


*Treating depression during COVID-19: Considerations for psychological and psychiatric treatment*

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Thursday, April 30, 2020




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*Quick overview of logistics*

Our speakers will give a 75-minute presentation.

Following the presentation, there will be a dedicated time to answer your questions.

- Please use the **Q&A feature**, located in the toolbar at the bottom of your screen, to send your question to the moderator.
- The presenter will review all questions submitted and select the most appropriate ones to ask the presenter.



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*Disclosures*

The presenters have each declared that s/he does not, nor does her/his family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation. The presenters have each declared that s/he does not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

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*Learning objectives*


Upon completion of the instructional program, participants should be able to:

1. Present the rationale for behavioral activation along with at least two specific examples for each aspect of the TRAP model;
2. Identify at least two modifications to pharmacotherapy due to the COVID-19 pandemic, including use of telepsychiatry;
3. Identify at least two adaptations to the implementation of behavioral activation in light of COVID-19 and/or use of telehealth.

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### What we'll cover in this webinar

- 1. Behavioral activation for the treatment of depression**
  - Theoretical rationale and treatment rationale
  - Activity scheduling
  - Rumination
- 2. Pharmacotherapy**
  - Standard practices for treating depression
- 3. Benefits of combined approach**
  - Efficacy of behavioral activation with medication
- 4. Considerations in light of COVID-19**
  - Telehealth recommendations
  - Modifications to psychiatry
  - Modifications to therapy

 Please use the Q&A feature to send your questions to the moderator.

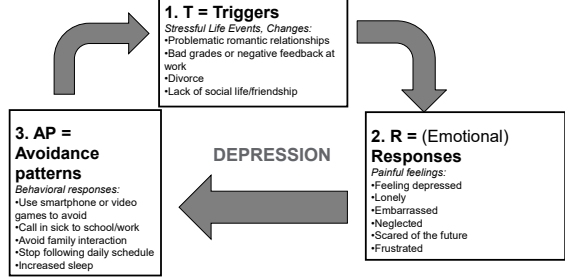
### Behavioral activation for the treatment of depression

- Theoretical rationale and treatment rationale
- Activity scheduling
- Rumination

### Research support

- BA is a **“well-established empirically validated treatment”** (Mazzucchelli et al., 2009).
- A number of studies have found that BA leads to better outcomes than control conditions and similar or better outcomes compared to other established treatments (Dimidjian et al., 2006; Mazzucchelli et al., 2009).
- Growing evidence for BA for adolescents (e.g., McCauley et al., 2016).
- BA may be more cost-effective and easier to disseminate than CBT (Richards et al., 2016).

### Rationale: How do people become depressed?



**1. T = Triggers**  
Stressful Life Events, Changes:  
• Problematic romantic relationships  
• Bad grades or negative feedback at work  
• Divorce  
• Lack of social life/friendship

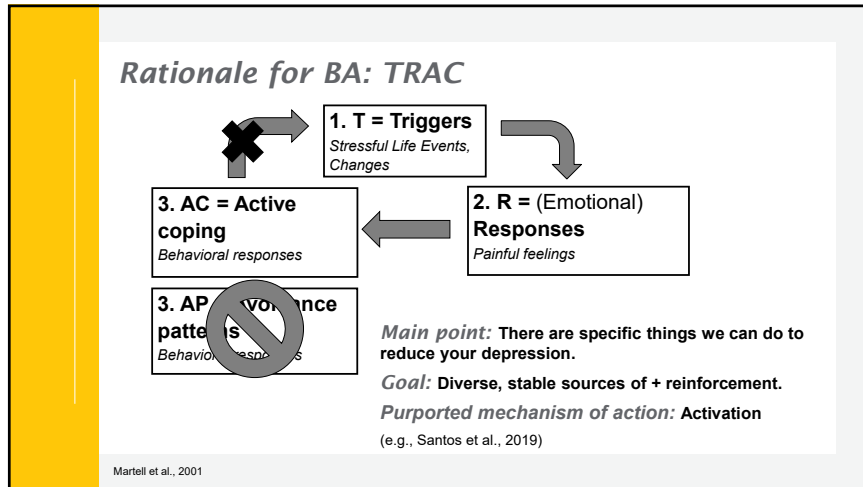
**2. R = (Emotional) Responses**  
Painful feelings:  
• Feeling depressed  
• Lonely  
• Embarrassed  
• Neglected  
• Scared of the future  
• Frustrated

**DEPRESSION**

**3. AP = Avoidance patterns**  
Behavioral responses:  
• Use smartphone or video games to avoid  
• Call in sick to school/work  
• Avoid family interaction  
• Stop following daily schedule  
• Increased sleep

**Main point: Your depression makes sense.**

Adapted from Martell et al., 2001; Kanter et al., 2009



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### Everyday TRAPs and TRACs

The TRAP/TRAC model is not just for discussing the BA model of depression and rationale for treatment.

The TRAP/TRAC model can also be applied to situations that occur throughout the patient's day. This can be especially helpful to identify recurring TRAPS and identify situations where they can try out active coping strategies.

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### Activity monitoring and activity scheduling

- **Intervention = specific activation assignments**
  - **Activity monitoring** to learn about current activities/schedule
  - **Activity scheduling for the following categories:**
    - Routine activities and overall schedule
    - Pleasant/enjoyable activities (that aren't avoidance!)
    - Valued activities
  - Organize these along an **Activity hierarchy**
    - Gradually increase engagement in these activities while simultaneously decreasing avoidance.
- Helpful to get patient started with activation assignments while continuing to assess

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### Routine activities

- Routine activities are things that are generally not fun to do, but need to be completed for health and quality of life reasons.
- Examples of routine activities include:
  - showering
  - brushing teeth
  - making your bed
  - doing laundry
  - eating regularly
  - maintaining a regular sleep schedule
  - paying bills
  - checking/going through mail



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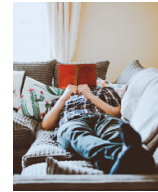
### Enjoyable activities

- Enjoyable activities often decrease in frequency when someone is depressed. They also may not be experienced as enjoyable in the way that they previously did.
- Important to increase these to help fight depression.
- Activities in the enjoyable activities category include:
  - **Activities you used to enjoy** (even if you don't currently enjoy them)
  - **Activities you currently enjoy** (even if you enjoy them just a little bit and still feel depressed). Sometimes a better way of thinking about this is **activities that make you feel slightly less bad**.
  - **Activities you have always thought you might enjoy but haven't tried.**

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### Enjoyable activities and avoidance

- Some activities may be enjoyable but also function as **avoidance** (e.g., video games, TV, phone/internet, etc.)
- While some activities could be harmful to the point where we may not recommend doing them at all (for example, using drugs to cope with painful emotions), others may still be acceptable to incorporate in reasonable amounts.



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### Values

- Adapted from Acceptance and Commitment Therapy (ACT; Hayes et al., 1999, 2011)
- Want activity scheduling to include meaningful/important activities, not just pleasurable ones
- Activities related to values more personally meaningful and reinforcing

Kanter et al., 2008.

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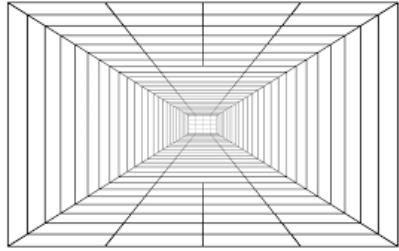
### Activity hierarchy example

Activity	Anticipated Difficulty
Get out of bed by 9:30 am	1
Shower every morning	2
Spend 5 min. picking up my room per day	3
Call best friend once per week	3
Take a 10-minute walk after school every day	3
Get out of bed by 8:30 am	3
Do yoga for 10 minutes at home	4
Work on one college application	5
Call to sign up for photography class	4
Watch football game with friends	5
Spend 20 min./day on college applications	6
Attend one photography class per week	7
Send in college applications	7

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**Targeting Rumination**


Addressing rumination with mindfulness



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**Rumination**

“Passively and repetitively focusing on one’s symptoms of distress and the circumstances surrounding these symptoms.”



(Nolen-Hoeksema et al., 1997)

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**Rumination as avoidance**

- *Instead of ruminating, what else could they be doing?*
  - When ruminating, individuals avoid engaging in their lives.
  - They may experience some short-term relief that by ruminating, they are avoiding interactions with others that may make them feel vulnerable or overwhelmed. On the other hand, this creates a host of new problems.

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**What does their experience tell them?**

- We want to learn:
  - What do they tend to ruminate about?
  - How much time do they spend ruminating?
  - How do they feel before, during, and after ruminating?
  - What might they be avoiding?
  - What else could they be doing instead of ruminating?

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### *How to stop ruminating?*

- Learn to notice when it is happening!
  - Track rumination over time (submits and resists).
- When they notice that they are ruminating, we would like them instead to practice **mindfulness**.

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### *Using mindfulness to combat rumination*

**Ideally: instead of ruminating, mindfully participate in a valued activity consistent with behavioral activation.**

- Other options to use initially until better able to use mindful, valued activation:
  - **Practice the 5-4-3-2-1 Mindfulness Exercise** to increase awareness
    - 5 things they **see**,
    - 4 things they **hear**,
    - 3 things they **feel**,
    - 2 things they **smell**, and
    - 1 thing they **taste**.

Do so with purpose and non-judgmentally.

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### *Using mindfulness to combat rumination*

- **Engage in an activity that requires their full attention** and therefore is incompatible with rumination
  - Working on a crossword puzzle or Sudoku
  - Counting backwards from 100 by 7s
  - Naming all of the colors you see in the room, in a painting, or out the window
  - Naming all of the animals that live in a zoo
  - Labeling objects in the room by the first letter they start with from A to Z

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## *Pharmacotherapy*

- Standard practices for treating depression

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**Standard practices**

- American Psychiatric Association (APA) Guidelines
  - Practice Guidelines – November 2009
- Psychopharmacology Algorithm Project 2019
  - David N. Osser, MD – Associate Professor, Harvard South Shore Program
  - Literature extensively reviewed and published as a peer reviewed article in preparation for creating the algorithm

Standard practices may be limited by provider knowledge of evidence-based treatment, treatment setting, local resources, patient safety

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**APA guidelines (not considering COVID-19)**

Understand patient needs:

- Establish and maintain therapeutic alliance
- Complete psychiatric assessment
- Evaluate safety
- Establish appropriate treatment setting

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**APA guidelines (not considering COVID-19)**

Contextual considerations:

- Evaluate and address functional impairments and quality of life
- Coordinate patient's care with other clinicians

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**APA guidelines (not considering COVID-19)**

Monitoring and intervention:

- Choose measures of progress
  - Quick Inventory of Depressive Symptomatology (QIDS; Rush et al., 2003)
  - Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996)
  - Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001)
- Enhance treatment adherence
- Psychoeducation

THEN choose an initial treatment...


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**TABLE 2. DOSING OF MEDICATIONS SHOWN TO BE EFFECTIVE IN TREATING MAJOR DEPRESSIVE DISORDER\***

Generic Name	Starting Dose (mg/day) <sup>a</sup>	Usual Dose (mg/day) <sup>b</sup>
<b>Selective serotonin reuptake inhibitors<sup>a</sup></b>		
Citalopram	20	20–60 <sup>a</sup>
Escitalopram	10	10–20
Fluoxetine	20	20–60 <sup>a</sup>
Paroxetine	20	20–60 <sup>a</sup>
Paroxetine, extended release	12.5	25–75
Sertraline	50	50–200 <sup>a</sup>
<b>Dopamine norepinephrine reuptake inhibitor<sup>a</sup></b>		
Bupropion, immediate release	150	300–450
Bupropion, sustained release	150	300–450
Bupropion, extended release	150	300–450
<b>Serotonin norepinephrine reuptake inhibitors<sup>a</sup></b>		
Venlafaxine, immediate release	37.5	75–375
Venlafaxine, extended release	37.5	75–375
Desvenlafaxine	50	50 <sup>a</sup>
Duloxetine	60	60–120
<b>Serotonin modulators</b>		
Nefazodone	50	150–300
Trazodone <sup>b</sup>	150	150–600
<b>Norepinephrine-serotonin modulator</b>		
Mirtazapine <sup>b</sup>	15	15–45
<b>Tricyclics and tetracyclics</b>		
Amitriptyline	25–50	100–300
Doxepin	25–50	100–300
Imipramine	25–50	100–300

Generic Name	Starting Dose (mg/day) <sup>a</sup>	Usual Dose (mg/day) <sup>b</sup>
<b>Tricyclics and tetracyclics (continued)</b>		
Desipramine	25–50	100–300
Nortriptyline	25	50–200
Trimipramine	25–50	75–300
Protriptyline	10–20	20–60
Maprotiline	75	100–225
<b>Monoamine oxidase inhibitors (MAOIs)</b>		
<b>Irreversible, nonselective inhibitors</b>		
Phenelzine	15	45–90
Tianeptin	10	30–60
Isocarboxazid	10–20	30–60
<b>Reversible, MAO B selective inhibitor</b>		
Selegriline transdermal <sup>b</sup>	6	6–12
<b>Reversible MAO A selective inhibitor</b>		
Moclobemide	150	300–600

APA, 2010.

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## Medication considerations

Consider side effects:

- Weight gain, sedation, GI issues, insomnia, orthostasis, headaches, sexual dysfunction

Dosing

Requires monitoring?

Timing of effects

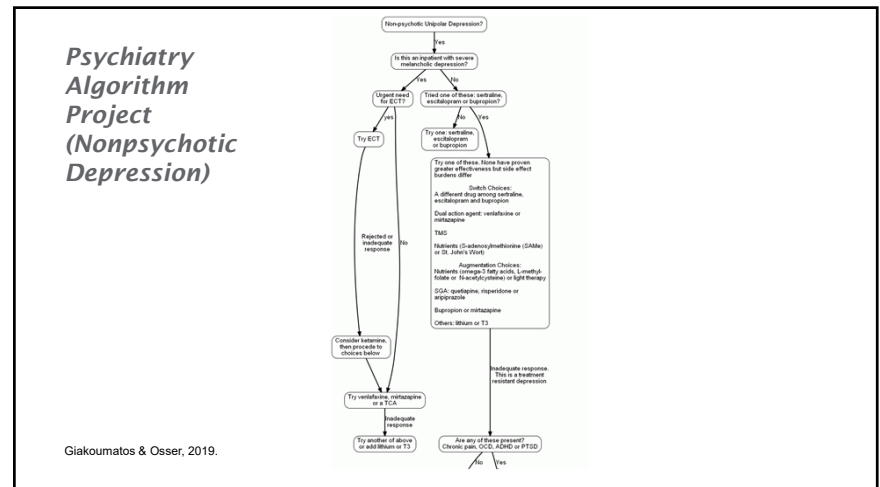
- May see improvement in 1-2 weeks
- Max improvement in 4-8 weeks (*at effective dosing*)

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## Guidelines (APA, 2010)

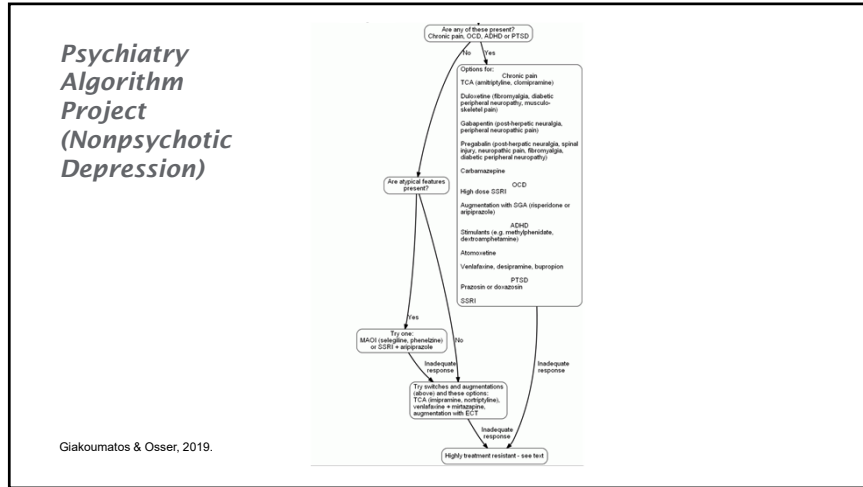
- For most patients, a SSRI, a SNRI, mirtazapine, or bupropion is optimal
- No treatment should continue unmodified if there has been no symptomatic improvement after 1 month
- Change vs. augmentation\*
  - Augmentation strategies – Psychotherapy, SGA, Lithium, add mirtazapine/bupropion, T3
  - Changing strategies – Alternative SSRI, SGA, MAO-I

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### Benefits of a combined approach

- Efficacy of behavioral activation with medication

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### Combination therapy

- Very few studies comparing medication only treatment to BA + medication
- Several meta-analyses comparing some form of psychotherapy against psychotherapy + medication.
  - Various effect sizes indicate benefit in short term and long term for combination therapy in depression

Cuijpers, Dekker, et al., 2009; Cuijpers et al., 2014; Cuijpers, van Straten, et al., 2009.

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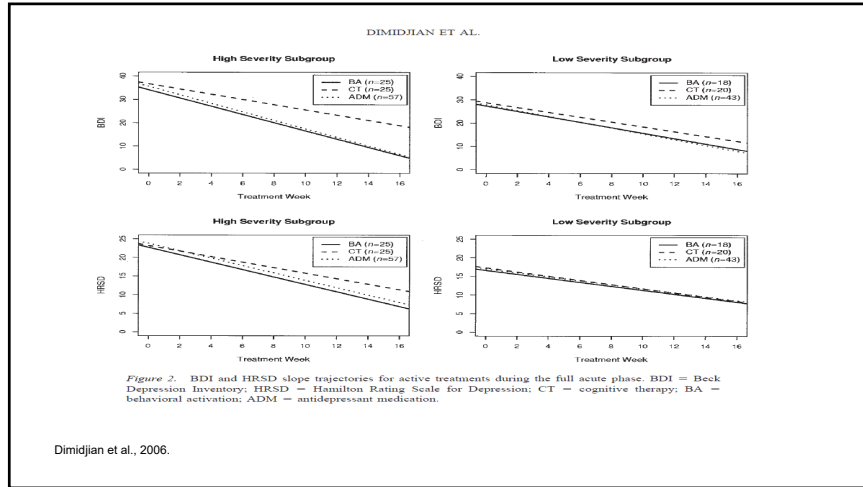
### Comparing treatment

Trial of Behavioral Activation, Cognitive Therapy, and Antidepressant Medication in the Acute Treatment of Adults With Major Depression

- Randomized placebo controlled (N=241)
- Severe Depression
  - BA = Meds
  - BA, Meds > CT
- Mild/Moderate Depression
  - Similar result across therapies

Dimidjian et al., 2006.

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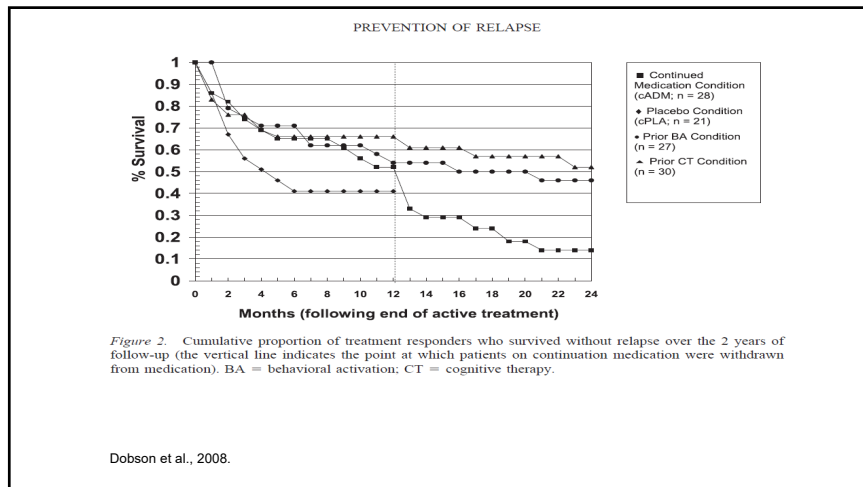
## Relapse prevention

Behavioral Activation, Cognitive Therapy, and Antidepressant Medication in the Prevention of Relapse and Recurrence in Major Depression

- Randomized Controlled Trial (N=106)
- Patients treated with medication but withdrawn onto pill-placebo had more relapse through 1 year of follow-up compared to patients who received prior BA, CT, or continued medication.

Dobson et al., 2008.

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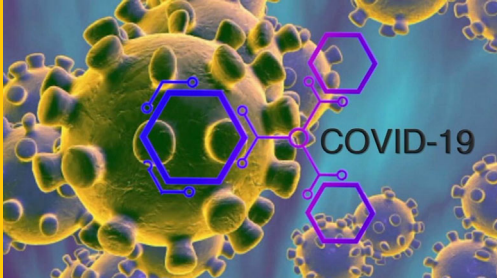
## Considerations in light of COVID-19

- Telehealth recommendations
- Modifications to psychiatry
- Modifications to therapy

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*Considerations*

**General telehealth recommendations**



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*Benefits of telehealth*

- May counteract impact of perceived **stigma** on treatment seeking.
- **Decreased patient cost** (e.g., transportation costs, time away from work) and increase the ability for providers to serve a **larger geographical area** (Dunn et al., 2000; Trott & Blignault, 1998).
- Reduced barriers to getting to treatment may increase **continued engagement**.

Wangelin et al., 2016.

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*Benefits of telehealth*

- Improved access to care
  - Rural communities
  - Ability to disseminate evidence-based treatments

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*Telehealth recommendations*

**Technology**

- Use of a secure HIPAA compliant platform
  - Skype for Business (E3 or E5 packages), Microsoft Teams, Updox, Doxy.me
- Electronic health record
- Ability to send and sign documents (e.g., DocuSign, Adobe Pro)
- Adequate internet speed
- Patients must have a microphone and camera with the camera enabled throughout the session
- Provider needs to be able to assist in troubleshooting patient technology issues or have an available help desk

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### *Telehealth recommendations*

#### **Technology and preparation**

- Electronic assessment measures
- Clinical materials available in the appropriate format
  - Worksheets available as fillable PDFs or Word documents
  - PowerPoints to use when providing psychoeducation or group therapy
  - Relevant videos to share to illustrate a concept

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### *Telehealth recommendations*

#### **Patient care**

- Have patient phone number in case of technology issues.
  - Can use Google Voice, Doximity Dialer, or something similar to protect personal cell phone number
- Clinicians and patients need a private space where they will not be interrupted and where others cannot see/hear the session.
  - Discuss telehealth etiquette (limiting distractions, etc.)
  - Discuss clothing guidelines up front

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### *Considerations*

#### **Modifications to psychiatry**



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### *Guidelines for telepsychiatry*

#### **APA Guidelines not very specific**

- There are no absolute contraindications to patients being assessed or treated using telemental health
- Providers **should** consider such things as patient's cognitive capacity, history regarding cooperativeness with treatment professionals, current and past difficulties with substance abuse, and history of violence or self-injurious behavior
- Providers **shall** consider geographic distance to the nearest emergency medical facility, efficacy of patient's support system, and current medical status.
- The consent process **shall** include discussion of circumstances around session management so that if a patient can no longer be safely managed through distance technology, the patient is aware that services may be discontinued.
- Providers **should** consider whether there are any medical aspects of care that would require in-person examination including physical exams.

Shore et al., 2018.

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### Guidelines for telepsychiatry

Providers **should** consider such things as patient's cognitive capacity, history regarding cooperativeness with treatment professionals, current and past difficulties with substance abuse, and history of violence or self-injurious behavior

- **Consider cognitive scale** (MoCA, MMSE) – document parts not able to do over video
- **Compliance** – Able to take meds without supervision? Able to show up for online appointments?
- **Substance Abuse** – Currently using? Possibility of withdrawal? How to assess danger in possibility of EtOH/benzo/opiate withdrawal?
- **Violence** – History of domestic violence? History of self-harm? Guns in the home?

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### Guidelines for telepsychiatry

Providers **shall** consider geographic distance to the nearest emergency medical facility, efficacy of patient's support system, and current medical status.

- When you call 9-1-1, what happens?
- Does patient have a preferred hospital/ED they go to? What is the number?
- Who else lives in the home? Reliable?
- Consider getting family involved earlier
- What other meds is patient taking? Are they stable? HTN? Diabetes?
- Are they mobile?

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### Guidelines for telepsychiatry

The consent process **shall** include discussion of circumstances around session management so that if a patient can no longer be safely managed through distance technology, the patient is aware that services may be discontinued.

- Decide what your limitations are
- Explain limitations to patient. Treatment contract if necessary?
- Do you trust patient to get labs/see PCP if needed/take prn medication appropriately?

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### Guidelines for telepsychiatry

Providers **should** consider whether there are any medical aspects of care that would require in-person examination including physical exams.

- Access to an outpatient lab? How will results be communicated?
- How to receive previous lab results?
- Does treatment intervention require regular vitals?
- Does patient have PCP or relatively quick access to PCP?
- AIMS test
- EPS

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### *Guidelines for telepsychiatry*

Does treatment algorithm change when medical monitoring or in-person examination is not possible?

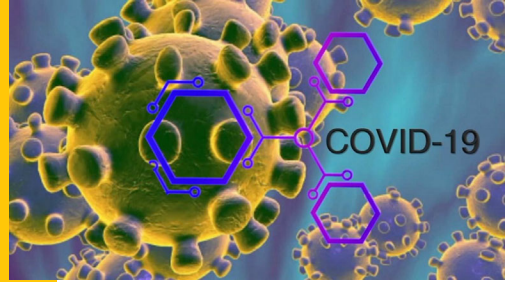
- SSRI/SNRI – Bruising, hyponatremia
- Bupropion – blood pressure
- Stimulants – blood pressure, cardiac history
- Lithium – levels, TSH, Creatinine, EKG
- Lamotrigine – rash
- Carbamazepine – hyponatremia, blood counts
- Depakote – Levels, LFTs, Ammonia
- Antipsychotics – weight, waist circumference, QTc, orthostasis, EPS

DOCUMENT,  
DOCUMENT,  
DOCUMENT!

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### *Considerations*

#### **Modifications to therapy**



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### *Research support for BA over telehealth*

- BA and therapeutic exposure for veterans with PTSD and major depression.
  - **Comparable improvement** between in person and home-based telehealth at post-treatment as well as 3- and 12-month follow-up (Acierno et al., 2016).
- 8 sessions of BA delivered to veterans via telehealth versus in person.
  - Strong improvements in depression and hopelessness for both groups, although some slight benefit to in person care esp. on hopelessness (Luxton et al., 2016).
- Meta-analysis of psychotherapy for depression using telehealth found **no evidence of inferiority** to standard non-telehealth treatment (Osenbach et al., 2013).

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### *Managing safety concerns*

- Patient location information for each day services are provided
- Have emergency contact information for someone living with the patient if possible and contact information for local emergency services
- At admission, notify about potential for a health and wellness check if needed to ensure safety

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***Managing safety concerns***

1. Assess suicide risk and use this to determine appropriateness for telehealth/current level of care.
2. Develop safety plan in response to identified risk, provide copy to patient/family. Involve support person when possible.
3. Assess risk at each session for those at intermediate or greater risk.
  - Standardized assessments, asking about SI/violence directly.
4. Intervene when needed (e.g., intent/plan) – consider inpatient hospitalization, health and wellness check, talk with support person.

Luxton et al., 2014.

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***Impact of telehealth and modifications***

- Need for more parental/spouse involvement
  - Accountability and assistance with safety monitoring
- Increased focus on rapport building and encouraging disclosure
- Address patient concerns with seeing/hearing themselves
- Gain useful information from seeing the patient's living space
- Benefits related to attendance and punctuality


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***Impact of social distancing/stay at home***

- Higher acuity due to reduced access to care
- Added stressors – need for more distress tolerance and/or anxiety management skills
  - Juggling multiple responsibilities
  - Challenges for essential workers
- Creativity needed for BA assignments
- Structure and a daily schedule more important than ever

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***Time for questions and answers...***



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### Where to get additional information...



<https://www.coronavirus.gov>



<https://www.nih.gov/health-information/coronavirus>



<https://www.psychiatry.org/>



<https://adaa.org/finding-help/coronavirus-anxiety-helpful-resources>

### About the presenters...



**Rachel C. Leonard, PhD, LP  
Clinical Director, St. Paul**

Rachel C. Leonard, PhD, is a licensed clinical psychologist who directs the clinical programming at Rogers Behavioral Health in St. Paul. Dr. Leonard specializes in utilizing behavioral activation and other cognitive behavioral-based interventions for individuals with mood, anxiety, and obsessive-compulsive spectrum disorders.



**Christopher Lowden, MD  
Psychiatrist, Hinsdale**

Christopher Lowden, MD, is a board-certified psychiatrist who works with adults enrolled in the Depression Recovery, Mental Health and Addiction Recovery, and OCD and Anxiety partial hospitalization and intensive outpatient levels of care at Rogers Behavioral Health in Hinsdale..

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800-767-4411  
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