Beyond just "Feeling Blue": Diagnosing and Treating

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Disclosures

- I have no relevant relationships with ineligible companies to disclose within the past 24 months.

Educational Objectives

- **Purpose**:
- The purpose of this talk is to provide tools to increase primary care clinician's confidence in diagnosing and treating depression. We will provide an opportunity to use a framework called AMPS (A: Anxiety disorders, M: Mood disorders, P: Psychotic disorders, S: Substance use disorders) and how to provide initial psychiatric assessment in the primary care setting.

- **At the conclusion of this session, participants should be able to:**
- – Recognize depression in the primary care setting
- – Effectively screen for depression in a primary care setting.
- – Implement evidence-based treatment for depression
- – Review the common management issues

~75%	• Patients seek help with depression do so with their PCP
Only 1/3	• internal medicine residents were comfortable in treating major depressive (JAMA 2002)
50%	• patients with mental health referrals did NOT follow up with referral (reasons include stigma, poverty, language barriers, financial constraints, transportation) 3
Less than half	• of primary care patients with mental illness receive any treatment
50-70%	• is not accurately diagnosed or treated in the primary setting
More than half	• of primary care patients on antidepressants do not meet criteria for MDD

"Looks like it could be depression."

References: CDC (2013) Burden of Mental Illness.
Psychosomatics 41:5 Sept 2000
Psychiatric Services Jan, 2006
WJM Jan 1999; 170, No.1
Psychosomatics 41:5 Sept 2000
Psychiatric Services Jan 2006
JAMA 2002

Case #1

26 y/o M with hx of "social drinking"

Brought in by his friend to the primary care clinic with concerns of the following symptoms for 2 months

- "sadness"
- "restlessness"
- "bad thoughts"
- "fast thoughts"
- Insomnia
- Headaches

- **History…**
- Problems with "depression" in the past with no past psychiatric admission
- No past treatment for mental illness
- Labs
  - CMP, CBC and TSH all wnl

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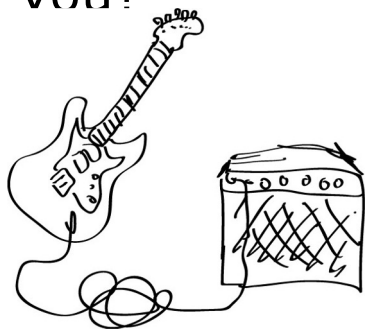
Screening– Primary Care Psychiatry

- **How can you organize your questions to help determine likely mental health diagnosis/diagnoses?**

- A. Ask about Sleep, Depression, Anhedonia and Physical Activity
- B. Ask about Anxiety, Mood, Psychosis and Substance Use
- C. Ask about Anxiety, Physical Activity, Substance Use and Suicide Risk
- D. Ask about Substance Use, Sleep, Anhedonia and Mania

Break it down with AMPS

- ***A**nxiety* – is anxiety or nervousness a problem for you?
  - GAD7
- ***M**ood* –
  - PHQ2 and PHQ9
  - Mood Questionnaire (MDQ)
- ***P**sychosis* – r/o A/VH, delusions
- ***S**ubstances* – quantify ETOH use, ask about MJ, cocaine, methamphetamine, heroin, PCP, LSD, ecstasy and other



AMPS

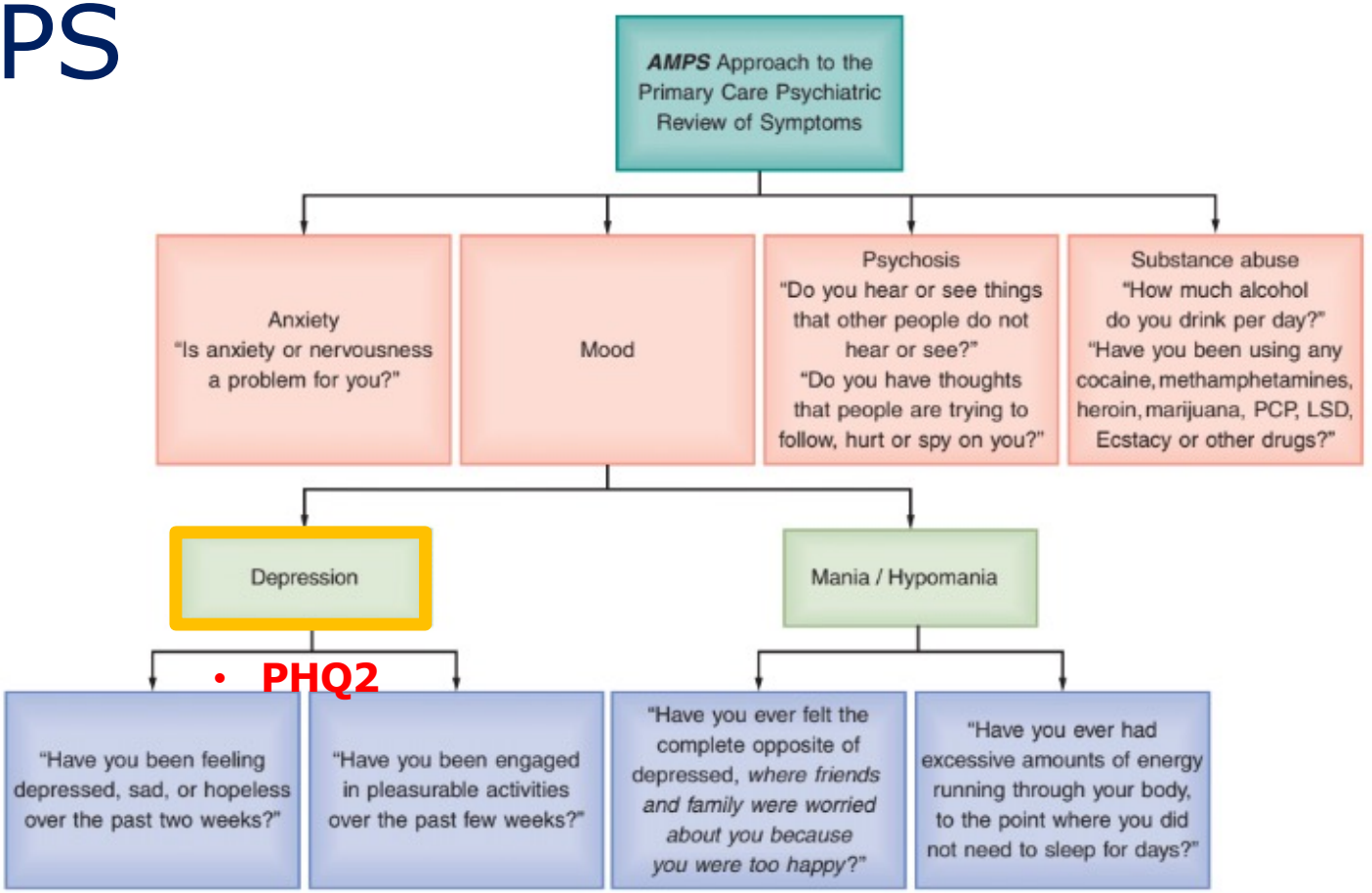


Figure 1.1 Psychiatric review of systems: AMPS screening tool.

Case #2

26-year-old man seen in the emergency department acknowledges persistent substance use until about the last 2 days, when he was evicted from his apartment. Which cluster of symptoms is typical stimulant withdrawal?

- A. Depression, fatigue, insomnia
- B. Diarrhea, nausea, anxiety
- C. Hypertension, tachycardia, seizures
- D. Vivid dreaming, nightmares, confusion

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Weiss, L., &Louie, A. (Eds.). (2015). *Study Guide to DSM-5*. American Psychiatric Publishing

Substance misuse

AMPS
Primary care psychiatric history

Substance misuse
"Do you smoke cigarettes (yes/no)"
"How much alcohol do you use per day?"
"Have you ever used cocaine, methamphetamines, heroin, marijuana, PCP, LSD, non-prescribed pain medications or other drugs? (yes/no)"

2021

Alcohol

45.1%

Alcohol Use in the Past Month, binge drinking

- **Naltrexone**
- **Acamprosate**
- **Disulfiram**

Marijuana

13%

Marijuana in the past month

no FDA-approved medications

Opioid

3.3%

Misused opioids (heroin or prescription pain relievers) in the past year *

- **Buprenorphine**
- **Methadone**
- **Naltrexone**

Cocaine & Amphetamine (Stimulant)

1.7%

Misused prescription stimulants in the past year *

no FDA-approved medications

Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. (Jan 4, 2023). *SAMHSA.* Retrieved Feb 26, 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf

After making the Diagnosis:

- Brief Intervention **= TRUTH ENCOUNTER**
  - Tell the patient your diagnosis.
  - Record the diagnosis in the medical record.
- Referral to Treatment
  - Decide whether or not you are comfortable treating the problem.
  - Consider requesting a consultation- formal or informal (formal is better)
  - If formal consultation is requested- tell the patient. Ask what (s)he would be willing to do to address the problem.
  - Remember 211

Case #3

A 56-year-old biologist has had a very successful career, publishing extensive research on the aging process. Now he believes he has found the key to eternal life. For he past several months, he has been quiet secretive and refuses to come to work group meetings regarding upcoming projects. H has installed a dead bolt on his office at home and insists that extra security personnel be hired to guard his research lab. He refuses to present his material or discuss it with his colleagues or family, claiming the knowledge is too powerful to be made public. He is not having any visual or auditory hallucinations, and he is able to support his statements with logical arguments. He has a history of depression. What is the likely diagnoses?

- A. Cocaine intoxication, without perceptual disturbances.
- B. Delusional disorder, grandiose type.
- C. Major depressive disorder with psychotic features.
- D. Schizophrenia.

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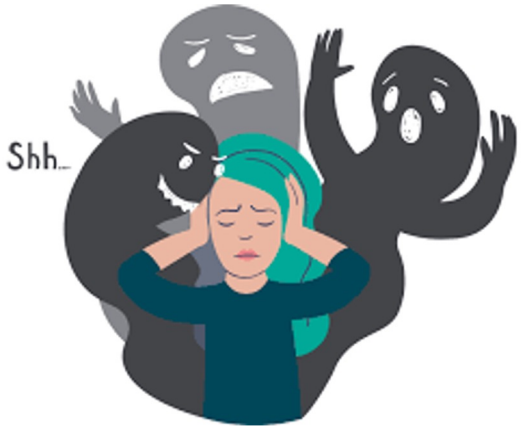
Psychosis

AMPS
Primary care psychiatric history

Psychosis
"Do you hear or see things that other people do not hear or see?"
"Do you have thoughts that people are trying to follow, hurt, or spy on you?"



Hallucinations, Delusions, Bizarre Delusions, Thought Disorder, Bizarre Behaviors

R/O Brief Psychotic disorder, Schizophreniform Disorder, Psychotic disorder NOS, Medication induced psychosis, Medical conditions (TBI, seizure, CNS infections), Delusional Disorder, **Bipolar**, **PTSD**, **BPD**, **Dissociative disorders**, Substance intoxication/withdrawal, Malingering, **MDD with psychosis**

If Schizophrenia:

Flat affect, Motivation, Alogia, Anhedonia, Asociality

1st line SGA

Case #4

A woman brings her 32-year-old husband to a psychiatrist for “unusual behavior.” She says that for the past 5 days he has been cleaning the house extensively, often late into the night. He wakes up 2 hours earlier than usual the next morning but does not appear tired. He says he feels “very happy and productive—the best I have ever been!” His wife denies any dangerous behaviors at home and reports he is able to continue working at his current job, albeit more productively than before. She recalls that 6 months ago, he seemed very depressed, with loss of interest, poor sleep, low energy, and impaired concentration that lasted 1 month. The patient has not been hospitalized previously. On interview, he is pleasant and cooperative. His speech is pressured but redirectable. His thought process is linear, and he denies any hallucinations. His urine toxicology screen is negative. What is the likely diagnosis?

- A. Bipolar I disorder.
- B. Bipolar II disorder
- C. Schizophrenia.
- D. Substance/ medication-induced bipolar and related disorder.

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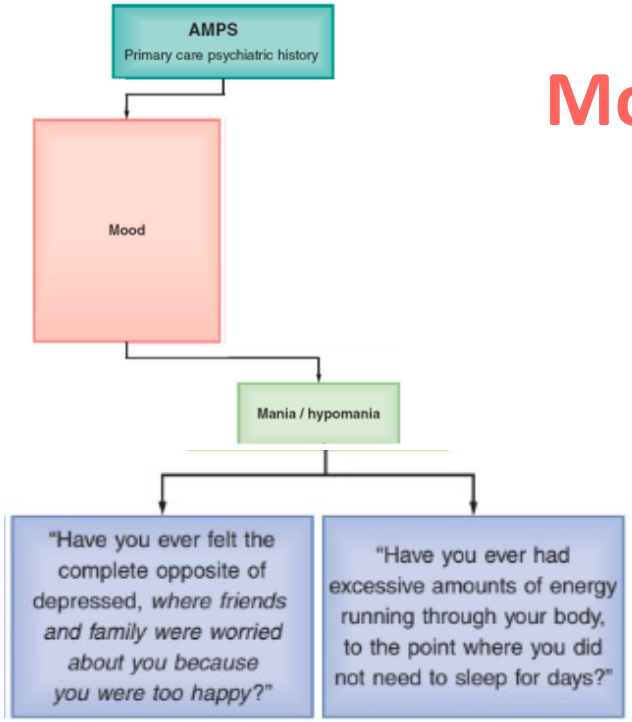
Weiss, L., &Louie, A. (Eds.). (2015). *Study Guide to DSM-5.* American Psychiatric Publishing



Mood → Mania / Hypomania

↑ *Mood*
Distracted
Impulsive (4)
Grandiose
Flight of Ideas
Activity ↑ (3)
Sleep ↓
Talking ↑

Follow up Questions

- **How long did these symptoms last?**

- **During these periods…**
  - did you feel like your thoughts were going really fast and it was hard to focus?
  - did you ever make impulsive decisions that you regretted later?
  - did your behaviors get you in trouble at work, at home or with the law, or cause you to end up in the hospital?

DX TIPS

Manic Episode

- **Distinct period-** abnormally
  - Expansive
  - Irritable
  - Elevated (euphoric)
- **Duration** of 1 week, hospitalization, or +psychotic features
- ≧ **3** specific sx present
- **4** sx if only an irritable mood

Hypomanic Episode

- **Distinct period- abnormally**
  - Expansive
  - Irritable
  - Elevated (euphoric)
- **Duration** of at least 4 consecutive days
- ≧ **3** specific sx present
- **4** sx if only an irritable mood

Case #5

A 22-year-old college student presents to a mental health clinic for an initial visit. She has not turned in any of her papers on time this term because she worries about getting poor grades, and this worry has affected her ability to concentrate. She is also very concerned about getting a job after she graduates, despite multiple meetings with a career counselor. She says that she is concerned with the sanitation at the local gym and prefers not to play recreational sports because she might be injured. She does not have any rituals or checking behaviors. She described her mood as "irritable" and says that she feels "tense all the time." Her appetite has not changed, and she continues to enjoy watching movies. She denies low energy and has not had any thoughts of harming herself. She tried cocaine last year but has not used any illicit substances or alcohol recently. What is the likely diagnosis?

- A. Adjustment disorder.
- B. Generalized anxiety disorder.
- C. Major depressive disorder.
- D. Obsessive-compulsive disorder.

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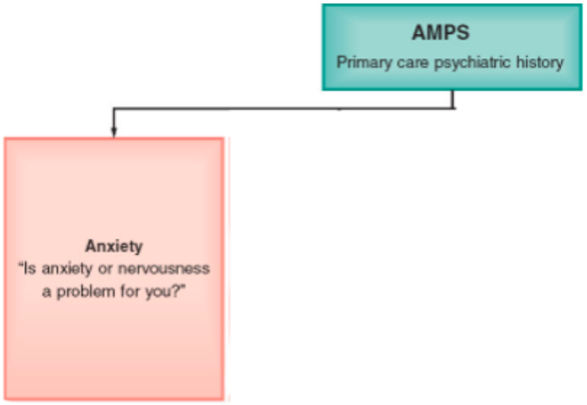
Weiss, L., &Louie, A. (Eds.). (2015). *Study Guide to DSM-5.* American Psychiatric Publishing



Anxiety

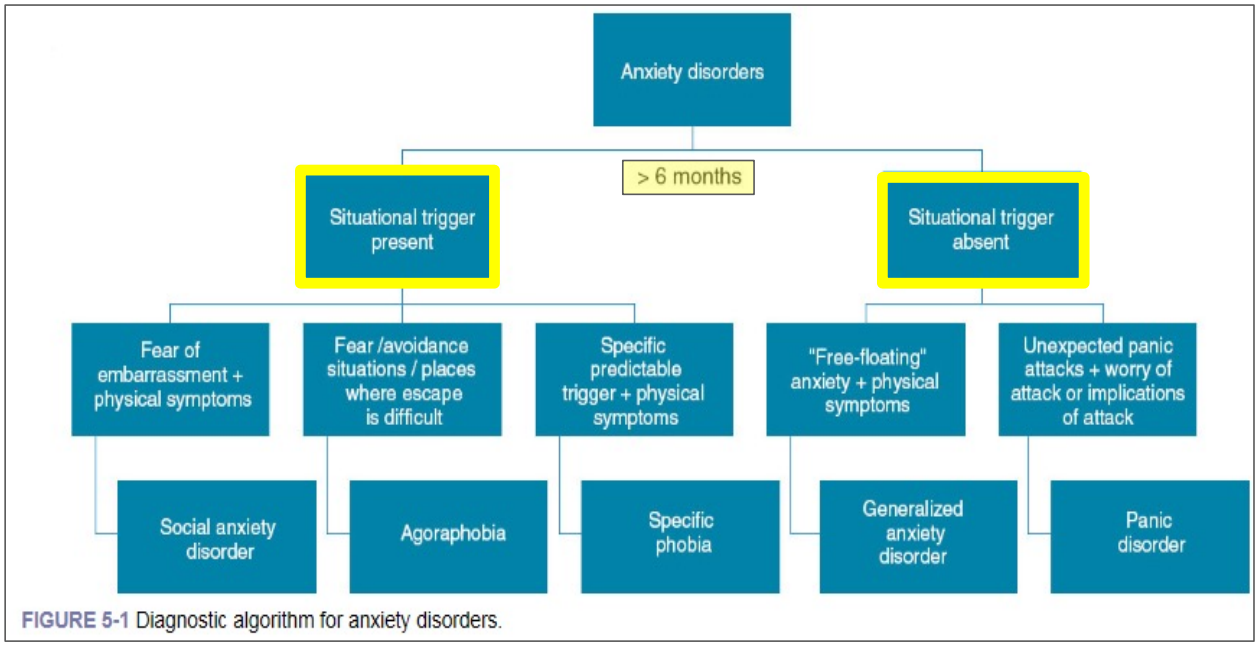


FIGURE 5-1 Diagnostic algorithm for anxiety disorders.

Follow up Questions

- "Please describe how your anxiety affects you on an everyday basis."
- "What makes your anxiety get better?"
- "What triggers your anxiety?"

McCarron, R., Xiong, G.L., Rivelli, S., Muskin, P.R., Summergrad, P, & Suo, S. (Eds.). (2019). *Primary Care Psychiatry*. Wolters Kluwer.

Do I have to differentiate before starting treatment??

Pearl

- Anxiety Disorder Unspecified (F41.9)
  - Reasonable Provisional Diagnosis
- Initial management largely the same!!

1st line TREATMENT OPTIONS across ANXIETY DISORDERS

	SSRI	CBT	CBT + SSRI ∓ If acute
PD	++	++	+
GAD	++	++	+/-
SAD	++	++	+/-
PTSD	++	++	+/-
OCD	++	++*	+

++ Good evidence
\+ Limited evidence
+/- Inadequate/Mixed Evidence
\- No evidence

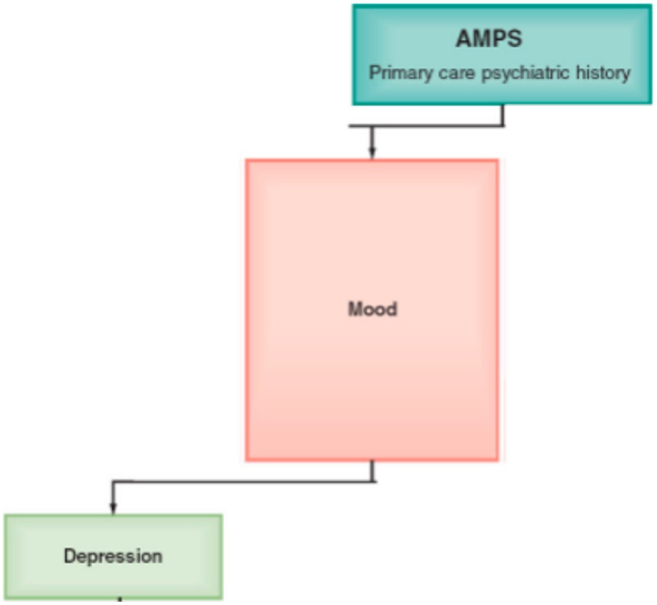
* Exposure Response Prevention
∓ Additional combined benefit

Lippincott 2009

PD = panic disorder
GAD = generalized anxiety disorder
SAD = social anxiety disorder
PTSD = post traumatic stress disorder
OCD = obsessive compulsive disorder
SSRI = selective serotonin reuptake inhibitor
CBT = cognitive behavioral therapy

McCarron, R., Xiong, G.L., & Bourgeois, J. (Eds.). (2009). *Lippincott's Primary Care Psychiatry*. Wolters Kluwer.

Depression



Mood → Depression

- **PHQ2** "Have you been depressed or sad over the past 2 weeks?"
  AND
  "Are there things you like to do for fun and have not been interested in doing over the past 2 weeks?"

If yes to either question

"How does your depressed mood, sadness, or low interest level affect your everyday life?"

Criteria for Major Depression:
Five or more symptoms have been present for two weeks and represent a change from previous functioning.
At least one of the symptoms is either **depressed mood** or **loss of interest or pleasure**

- **PHQ9**

While depressed or experiencing decreased interest or pleasure:
"Have you had any problems with your sleep?"
"Have you had any changes in your appetite and have you gained or lost any weight?"
"Have you noticed any changes with your energy or ability to focus and concentrate?"
"Have your family or friends mentioned that you have been moving or speaking slower than usual?"
"Have you been having guilty thoughts running through your head that bother you or keep you up at night?"
"Do you have thoughts or plans of hurting or killing yourself or anyone else?"
"Do you have any firearms at home or at your workplace?"

Follow up Questions

- How are things at home/work?
- What is the "#1 biggest problem?
  What happens to <complaint> when <primary stress>occurs?

DEPRESSION DIAGNOSIS

- ***S*** leep - (too much or too little)
- ***I*** nterest – (diminished)
- ***G*** uilt – (feelings of worthlessness)

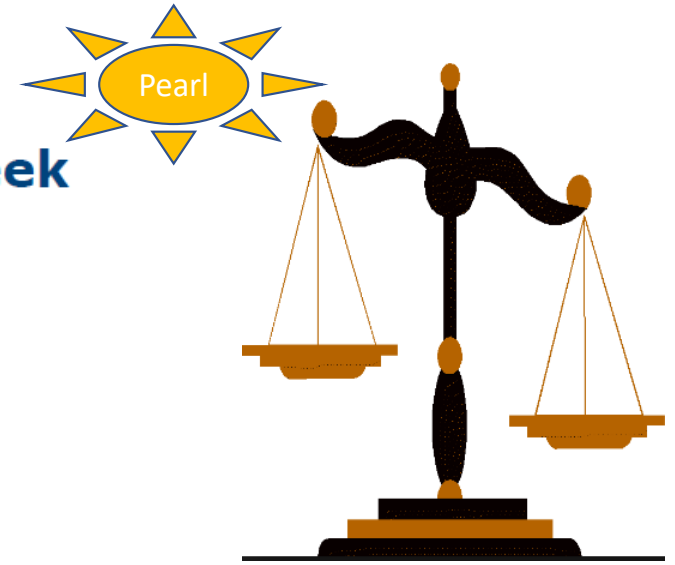
- ***E*** nergy – (loss of energy)

- ***C*** oncentration – (indecisive)
- ***A*** ppetite – (↑ or ↓ with 5% change over one month)
- ***P*** sychomotor retardation or agitation (observed by others)
- ***S*** uicide – (recurrent thoughts of death)

Antidepressant Use

EFFICACY: All antidepressants are considered to be equally effective when starting out

- **First line for depression is SSRI or bupropion** (if low anxiety)
  - Tolerable and safe
- **Second line is usually SNRI**
  - Less tolerable



SIDE EFFECTS: usually worst in 1st week

- Feeling stimulated or sedated
- Upset stomach
- Dry mouth
- Headache
- Sexual difficulties

Medications & Abbreviations

For Depression

SSRI = selective serotonin reuptake inhibitor

Citalopram = Celexa
Escitalopram = Lexapro♡
Fluoxetine = Prozac ♡
Sertraline = Zoloft
Fluvoxamine = Luvox
Paroxetine = Paxil

Key - FDA Approved	
♡	Pediatric Depression
red	Adults (FDA approved)

SNRI = Serotonin and norepinephrine reuptake

Duloxetine = Cymbalta
Venlafaxine = Effexor
Desvenlafaxine = Pristiq

NDRI = Norepinephrine dopamine reuptake inhibitor

Bupropion = Wellbutrin

SPARI = serotonin partial agonist reuptake inhibitor

Vilazodone = Viibryd

Multimodal antidepressant

Vortioxetine = Brintellix

Anxiolytic /Non-benzodiazepines

Buspirone = BuSpar (adjunct)

TCA = Tricyclic Antidepressant

Amitriptyline = Elavil
Clomipramine = Anafranil
Doxepin = Silenor
Imipramine = Tofranil
Nortriptyline = Pamelor

NaSSA = noradrenaline and specific serotonergic agent

(tetracyclic antidepressant)
Mirtazapine = Remeron

SARI = serotonin 2 antagonist /reuptake inhibitor

Nefazodone = Dutonin

Serotonin Modulator

Trazodone

AAP = atypical antipsychotics

SGA = second generation antipsychotics
Aripiprazole = abilify (adjunct)
Quetiapine = Seroquel (adjunct) * XR
Lurasidone = Latuda (adjunct)

COMMON MANAGEMENT TIPS

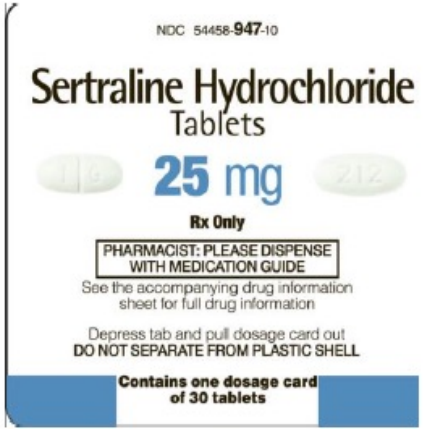
- Steps
  - **Start med** based on BMI, past success and failures
  - **Consider** medical comorbidities
  - **Increase** at 7 days then q 4 weeks to effect & augment partial effect near max
  - **Treat** for 6 – 12 months for 1st-2nd episode (of depression) then taper OR treat lifelong if ≧ 3

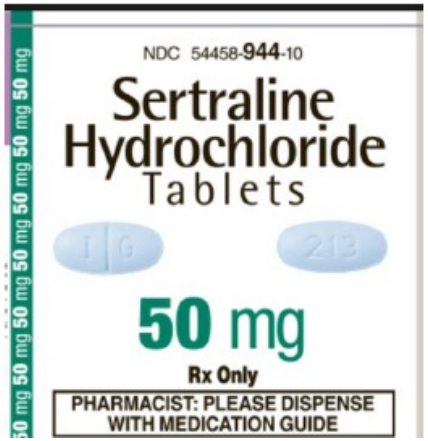
- In Medically Ill Patients:
  - **Sertraline, Citalopram, Escitalopram** – little to no DDIs, well tolerated
  - **Rarely** use Paroxetine in medically ill (highly anticholinergic, very sedating, many DDIs, short half-life)
  - **Fluoxetine** (very long half life) – good for intermittent compliance Significant DDIs.
  - SNRI such as **duloxetine and venlafaxine** – monitor BP

Starting Sertraline . . .

- For depression, start 50 mg daily
- If + anxiety, at **most** start 25 mg daily x 1 + weeks then 50 mg daily
- If ↑ anxiety, consider 12.5 mg daily x1 week, then 25 mg daily x 1 week then 50 mg daily

Pearl





Case #6

… 56-year-old perimenopausal patient with a history of depression. Her depressed mood seems to be responding to her current treatment with selective serotonin reuptake inhibitor (SSRI) fluoxetine (40 mg/day); however, she is troubled by hot flashes and night sweats, and she reports some residual depressed mood. Which treatment strategy is likely to optimize this patient's chance for remission?

- A. Maintain current fluoxetine dose
- B. Decrease fluoxetine dose
- C. Switch to a different selective serotonin reuptake inhibitor (SSRI)
- D. Switch to a serotonin and norepinephrine reuptake inhibitor (SNRI)

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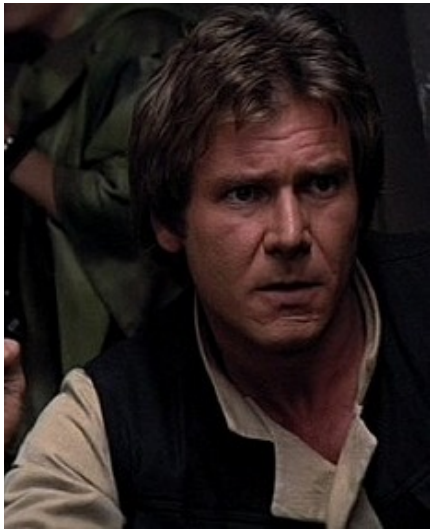
Stahl, A. (2016). *Stahl's Self-Assessment Examination in Psychiatry: Multiple Choice Questions for Clinicians, 2nd edition*. Cambridge University Press.

Case #7

36-year-old patient has only partially responded to his second monotherapy with a first-line antidepressant. Which of the following has the best evidence of efficacy for augmenting anti-depressants in patients with inadequate response?

- A. Adding an atypical antipsychotic
- B. Adding buspirone
- C. Adding a stimulant



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Stahl, A. (2016). *Stahl's Self-Assessment Examination in Psychiatry: Multiple Choice Questions for Clinicians, 2nd edition*. Cambridge University Press.

Case #8

…42-year-old patient with untreated depression. She is reluctant to begin antidepressant treatment due to concerns about treatment-induced weight gain. Which of the following antidepressant treatment is associated with greatest risk of weight gain?

- A. Escitalopram
- B. Fluoxetine
- C. Mirtazapine
- D. Vilazodone

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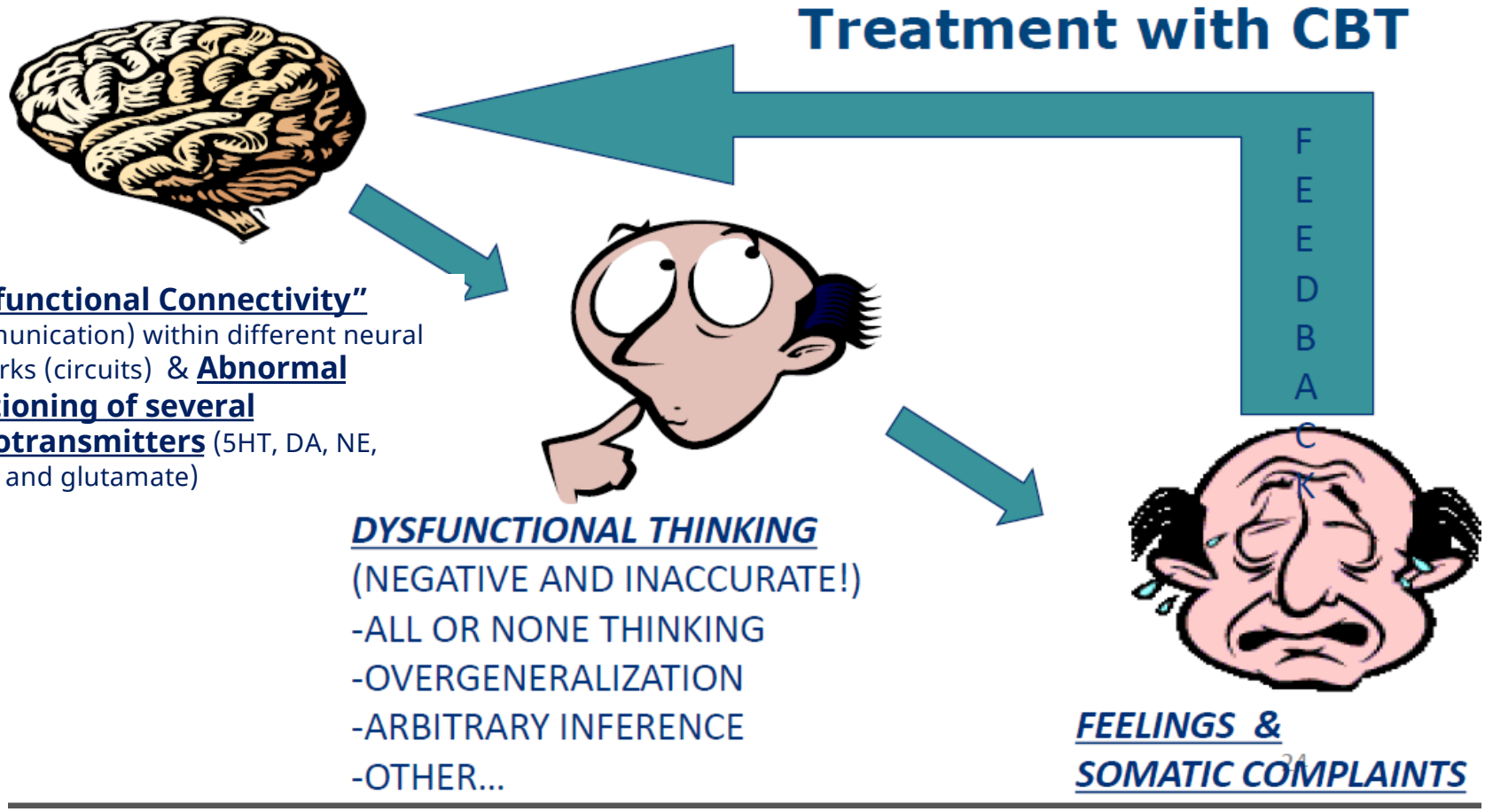
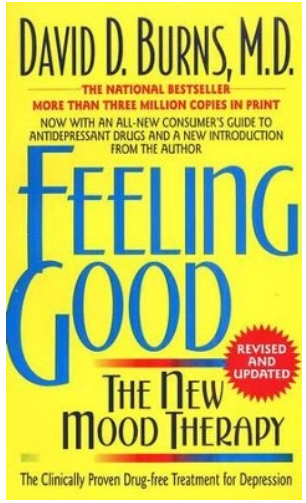
Stahl, A. (2016). *Stahl's Self-Assessment Examination in Psychiatry: Multiple Choice Questions for Clinicians, 2nd edition*. Cambridge University Press.


Treatment with CBT
FEEDBACK
"Dysfunctional Connectivity" (communication) within different neural networks (circuits) & Abnormal functioning of several neurotransmitters (5HT, DA, NE, GABA, and glutamate)
DYSFUNCTIONAL THINKING
(NEGATIVE AND INACCURATE!)
-ALL OR NONE THINKING
-OVERGENERALIZATION
-ARBITRARY INFERENCE
-OTHER...
FEELINGS & SOMATIC COMPLAINTS

The Three R's...for the patient

- **RECOGNIZE** automatic and negative thoughts
- **RECONSTRUCT** to more realistic thoughts
- **REPEAT** indefinitely!!



Introduction to Thought Record

Emotions	Automatic Thoughts	Rational Response	Outcome
Rate feelings 1-10 (where 10 is most intense)	"What is running through your head" (Not an emotion or feeling)	Why is the automatic thought inaccurate (Be specific)?	Rate your feeling again on a scale of 1-10
"Sad" 8/10	"My pain will *never* go away."	"Not true – I am working hard with my doctor so my pain will get better over time." "Never is a strong word to use."	"Sad" 5/10

McCarron, R., Xiong, G.L., & Bourgeois, J. (Eds.). (2009). *Lippincott's Primary Care Psychiatry*. Wolters Kluwer.

Strategies for Regulating the Toxic Stress Response

Build or maintain Social connections
Healthy family supports

Facilitating connection to resources for treatment AND resources

Self care

Source: Adapted from Burke Harris, Nadine. *The Deepest Well: Healing the Long-Term Effects of Childhood Adversity*. Boston: Houghton Mifflin Harcourt, 2018; Gilgoff et al. Adverse Childhood Experiences, outcomes, and interventions. *Pediatric Clinics* 2020; **67**(2): 259-73;

As found in The Science of ACES and toxic stress, Dr. Nadine Burke Harris June 2021. The Science of ACEs and Toxic Stress (Part 1) (acesaware.org)

AMPS:

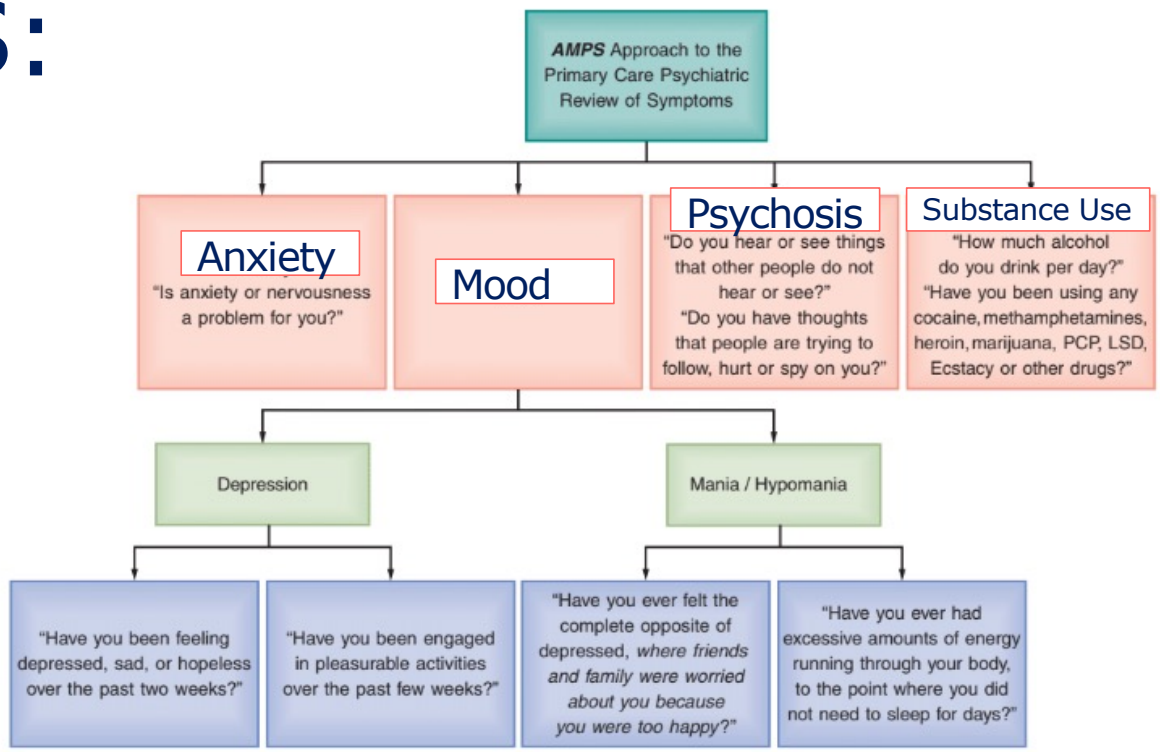
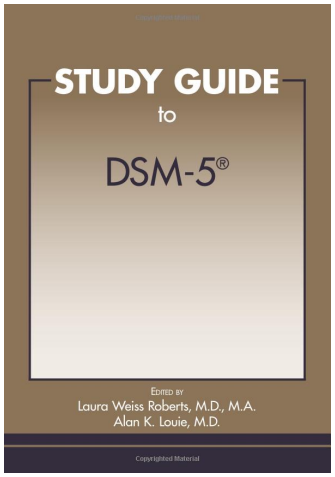
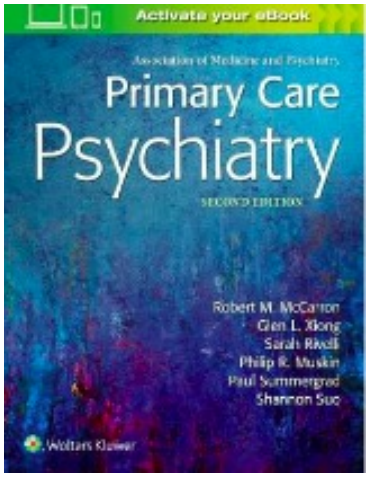
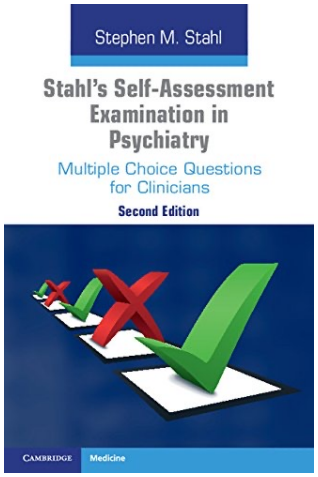
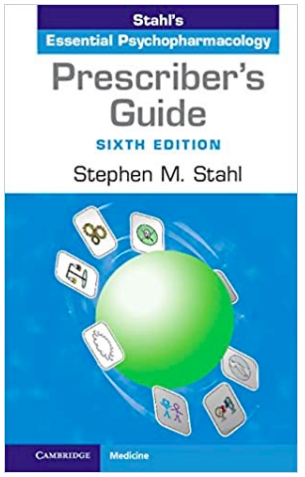


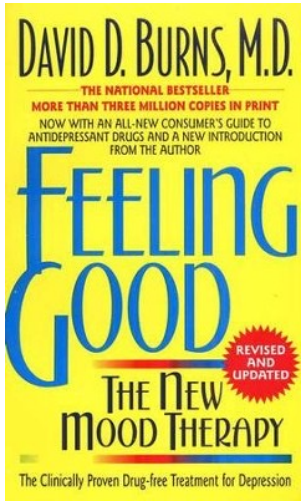
Figure 1.1 Psychiatric review of systems: AMPS screening tool.

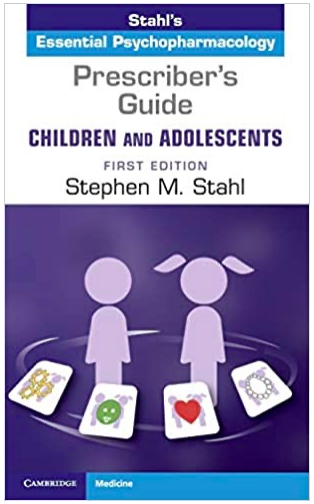












Books

- Lippincott's Primary Care Psychiatry
- Study Guide to DSM-5
- Stahl's Self-Assessment Examination in Psychiatry: Multiple Choice Questions for Clinicians
- Prescriber's Guide – Children and Adolescents
- Prescriber's Guide: Stahl's Essential Psychopharmacology
- Feeling Good: The New Mood Therapy by Dr. David Burns

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