What Does FBS and A1C have to do with Mood Disorders?

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Disclosures

None

Objectives

- List the principles of collaborative care treatment in mood disorders.
- List 3 ways that antidepressant therapy may affect outcomes in mood disorders.
- Describe when to switch AD and 3 methods for doing so
- Provide names, doses and common side effects of 4 mood stabilizers
- Become a de-prescriber-A Prescription for “Deprescribing” in Psychiatry | Psychiatric Services (psychiatryonline.org)

Patients With Mood Disorders Have

- Limited access
- Under identified
- Undertreated
- Don’t get measurement-based care
- Don’t get evidenced based care
- Too many fail to reach remission/stability

The Numbers

51.5 Million US adults experienced a MI in 2019

1 in 5 people

20% of people living in US

More women than men 24% vs 16 %

Youth 18-25 years old 29%

People of color have higher rates

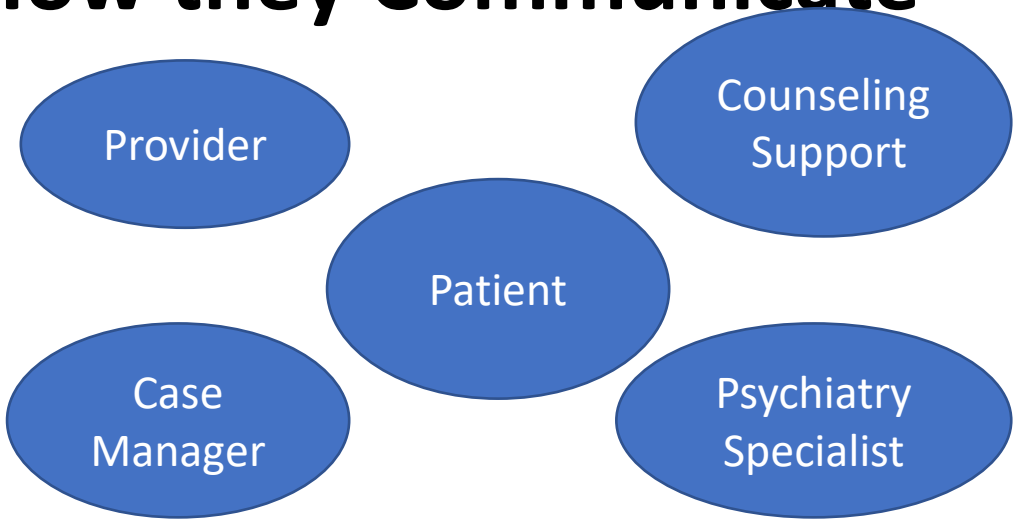
- 2 > races 31%
- white 22%
- Asians 14%

Collaborative or Integrated MH Care in PC

Basic Elements

1. Patient Centered
2. Population Based
3. Measurement Guided
4. Evidenced Based
5. Accountable

Team Roles and How they Communicate



How to Implement

- Several Models

American Psychiatric Association (APA) AIMS Center

AIMS Center | Advancing Integrated Mental Health Solutions in Integrated Care (uw.edu)

Integrated Models for Behavioral Health and Primary Care

Integrated Models for Behavioral Health and Primary Care | SAMHSA

SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) | SAMHSA

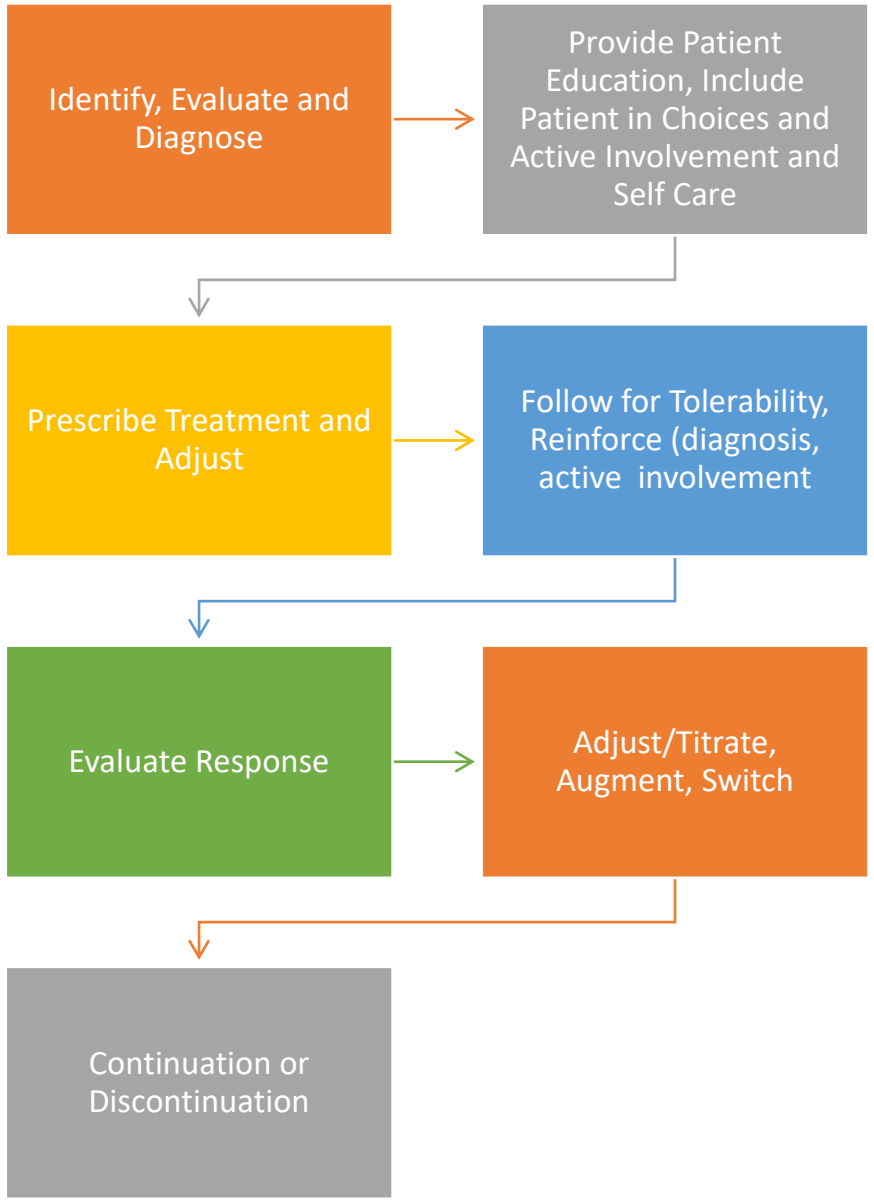
National Council for Behavior Health

Models of Integrated Care - National Council (thenationalcouncil.org)

Adopt what you Can Invent Your Own

What Can Each of You Do?
Steps in Management of Mood Disorders

Steps in Mood Disorder Management



Stepped care= Good Outcomes

Outcomes of Supportive Algorithmic Approaches: STAR*D
Multistep Algorithmic Depression Treatment i n Primary Care

- Step 1 Remission: 36.8%
- Step 2 Remission: 30.6%
- Step 3 Remission: 13.7% Step
- 4 Remission: 13.0%

- TMAP Trivedi et al 2004
- Overall Cumulative Remission: 67%
  - Rush et al 2006

Rating Progress Using Scales

- Percent of Improvement
- >50%=remission
- 25-50%= partial response
- <25%=non-responsive
  - Current Score divided by first. PDQ of 22 initially and 14 at 4 week follow-up gives you a 63% improvement.
  - Does not mean can't get better, should there be augmentation, further titration, more non-pharmacologic treatment?
  - Depends on patient and function.

Appropriate Use of Scales in Diagnosis and Treatment

Screens are not diagnostic- can lead you in getting further data

- history
- presentation
- observations (MSE)
- collateral data
- even secondary gain.

Resource for use of Scales in PC

Vohringer PA, Jimenez MI, Igor MA, et al.
Detecing mood disorder in resource-limited
primary care settings: comparison of a self-
administered screening tool to general practitioner assessment.
J Med Screen. 2013;20:118-124

Patient Health Questionnaire-9
PDQ-9

9 Questions and one summary of symptom difficulty

Patient competes

Rate 0-3 (not at all, several days, more than ½ days, nearly everyday)

Score to the sum of question 1-9

- 1-4 minimal 5-9 mild 10-14 moderate
- 15-19 moderately severe 20-27 severe

Then patient rates difficulty in terms of activities at home, work or in relationships of any symptoms

- Microsoft Word - PHQ9.doc (apa.org)
- SMI app

Considerations in Mood Disorders

Give	If positive screen for depression, give screen for bipolar disorder and anxiety
Remember	Remember there are co-morbidities- psychiatric and medical
Rule out	Rule out medical causes
Try	Try to think in spectrums

Mood Disorder Questionnaire-MDQ

Questionnaire (sadag.org)

Question 1 ask if patient has ever or currently experiences any of 13 symptoms

2-if yes have several occurred at the same time

3-asks how much of a problem have the symptoms been

4-have any blood relatives had similar problems, been diagnose

5-Positive if 7> on 1., yes 0n ., & Mod. Or serious

The Generalized Anxiety Scale-7

Generalized Anxiety Disorder.pdf (crossroadscounselingcenters.com)

7 Questions Rated 0 (none) to 3 (nearly every day)

- Feeling nervous, anxious, or on edge
- Not being able to stop or control worrying
- Worrying too much about different things
- Trouble relaxing
- Being so restless that it's hard to sit still
- Becoming easily annoyed or irritable
- Feeling afraid as if something awful might happen

Rate Difficulty of effect on work, school, home, getting along.

Score 0=minimal, 5-9=mild, 10-14=moderate, 15-21=severe

Substance Use Scales

- CAGE CAGE Substance Screening Tool.pdf (hopkinsmedicine.org)
- AUDIT AUDIT.PDF (sbirt.care)
- DAST DAST-English-pdf.pdf (sbirtoregon.org)
- S2BI-Screening to Brief Intervention—on-line, clinician or patient
    - NIDA Drug Screening Tool (drugabuse.gov)

- NM ASSIST-taken on-line

  NIDA Drug Screening Tool (drugabuse.gov)

- General info American Psychiatric Association Adapted NIDA Modified ASSIST Tools | National Institute on Drug Abuse (NIDA)

Basic Mood Chart

Pt. Name

Date

- 10 years old 20 years old 30 years old
- Mania----------
-
- Hypomania----------
- Elevated temperament
- Euthymic----------
- Depressed temperament
- Dysphoric----------
-
- Depression----------
- Comment space on back of card

Compare and contrast

- Grief
- Emptiness/loss
- Retain self esteem
- Retains humor
- SI- “join deceased”

MDD

persistent depressed mood

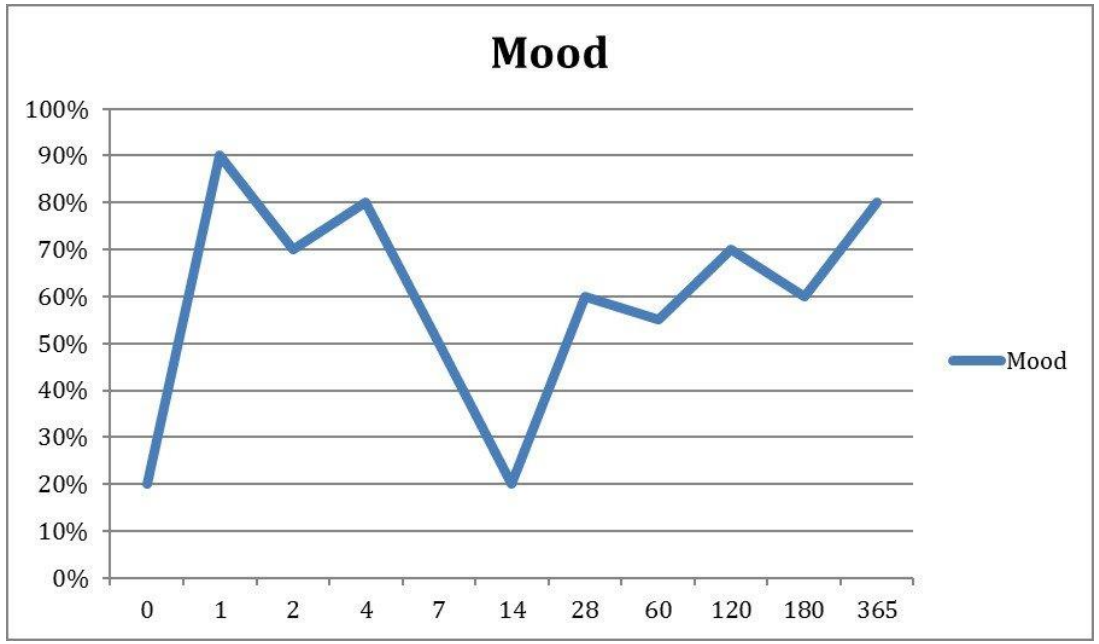
worthlessness/undeserving

inability to anticipate joy

SI- “not missed/relief of burden”

Think: Spectrums of Mood

Mania	10	Total loss of judgement, exorbitant spending, religious delusions and hallucinations.
	9	Lost touch with reality, incoherent, no sleep, paranoid and vindictive, reckless behaviour.
Hypomania	8	Inflated self-esteem, rapid thoughts and speech, counter-productive simultaneous tasks.
	7	Very productive, everything to excess (phone calls, writing, smoking, tea), charming and talkative.
Balanced Mood	6	Self-esteem good, optimistic, sociable and articulate, good decisions and get work done.
	5	Mood in balance, no symptoms of depression or mania. Life is going well and the outlook is good.
	4	Slight withdrawal from social situations, concentration less than usual, slight agitation.
Mild to Moderate Depression	3	Feelings of panic and anxiety, concentration difficult and memory poor, some comfort in routine.
	2	Slow thinking, no appetite, need to be alone, sleep excessive or difficult, everything a struggle.
Severe Depression	1	Feelings of hopelessness and guilt, thoughts of suicide, little movement, impossible to do anything.
	0	Endless suicidal thoughts, no way out, no movement, everything is bleak and it will always be like this.



Use Evidence Based Treatment Algorithm

1. Select Any Class, titrate to Max Tolerable Dose, f/u, measure at 2,4 & 6 weeks
2. Intolerable? -> Switch to Different Class (can happen at anytime, but measure if possible)

   Remission? -> Continue
   Response -> Titrate or Augment
   Partial Response -> Titrate or Augment
   No Response? -> Switch to Different Class For Example

   Fluoxetine 20mg (Intolerable) -> Duloxetine titrate to120mg (No Response)
   Bupropion 300mg (Response) -> Bupropion 450mg (Remission)
   Bupropion 450mg (No Response) -> Sertraline 200mg (Partial Response)
   -> Augment: Add Aripiprazole 2.5 to 5 mg; lithium, Lamictal, mirtazapine (Remission)

Trivedi et al 2004

Algorithms

Psychopharmacology Algorithms

Algorithms (psychopharm.mobi)

Canadian Network for Mood and Anxiety Treatments

CANMAT - Canadian Network for Mood and Anxiety Treatments

First Patient Visit

- Medication is ONE part of successful multi-component depression treatment
- We want you to feel and function better- so we need your help
- Communicate right away if SEs, s/s, feelings, details of mood, fam.hx… Learn about disorder
- Use a team approach so nurse, MA, Case-manager may see/contact you
- Where we think depression comes from
  - Genetics—risk, Neurochemistry, Neural pathways, Brain Circuits, Life Events/Stress/Trauma
  - Change in neurochemistry, pathways or circuits
    - A gene part, is set off by stress or at random, that makes various neurochemicals react and then pathways and circuits-- produces insufficient information and communication resulting in symptom complexes. Which symptoms you have now and which may linger after initial treatments affect our next steps.

Depressive and Related Disorders 1

Disruptive mood dysregulation disorder (DMDD)

Major Depressive Disorder (MDD)

- Single
- Recurrent

Persistent depressive Disorder (PDD) dysthymia

Premenstrual dysphoric disorder

Substance/medication-induced depressive disorder

Depressive Disorder due to another medical condition

Antidepressants Types

- SSRIs
- NDRI
- SNRIs
- 5HT1A Partial Agonist
- TCAs
- Others-Alpha 2 Agonist
- MAOIs

AD Good and Negative Effects

- Look up side effects if you are not familiar
- AD improve mood, sleep, increase appetite, < fatigue
- Cause emotional flattening, sexual dysfunction-men and women (arousal, libido, orgasm)-ask about all of them
- Increase risk of suicide in teens
- Discontinuation syndromes
- Potential fetal risks-low birth wt., risk/benefit
- Induce hypomania or mania--Increase rate of cycling or

Tidbits 1

- Sertraline- has some DA activity so may cover more s/s
- Paroxetine-has some anticholinergic activity-?avoid in gere
- Escitalopram-may be most tolerated-fewer pharmacologic interactions
- Fluoxetine—atypical depression, activating, has data for use with olanzapine in TRD
- Fluvoxamine-approved OCD-not depression—use with co-morbid depression and anxiety disorders, especially OCD

Tidbits 2

- Venlafaxine-better in TRD, or in combination, more seretoninthan norepinephrine blockade
- Desvenlafaxine-once daily, off lable for perimenasal s/s if do not/can not take estrogen
- Duloxetine- Qday dosing have potential for pain symptoms
- Milnacipran-specifically indication for fibromyalgia, high neuroadrenergic (sweating, fog)
- Bupropion-can improve cognitive slowness,fatigue, go to if SSRI “pooped out”

Tidbits 3

- Atomoxetine- older weight gain and sedation (maily blocks DA and NE)
- Trazodone-mainly used for sedation, initially for AD but to get to tx range needed doses of 450 to 600 mg day and too sedating, priapism
- Nefazdone-same
- Mirtazepine- helps sleep in lower doses due to anti-hist effect, good for anxiety, not much sexual dysf. Appears synergistic when added to SSRI/SNRI in severe depression

Pregnancy

- Pregnancy
- Consider the risks with patient, OB-GYN
- All have risks generally accepted as ok given risk/benefit of treating depression in pregnancy, especially after first trimester, many women want to avoid and always discuss birth control and risks when starting AD treatment.

Treatments Generally Reserved for Treatment Resistant, Special Circumstances

- ECT
- rTMS
- Ketamine

Ketamine: a paradigm shift for depression research and treatment (nih.gov)

Ketamine and depression: a narrative review (nih.gov)

Esketamine Nasal Spray for Rapid Reduction of Major Depressive Disorder Symptoms in Patients Who Have Active Suicidal Ideation With Intent: Double-Blind, Randomized Study (ASPIRE I) - PubMed (nih.gov)

- Vagal Stimulation
- Psychedelics –psilocybin and MNDA
  - Reiff etal, Work Group on Biomarkers and Novel Treatments,
    a Division of the American Psychiatric Association Council of Research.
    Psychedelics and Psychedelic-Assisted Psychotherapy.
    Am J Psychiatry. 2020 May 1;177(5):391-410. doi:
    10.1176/appi.ajp.2019.19010035. Epub 2020 Feb 26. PMID: 32098487.

Augmenting in Depression

Non Medication

- Psychotherapy
- Meditation, Self Care
- Bright Light Therapy
- Exercise

Medication

- Bupropion
- Buspirone
- Lithium T3 (Liothyronine)
- Second Generation Antipsychotics
- Modafinil
- Pramipexole

Pharmacogenetics

- Indications-depends on what you are selling
- Pharmacogenomic Tests in Psychiatry: Not Ready for Prime Time | Psychiatric News (psychiatryonline.org)-Charles Nemeroff, MD, Ph.D.
  - APA Workgroup for Novel Biomarkers and Treatments, published our findings in the *AJP* " insufficient data to support the widespread use" now more data and FDA consumer warning.
  - No support for most, esp. that pharmacogenetics lead tx is better than what we already do.
- How it helps
  - reduce adverse events, optimize drug dosing, and guide treatment decisions
- How it does not help
  - Data on efficacy is not there
  - Clinician lack of understanding of when to use, the meaning of report
- Table of Pharmacogenomic Biomarkers in Drug Labeling | FDA

Switching Strategies

- Direct –stop current and start another
  - Done if only a few days on current
  - If current has a long 1/2 life (fluoxetine)
- Cross taper- reduce current medication as titrate up on another
  - If has been on medication a long time and tolerates
  - Allows for keeping any benefit while titrating new medication
- Cross over-titrate down or stop current medication and start new medication following a clearing period

Psychotic Depression

- Consider if psychosis is ego-congruent or ego-dystonic
- Screen carefully in peri-natal -likely need hospital (ego-dystonic)
- Optimal antipsychotic duration is about 5-6 months after stable for 5 weeks
- Always taper off slowly
- 70% remain better

Other thoughts and tidbits

- Perinatal Depression is a subject of its own; but look and if psychotic consider hospitalization
- Women tend to respond better to SSRI
- Hormones may make a difference
- Over 50% have co-morbid anxiety
- Consider melancholic vs atypical
- Consider trauma-including race, now COVID
- Resistance might just be intolerance, but consider non-adherence

Meloncholic and Atypical Depression

- Melancholic- must have loss of pleasure and inability to respond to pleasure
  - +2 of distinct quality of mood, morning diurnal variation, terminal insomnia, psychomotor agitation or retardation, guilt, < appetite and wt. loss
  - more often severe, more with psychosis, responds to ECT and AD
- Atypical – not generally insomnia, wt. loss or low appetite, they tend to have rejection sensitivity (if complimented feel happy, but on other hand take or perceived comments as rejection= relationships hard, feeling hurt and often breakup, they feel heavy, “leaden paralysis”. MAOI’s or SSRI’s
  - Often confused with borderline personality or maybe

    depressed + traits of borderline

Conclusions on Depression

- Antidepressant medication management is one part of successful, wrap-around depression treat ment
- Patient education, empowerment, activation, and support are crucial ingredients of antidepress ant medication management
- Problem solving medication access and tolerability can help ensure patient adherence to treatm ent
- Titrating to maximum dose and monitoring response clinically with scales allows for optimal outcomes
- Successful antidepressant medication should continue for 6 months to indefinitely

Bipolar and Related Disorders

- Bipolar I Disorder
- Bipolar II Disorder
- Cyclothymic Disorder
- Substance/medication-induced depressive disorder
- Depressive Disorder due to another medical condition

Cyclothymia and Hypomania

Hypomania

- Same symptoms as mania, less severe and not as long<4 days
- At lower spectrum of difficulty in function and disability
- No delusions or hallucinations
- Generally no hospitalization required
- Often also experience chronic depression

Cyclothymia

- High/elevated mood in hypomanic state, not much effect on function
- Some depressed mood but not meeting criteria in severity, # of symptoms
- Like a chronically instable mood

Bipolar I

- Bipolar I, periods of distinct moods
  - chronic, still a spectrum
  - 1 week or more of manic symptoms interspaced with depression
- Mania
  - period of elated, expansive or irritable mood
  - +3> (4> if irritable) increased self esteem, grandiosity, < need for sleep, > talking, >active,>sex interest, risk taking, distraction, flight of ideas, racing thoughts
- Depression episodes fit criteria for MDD
- Most present as depressed, meet criteria for depressive disorder but have hx of hypomania or mania

Other Considerations in BIPOLAR Diagnosis

- MDD can be superimposed on Cyclothymic Disorders
  - looks like Bipolar Disorder
- BP-DEP can present in
  - bipolar I or bipolar II disorders,
  - with mixed features or rapid cycling
  - Unipolar depression and BP-Dep respond differently to meds
- Bipolar II and Cyclothymia often misdiagnosed as BPD or other of the ‘dramatic’ mood disorders
- BPD pts spend most time in depressive state, but will present for acute and maintenance mania as well

Compare and Contrast

Bipolar	Cyclothymia	Borderline
• **Begins in teens/20s** • **Meets criteria for Mania and MDD** • **Impulsive or risky but less dangerous than BPD** • **random**	• Child or adult • Never meets criteria for BP or MDD • Low rates & intensity of risky and impulsive behavior • Random	• Ongoing • Pattern of instability of affect, self, and relationships • Dangerous impulsivity • Situational

Consider Prodromal Bipolar or Pre-Bipolar

Characteristics of “pre-bipolar” presentation of MDD

1. Young age of onset
2. Family history of bipolar disorder
3. History of antidepressant-emergent irritability, agitation or suicidality
4. Family history of suicide

Screening Tools for Bipolar Disorder

- Mood Disorder Questionnaire (MDQ) MECH (ohsu.edu)
  - https://www.Integration.samhsa.gov/images/res/MDQ.pdf
- Young Mania Rating Scale (YMARS)
  - Combined PDQ9 and MDQ have good sensitivity, have been shown to outperform generalist interviews
  - Use the scales and dig deeper for detail and nuisance

Take minutes, both can be done by pt., high sensitivity and specificity

Algorithms for Bipolar Depression

Name

- The psychopharmacology algorithm project at the Harvard South Shore Program:
- Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBP) collaborative update of CANMAT guidelines for the management of patients with bipolar disorder: update 2013[135]
- Evidence-based guidelines for treating bipolar disorder: Revised third edition recommendations from the British Association for Psychopharmacology[212]
- NIMH » Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) (nih.gov)

Summary of Steps

- Lithium, quetiapine, and lamotrigine -first-line options, with a slight preference for lithium.
- Adding an antidepressant could be considered after above options in low-risk patients
- Bipolar I: first-line lithium, lamotrigine, quetiapine monotherapy, olanzapine plus SSRI, or combinations with lithium, valproate plus antidepressant.
- Bipolar II: first-line quetiapine only; second-line lithium, lamotrigine, atypical antipsychotic plus antidepressants, and others
- first-line medications included quetiapine, lurasidone, olanzapine, and OFC
- Lamotrigine was second line.
- Escitalopram, fluoxetine, lithium, and paroxetine were third-line recommendations

Consider Binge Eating and Bipolar

- Parental bipolar disorder increases risk of Eating Disorders (EDs) in their children (Adjusted Hazard Ratio of 2.28)
- Familial binge eating disorder and Bulimia Nervosa predicts greater bipolar disorder occurrence
- Suggested genetic correlation in population and statistical models
  - Estimated moderate heritability:
    - 33-74% BE Disorder (BED)
    - 55-62% for Bulimia Nervosa (BN)

Consider Effects of Prior Meds & Comorbidities

- MDD can be superimposed on Cyclothymic Disorders
  - looks like Bipolar Disorder,
- Bipolar II and Cyclothymia often misdiagnosed as Borderline Personality Disorder or other of the ‘dramatic’ mood disorders
- Bipolar I-II & antidepressant
  - Bipolar II patients may have less cyclic changes on AD
  - There may have been a difference in response to bupropion vs SSRI or SNRI
  - Hx of substance abuse generally respond worse to AD
  - Head Injury (mood disorder an outcome)

Algorithm for Mania

- Mixed
  - Atypical AP, preference for quetiapine- efficacy for depressive s/s & episodes
    - ? cariprazine (Vraylar)-but not as much data, expensive
  - Valproate (divalproex, Depakote)
  - Lithium or Carbamazepine
- Non-mixed
  - Lithium +/- second generation (atypical) AP (quetiapine, risperidone)
    - Olanzapine not better due to long term side effects
- Non-responsive: Mixed or not
  1. olanzapine, risperidone, cariprazine, carbamazepine, haloperidol
  2. aripiprazole, aenapine, and ziprasidone and finally
  3. Clozapine—have to register on REMS

ECT

- In severe Bipolar Depression or Depression (most efficacy)
- Severe Suicidality
- Poor Health-low oral intake
- Catatonia
- Pregnancy or other conditions that limit us of AP (hx of TD)
- Response Rates are higher than medication in initial and treatment resistant cases

Mood Stabilizers 1

- Atypical Antipsychotics
  - Quetiapine generally 1st line in bipolar I
    - Others olanzapine, cariprazine, ziprasidone…
  - Lurasidone often used in bipolar II alone
- Typical Antipsychotics
  - ED haloperidol used in acute mania w/ or w/o psychosis, dangerous or aggression-give with
  - Some pts continue to have psychotic symptoms with highest tolerable atypical
  - Some use of ketamine for behavior-even by EMT but not recommended

Note: must do metabolic monitoring –includes when add to AD

all atypical, olanzapine and clozapine highest

minimal BMI, waist, HbA1c, FBS, F lipids –initially Qmo, then 3 mo then 6 mo

Counseling on diet, exercise

Mood Stabilizers 2

- Anticonvulsants/Antiepileptics
  - Depakote
  - Carbamazepine
  - Lamotrigine
    - North American Antiepileptic Drug pregnancy 1-888-233-2334
- Lithium

Rapid Cycling

- 4 > episodes of mania in a year
  - Several controversies, transient or chronic or a subtype
  - More total time in depression than mania and tend to be more refractory
  - AD use is more likely associated with onset or worsening
  - STEP-BD found an association between rapid cycling and depression and younger age of onset
  - Treatment
    - Stop any medication that might promote cycling
    - Add and /or optimize mood stabilizers
    - Trial of more experimental or assumptive treatments

Favorite Books and Resources

- Introductory Textbook of Psychiatry, 6th ed. Black and Andreasen
- DSM 5 –Big book –much more information
- Stephen Stahl –any, if you join NIE you get some online free neiglobal/cme - Bing
- Gobbard's Treatment of Psychiatric Disorders, 5th ed.
- NIMH » Animal Research Issues (nih.gov)
- SMI app, website education

Resources

- Integrated Care: Creating Effective Mental and Primary Health Care Teams, Anna Ratzliff, Jurgen Unutzer+
- Aims.uw.edu
- neiglobal.com
- www.mdlinx.com
- Psychcongress, www.psychiatrycarelive.com/app/login
- www.psychopharmacologyinstitute.com
- American Psychiatric Association. APA, app and website
- Serious Mental Illness app-https://apps.apple.com/us/app/smi-adviser/id1473024646

My Daily Bread

- Psychiatry News, Information, Videos, Treatment Articles & More (psychiatryadvisor.com)
- Smartest Doc Psychiatry December Questions (mdlinx.com)
- Home (neiglobal.com)
- Psychiatric Times on-line newsletter
- Lots of lists that send e-mails almost daily about medicine and psychiatry both

Podcasts

Psychopharm Updates

AJP Audio (Am Journal of Psychiatry)

Psychedelics Today

The Carlat Psychiatry

Thank-you for listening

- Feel free to contact me directly at Psychpa@hotmain.com
- Association of PAs in psychiatry Association of PAs in Psychiatry | My PA Network

Case I

- 59 year old MWF cc: medication no longer helping, on 40 fluoxetine
- PMH of idiopathic hypersomnia, alcoholism in 16 year remission, caregiver husband with Alzheimer's, retired, moved to be closer to fam., husband worsening, ESRD, on HD total ADL care, can’t leave alone past 6 months
- PsychHx; fluoxetine about ?18 years increased soon after husband
- Symptoms: fears the end is near, and wonders/worries, some panic and not sleeping well, overeating, no periods of elation, increased energy, no psychosis, constant worry and negative rumination, suicidal thoughts, low mood, lack of interest, some hopelessness and helplessness, she feels worthless, struggles with decisions
- Denies cravings for alcohol but says her eating is like an addictions-understands feeding her emotions . Has sponsor and goes to local AA meetings 3 x weekly. , attends an Alzheimer's support group, son visits, just got some aide few hours week

Discussion

- What is on differential?
  - MDD, anxious depr. Specifier vs comorbid GADETOH induced depr, PDD, Bereavement, PTSD, Anxiety
  - Any of these could be co-morbid or added to the prior MDD
- What other info would you want?
  - Labs, scales, full hx, explore traumas, MSE
- What do you do and why:
  - MSE: consistent with severe depr, low self esteem, joy, cognitively intact, not psychotic, no indication ETOH, labs and drug screen N
  - Assess how to help with her—Motivational interview, revealed sad just got PhD and not using, misses routine of work, worthiness, belonging, feels bad about wt. gain, guilty about wanting more than caring for husband.
  - Titrate medication up, exercise plan, getting help in, transportation for HD, mindfulness re emotional eating, given resources in area and written material, go to Alzheimer Group > talk to sponsor

Follow-up

- 2 weeks not much change but talked more about her self and hx and was doing some of the non-pharm tx
- 1 month-doing better, focus on building self worth, activities, exercise, healthy eating
- 3 months- continues to do well, has arranged care for Fridays and plans to write in prep for developing a course in cultural responsiveness for teachers to present to local ISDs
- refer back to PCP, continue exercise, healthy eating, self care including increased help as caregiver, consider counseling (grief, general)

A patient with PDD would like to start treatment. What would you recommend?

1. Psychotherapy referral only
2. Escitalopram 5mg daily
3. Psychotherapy referral plus escitalopram 5mg daily
4. Escitalopram 10mg daily, titration to 20mg daily

1.Electroconvulsive Therapy (ECT)-is the most effective

2.Medication—

Consistently more efficacious than psychotherapy in direct comparisons

In the above case escitalopram 10mg daily week if tolerating go to 15, f/u in office 2 -3 weeks, may go to 20 depending on improvement

or if fearful of SE's 5 mg x 3 days then 10 mg daily, recheck 2 weeks

Psychotherapy-Not shown to be effective but

Recommended if co-occurring disorders like PTSD, SUD, PD

Question

- After six weeks on fluoxetine 40mg daily, a patient's PHQ-9 score drops from 22 to 14. The patient has tolerated fluoxetine well to date. He declines psychotherapy. What would you do?
    1. Add bupropion
    2. Switch to duloxetine
    3. Add mirtazapine
    4. Titrate fluoxetine

Patient 63 % improvement—easy way to get % --take current score and divide by initial (14 divided by 22)

Max dose for Fluoxetine ? So titrate up –if were at 80 would augment depending on which side effects were "leftover"