Psychopharmacology

Best practices for non-prescribers

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Overview and Objectives

- Provide overview of common diagnoses observed in Collaborative Care model
- Articulate Rationale for the use of Psychotropic medications
- Better understand side effects, titration and Discontinuation Syndrome
- Best practices to support clients engaged in Collaborative Care model

Major Depressive Disorders and Differential Diagnosis

- **Reactive Sadness** -reaction to a minor event, rarely interferes with functioning is transient lasting from a few hours to a few days
- **Grief** - typical response to a interpersonal loss (death/separation/divorce) more prolonged than reactive sadness, can last for many months sadness and loneliness can persist for many years following a significant loss. It is important to note approximately **25%** of individuals who experience a significant loss will go on to develop **Persistent Complex Bereavement Disorder: DSM 5 2013**. Additionally approximately **10%** will develop symptoms of **Post Traumatic Stress Disorder**.

Major Depressive Disorders and Differential Diagnosis

Medical Illnesses and Medications- certain medical disorders and medications can sometimes result in biochemical changes that affect the neurotransmitters in the brain which can cause depressive symptoms.

The most common medical disorder accounting for approximately 5-10% of major depressive episodes is … **HYPOTHYROIDISM**

********* ***Always important to screen for thyroid disease**********

Some Common Disorders That May Cause Depression

- Anemia
- Apnea
- Asthma
- Chronic Fatigue Syndrome
- Thyroid Disease
- Diabetes
- Influenza
- Lyme Disease
- Malignancies
- Menopause
- Multiple Sclerosis
- Parkinson’s Disease
- Postpartum Hormonal Changes
- Rheumatoid Arthritis
- Ulcerative Colitis

Please note *** this is not a comprehensive list**

Some Drugs that May cause Depressive Symptoms

- Antihypertensives
  - Propranolol
  - Methyldopa
  - Clonidine
- Corticosteroids/Hormones
  - Cortisone acetate
  - estrogen/progesterone (BCP)
- Antiparkisons
  - Levodopa
  - Carbidopa
  - Amantadine
- Alcohol
- Caffeine

Please note *** this is not a comprehensive list*****

Major Depressive Disorders and Differential Diagnosis

Clinical Depression- Pathological process

Characteristics:

Can occur in response to psychological stressors or may occur without precipitating factors

Specific changes in vegetative patterns (sleep, appetite, sex drive) and non specific physical complaints

Depressed mood often with irritability (continuous and pervasive)

Loss interest in daily activities

Irrational or exaggerated erosion of self esteem

Increasing impairment of normal functioning (work, school, intimate relationships)

SIGECAPS

S-Changes in sleep pattern

i - Changes in interests or activities

G- Feelings of Guilt or increased worry

E- Changes in Energy

C-Changes in Concentration

A-Changes in Appetites

P- Psychomotor disturbances

S Suicidal Ideation

When to Prescribe

The most important guideline for prescribing antidepressant medication is whether or not there are sustained physiological symptoms. Occasional disturbances of sleep or appetite DO NOT warrant medication treatment,

However continued weight loss, marked fatigue, and poor sleep most nights indicate a trial of antidepressant medications, also clients who may be deemed poor candidates for psychotherapy should be considered for trial of medications

Outcome Targets and Goals in medication therapy for CCMP

Improvement defined as:

50% decrease in PHQ 9/GAD 7 score AND/OR

PHQ 9/GAD 7 score below 10

Remission defined as:

PHQ 9/GAD 7 score of less than 5

Clinical Milestones in Treatment

Acute treatment phase

Goal: Relieve symptoms, identify correct medication and optimize dose

duration : 1-3 months

Continuation of therapy phase:

Goal: Resolve depressive episode, return to functioning

Duration 4-6 months

Long -term maintenance phase:

Goal: Prevent relapse

Duration: 3 months to 5 years - depending on # of lifetime episodes

Treatment Considerations

- Prior Response and/or treatment history in patient and family members
- Patient Preferences
- Side effect profile
- Safety in overdose
- Availability and costs
- Drug to Drug Interactions

Pharmacotherapy

Key Principles

- Use adequate doses for adequate amount of time
- Start SLOW and work with side effects
- Titrate to effective dose
- Change medication if not effective

Usually after 8-10 weeks

Pharmacotherapy

Effective in:

Major Depressive Disorder

Chronic depression

Comorbid Medical illness

- Chronic pain

Antidepressant Medications

SSRI- Selective Serotonin Reuptake Inhibitors

Citalopram (Celexa)

Escitalopram (Lexapro)

Fluoxetine (Prozac)

Paroxetine (Paxil)

Setraline (Zoloft)

Viibryd (Vilazodone)

Antidepressant Medications

SNRI- Selective Norepinephrine Reuptake Inhibitors

Desvenlafaxine (Pristiq)

Duloxetine (Cymbalta)

Milnacipran (Savella)

Venlafaxine (Effexor)

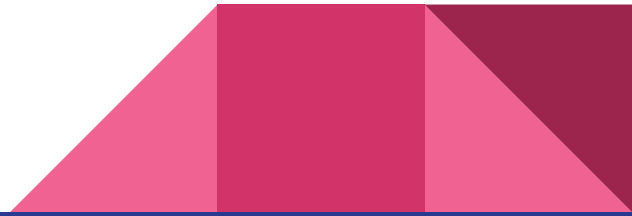
Antidepressant Medications

Others:

Buproprion (Wellbutrin)

Mirtazapine (Remeron)

Trazodone (Desyrel)



Medication Guidelines

Acute Phase:

- Elicit patient commitment
- Start with SSRI (Escitalopram, Sertraline)
- Early follow up (within 1-3 weeks)
- Repeat screener tool (PHQ9) at every visit
- Increase dose of medication every 2-4 weeks up to maximum dose or until remission

Medication Guidelines

Continuation Phase:

Adequate Response:

Continue follow up with screener (PHQ9) administration and treatment

Inadequate Response:

Consult psychiatry

Formulate secondary treatment plan in conjunction with psychiatry and implement with oversight

Medication Guidelines

First Episode- after successful completion of Acute and Continuation phase in first episode depression gradually reduce dose over a period of 4-6 weeks.

- No return of symptoms discontinue medication and educate patient to be aware of re-emerging symptoms and seek care should symptoms re-emerge.

Second Episode- With Risk factors (family history, first episode occurring before age 18, or first episode severe.- Recommend life long medication treatment

Without Risk Factors gradually discontinue medications

Third or later episode- Recommend life long medication treatment

Antidepressant Side Effects

- SSRI and SNRI very effective in treatment of depression
- Many patients experience a increase in anxiety, restlessness, and insomnia during the first 1-2 weeks of treatment (activation)
    - Can lead to patient discontinuing medication
    - Effective solution can be to co administer low dose benzodiazepine for first 3-4 weeks then discontinued
    - If only symptom of activation is insomnia consider Trazodone

Antidepressant Side Effects

SSRI:

GI Distress

Insomnia

Restlessness

Agitation

Headache

Fine Tremor

Dizziness

Sexual Dysfunction

SNRI:

Same as SSRI

- Small risk of blood pressure elevation at higher doses = Check BP

Common Antidepressants and Side Effects

Buproprion - (Wellbutrin)

- Agitation
- Decreases seizure threshold

Duloxetine (Cymbalta)

- Nausea

Mirtazapine (Remeron)

- Sedation
- Weight Gain
- Restless leg

Discontinuation Syndrome

Emerges 1-3 days after discontinuation of medication

Symptoms: dizziness, nausea, vomiting, lethargy, fatigue, Flu-like symptoms (aches, chills) and sleep disturbance

Psychological Symptoms: irritability, anxiety.

Most frequently occurs with Paroxetine (Paxil) due to short elimination.

Least frequently occurs with Fluoxetine long ½ half and active metabolite

IMPORTANT- ALWAYS UTILIZE SLOW TAPER OF SLOW ACTING

FDA “Black Box” Warning

Suicidality and Antidepressant Medications

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of [Insert established name] or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber.

Anxiety: Biological Psychiatry

Neurotransmitter dysfunction in anxiety disorders is influenced by:

Genetics

Life experiences

Dysregulated Neurotransmitters in Anxiety Disorders:

Low Serotonin

Also plays role in depressive disorders

Overactive/Excess stress hormones:

Norepinephrine/epinephrine and cortisol -causes physical affects of anxiety (rapid heartbeat, sweating)

Low levels of Gaba

Calming neurotransmitter when low - we are on “edge”

Generalized Anxiety and Differential Diagnosis

Generalized Anxiety Disorder - long term, low level fairly continuous anxiety

No specific current life stressors .

Stress Related Anxiety- typically functions well, symptoms emerge in the face of major life stressor

Panic Disorder- Repeated episodes of full blown panic. Phobias can at times develop

Social Anxiety-Anxiety experienced only in social settings

Medical illnesses and Medications presenting with Anxiety Symptoms- Certain diseases/conditions can result in biochemical changes that produce anxiety symptoms

Anxiety as part of a Primary Mental Disorder - Anxiety which accompanies a comorbid diagnosis

Symptoms of Anxiety

- Trembling, feeling shaky, restlessness, Muscle Tension
- Shortness of breath, smothering sensation
- Tachycardia (rapid heart rate)
- Sweating, cold hands and feet
- Lightheadedness, dizziness
- Tingling of skin
- Diarrhea, frequent urination
- Feelings on unreality
- Initial Insomnia (difficulty falling asleep)
- Impaired attention and concentration
- Nervousness, edginess, tension

Common Disorders that May Cause Anxiety

Adrenal Tumor

Alcoholism

Angina

Cardiac Arrhythmia

Cushing Disease

Coronary Insufficency

Delirium

Hypoglycemia

Thyroid disease

Mitral Valve Prolapse

Parathyroid Disease

Partial Complex seizures

Post Concussion Syndrome

Premenstrual Syndrome

****** Please Note this is not a comprehensive List******

Drugs that May Cause Anxiety

Amphetamines

Appetite Suppressants

Asthma medications

Caffeine/energy drinks

CNS Depressants (withdrawal)

Cocaine

Nasal Decongestants

Steroids

Stimulants

When to Prescribe

Treatment differs depending on differential diagnosis.

Generalized Anxiety Disorder -SSRI, Venlafaxine and Buspirone have been shown to be effective in treating symptoms and do not cause dependence

Stress Related Anxiety- Minor tranquilizers (Benzodiazepines) are very helpful in reducing anxiety symptoms (especially insomnia and restlessness) which often accompany situational stress. Tranquilizers should only be used for SHORT TERM (1-4 weeks)

When to Prescribe

Panic Disorder - a isolated panic attack is not sufficient evidence of true panic disorder. Four or more panic attacks within a period of one month suggest panic disorder. Spontaneous attacks (coming out of the blue) lasting minutes not hours.

Social Phobia generally treated with psychotherapy, at times SSRI therapy can be beneficial.

Medical Illnesses/Medications Causing Anxiety- in almost all instances treating underlying cause or stopping offending drug will result in termination of symptoms

Anxiety Disorder as part of another Primary Mental disorder- Treat underlying disorder

Approved Generalized Anxiety Medications

SSRI:

Paroxetine (Paxil)

Escitalopram (Lexapro)

SNRI:

Duloxetine

Venlafaxine

Benzodiazepine:

Alprazolam (Xanax)

Clonazepam (Klonopin)

Other Medications:

Diphenhydramine (Benadryl)

Hydroxyzine (Vistaril)

Gabapentin (Neurotin)

Medication Guidelines

SNRIs- Venlafaxine, Duloxetine, Desvenlafaxine - effects both Serotonin and norepinephrine

Generally used after failed trial of two SSRI

Buspirone- unique non addictive agent with effects on Serotonin and Dopamine

approved for the treatment of Anxiety Disorders*

Add to SSRI or use in those who can’t tolerate SSRI

2-3 times daily dosing

Medication Guidelines

Benzodiazepines:

- Controlled substances - tightly regulated
- Potential for addiction
- Not FDA approved for more than 6 weeks of use
- Helpful for acute anxiety and episodic panic (PRN)
- Increased risk for falls in elderly

Long term use associated with depression, cognitive risks include dementia

Benzodiazepines

Patients with substance use disorders should not use benzodiazepines to treat anxiety, insomnia or anything else, for the same reason the should not consume alcohol, regardless of the primary drug used. Once the addiction “switch” has been activated, it never goes off again.

Strategies for Optimizing Adherence

- Provide rationale for medication use
- Careful attention to side effects
- Address fear of dependence and loss of control
- Enlist a “team (PCP, Family, Spouse)
- Address concerns in relation to prior experience with medication
- Increase contact with brief check-ins
- Provide specific instructions (don’t stop taking medications regardless of symptoms changing without consulting provider)
- Use screener tools (PHQ 9, GAD 7)
- Controlled Medication agreement - Benzodiazepines

Key Educational Points for Clients

- Antidepressants only work if taken every day
- Antidepressants are not addictive
- Benefits from medication appear slowly
- Continue antidepressants even after you feel better
- Mild Side effects are common and usually improve over time
- If you are thinking about stopping medication -call first
- The goal of treatment is complete remission; sometimes it takes a few tries