Depression and Anxiety for the non-Psychiatrist

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Background/Disclosures

- **Present Life**

  -Professor Emerita at UAB
  -Editor-in-Chief: *Community Mental Health Journal*
  -NAMI National Associate Medical Director
  -Chair, APA Annual Meeting, Scientific Program Committee

- **Past Life**

  -Consultant to AL Department of Corrections
  -Consultant to Department of Justice (investigations of state hospitals in Georgia)
  -Medical Director/Executive Dir/clinician: UAB CCMHC
  -Research on genetic liability for Schizophrenia; ACT; Dual Diagnosis; Jail Diversion
  -American Association of Community Psychiatrists
  -NAMI State Board

Outline/Objectives

- Prevalence and impact
- Review symptoms and treatment of depression
- Review symptoms and treatment of anxiety
- Review differential diagnoses and potential pitfalls when working with people living with depression and anxiety

Prevalence and Impact

- 16 million or 7% of the American population had a major depressive episode in the last year
- Over a lifetime, 10% of men and 20% of women are likely to experience a depression.
- WHO: World-wide depression affects 121 million people, and is the 4th leading contributor to global burden of disease
- 30% of folks living with substance use disorders also have depression
- Often impairs occupational and interpersonal functioning, with considerable costs in lost or unproductive work days. It can adversely affect medical illnesses (in terms of adherence)
- CDC (June, '18): in 2016, almost 45,000 Americans died by suicide; it is the 10th leading cause of death in America

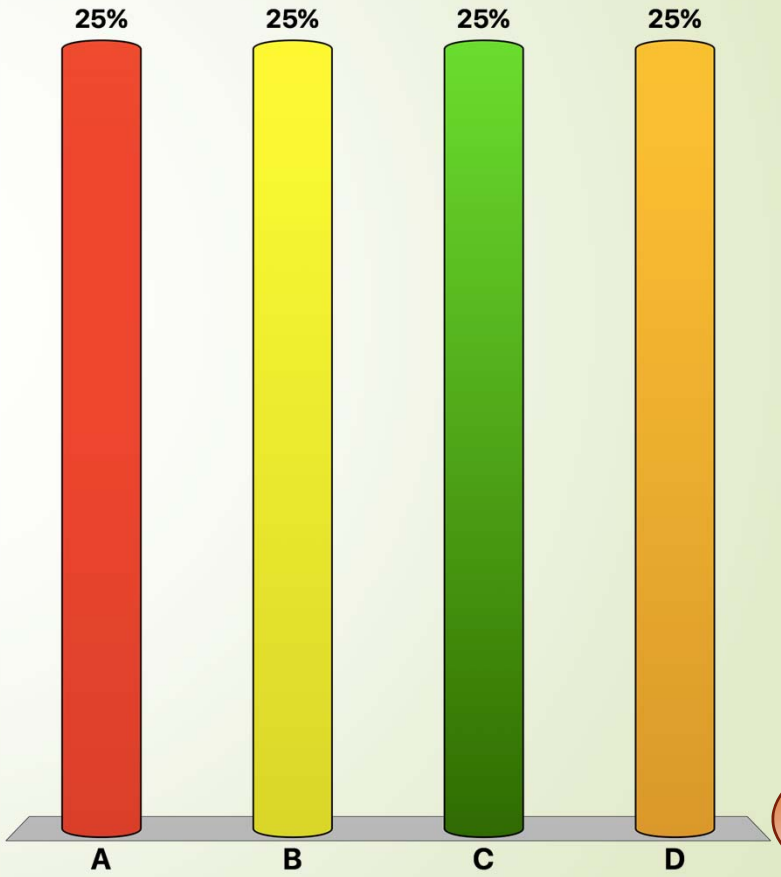
Which of the following is true for depression?

A. Men are more likely to experience a major depression than women

✓ B. Completed suicides are increasing in the United States

C. Traumatic life experiences rarely contribute to depression

D. Quantifying sleep and appetite do not help in making the diagnosis



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Contributors to Depression

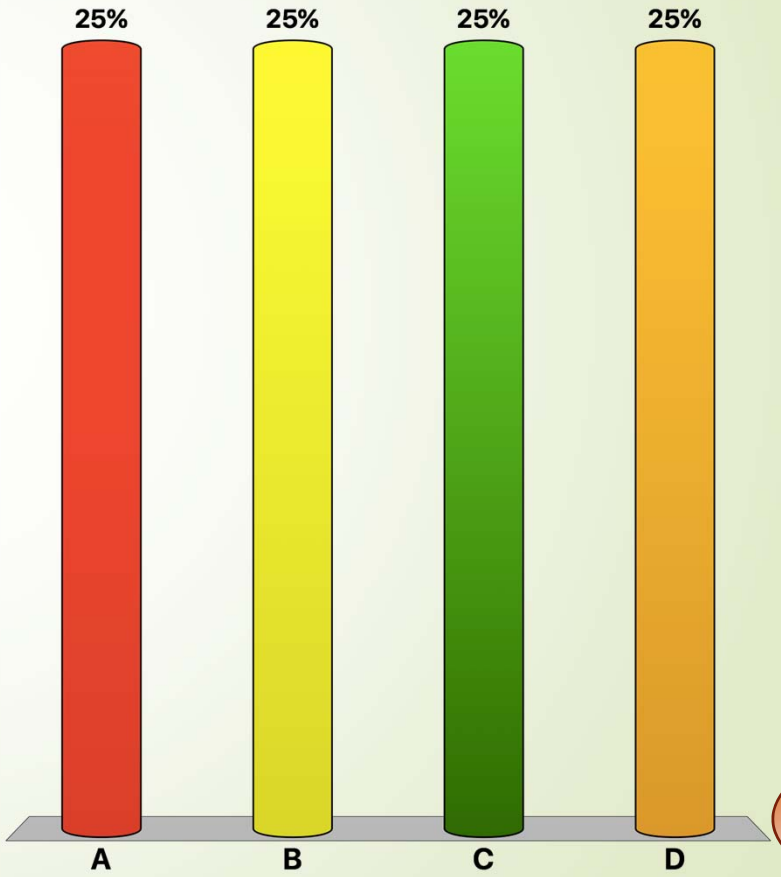
- Trauma (childhood, military, sexual, disasters)
- Genetics
- Life circumstances (housing, job, health, financial losses; relationship discord or terminations; deaths of family, friends, pets). Remember that “loss” is in the eye of the beholder.
- Substance use

Other Considerations

- Medications (steroids)
- S/P myocardial infarctions
- S/P cardiac surgery
- Chronic pain (and opioid abuse)
- Medical illnesses (Hypothyroidism, Pancreatic Cancer, Chronic Fatigue Syndrome, Vitamin D Deficiency, Dehydration, UTIs in elderly))
- May be seeing the “depressed” portion of a bipolar cycle

A brief paper-and-pencil test that can be used in the office to assess for depression is:

- ✓ A. PHQ-9
- B. MMPI
- C. Rohrschach
- D. Millon



Symptoms of Depression

- Often see tearfulness, blunted affect, anergia, poor hygiene
- Consider paper and pencil depression "tests": PHQ-9, Beck Depression Inventory
- DSM-5: 5 of the following for > 2 weeks
  - Depressed mood
  - Decreased interests, or capacity for pleasure
  - Appetite change (lose/gain weight)
  - Disrupted sleep
  - Psychomotor agitation or retardation (slowed motor, slowed speech)
  - Fatigue
  - Feelings of worthlessness
  - Decreased concentration or indecisiveness
  - **Recurrent thoughts of death, suicide, hopelessness: YOU HAVE TO ASK!!**

Treatment of Depression

- Multi-pronged approach
  - Pharmacologic
  - Therapy
  - Nutrition
  - Exercise
  - Faith-based considerations
  - Brain stimulation (TMS (transcranial magnetic stimulation); ECT; light therapy)

Pharmacologic Approaches

- Remember it takes weeks (except for esketamine) for medications to work, so education and adherence is imperative.
- SSRIs (serotonin specific reuptake inhibitors)
- NSRI (norepinephrine serotonin reuptake inhibitors)
- Atypical antidepressants
- MAOIs, TCAs
- SDAM (serotonin/dopamine activity modulators): typically add-ons
- Esketamine: recent FDA approval, nasal spray, only provided on-site of certified treatment centers; once administered must remain in clinic for observation
- Psilocybin

Pharmacologic Approaches

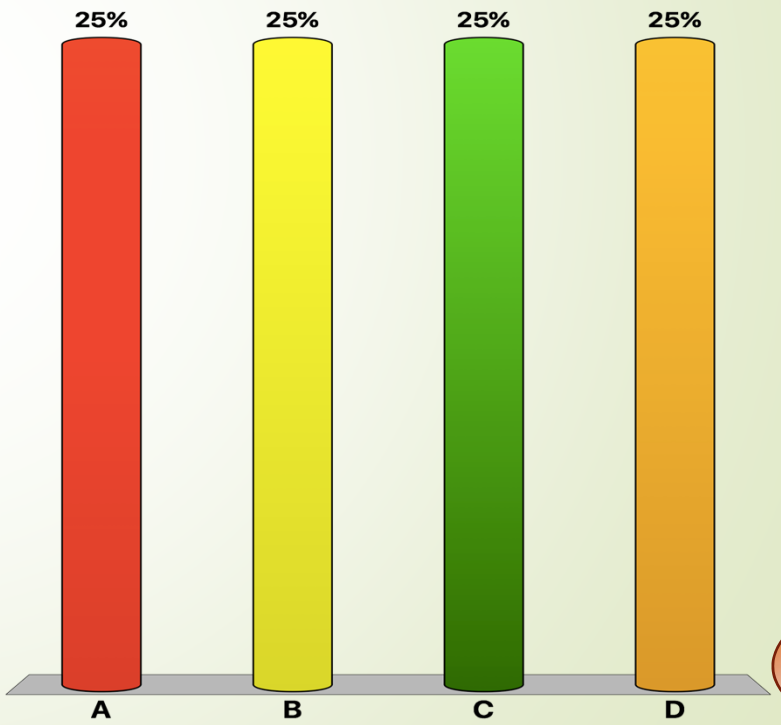
- Educate about response time
- Educate about potential side effects: akathisia, sexual side-effects, sedation, gastric symptoms, headaches, serotonin syndrome. Prolonged QT has been seen in citalopram.
- For SDAM be aware of side effects of atypical antipsychotics (akathisia, GI symptoms, metabolic syndrome, tardive dyskinesia, weight gain, sedation, NMS)
- If patient is in reproductive age, note the potential for potential impact on pregnancies
- Avoid abrupt withdrawal

Therapy

- Cognitive behavioral therapy
- Interpersonal Therapy
- Psych-dynamic therapy
- Supportive therapy
- When in doubt, refer

This is the term for those whose anxiety manifests with a sudden onset of fear, combined with racing heart, sweating, shakiness, shortness of breath and a sense of impending doom

A. Generalized anxiety disorder
B. Phobias
✓ C. Panic attacks
D. Post-traumatic stress disorder



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Anxiety: Excessive worry, > 6 months, causes significant problems in one's life

- Generalized anxiety disorder: restless, easily fatigued, decreased concentration, irritable, muscle tension, difficulty controlling worry, poor sleep
- Panic Attacks (2.7%): sudden, intense fear; heart palpitations, tachycardia, diaphoretic, shakiness, short of breath/choking, feelings of impending doom, out of control; sets up anticipatory concern and avoidance
- Phobias (8.7%): intense fear of specific object or situation (especially common is social anxiety: fear of social performance)
- Obsessive-compulsive disorder (OCD)(1%): recurrent thoughts, urges, images; repetitive behaviors
- Post-traumatic Stress Disorder (PTSD) (3.5%): had stressor, now with intrusive symptoms, avoidance, negative alteration of mood/cognition, alteration in reaction/arousal, > 1 month, causing functional impairment

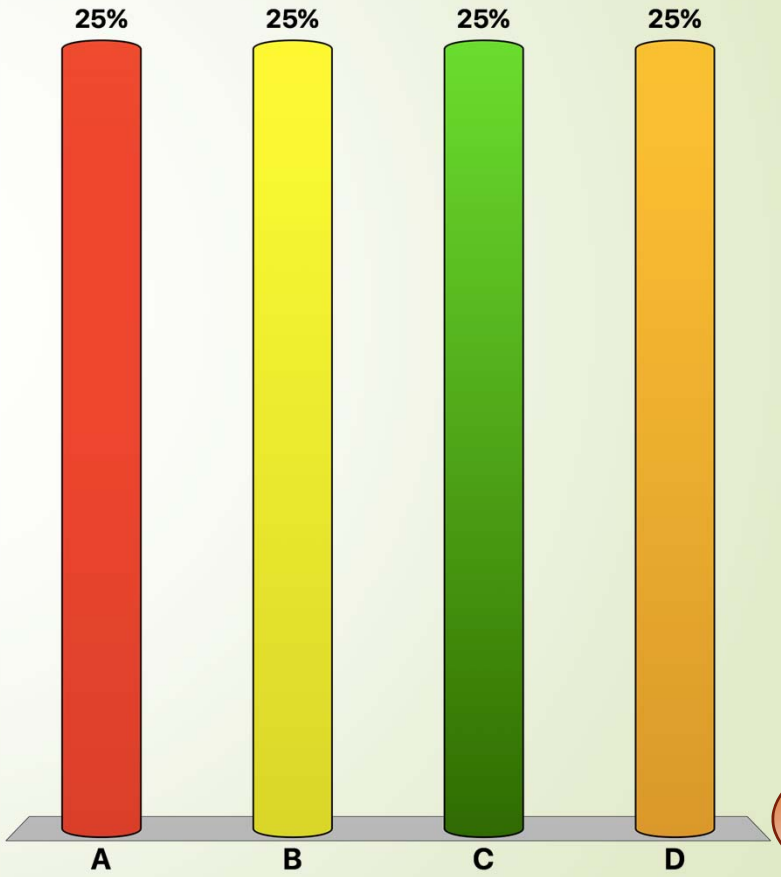
Which of the following is false?

A. Thyroid disease can be an alternative biologic cause for both depression and anxiety

B. Substance use disorders are often associated with anxiety

C. There are multiple medications available to treat depression; they just take a while to work

✓ D. Long term benzodiazepine use is ideal for treatment of anxiety disorder



Prevalence and Impact

- NIMH: 18.1% of adults (or 40 million Americans) from ages 18-54 have some form of anxiety disorder
- 3-5 times more likely to go to their doctor, and 4-6 times more likely to be hospitalized psychiatrically
- 41% of employees surveys in industry report high anxiety
- ½ of college students seek help for anxiety
- **Increased use of alcohol and marijuana to "treat" anxiety**

Other Considerations, Contributors

- Shy or behaviorally inhibited as a child
- Exposure to stressful, negative life or environmental events
- Genetics (anxiety or other mental illness in biologic relatives)
- Health: thyroid, carcinoids, heart arrhythmias, caffeine

Treatment Considerations

- Pharmacologic:
  - Benzodiazepines: use for short time, concern for tolerance, addiction, misuse
  - Antidepressants: SSRIs, SNRIs
  - Beta blockers:
  - Buspirone

  - OCD: Clomipramine, fluvoxamine, fluoxetine, sertraline
  - PTSD: Sertraline, Prazosin (for nightmares)

Therapy

- Cognitive behavioral therapy (individual, groups)
- Exposure therapy
- Relaxation techniques (breathing, muscle)
- Stress management
- Mindfulness
- Meditation

Summary

- Depression and anxiety are common, their symptoms are not subtle (if you can get patients to talk about them), and their impact can be profound.
- There continues to be stigma related to mental illness, so engagement techniques should be utilized (paper quizzes, open-ended questions, non-judgement re: symptoms). It's helpful to get collateral input.
- These conditions are treatable, and patients need education, quick follow-up, referral for therapy and peer and family supports.
- If patients are suicidal or psychotic, refer for same day evaluation (typically ER)