PRACTICAL PSYCHIATRY FOR ALL DISCIPLINES

Neel Doshi, DO

Disclosure

- I have no financial relationships to disclose relating to the subject matter of this presentation

Objectives

- Familiarity with Depression/Anxiety diagnoses
- Knowing when to refer and when to treat
- Basic Psychopharmacology
- Understand available community/online resources

Depression

- "Depression is the most unpleasant thing I have ever experienced. . . .The absence of hope. That very deadened feeling, which is so very different from feeling sad. Sad hurts but it's a healthy feeling. It is a necessary thing to feel. Depression is very different."

  – **J.K. Rowling**

The Why

- >75% of all psychotropic medications prescribed by Primary Care.

  Pincus et al. 1998. JAMA, 279, 526-531

- >50% of people treated for depression receive all treatment in primary care.

  Katon, *Arch Gen Psych* 1996

- Only 41% with mental health conditions receive any treatment

  Wang, Lane, Olfsen et al; Arch Gen Psych, 2005

  - 8 times as many undiagnosed, asymptomatic adults stated more likely to see PCP than a psychiatric professional

    NMHA.America's mental health survey, May 2000. www.roper.com/Newsroom/content/news189.htm

*Star*D Trial*

TABLE 4

COMPARISON OF PRIMARY VS. PSYCHIATRIC CARE IN STAR*D

- No differences in severity of depressive illness
- Minimal differences in depressive symptom presentation
- Approximately 50% of patients had recent suicidal ideation in both
- More medical comorbidity in primary care
- More psychiatric comorbidity in primary care
- Chronic depressions more prevalent in primary care
- No differences in remission rates with optimized SSRI treatment

vs.=versus; STAR*D=Sequenced Treatment Alternatives to Relieve Depression; SSRI=selective serotonin reuptake inhibitor.

Ziffra MS, Gilmer WS. *Primary Psychiatry*. Vol 14, No 1. 2007.

The How

- **Core symptoms: SIGECAPS**
  - Depressed mood (S) AND/OR
  - Reduced interest or pleasure (I)
- **Somatic symptoms:**
  - Change in appetite (A)
  - Change in sleep pattern (S)
  - Reduced energy level (E)
  - Psychomotor agitation/retardation (P)
- **Cognitive symptoms:**
  - Poor concentration/easy distraction (C)
  - Inappropriate guilt/self reproach (G)
  - Thoughts of death, dying, suicide (S)
- **5 out of 9 for at least two weeks**

Tools

- QIDS: Quick Inventory of Depressive Symptomatology
  - WWW.IDS-QIDS.ORG
- PHQ-9: Patient Health Questionnaire-9
  - WWW.PHQSCREENERS.COM
- Both Instruments are:
  - Validated/Studied
  - Quick and Easy to take & score
  - Available for download in English and Spanish
  - Helpful for initial screening AND treatment response

Depressive Disorders

- Major Depressive Disorder
- Dysthymia / Persistent Depressive Disorder
- Seasonal Affective Disorder
- Psychotic Depression
- Adjustment d/o with depressed mood
- Bereavement

SSRIs - General Info

- Defer, if possible, in reactive depression
- Careful consideration before prescribing for mild depression
- Helpful for moderate-severe depression
- Must consider potential for hypomanic/manic conversion
- Category C for the most part. Zoloft and Prozac probably best, Paxil worst.
  - WomensMentalHealth.org
- Serotonin syndrome: signs/symptoms

Patient Education

- These are NOT happy pills, these are ANTIdepressants
- Will you still have depression/anxiety?
  - Decreases the severity and frequency
- "How long do I have to take these, doc?"
- "I don't want to become dependent on them"
- "I read that they aren't helpful"
- "My neighbor takes Xanax, can I just do that?"
- "I drink a blueberry-Acai infused almond milk with chia seeds extracted by pinky finger from the Na'Pali coast for my depression"

Medications

- Prozac (Fluoxetine)
- Lexapro (Escitalopram)
- Celexa (Citalopram)
- Zoloft (Sertraline)
- Paxil (Paroxetine)
- Wellbutrin (Bupropion)
- Effexor XR (Venlafaxine)
- Cymbalta (Duloxetine)
- Remeron (Mirtazepine)
- Trintellix (Vortioxetine)
- Elavil (Amitriptyline)
- Pamelor (Nortriptyline)
- Fluvoxamine (Luvox)

SSRIs

- Prozac – Lots of data. May cause increased anxiety/activation in ~10%. Usually dosed in AM but for some causes sedation and can be taken HS.
- Celexa / Lexapro – Low drug interactions. Flexible timing. Caution with Celexa in 65+.
- Zoloft – good for anxiety especially, and depression. Slight NE activity at lower doses. Generally dosed HS.
- Paxil – sedating, generally given HS. *Risk of discontinuation is higher than other SSRIs. Caution in Females 16-45. Category D in pregnancy.

Wellbutrin (Bupropion)

- Novel antidepressant
- Dosed in AM, generally
- May help with focus due to dopaminergic activity.
- May increase anxiety, may even cause psychosis
- Smoking Cessation / Zyban
- Weight neutral
- IR, SR, XL formulations
- Less sexual side effects
- CAUTION if Seizure history, avoid in eating d/o

Remeron (Mirtazapine)

- Unique MOA: Increases NE + 5HT by blocking alpha adrenergic receptors.
- Appetite increase in many
- Sedation
- Often used as an augmentation agent
- Low risk of withdrawal
- Often tried when SSRI trials fail or patient has trauma preventing sleep initiation.

SNRIs

- Effexor XR (Venlafaxine) – Use this formulation, not Effexor IR
- Generally dosed in AM
- Helpful for Anxiety/Depression, may have some benefit for hot flashes, pain.
- Higher risk of Discontinuation syndrome

- Cymbalta (Duloxetine) – Expensive / may be better for those with chronic pain.
- Also has Discontinuation syndrome risk

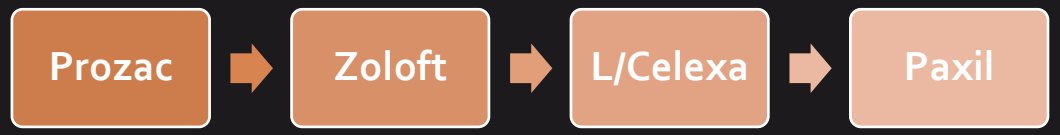
Choosing the right Medication

1. Recognize that some antidepressants may be more effective in certain populations even though most are generally of equal effectiveness.
2. Ask about personal or family history of treatment with antidepressants, particularly about side effects.
3. Consider the burden of side effects, particularly weight gain and sexual side effects.
4. Consider drug-drug interactions with other medications the patient is taking or may take.
5. Consider the potential lethality of the antidepressant in the case of an overdose.
6. Use antidepressant side effects for efficacy.
7. COMPLIANCE > Choice

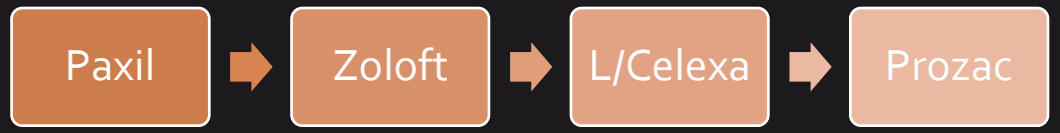
Moore DP, Jefferson JW. Mood Disorders. In: Moore & Jefferson: Handbook of Medical Psychiatry, 2nd ed. Philadelphia: Mosby; 2004.

Choosing the Right Medication

- Consider Activation vs. Sedation



- Consider Weight Gain potential



- Nausea/GI upset: Consider Probiotics – Coconut yogurt, Keffir, Sauerkraut, Pickles, Kombucha, Bananas
- Headaches: Increase fluids, change timing of dose

Common Side Effects

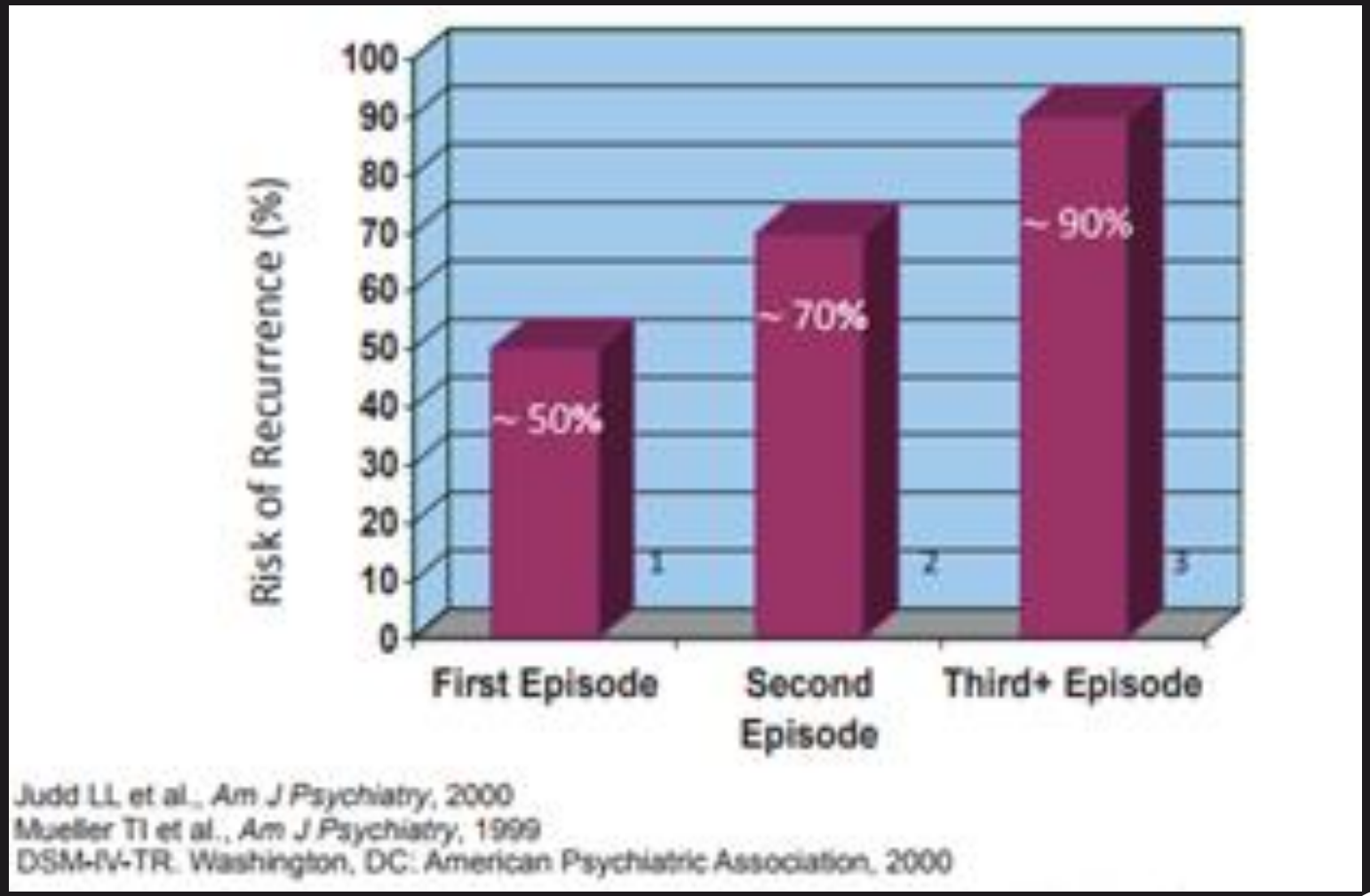
- Orgasmic Dysfunction - ~25% of patients at some level
  - Be comfortable switching, #1 try should be Prozac.
  - #2- Augment with Bupropion vs. Augment with Buspirone (if anxious)
  - #3- Change to Bupropion
  - #4- Change to Mirtazapine
  - Or can lower dosage, change timing
- Weight Gain - ~5-10% of patients
  - Work with them on diet/exercise
  - Change to Fluoxetine or Bupropion

Maintenance

- Patients with one lifetime episode of MDD who achieve remission on antidepressants should continue to take them for another 6 to 12 months.
- Patients with two or more episodes should be maintained an additional 15 months to 3 years.
- Patients with chronic MDD or MDD with concurrent dysthymia should be continued on antidepressants an additional 15 to 28 months after the acute phase treatment.

- Kaiser Permanente Care Management Institute. Depression clinical guidelines. http://www.guideline.gov/summary/summary.aspx?doc_id=9632&nbr=5152&ss=6&xl=999

Maintenance



Judd LL et al., *Am J Psychiatry*, 2000
Mueller TI et al., *Am J Psychiatry*, 1999
DSM-IV-TR. Washington, DC: American Psychiatric Association, 2000

Trust the Process

- If not progressing in tx, check compliance first, then push toward max dosage.
- Is there substance abuse?
- Life stressors + Therapy
- There are 30+ FDA-approved antidepressants; Each is effective in 40-50% of patients; often takes 2-3 trials before we settle on one

Pregnancy

- Prozac (Fluoxetine)
- Lexapro (Escitalopram)
- Celexa (Citalopram)
- Zoloft (Sertraline)
- Paxil (Paroxetine)
- Effexor XR (Venlafaxine)
- Cymbalta (Duloxetine)
- Wellbutrin (Bupropion)

Pregnancy

- Prozac (Fluoxetine) *** - Over 2500 cases, no increased risk of major congenital malformation
- Lexapro (Escitalopram)
- Celexa (Citalopram) * – One study (n=375) showed no increased risk of organ malformation
- Zoloft (Sertraline) *** Undetectable in breastmilk
- ~~Paxil (Paroxetine) -~~ Increased risk of Atrial/Ventricular Septal defects with 1st trimester exposure (although not replicated, nevertheless don't use if possible)
- Effexor XR (Venlafaxine) – Withdrawal risk but short-lived, good case history
- Cymbalta (Duloxetine)
- Wellbutrin (Bupropion) – Recent studies look good (n=1200), debunking concerns that there might be increased risk of congenital heart issues

Pregnancy – Debunking Bad Science

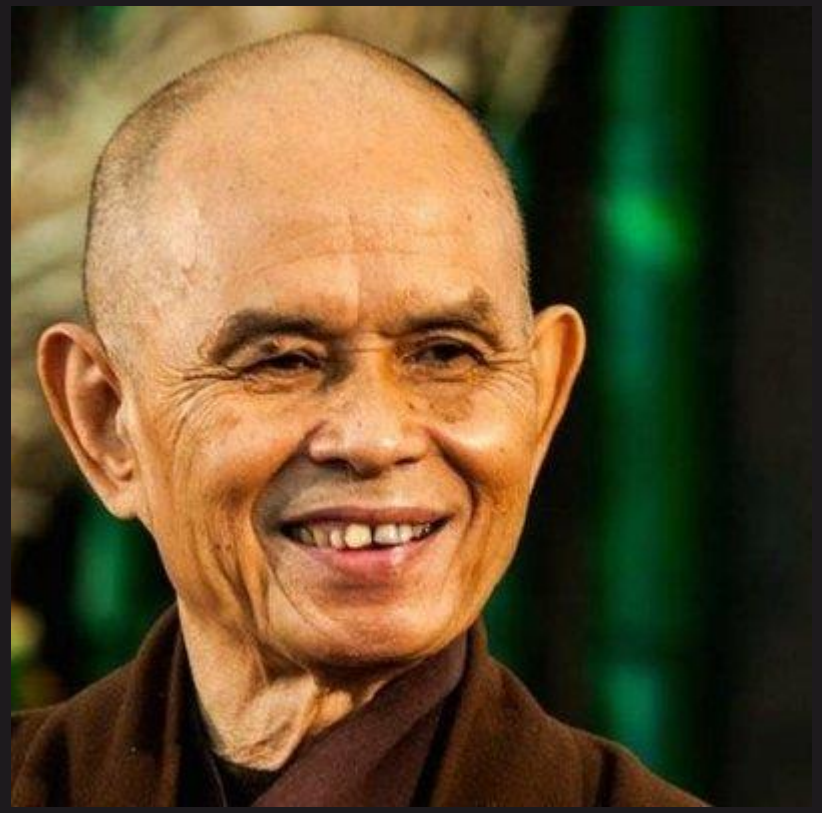
- A Recent study indicated exposure to SSRIs near time of delivery may be associated with poor perinatal outcomes. Recommendations were made to taper off medications toward the end of the 3rd trimester. Follow up study disproved this, no change in neonatal outcomes with this recommendation.
- Persistent Pulmonary Hypertension of the Newborn (PPHN) – Original 2006 report showed a 6-fold increase in PPHN with antidepressant exposure (still less than 1% overall). 4 follow up studies have shown no such association.
- Behavioral Changes – Several cohort studies showing no significant differences in IQ, temperament, behavior, reactivity, mood, distractibility, or activity level between exposed and non-exposed children followed up to 7 years of age.

Suicidality

- Ideations vs. Intent vs. Plan
- Perturbation + Lethality
- Black Box warning for antidepressants

Anxiety / Neurosis

- Anxiety, the illness of our time, comes from our inability to dwell in the present moment.
  - Thich Nhat Hanh



Anxiety Disorders

- Generalized Anxiety Disorder
- Obsessive Compulsive Disorder
- Simple Phobias
- Panic Disorder
- PTSD
- Social Anxiety Disorder

The Basics

- Often have an early onset- teens or early twenties
- Show 2:1 female predominance
- Have a waxing and waning course over lifetime
- Similar to major depression and chronic diseases such as diabetes in functional impairment and decreased quality of life

Patient Education

- Normal anxiety is adaptive. It is an inborn response to threat and can result in cognitive (worry) and somatic (racing heart, sweating, shaking, freezing, etc) symptoms.
- Pathologic anxiety is anxiety that is excessive, impairs function.

How our patients experience Anxiety

Comparison of % Time With Symptoms

- High--|----------|----------|----------|--Low
  GAD PTSD/OCD Panic Disorder SAD

Treatment

- Traditional Antidepressants/SSRIs are our first line of treatment
- Start at ½ the usual dose used for antidepressant benefit i.e Escitalopram (Lexapro) at 2.5mg rather than the usual 5mg
- ***Warn them that their anxiety may paradoxically get worse before it gets better. (NorEpi pathway)

Other Treatment Options

- Buspirone (Buspar) – FDA approved for anxiety. Best in treatment naïve. Start at 5mg BID and can move to 10mg TID fairly quickly.
- Gabapentin – Off-label use, lots of community support. Can be started at 100mg TID and then advanced as needed. Most of my patients take 300mg 1-2 times daily.
- Propranolol – Excellent for discrete social phobias / performance anxiety (musicians, public presentations, meetings with supervisors etc)
- Hydroxyzine (Vistaril/Atarax) – prn use

#30 for 30 days

Herbal Supplements

- Melatonin / Valerian for Sleep
- GABA for anxiety
- SAM-e for Mood
- Rhodiola for anxiety/inattention
- Omega FA for cognition/inattention (EPA>DHA)

Resources

- WomensMentalHealth.org (Physicians) + PostPartumProgress.Com (Patients)
- NAMI
- *211
- CALM app / HEADSPACE / BREATHE2RELAX
- WWW.ADAA.ORG – Anxiety & Depression Assoc. of America

Reference Table for Child/Adol Prescribing

Table 1 SELECTIVE SEROTONIN REUPTAKE INHIBITORS

Medication	FDA Approval Status	Starting Daily Dose	Usual Effective Daily Dose	Maximum Daily Recommended Dose
citalopram	not approved for children or adolescents	5-10 mg	20-40 mg/d	60 mg/d
escitalopram	major depression-12 years & up	2.5-5 mg/d	5-20 mg/d	30 mg/d
fluoxetine	depression-8 years & up, OCD-7 years & up	5-10 mg/d	10-40 mg/d	60 mg/d
fluvoxamine	OCD-8 years & up	25-50 mg/d	50-200 mg/d	300 mg/d
paroxetine	not approved for children or adolescents	5-10 mg/d	10-40 mg/d	60 mg/d
sertraline	OCD-6 years & up	12.5-25 mg/d	25-100 mg/d	200 mg/d