Western Headicine

Diagnosis and Management of Core Psychiatric Complaints

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Disclosures

- *I have no relevant relationships with ineligible companies to disclose within the past 24 months. (Note: Ineligible companies are defined as those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.)*

Educational Objectives

- **At the conclusion of this session, participants should be able to:**

•Describe symptoms and treatment of Major Depressive D/O (and also review background pathophysiology, etiology and epidemiology)

•Describe Generalized Anxiety Disorder (GAD) and differentiate this from Panic Disorder and Obsessive-Compulsive Disorder (OCD)

•Discuss first line psychopharmacology to treat MDD, GAD, OCD, and PTSD.

Overview

Today our real objective is to address a few common Mental Health conditions that can be very difficult to discuss[1] in every sense.

We want to bolster recognition of these conditions, help you understand treatments so you can confidently counsel your patients, and ultimately work to reduce the suffering these conditions cause.

We'll also talk about how the fundamental challenges of managing treatment expectations, to help the patients and the providers persist in their pursuit of wellness.

We *won't* be focusing on suicide, or r/t screening or preventive steps[2]

Major Depressive Disorder

A condition of multi-symptom clinical depression[3] as codified by The American Psychiatric Assoc'n and adopted into DSM in 1980.

- **"Depression" is truly defined by its symptoms, but especially in a Primary Care setting, it is important to recognize that initial presentation can be – and frequently is – deceptive! Patients will often discuss their symptoms in terms of somatic complaints before they register emotional complaints. They may guard and minimize the severity of their emotional distress, at times unconsciously. Depression cannot accurately be diagnosed on sight! Diagnosis requires openness, candor, and investigation. I really think it is easiest to begin with discussing symptoms first, and then additional facts about the condition.**

•DSM 5 Criteria

For 2+ weeks patient has (A) DEPRESSED MOOD (low, sad, unhappy [in children + adolescents can be irritability]) and/or ANHEDONIA (diminished interest of loss of enjoyment in most/all activities) as part of (B) a total of at least 5 of the following symptoms:

C oncentration difficulties
G uilt or feeling worthless
A ppetite abnormality/wt change
S leep disturbance
P sychomotor change
D eath or suicide (thoughts or acts toward)
I nterest (diminished)
E nergy (loss)

Mnemonic: C GASP DIE (updates SIGECAPS)[4]

Major Depressive Disorder

SYMPTOMS, C GASP DIE, Cont'd.

•**C Concentration Difficulties:** pts subjectively report trouble focusing, making decisions, remembering things, being more inattentive, distracted, or having a 'foggy' mind. They feel more blank and less present.

•**G Guilty (feeling worthless):** pts describe or experience excessive or inappropriate guilt, ruminating over past failures or mistakes. They might also feel a pervasive sense of worthlessness or a belief that they are a burden to others (the world would be better off without me; I'm not worth being cared about

•**A Appetite change *or* weight gain:** pts report subjective disinterest in food, but sometimes, overly interested in unhealthy 'rewarding' foods, i.e. eating their feelings. In depression it is difficult to manifest physical & emotional energy to care for the self, so the preparation of nourishing food is harder than not eating much or reaching for junk[5]

•**S Sleep Disturbance:** among the most common complaints in depression. Can manifest as insomnia (difficulty falling or staying asleep) or hypersomnia (excessive sleep). These disturbances are not just occasional but are persistent and affect daily functioning and tend to exacerbate other sxs of depression.

•**P Psychomotor Change:** alterations in activity influenced by mental processes. **Psychomotor Agitation** includes symptoms like restlessness, pacing, hand-wringing, pulling or rubbing of the skin, clothes, or other objects. **Psychomotor Retardation** involves a slowing of thoughts and reduction of physical movements. Patients may speak slowly, have delayed (and laconic, monotonous) verbal responses, decreased eye contact, and reduced body language. NOTE: this symptom is less commonly reported by pts but is observed by the clinician or close contacts.

Major Depressive Disorder

SYMPTOMS, "DIE" Cont'd.

•**D Death (thoughts thereof, or acts toward):** like many symptoms exist on a continuum, extending from the feeling of worthlessness found in guilt and a desire that one perhaps had never been born; to a sense of relief when contemplating an end to emotional pain through accidental death, or suicide. That urge to reduce emotional pain can lead to SIB, Self-Injury Behavior such as cutting or burning; or to thoughts or plans to harm the self. [It is also part of the motive to escape from or numb emotional pain through self-medicating – so on encountering this symptom, make a note to screen for self-medicating!]

"Death" is the most serious symptom of depression and warrants immediate clinical attention and thorough documentation. Indicates a high level of psychological distress and risk. That said, there is often correlation between depression duration and suicide risk – best examined elsewhere.

•**I Interest (diminished), AKA Anhedonia, "the absence of joy."** a loss of interest or pleasure in all (or almost all) activities. Activities **and relationships** that were once enjoyable become unappealing, avoided. Anhedonia can lead to social withdrawal, exacerbate feelings of isolation.

•**E Energy change:** pts may report fatigue unrelieved by rest, a persistent sense of tiredness or weakness; the emotional and physical complement to concentration difficulties. Unlike psychomotor changes this *is* typically reported by the patient. They may describe feeling physically drained, having no motivation, or ordinary tasks consuming inappropriate effort. For example, doing the dishes, tending to laundry, completing homework, going to work, all begins to feel overwhelming. [In my experience , sudden change in toothbrushing is a sign.]

How’s everyone feeling?

Next: MDD Etiology + Pathophysiology, then Case Studies!

Major Depressive Disorder

Pathophysiology

Neurotransmitter Dysregulation: MDD has been closely linked to imbalances in neurotransmitters, particularly serotonin, norepinephrine, and dopamine, all of which are involved in mood regulation and cognitive functions.

Hypothalamic-Pituitary-Adrenal (HPA) Axis Dysregulation: Chronic stress can lead to dysregulation of the HPA axis, resulting in elevated cortisol levels which have been associated w/ development of depressive symptoms.

Neuroplasticity and Brain Structure Changes: Studies have shown that individuals with MDD often exhibit changes in brain structure and function, particularly in areas like the prefrontal cortex and hippocampus. Reduced neuroplasticity, which affects the brain's ability to adapt and form new connections, is also observed.

Inflammatory Processes: Emerging research suggests a role for inflammation and the immune system (and enteric nervous system, mind-gut connection) in the pathogenesis of depression. Elevated levels of pro-inflammatory cytokines have been noted in some individuals with MDD, and are the basis for investigatory laboratory tests for depression. (Not something I use myself – I've no idea if that's available now).

Major Depressive Disorder

Etiology

Bad news: still don't really know. Good news: we're less ignorant than ages past.

1.Genetic Factors: Strong evidence suggests a genetic component to MDD. Twin studies of MDD have concordance of 40-50%. First-degree relatives of depressed individuals are about 3 times as likely to develop depression as the Gen Pop [5].
Two susceptibility loci have been ID'd, one linked to MDD in males, one to early onset depression[6] [7]
Takeaway: Family Hx of major mood conditions is important, even if pt hx/recall is fuzzy re: diagnoses of family members.

2.Environmental and Psychosocial Factors: Life events such as trauma, loss of a loved one, chronic stress, and social isolation are significant risk factors. The interaction between these factors and genetics is implicated in MDD, with good data re: genes involved in the production of serotonin (TPH2 gene); and the Serotonin Transporter (the 5-HT transporter). Individuals that are homozygous or heterozygous for the short allele version of the SLC6A4 gene have ⇧ lifetime incidence of depressive episodes and suicide risk *associated with stressful events*.[8]

3.Neuroendocrine Factors: Changes in neuroendocrine systems, especially those involving the thyroid and sex hormones, have been implicated in the development of depression. This partially accounts for the greater OR for lifetime incidence of depression in XX vs XY individuals.[9]

4. Biopsychosocial Model (Developmental, ACE): significant research underscores that stress, trauma, nutrition, and the health of the parent-child bond especially during years 0-3, influence lifetime MH/MDD + metabolic risk; see ACE study etc. [10]

Major Depressive Disorder

Epidemiology

Bad news: you're going to see a lot of it. Good news: it does respond to treatment.

Back in 2019, at any given time about 2.8% of U.S. adults exhibited severe symptoms of depression lasting longer than 2 weeks, 4.2% moderate depressions, and 11.5% mild symptoms of depression – all told, almost 20% at any given time.

FREQUENCY was greatest in young adults aged 18-29 (21%), followed by 45-64 YO adults, and 18.4% of > 65.
Females were about twice as likely to be *diagnosed* with depression vs males.
Non-Hispanic individuals of Asian heritage were least likely to experience depression symptoms…
…compared to Hispanic, non-Hispanic White, non-Hispanic black adults and Indigenous adults (esp. women) in that order.

AMONGST CHILDREN AND ADOLESCENTS the data has been variable. Per the CDC in 2016-2019, about 4.5% of children 3-17 were diagnosed w/ MDD. In one study of high schoolers 22% of female students reported depression vs 11% of males, matching the neat "twice as likely" pattern, BUT a different study found that 4.9% of male students had 2 episodes of unipolar depression whereas only 1.6% of female students had 2+ episodes of unipolar depression.

SOCIAL FACTORS: without getting into the weeds, frequency of MDD increases as underlying factors of security decrease AND YES, unhealthy relationship w/ technology – feeds isolation, distorts self & world image – worthy of its own talk!

Major Depressive Disorder

Case Study #1: Luis

Patient 1 ID: 20-year-old Hispanic male, here at the request of his father

HPI: pt states that he became aware of depression symptoms ~ 2 yrs ago, while finishing high school. He was a musician, but a future in music felt impossible. He began isolating, became disinterested, wouldn't do much of anything. He reports he often has trouble sleeping; has the daily thought that he would be better off dead; frequent episodes of profound sadness; feels isolated, and angry and irritable often. **PHQ-9 today: 20. GAD-7: 5.**

Past Psych Hx: Unremarkable; no hospitalizations, self-injury, mania, suicide attempts, eating disorders. No substance use whatsoever, not even Cannabis. Brief therapy x 1 mo w/o results, minimal engagement.

Family Psych Hx: father struggled with depression and anxiety over his lifetime and had EtOH issues as a young adult, and hx of SI. Pt's mother has struggled with anxiety. Older sister and younger brother both well.

PMHx: unremarkable. **PSHx**: none. **Allergies**: none. **ROS**: negative.

SOC Hx: safe, secure, denies P/E/S abuse. HS grad. No kids/job/relationship. Hobbies? Passive screens. No substances; no legal hx.

QUESTIONS: do we have a DDx? (Always). If diagnosing MDD – what severity? What treatment approach?

Major Depressive Disorder

Case Study #2: Kelly

Patient 1 ID: 62-year-old married Caucasian woman

HPI: pt w/ h/o of MDD-R, GAD, establishing care after her previous psychiatrist retired. C/o feeling fatigued and overwhelmed constantly in life, more in the last few years. Worried about whether her current medications are effective or a waste of time or endangering her health, after her most recent labs f/ PCP (CBC, TSH, Lipids WNL; CMP WNL except mild AST, ALT elevation; suspect OTC HA Tx, b/c she thinks her meds cause HA, especially if mis-times Effexor). Feels bad about herself, inadequate, low-energy. Sometimes thinks she'd be better off dead, BUT her brother completed suicide at age 25, imprinted lifetime tragedy on the pt and her parents – and she states she could never, ever do that to her own children. During the encounter she reiterates the above concerns a few times – demonstrated ruminative thinking. **PHQ-9 today: 15. GAD-7: 13.**

Past Psych Hx: Dx'd MDD, anorexia, GAD, in early adulthood. Reports anorexia remission since mid 20s. Decades of outpatient therapy, 30 years+. Many medication trials (TCAs, SSRIs, SNRIs) through PCPs and psychiatry. No inpatient history, no psychosis history, no suicide attempts but has a remote history of punching herself and hitting her head into walls at her absolute worst symptom severity as a young woman.

Family Psych Hx:Mom: ANX NOS, MDD-R, ? Personality D/O (Cluster B, Narcissism?); Older Br. SZO, suicide. Pt's daughter: anorexia nervosa; GAD. (FHx of diabetes and also Parkinsons Dz.)

PMHx: healthy, unremarkable. Has a PCP and recent labs unremarkable except mild AST, ALT elevation; suspect OTC HA Tx.
PSHx: none. **Allergies**: none. **ROS**: negative.

SOC Hx: Complicated upbringing with harsh, emotionally abusive mom . College, fine arts degree, used to work in special education, and is a self-employed artist. Financially secure, married twice, widowed once. 3 children , the youngest with mental health issues. No legal issues. Substances: Glass of wine nightly, remote history of marijuana, no rehab , no legal issues. Does art (watercolors) and walks daily.

CURRENT PSYCH Tx: Venlafaxine ER 150 mg capsule every morning, Abilify 5 mg, Lexapro 20 mg.

Major Depressive Disorder

DDx and Workup

Workup: Screening Questionnaires! Use them! U.S. Preventive Services Task Force (USPSTF) recommends them for adults generally. That encompasses older adults, and pregnant and postpartum women, but it is worth remembering relative risk there.

Simple workup does not suffice. The single question “are you depressed” has a specificity of 97% but sensitivity of 32%, so would only identify 3 out of 10 depressed individuals under clinical care. I have not assessed the specificity or sensitivity of the question "how are you doing?” but based on the previous data, we can conclude that is not enough to assess for depression.

If you are rushed and can’t/couldn’t collect PHQ-9, or GAD-7, this 2-item test:

Q1: During the past month have you been bothered by feeling down, depressed or hopeless? AND
Q2: During the past month have you been bothered by little interest or pleasure in doing things?

Has a sensitivity of 97% and specificity of 67%. [11]

LABS: Diagnosis is mostly clinical and based on history and direct interview findings. Some labs may He used to exclude potential medical illness as part of the differential, including: CBC (rule out anemias), TSH, B12/MMA, HIV +/-, CMP (liver function, BUN and creatinine are all good ideas, as is the electrolyte panel; consider adding magnesium). Rare labs as part of extensive workup would include dexamethasone suppression to rule out Cushing Dz, ACTH stimulation for Addison Dz.

Neuroimaging: if focal neuro signs or high suspicion – NOT common. (I almost never order them).

Ready for ANXIETY?

Generalized Anxiety Disorder

Flagship diagnosis of the most common type of Psychiatric Disorders.
Evolved from 19th century "melancholia" into neurosis… and GAD in the 80s.

BACKGROUND: pts with anxiety disorders experience often visit PCPs with somatic physical complaints. Despite anxiety being highly prevalent, it is often underrecognized and undertreated. Anxiety disorders share features of excessive fear and nervousness and include: separation anxiety disorder, selective mutism, specific phobias, social anxiety disorder (social phobia), panic disorder (with or w/o agoraphobia and vice versa), substance/medication-induced anxiety disorder, secondary anxiety disorder due to other conditions… and GAD.

DSM- 5 DIAGNOSTIC CRITERIA

•(A) Excessive anxiety or worry for 6+ MONTHS re: a variety of topics (often minor). (B) The worry is subjectively experienced as very challenging to control, and easily shifts focus. (C) Accompanied by at least 3 of the following symptoms (in kids, 1 suffices): edginess or restlessness; tiring easily, feeling more fatigued than usual; impaired concentration or feeling like the mind goes blank; irritability; increased muscle aches or soreness; difficulty sleeping/unsatisfying sleep. (D) symptoms cause clinically significant distress or impairment in social, occupational or other important area of function. (E) Disturbance not attributable to another condition (e.g. hyperthyroidism) or effect of a substance (e.g. cocaine). (F) It is not better explained by… another MH condition (the DSM-5 here helpfully lists the kitchen sink).

Generalized Anxiety Disorder

Screening, DDx and Background Factors

SCREENING: per USPSTF is NOT universally recommended for adults at this time. But, the GAD-7 has decent sensitivity (92%) and specificity (76%). GAD should be considered for patients who express anxiety, pervasive worry or recurrent somatic symptoms unrelated to underlying physical conditions - so, presentation of health anxiety might spur you to inquire about what else the patient is worrying about.

DDx: Hyperthyroidism, arrhythmias, asthma, COPD, steroid/BZD/EtOH use or withdrawal, stimulants – which includes nicotine! Smoking cessation decreases short and long-term anxiety.
Also, commonly overlaps with: MDD, hypomania, dysthymia, (Poly)Substance use D/O; and Panic D/O.

Epidemiology; Etiology / Pathophysiology: in the U.S. 8% lifetime prevalence of GAD. Depending on the study, women are 2-3 times more likely to experience GAD or panic disorder. Etiology & Pathophys are clearly multifactorial, with overlapping psychological theories (misperception of fear, heightened agent/threat detection); biological theories (overstimulation of limbic system circuits - amygdala, hippocampus – assoc'd w/ fearful or noxious stimuli), genetics (32% heritability in twin studies) and environmental theories (lifetime exposure to adversity increases anxiety prevalance; and gut microbiome behavioral modulation), etc, etc. We don't know, *but do know more*.

PHQ-9

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or over eating	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

GAD-7

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

Panic Disorder

2.5% of individuals across the lifetime but the costliest of anxiety conditions

BACKGROUND: as symptom severity drives urgency of treatment, this anxiety condition is routinely seen in Primary Care offices as well as Emergency Depts. It is the condition of having panic attacks AND the fear of (the distress and discomfort) having more of them.

Panic Attacks are characterized by recurrent, unexpected panic attacks, defined as an abrupt surge w/o warning of intense fear or discomfort and reaching a peak within minutes. Symptoms are predominantly physical - not cognitive – and to meet criteria must include 4+ of the following: palpitations or tachycardia; sweating; trembling or shaking; sensations of SOB or smothering; choking sensation; chest pain or discomfort; nausea; feeling dizzy, unsteady, or faint; chills or heat sensations; paresthesias (numbness or tingling sensations); derealization (feelings of unreality); or depersonalization (being detached from oneself); fear of losing control or "going crazy;" and fear of dying.

Such attacks may occur several times daily, or across intervals of months or years. They can occur alongside other conditions or medical disorders; are associated with diminished treatment outcomes for comorbid anxiety and mental disorders; and with an increase in risk of SI or suicide completion.

Panic Disorder IS NOT diagnosed with panic attacks or panic feelings occuring with known triggers, e.g., a panic attack after social speaking and related to future 'speeches' for someone with a known social phobia

King George IV, ‘The King’s Speech’ - arguably not Panic Disorder. *Panic Attacks*, yes but with known trigger.

© 2010, Paramount Pictures

Piglet: GAD

© Disney (various years), A.A. Milne

Ted Lasso: spoiler alert, Panic Attacks and Panic Disorder. He is in a high-stakes situation, but it comes without warning – and he fears having another attack later.

© Apple TV, Ted Lasso Productions 2020

PHQ-PD Screening Tool for Panic Disorder

Questions	Answers	
In the past four weeks, have you had an anxiety attack—suddenly feeling fear or panic?	No	Yes
Has this ever happened before?	No	Yes
Do some of these attacks come suddenly out of the blue — that is, in situations where you do not expect to be nervous or uncomfortable?	No	Yes
Do these attacks bother you a lot or are you worried about having another attack?	No	Yes
Think about your last bad anxiety attack.		
Were you short of breath?	No	Yes
Did your heart race, pound, or skip?	No	Yes
Did you have chest pain or pressure?	No	Yes
Did you sweat?	No	Yes
Did you feel as though you were choking?	No	Yes
Did you have hot flashes or chills?	No	Yes
Did you have nausea or an upset stomach or the feeling that you were going to have diarrhea?	No	Yes
Did you feel dizzy, unsteady, or faint?	No	Yes
Did you have tingling or numbness in parts of your body?	No	Yes
Did you tremble or shake?	No	Yes
Were you afraid you were dying?	No	Yes

Panic Disorder Criteria, Continued

After meeting criteria for a panic attack, *at least one* of the attacks has been followed by 1 month or more of 1 or both of the following: 1) a persistent concern and worry about additional panic attacks and the consequences, such as having a heart attack or going crazy; 2) significant maladaptive change in behavior related to the attacks, such as avoiding exercise or situations conceived as potentiating attacks (misattribution)

Disturbance cannot be attributed to the physiological effects of a substance or another medical condition, AND,

Disturbance is not better explained by another mental disorder. Examples: attacks after phobic individuals encountering their triggers, or children with *Separation Anxiety D/O* panicking after being separated.

There is screening for Panic Disorder – helps monitor tx response

(Side note: I could not find attribution for the image excerpted here, which was taken f/ Tabele 4 of "Generalized Anxiety Disorder and Panic Disorder in Adults" Dr. Katherine C DeGeorge, et al, *Am. Fam. Physician.* 2022;106(2):157-164 by.).
I don't know if they made it, or borrowed from elsewhere and the web didn't credit.

Obsessive – Compulsive Disorder

Neuropsychiatric condition characterized by recurrent distressing thoughts and/or repetitive behaviors, and rituals intended to reduce distress. First described in *The Anatomy of Melancholy* (1621), by Robert Burton.

BACKGROUND: A. *Chronic* disorder characterized by uncontrollable, recurring thoughts (obsesssions) and behaviors (compulsions) accompanied by the urge to repeat them again and again.

Obsessions: unwanted, intrusive thoughts, images, or urges that trigger distressing feelings. Common obsessions include fears of germs or contamination, fears of harm to oneself or others, and unwanted taboo thoughts. Obsessive individuals repeatedly attempt to ignore or suppress such thoughts or urges (ie w/ compulsions).

Compulsions: repetitive behaviors (hand-washing, checking, cleaning) or mental acts (praying, counting, repeating phrases silently) that the individual feels driven to perform according to rules that must be applied rigidly. Compulsions are meant to prevent or reduce anxiety or distress, or prevent a dreaded event , but the behaviors or mental acts do not realistically connect to what they are intended to neutralize, and/or are clearly excessive.

Diagnosis requires **A.** presence of obsessions, compulsions, or both, continuously **for a minimum of two weeks** [Note: most patients have duration of untreated illness of ~7 years before Dx] **and B.** the obsessions/compulsions **are time-consuming** (e.g., 1+ hour/day, often more) or cause significant distress or impairment in important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. **D.** Not explained better by another Psych condition.
Specifiers: w/ Good Insight (pt knows: not true); Poor Insight (thinks are somewhat true); Delusional (adamant).

Common OCD Patterns / Symptoms

Obsession	Thought Content	Associated Compulsions
Aggressive	Fear of harming others, recurrent violent images	Monitoring the news for reports of violent crimes, asking for reassurance about being a good person
Contamination	Fear of being contaminated or contaminating others; fear of being contaminated by germs, infections, or environmental factors; fear of being contaminated by bad or immoral persons	Washing or cleaning rituals
Pathologic doubt, completeness	Recurrent worries about doing things incorrectly or incompletely, thereby negatively affecting the patient or others	Checking excessively, performing actions in a particular order
Religious	Thoughts about being immoral and eternal damnation	Asking forgiveness, praying, reassurance seeking
Self-control	Fear of making inappropriate comments in public	Avoiding being around others
Sexual	Recurrent thoughts about being a pedophile or sexually deviant; recurrent thoughts about acting sexually inappropriate toward others	Avoiding situations that trigger the thoughts, performing mental rituals to counteract the thoughts
Superstition	Fears of certain "bad" numbers or colors	Counting excessively
Symmetry and exactness	Recurrent thoughts of needing to do things in a balanced or exact fashion	Ordering and arranging

OCD (and GAD)

Case Study:

Patient 1 ID: 20-year-old single woman here w/ her mom. CC: "The ER told me I should come here."
HPI: Patient complains of palpable daily anxiety present for 2+ years, which had been partially controlled by Citalopram 20 mg daily but recently (3 mos) life feels in total disarray. She is a young Christian woman who recently became sexually active. She and her partner are monogamous, practice safety w/ condoms, and are not disapproved of by parents. However, she has begun having severe dread about her health (really: contamination, blood, illness). She cannot stop thinking she will be HIV+. She has not had any exposure to, thoughts of, or connections in her life to HIV. When walking through a pile of fallen red maple leaves, she experienced major distress at the idea that an HIV infected needle pricked her through the leaves or one day will. She then panicked. For several weeks she's calling friends and relatives incessantly for reassurance, 40+ times per day. She worries that she will hurt herself b/c of anxiety**. PHQ-9: 22. GAD-7: 20.**

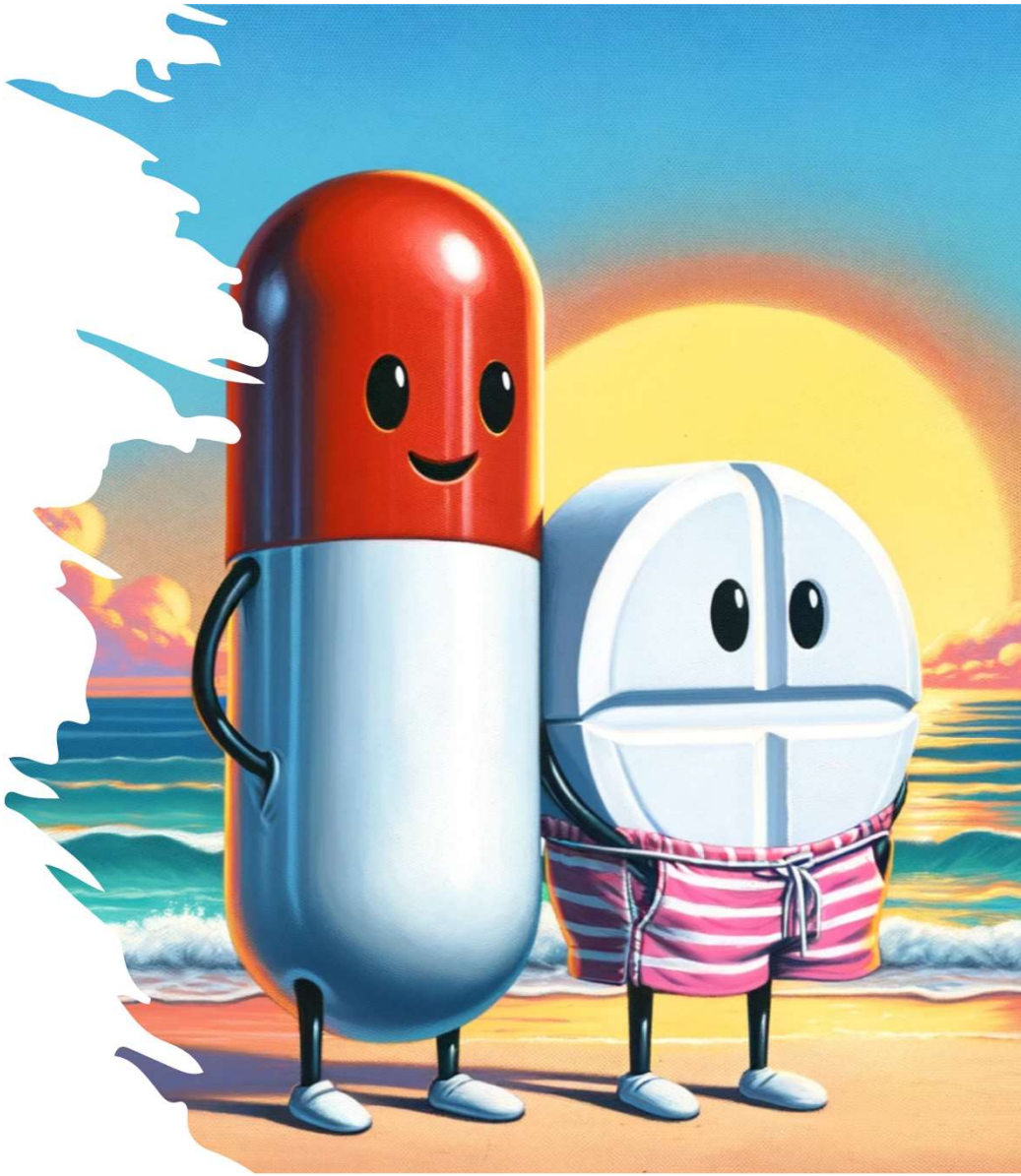
Past Psych Hx: GAD dx'd at 18, w/ early onset anxiety f/ childhood. Citalopram (compliant) x 2 years. NO: hospitalization, self-injury, mania, SI/attempts, eating disorder, substance use.

Family Psych Hx: none **PMHx**: unremarkable. **PSHx**: none. **Allergies**: pollen, o/w none. **ROS**: negative.

SOC Hx: safe, secure, denies P/E/S abuse. 2 younger sisters who are well. In college, wants to teach. Safe, supportive relationship, but taking a break f/ intimacy (too triggering!). No kids, substances, legal hx.

OBJ – MSE: Affect is anxious, congruent. No SI (but fearful of one day). No AH, paranoia. Reality testing intact. Intellect, motor, speech all WNL. Judgment, insight – fair (knows she is unwell and symptomatic, is seeking help).

Treatment Considerations



Treatments

SSRIs and SNRIs are "A" Evidence Rated, first-line tx of choice for MDD, GAD, and OCD. They are effective. They are generally well-tolerated. They improve symptoms vs placebo.

Review risks, including to libido, and negative impact on sleep, appetite, and nausea in particular.[11-14] Recommend patients take at least 6 weeks before evaluating efficacy; and changing after 12 weeks if no response. **Go to ceiling dose on one agent, before changing class or augmenting**

TOTAL TX DURATION? Counsel patients to take Rx for 6 to 12 months to minimize relapse.[15] ~16-20% of patients relapse despite compliance with medications, but, discontinuing antidepressants before one year leads to symptom relapse in up to 50% of patients being treated.

WHICH ONE? Similar efficacy for many meds, BUT, Escitalopram, Cymbalta, and Effexor (also Pristiq) generally perform at 'top tier' levels. However, be cognizant of non-compliance side-effects.

IF CONCERNED RE COMPLIANCE, REACH FOR FLUOXETINE (PROZAC).
Longest half-life. Simple dosing. Approved for all ages..

I NEVER RECOMMEND PAXIL. It induces its own metabolism, interferes w/ other Rxs, has 20+% rate of [>7% pre-Rx] weight gain, and has been flagged for overly aggressive CYP 2D6 inhibition…

Treatments

Counsel patients to expect at least partial relief but not necessarily total relief w/ Rx. A 20% reduction in symptom frequency and intensity, which yes exceeds placebo, is a reasonable response to initial treatment for a compliant patient. Give hope, but not 'commercial grade' hope.

MONITOR FOR SUICIDE RISK IN MDD. (Not quite as much OCD or uncomplicated GAD).
Keep in the back of your mind that suicide is always a risk in depression, and especially with patients who prolific individual and/or family risk factors (esp. medication naïve pt) antidepressants may increase suicidal thoughts.

As assessed severity increases, visit interval should decrease if at all possible. You will not be faulted for seeing your patients more frequently, especially w/ severe MDD. (You will bolster compliance).

Benzodiazepines: NOT FIRST LINE in GAD or PANIC D/O. for patients and whom I have good trust and rapport, and who do not have substance issues, I may consider a small quantity of break the glass clonazepam, during the first several weeks while waiting for antidepressants to reach treatment efficacy.

THERAPY: CBT is first line treatment in panic disorder; and also OCD, with specifically exposure and response prevention being the most effective psychotherapy method for treating OCD.

References

[All diagnostic criteria is adapted from DSM-5]

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Questions?

- I will be available after this lecture, or you may reach me at…
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  Thank you!