They also may repeat certain actions over and over. They may follow rigid routines or be obsessed with parts of objects. A few may even try to harm themselves or others.

Signs of Autism

Each person with autism is unique. Some characteristics are:

- Slowness in learning to talk or not learning to talk at all.
- Preferring to be alone rather than with others.
- Not sharing and playing the way other children do.
- Sensitivity to sounds, touch, smells, or tastes.
- Throwing tantrums or trying to harm themselves or others.

Who Does It Affect?

Boys are four times more likely to have autism than girls. Autism crosses all ethnic and social lines. Any child can develop this disorder.

What Causes It?

Parents of children with autism often blame themselves, but autism is no one's fault. Certain genes may affect the way your child's brain develops. Other factors, such as viruses or chemicals, may also play a role.

What Can Help?

Early help is crucial for children with autism because children learn best when they're very young. Special therapists can help your child learn social and language skills. School programs can be tailored to your child's needs. As

your child matures, many caring professionals can help. Talking to your doctor is a good place to start.

El autismo

A la mayoría de los bebés y niños pequeños les gusta que los abracen y les den cariño. Esto contribuye a la formación de vínculos fuertes con sus padres y con las personas que se encargan de ellos. Pero los niños con autismo se resisten a que les toquen, y a menudo se muestran distantes y retraídos. Algunos nunca aprenden a hablar. Aunque el autismo no puede curarse completamente, puede mejorarse mucho mediante terapia.

¿En qué consiste el autismo?

El autismo no es una enfermedad mental, sino un trastorno causado por el desarrollo anormal del cerebro. Los síntomas—que suelen manifestarse antes de los 3 años de edad y persistir durante toda la vida del niño—pueden ser muy diversos: desde leves a severos. La mayoría de las personas con autismo tienen dificultad para comunicarse y relacionarse con los demás, y a menudo parecen estar ensimismados en su propio mundo. Algunos de los niños que tienen este trastorno no responden a las sonrisas ni a las miradas directas. También es posible que repitan ciertas actividades una y otra vez, o que sigan una rutina extremadamente rígida o se obsesionen con las piezas de ciertos objetos. Algunos pueden llegar a intentar hacerse daño a sí mismos o a los demás.

Señales de autismo

El autismo adopta una forma distinta en cada persona. Algunas de sus características son:

- Dificultad o incapacidad total para el aprendizaje.
- Aislarse de los demás.
- No relacionarse ni jugar con los otros niños.
- Alta sensibilidad a los sonidos, al tacto, olores y sabores.
- Tener berrinches y rabietas o a hacerse daño a sí mismo o a los demás.

¿A quiénes afecta?

El autismo es cuatro veces más frecuente en los niños que en las niñas.

¿Cuál es su causa?

Los padres de los niños con autismo suelen culparse a sí mismos, pero este trastorno no es culpa de nadie. Ciertos genes pueden afectar la manera en que se desarrolla el cerebro del niño. Existen también otros factores que pueden influir, como ciertos virus o la exposición a ciertas sustancias químicas.

¿Cómo se puede aliviar?

Es esencial proporcionar ayuda lo más pronto posible, ya que el aprendizaje es más eficaz cuanto más temprano se intente. Hay terapeutas especiales que pueden ayudar al niño a desarrollar sus aptitudes sociales y lingüísticas. Los programas escolares pueden adaptarse a las necesidades de su hijo. A medida que el niño va madurando, muchos profesionales podrán proporcionarle ayuda. Una buena manera de comenzar es consultar con su médico.

Managing Autism

Kids with autism have trouble with others. They may not respond to smiles or eye contact. They may not like being held or touched. They may be slow learning to talk. There is help. There is no one right treatment. Some kids do well with therapy. Others do well with medicine. There are lots of support services for you and your child.

Behavioral-Educational Therapy

Therapy can help your child learn language and social skills. It can also help your child with life tasks like learning to cross a street. Kids with autism do best with school programs that meet their unique needs. Some do well one-on-one or in a small group. Others do well in public classes with help. All kids learn best when they are very young. This is why your child should start therapy as soon as he or she can.

Medication Therapy

There are medicines to help treat the symptoms of autism. Talk to your doctor to find out what medicines are right for your child.

Getting Support

You can do a lot at home to help your child. There are services that can help you. Some kids need other kinds of support. Group homes can provide a safe place for your child.

Looking Ahead

Each child with autism is unique. Some may have mild symptoms. Others may have symptoms that lessen as they get older. These children can lead normal lives. Children whose autism is more severe need more help. All kids with autism can look forward to better lives.

Resources

Autism Society of America 800-328-8476 www.autism-society.org

National Institute of Child Health and Human Development 800-370-2943 www.nichd.nih.gov/autism

Families for Early Autism Treatment 916-303-7405 www.feat.org

For L.A. Care members with special needs, call 1-888-439-5123 or TTY 1-866-522-2731.

Control del autismo

Los niños que tienen autismo muestran dificultad para relacionarse con los demás. Es posible que no respondan a ciertas señales y gestos comunes de comunicación social, como la sonrisa o la mirada, que no les guste que los abracen y que tarden más de lo normal en aprender a hablar. Pero muchos niños con autismo pueden mejorar mucho si reciben ayuda a tiempo, aunque no existe un tipo de programa o tratamiento que sea adecuado para todos. En muchos casos la terapia educacional y de comportamiento da buenos resultados, mientras que en otros puede ser mejor una terapia con medicamentos. También existen servicios de apoyo para niños con autismo y para sus familiares.

Terapia educacional y de conducta

Existen terapeutas especiales que pueden ayudar a su hijo a desarrollar sus aptitudes lingüísticas y sociales, y enseñarle a realizar las tareas básicas de la vida diaria, como por ejemplo cruzar la calle sin peligro o contar el dinero. Los niños que tienen autismo se benefician más de los programas escolares bien estructurados y adaptados a sus necesidades. Algunos pueden tener más éxito trabajando con instrucción individualizada o en grupos pequeños, mientras que otros pueden funcionar bien en los cursos normales con ayuda especial. Debido a que todos los niños aprenden mejor cuando son muy jóvenes, la terapia debe comenzarse lo antes posible, tan pronto como el niño esté listo para recibirla.

Recursos

Autism Society of America

800-328-8476

www.autism-society.org

National Institute of Child Health and Human Development

800-370-2943

www.nichd.nih.gov/autism

Families for Early Autism Treatment

916-843-1536

www.feat.org

Terapia con medicamentos

Ciertos medicamentos pueden ayudar a tratar los comportamientos asociados con el autismo y reducir la ansiedad y otros síntomas.

Soporte continuo

En la mayoría de los casos, podrá ayudar a su hijo en su propia casa. Existen muchos servicios que pueden serle útiles. Algunos niños pueden necesitar otros tipos de apoyo. Para los casos que requieran otros tipos de ayuda existen residencias especiales e instalaciones que proporcionan un lugar seguro para el niño.

Mirar hacia el futuro

Cada niño con autismo es un caso único. Algunos pueden tener sólo síntomas leves, mientras que en otros los síntomas pueden disminuir a medida que se hacen mayores. Estos niños suelen ser capaces de llevar una vida completamente normal. Los niños que tienen un tipo de autismo más grave pueden necesitar apoyo continuo. Con la ayuda adecuada, un niño con autismo puede contemplar un futuro mejor.

Health in Motion™

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Autism in Adults

Autism lasts a lifetime. It affects how the brain takes in and works with information. Children with autism get older. They become adults with autism. Adults with autism have choices to make about where to live, where to work, and where to get help.

Signs of Autism in Adults

Adults with autism may have trouble with:

- Talking, making eye contact, and listening
- Understanding the feelings of others
- Changes in daily routine
- Sensory input (feeling a light touch as painful, sensitivity to loud sounds, or strong food likes and dislikes)
- Sleep and anxiety

Living with Autism

Some adults are able to live and work on their own. This largely depends on how well one talks and works with others.

Some adults are able to live and work with help from family or health care professionals. They can live at home or in a group setting.

People with may be able to get help through Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). Contact the Social Security Administration (SSA) to learn more.

Where to Get Help

Autism Society of America
800-328-8476
www.autism-society.org

Autism Society of Los Angeles
(562) 804-5556
http://autismla.org/

Social Security Administration
1-800-772-1213
TTY 1-800-325-0778
http://www.ssa.gov/

For accommodation of persons with special needs, call 1-888-439-5123 or TTY 1-866-522-2731.

www.lacare.org

L.A. Care HEALTH PLAN
For a Healthy Life

El autismo en los adultos

El autismo dura toda la vida. Afecta la forma en que el cerebro registra y procesa la información. Los niños con autismo crecen y se convierten en adultos con autismo. Los adultos con autismo tienen que decidir donde van a vivir, trabajar y obtener ayuda.

Señales de autismo en adultos

Los adultos que tienen autismo pueden tener problemas con lo siguiente:

- Para hablar, hacer contacto visual y escuchar.
- Para entender los sentimientos de los demás.
- Para hacer cambios en su rutina diaria.
- Con los estímulos sensoriales (sentir que una pequeña caricia es dolorosa, sensibilidad a los ruidos o gustos y disgustos muy marcados hacia la comida).
- Para dormir y con la ansiedad.

Cómo vivir con autismo

Algunos adultos pueden vivir y trabajar por sí solos. Esto depende, en gran parte, de cuán bien la persona habla o trabaja con los demás.

Algunos adultos pueden vivir y trabajar con la ayuda de familiares o profesionales de atención médica. Pueden vivir en la casa o con un grupo.

Las personas que tienen autismo pueden obtener ayuda a través del Seguro de Discapacidad del Seguro Social (Social Security Disability Insurance, SSDI) y del Ingreso Social Suplementario (Supplemental Security Income, SSI). Si desea más información, comuníquese con la Administración del Seguro Social (Social Security Administration, SSA).

Dónde obtener ayuda

Sociedad Americana del Autismo (Autism Society of America)
800-328-8476
www.autism-society.org

Sociedad para el Autismo de Los Ángeles (Autism Society of Los Angeles)
(562) 804-5556
http://autismla.org/

Administración del Seguro Social
1-800-772-1213
TTY 1-800-325-0778
http://www.ssa.gov/

Si desea arreglos específicos para personas con necesidades especiales, llame al 1-888-439-5123 o a la línea TTY 1-866-522-2731.

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