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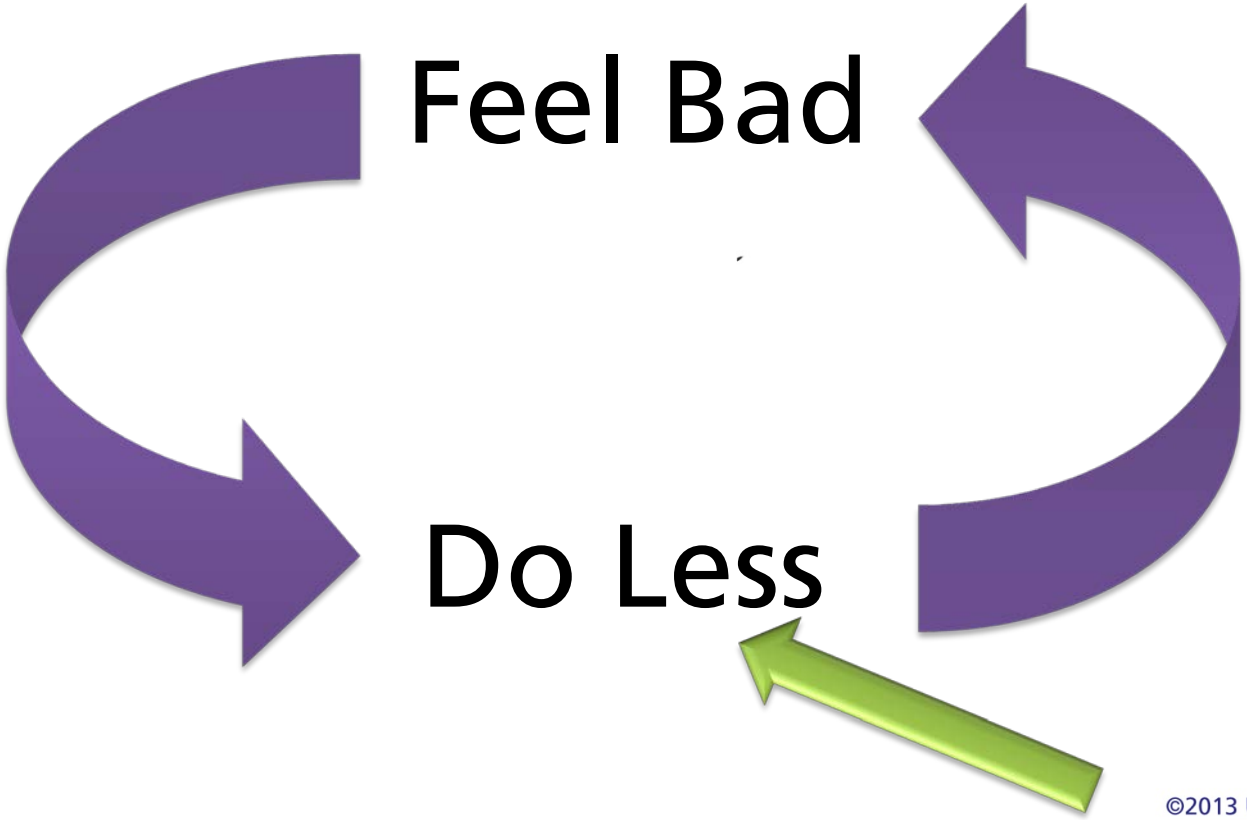
Psychiatry & Behavioral Sciences

Evidence-Based Depression Treatment

Many Treatment Options

- *Brief Behavioral Interventions for Primary Care*
  - Pleasant Event Scheduling / Behavioral Activation
  - Problem-Solving Treatment
  - Other Evidence-based Therapies
- *Medication Primer for Primary Care*
  - Psychopharmacology for primary care
  - Supporting medication therapy as a team
  - Talking with patients about medication

Why brief behavioral interventions?



Role for PCPs in Behavioral Treatment

Opportunity

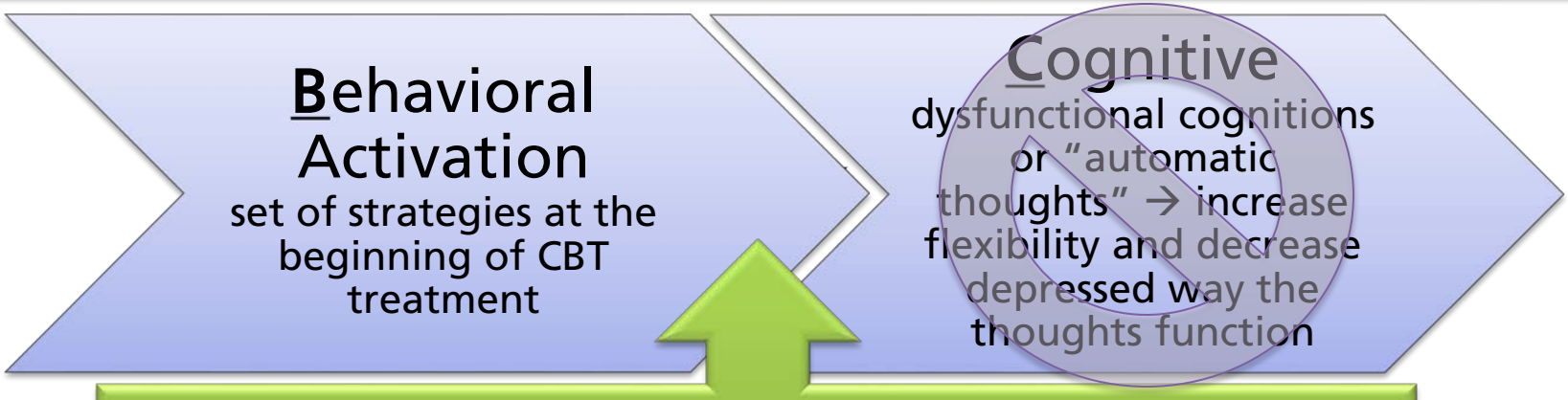
- Sell
- Explain WHY recommending engagement in Collaborative Care

Relationship

- Engage patients and strengthen commitment
- Integrate with medication treatment

CBT

First line depression treatment



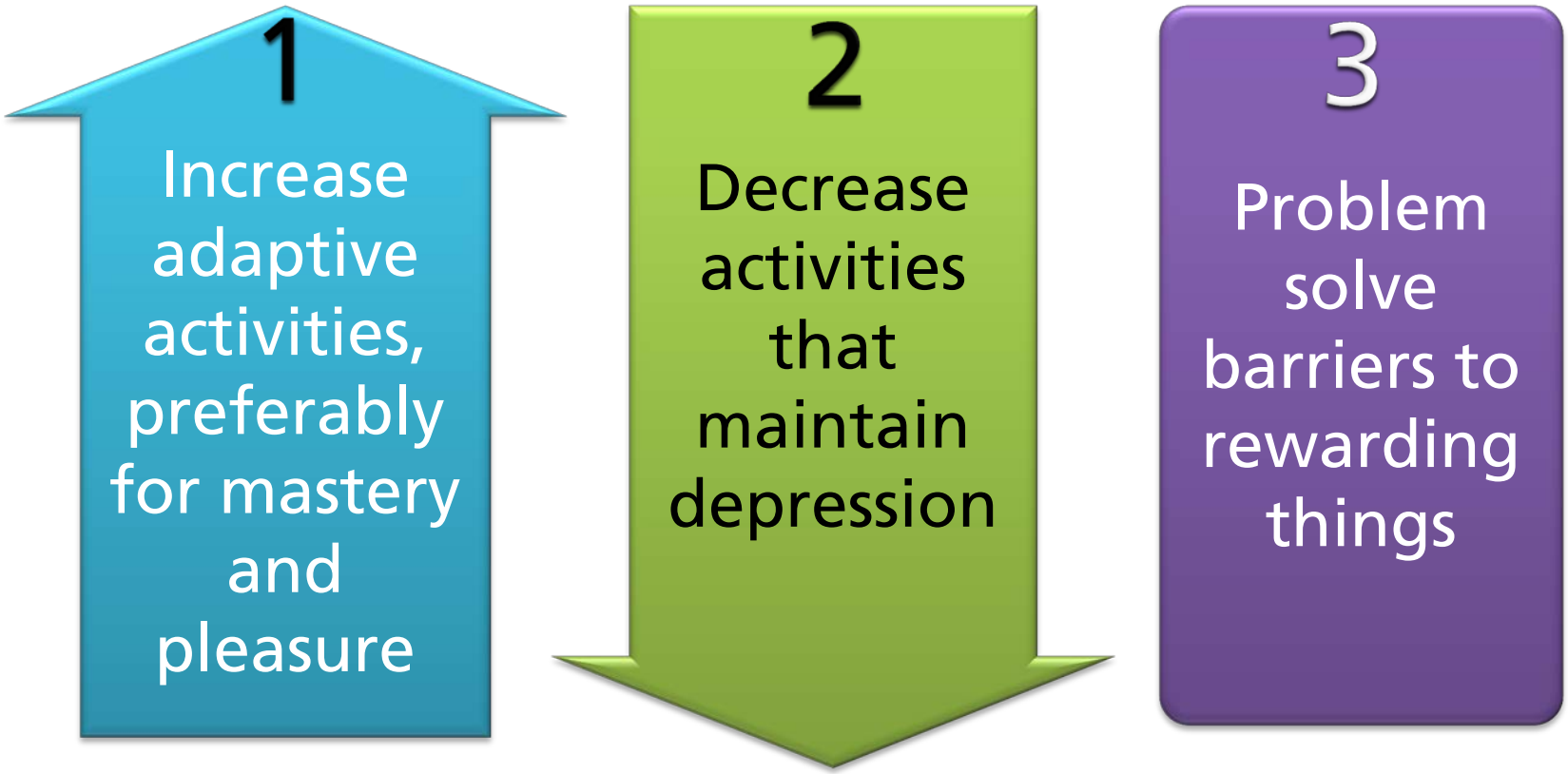
Good evidence for C, B, and C+B

BA: Cuijpers et al 2007, Ekers et al 2008, Mazzucchelli et al 2009; listed as an evidence-based treatment for depression by the National Institute for Health and Clinical Excellence (2009)

Case Example: RB

- 30 y/o Caucasian woman, mother of 2 (ages 8 and 2), 2nd marriage, unemployed since pain began, some college
- Lifetime pattern of depressive episodes starting as a teenager, baseline PHQ-9 23 (severe) & GAD-7 11 (moderate), average pain rating 5/10

3 Goals of Behavioral Activation



Doing BA in Primary Care

- Explain the model
- Ask lots of questions until you have a good formulation
- Select BA targets
- Follow-up

Explaining the Model: How depression happens

Case Example: RB

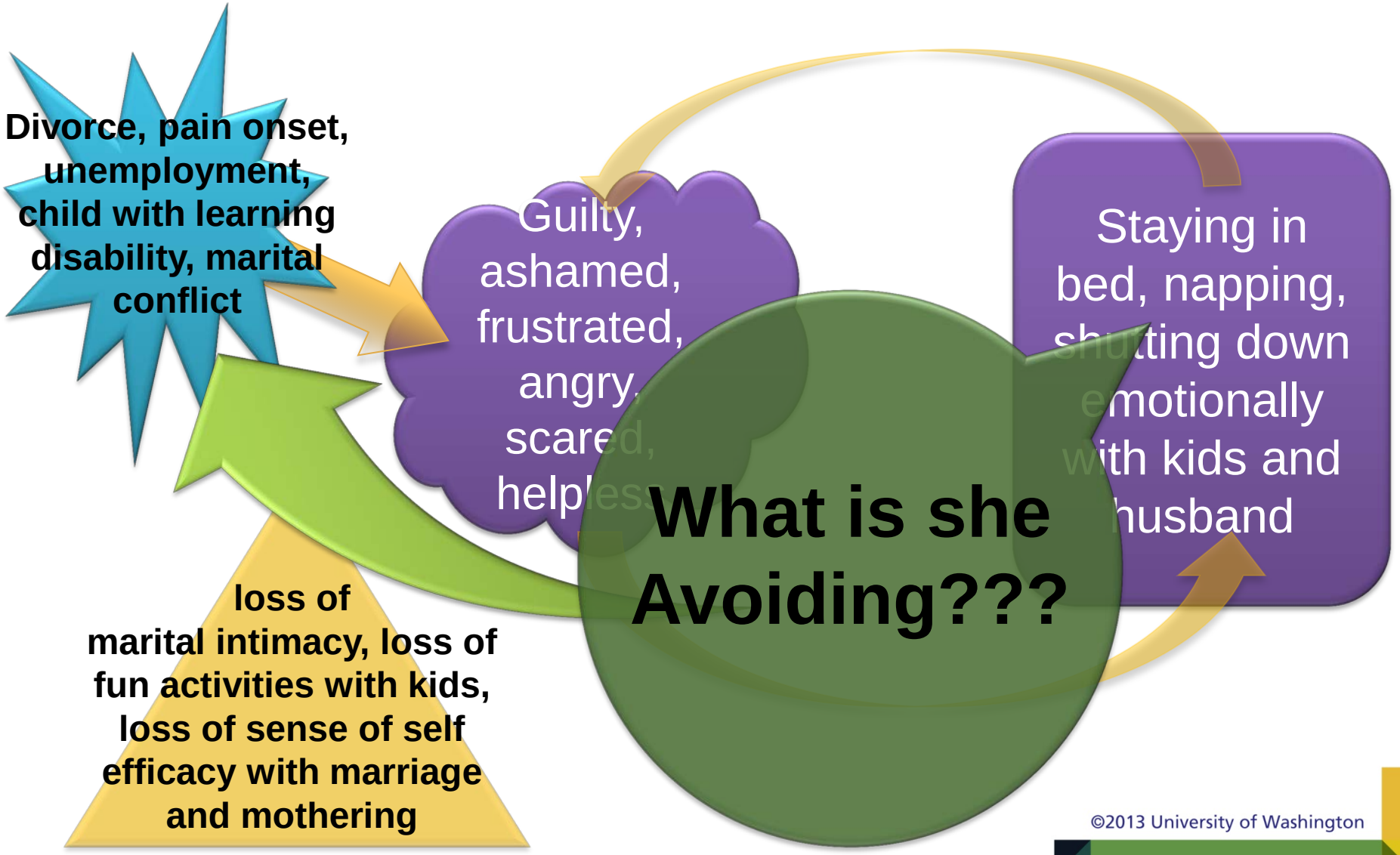
- 30 y/o Caucasian woman, mother of 2 (ages 8 and 2), 2nd marriage, unemployed since pain began, some college
- Lifetime pattern of depressive episodes starting as a teenager, baseline PHQ-9 23 (severe) & GAD-7 11 (moderate), average pain rating 5/10
- Key complaints: my neck hurts; my arm is screwed up; what is wrong with me?; the pain is ruining my life and ability to care for my children
- 1-2 years of worsening neck pain and tingling, numbness, weakness in left lower extremity; MRI evidence of disk degeneration in C5-6
- Course of tx in the Center for Pain Relief:
  - Increase sertraline to 100mg
  - gabapentin 900mg
  - trigger point injections – no pain reduction
  - nortriptyline 10mg at bedtime
  - baclofen
  - brief cognitive behavior therapy

RB: Pitching the Model

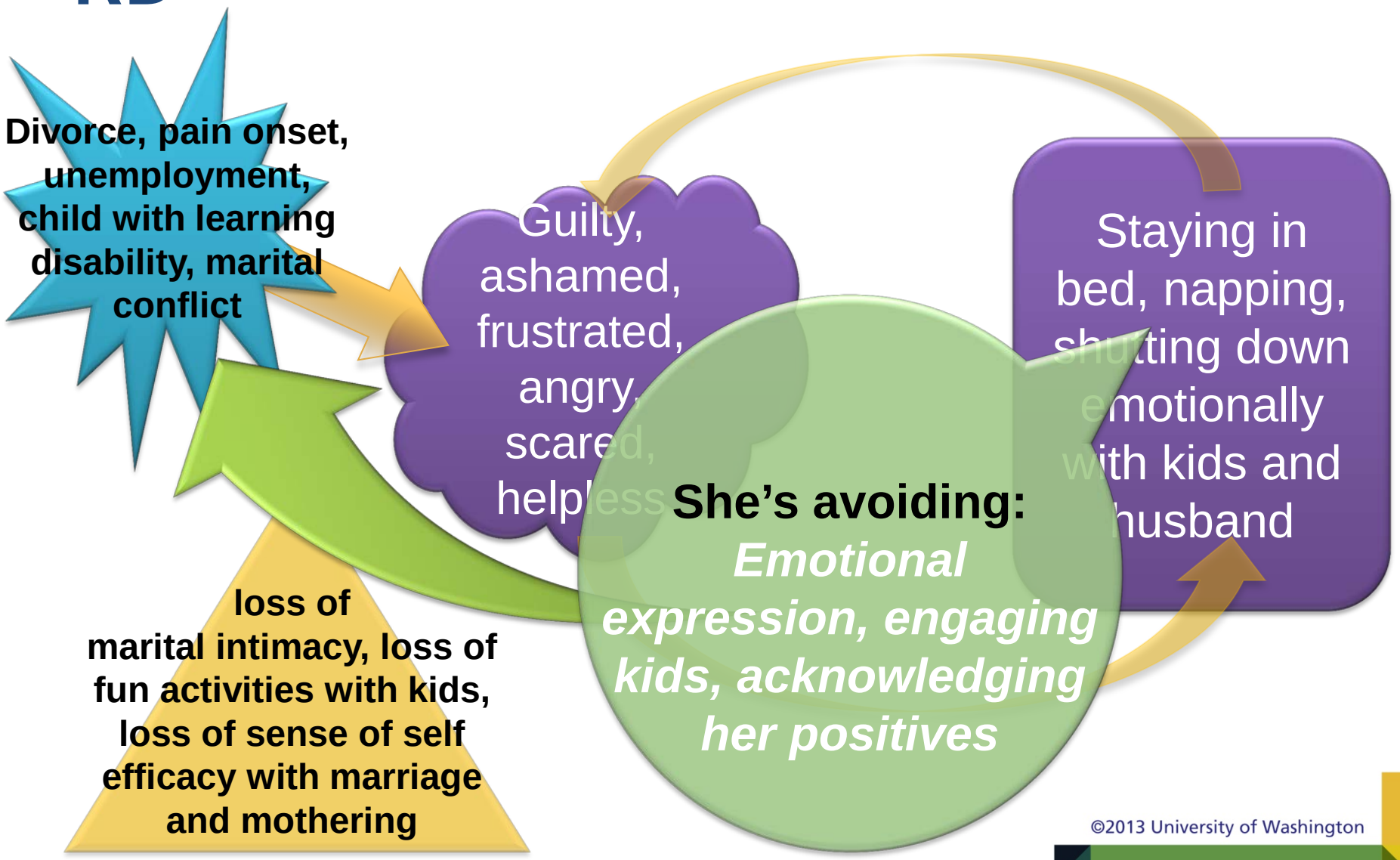
Formulation

- What are the avoidance patterns?
- How can we interrupt the avoidance and/or switch to approach rather than avoidance?
- How can we build mastery and pleasure?

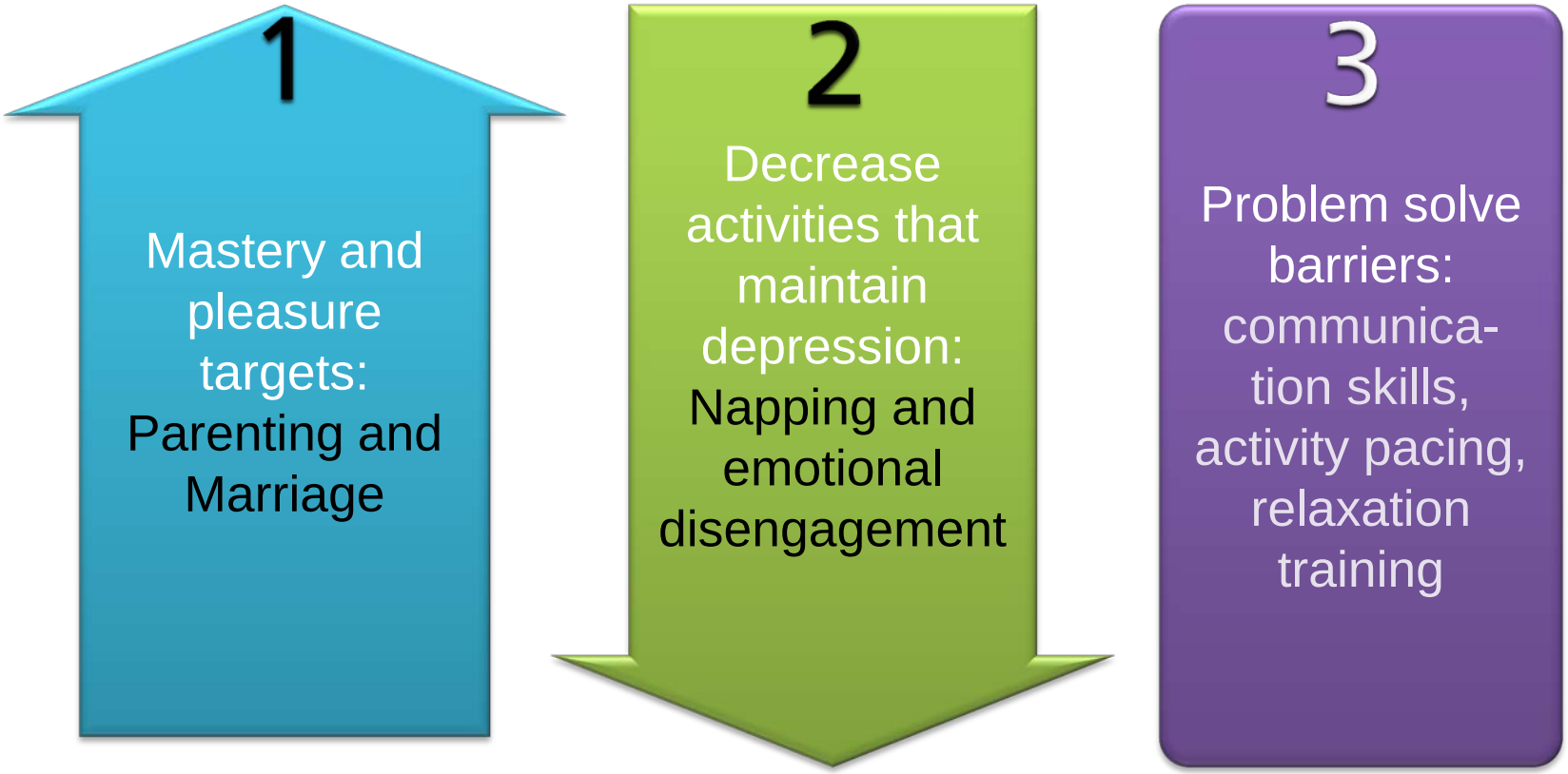
RB



RB



3 Goals of BA



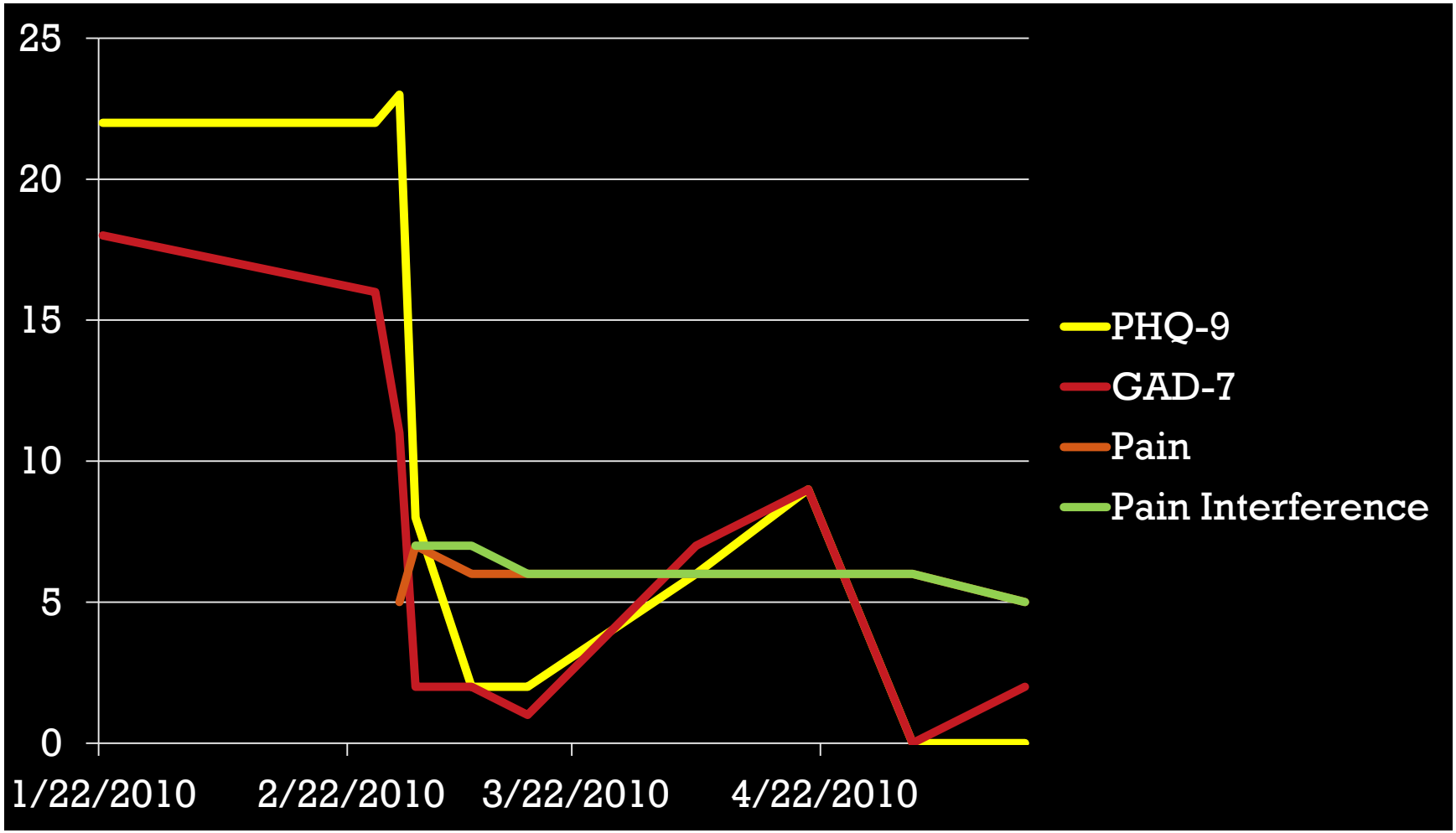
Selecting RB's BA targets:

- **What she worked on…**

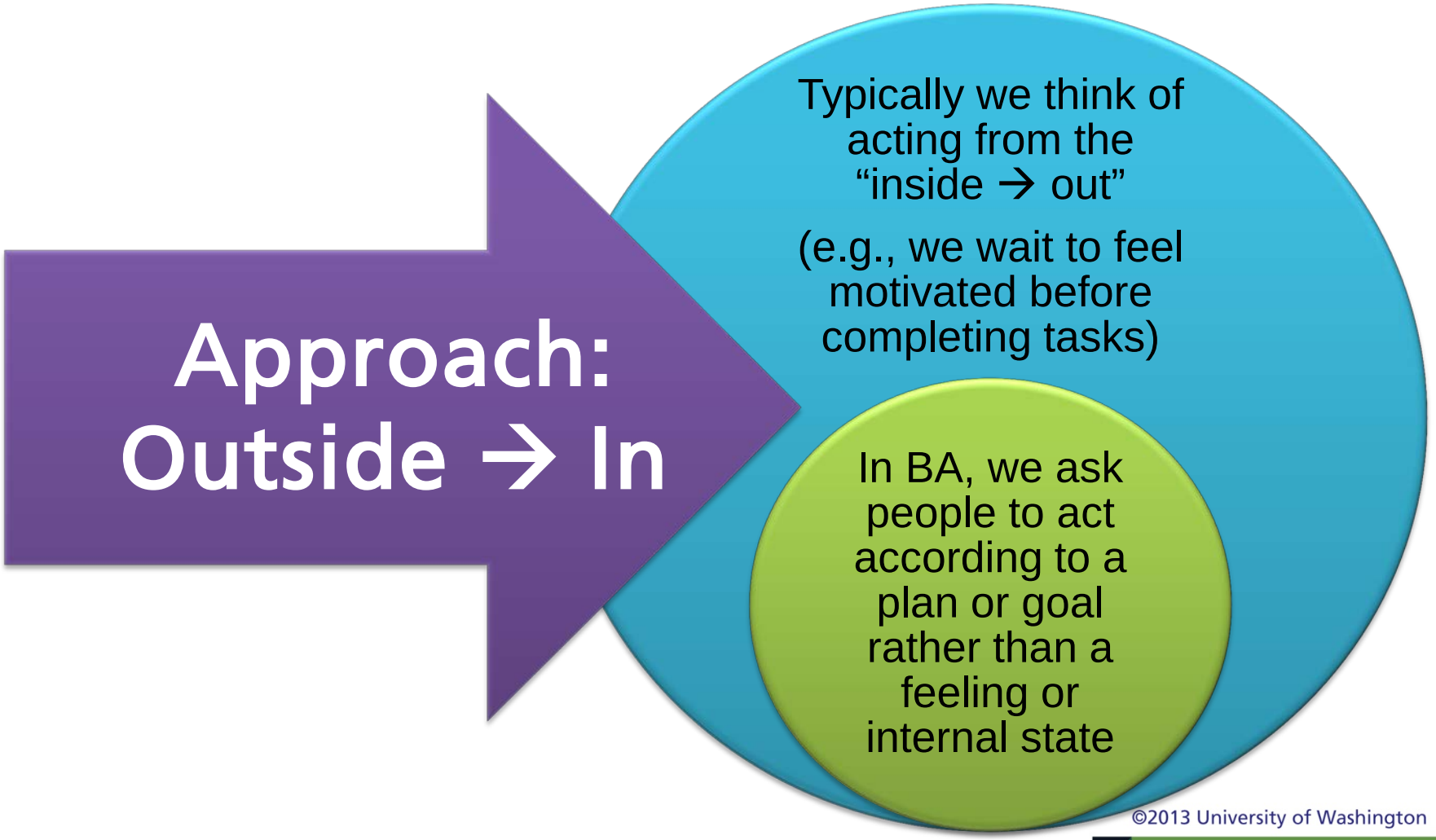
Won't talk to husband, avoiding emotional expression with her partner	Stopped activities with kids	Won't acknowledge her accomplishments

• Talk to husband about frustrations
• Take timeouts but plan when you will re-engage when fights happen
• Try reflective listening
• Increase physical intimacy
	• Pace activities with kids
	• Dance with them, moving her neck especially; reduce guarding activity
		• Internal validations for her motherhood and accomplishments
		• She chose to:
		  • Organize and decorate her house
		  • Improve her attire, put on make-up, do her hair

RB's Symptoms: 8 visits over 4 mos



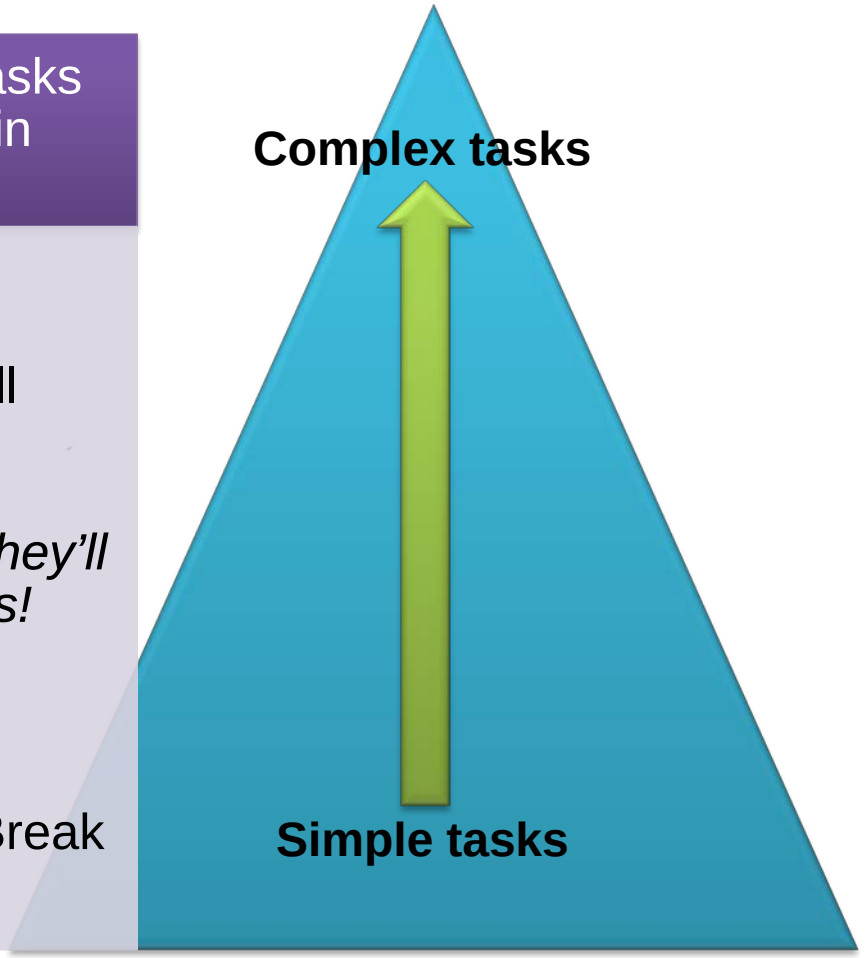
Maximizing Activation



Avoiding Mount Everest: Selecting the BA Targets

Assign increasingly more difficult tasks to move toward full participation in activities

- *Help break tasks down into manageable tasks*
  - Mastery and success of one small task will increase likelihood of completing other tasks
- *Have them tell you what and how they'll do the task (Details! Details! Details! Have them walk you through it)*
  - Help problem solve and ask how likely it is they will do it.
  - If it seems too challenging, it is! Break it down further.



Follow-up

ALWAYS ask about the target behavior the next time you see the patient

Expect them to not do the activity and don't punish

If goal was not accomplished →

Ask 3 questions:

Do they have buy in to the treatment?

Did they simply forget?

Was it a Mt Everest?

Role Play with Patient from Video

- 60yo female presenting with depression and pain
  - Life events: Pain
  - Feeling Bad: Not feeling like doing anything,
  - Doing Less: Not swimming, less contact with grandchildren, poor sleep
- Instructions:
  - Each person will play their part on the team
    - care manger is care manger, PCP is PCP etc…
  - Choose one person to be the patient
  - Take turns explaining the model of depression

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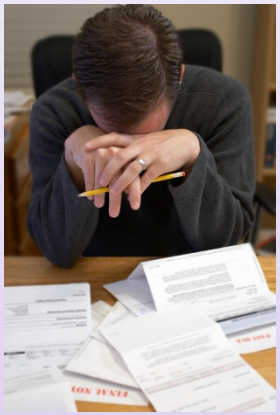
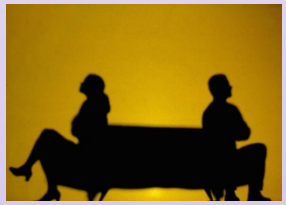
Problem-Solving Treatment (PST):

Introduction

Problem-Solving Treatment (PST):

UNIVERSE OF PROBLEMS





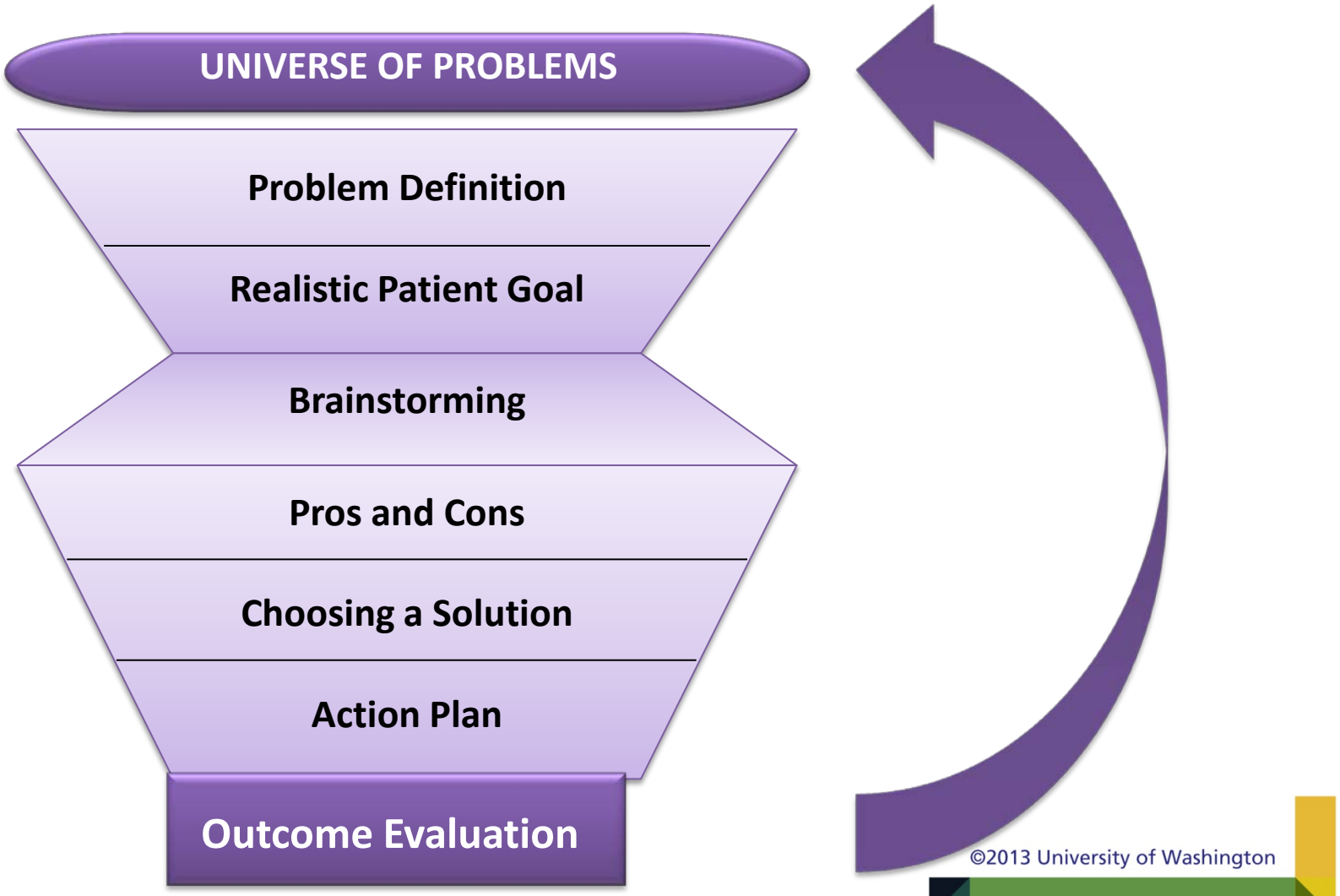
FAST

- Engage patient in what they care most about

FOCUS ATTENTION

- Training brain to solve problems

Problem-Solving Process



Team Approach to PST

PCP

- Explains the model of depression (basic)
- Provides referral to CM

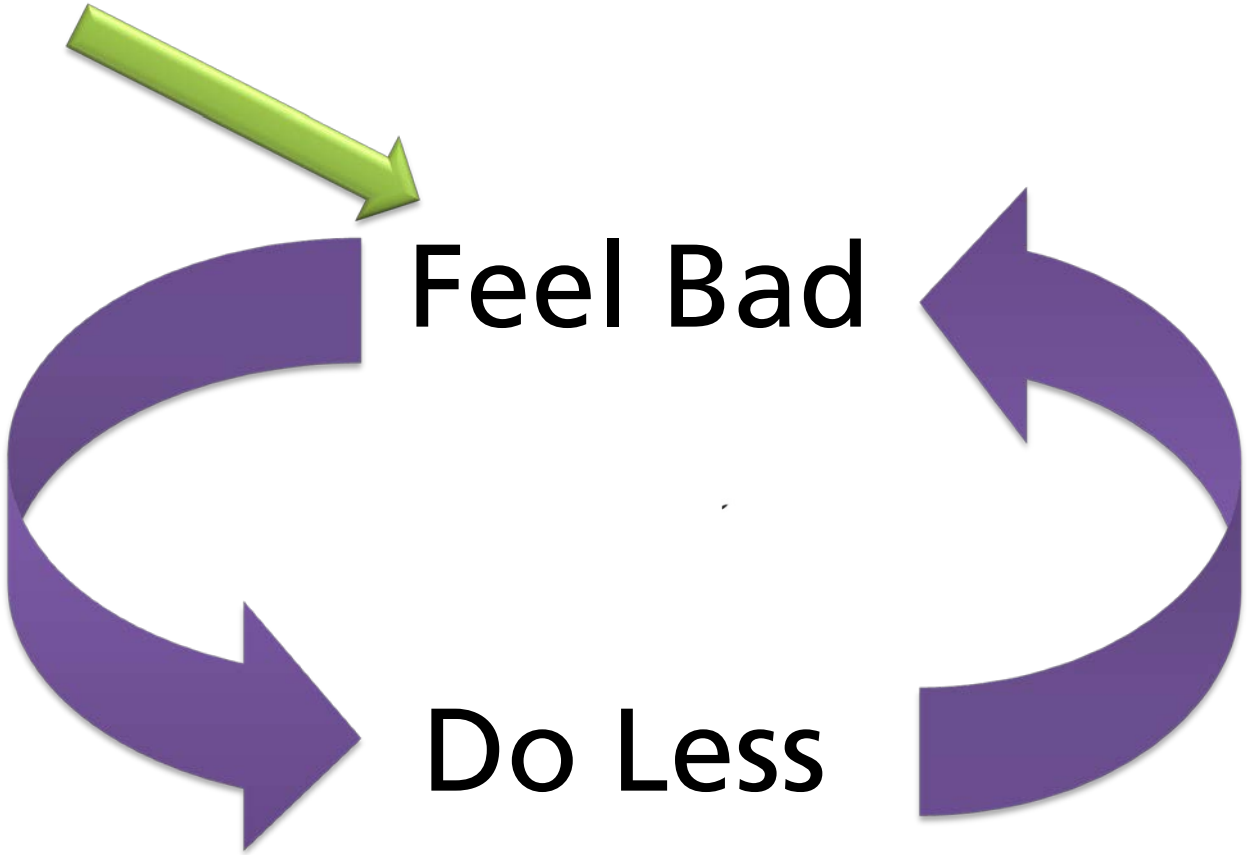
Care Manager

- Engages the patient in PST
- Delivers PST in primary care setting

Psychiatric Consultant

- Supports Care Manager during consultation
- Makes additional recommendations as needed

Medications



Role for Care Managers in Medication Treatment

Opportunity

- Time
- Different relationship

Skills

- Engaging patients
- Assessing patients
- Supporting patients

Antidepressants 101

Choosing Antidepressants

- Prior treatment history in patient/family members
- Patient preferences
- Expertise of prescribing provider
- Side effect profile
- Safety in overdose
  - 10 days of a TCA can be a lethal overdose
- Availability and costs
- Drug-drug interactions

Taking a medication history

History

- Bring in bottles of current medications
- Ask for list of past medications
- What has been your experience with medications? Helped? Side effects?

Assess adherence

- How are you taking this medication?
- Most people miss doses. How many times do you think you missed a dose of medication in the last week?
- How do you remember to take your medications?

Ask about concerns

- How is this medication working for you? What has improved? Anything worse? Quantify.
- Any side effects? What, when, how much do they bother you?
- Do you think this medication is helping you reach your goals?

COMMONLY PRESCRIBED PSYCHOTROPIC MEDICATIONS

NAME Generic (Trade)	DOSAGE	KEY CLINICAL INFORMATION
Antidepressant Medications*		
Bupropion (Wellbutrin)	Start: IR-100 mg bid X 4d then ↑ to 100 mg tid; SR-150 mg qam X 4d then ↑ to 150 mg bid; XL-150 mg qam X 4d, then ↑ to 300 mg qam. Range: 300-450 mg/d.	**Contraindicated in seizure disorder** because it decreases seizure threshold; **stimulating; not good for treating anxiety disorders;** second line TX for ADHD; **abuse potential.** ¢ **(IR/SR), $ (XL)**
Citalopram (Celexa)	Start: 10-20 mg qday, ↑10-20 mg q4-7d to 30-40 mg qday. Range: 20-60 mg/d.	Best tolerated of SSRIs; very few and limited CYP 450 interactions; good choice for anxious pt. ¢
Duloxetine (Cymbalta)	Start: 30 mg qday X 1 wk, then ↑ to 60 mg qday. Range: 60-120 mg/d.	More GI side effects than SSRIs; tx neuropathic pain; **need to monitor BP**; 2nd line tx for ADHD. $
Escitalopram (Lexapro)	Start: 5 mg qday X 4-7d then ↑ to 10 mg qday. Range 10-30 mg/d (3X potent vs. Celexa).	Best tolerated of SSRIs, very few and limited CYP 450 interactions. Good choice for anxious pt. $
Fluoxetine (Prozac)	Start: 10 mg qam X 4-7d then ↑ to 20 mg qday. Range: 20-60 mg/d.	More activating than other SSRIs; long half-life reduces withdrawal (t ½ = 4-6 d). ¢
Mirtazapine (Remeron)	Start: 15 mg qhs. X 4-7d then ↑ to 30 mg qhs. Range: 30-60 mg/qhs.	Sedating and appetite promoting; Neutropenia risk (1 in 1000) so avoid in immunosupressed patients. ¢
Paroxetine (Paxil)	Start: 10 mg qhs X 4-7d then ↑ to 20 mg qday. Range: 20-60 mg/d.	Anticholinergic; sedating; **significant withdrawal syndrome.** ¢
Sertraline (Zoloft)	Start: 25 mg qam X 4-7d then ↑ to 50 mg qday. Range: 50-200 mg/d.	Few and limited CYP 450 interactions; mildly activating. ¢
Venlafaxine (Effexor)	Start: IR-37.5 mg bid X 4d then ↑ to 75 mg bid; XR-75 mg qam X 4d then ↑ to 150 qAM. Range: 150-375 mg/d.	More agitation & GI side effects than SSRIs; tx neuropathic pain above 150 mg qday; **need to monitor BP;** 2nd line tx for ADHD. **Significant withdrawal syndrome. ¢ (IR), $ (XR)**
*Warnings/precautions: 1) Potential increased suicidality in first few months, 2) Long term weight gain likely (except fluoxetine & bupropion), 3) Sexual side effects common (except bupropion & mirtazapine), 4) Withdrawal syndrome frequently occurs with abrupt cessation (especially with SSRIs and SNRIs), Increased risk of bleeding with SSRIs and SNRIs (especially in combo with NSAIDs), 5) Risk for Serotonin Syndrome (except bupropion), especially with combination of drugs effecting serotonin metabolism, 6) Hyponatremia sometimes seen with SSRIs and SNRIs.		
Antianxiety and Sleep (Hypnotic) Medications		
Alprazolam (Xanax)	Start: 0.25 mg – 0.5 mg tid. Usual MAX: 4 mg/d.	**Equiv. dose: 0.50 mg.** Onset: *intermediate* (1-2 hrs). T½: 11 hrs. More addictive than other benzos and has uniquely problematic withdrawal syndrome. **Try to avoid as 1st line tx.** ¢
Chlordiazepoxide (Librium)	Start: 10-20 mg 3-4X daily. Usual MAX: 200 mg/d	**Equiv. dose: 25 mg.** Onset: *intermediate* (0.5-2 hrs). T1/2: 10-48 hrs (parent compound), 14-95 hrs (metabolites). Useful for treating outpatient ETOH withdrawal because of long half-life. ¢
Clonazepam (Klonopin)	Start: 0.25 mg bid or tid. Usual MAX: 3 mg/d.	**Equiv. dose: 0.25 mg.** Onset: *intermediate* (1-4 hrs). T½: 40-50 hrs. Helpful in tx mania. ¢
Diazepam (Valium)	Start: 2–10 mg bid to qid with doses depending on symptoms severity. Usual MAX: 30-40 mg/d.	**Equiv. dose: 5 mg.** Onset: *immediate* (highly lipophilic). T½: 20-50 hrs. Note: the presence of liver disease will significantly lengthen half-life. ¢
Lorazepam (Ativan)	Start: 0.5-1 mg bid to tid. Usual MAX: 6 mg/d. Insomnia: 0.5-2 mg qhs.	**Equiv. dose: 1 mg.** Onset: *intermediate*. T½: 12 hrs. No active metabolites, so safer in liver dz. ¢
Buspirone (Buspar)	Start: 7.5 mg bid. Range: 10-30 mg bid.	Non-benzo SSRI-like drug FDA approved for anxiety. May take 4-6 weeks to become fully effective. ¢
Hydroxyzine (Vistaril)	Start: 25-100 mg 3-4 X per day. Usual MAX: 400 mg per day.	Antihistamine/antiemetic drug FDA approved for anxiety. Consider in pts w/ hx of substance abuse. ¢
Prazosin (Minipress)	Start: 1 mg qhs. Increase q 2-3 d until symptoms abate. Usual MAX: 10 mg qhs.	Old antihypertensive used to tx nightmares and night sweats d/t PTSD. Need to warn about orthostasis particularly in AM after first dose and after each new dosage change. ¢
Trazodone (Desyrel)	Start: 25-50 mg qhs. Range: 50-150 mg/qhs.	Commonly used as sleep aid; **inform about priapism risk in men.** ¢
Temazepam (Restoril)	Start: 15 mg at bedtime. MAX: 45 mg qhs.	**T½: 8.8 hrs.** Older benzo hypnotic. No P450 metabolism. More potential for physical dependence than Ambien/Sonata. ¢
Zolpidem (Ambien)	Start: 5-10 mg qhs. MAX: 20 mg qhs.	**T½: 2.6 hrs.** Potential for sleep-eating and sleep-driving. ¢ Available in longer acting form (CR $)
Mood Stabilizers		
Lithium	Start: 300 mg bid to tid. Target plasma level: acute mania & bipolar depression: **0.8-1.2 meq/L**; Maintenance: **0.6-0.8 meq/L**. Available in ER form dosed once daily (usually at HS, Lithobid & Eskalith). Plasma levels related to renal clearance.	**Black box warning for toxicity.** Teratogenic (cardiac malform.) and will **need to inform women of childbearing age of this risk.** Check TSH and BMP before starting and q 6-12 months thereafter. Advise pt about concurrent use of NSAIDS and HTN meds as can decrease renal clearance. Lithium strongly anti-suicidal. **¢, (lithium carbonate, citrate & SR), $ (Lithobid, Eskalith)**
Divalproex (Depakote)	Start: 750 mg daily (bid or tid, DR; qday, ER); increase dose as quickly as tolerated to clinical effect. Target plasma level: **75 to 100 mcg/mL (DR) & 85-125 mcg/ml (ER).**	**Multiple black box warnings** including for hepatotoxicity, pancreatitis, and teratogenicity (**need to inform women of childbearing age of this risk**). Need to monitor LFTs, platelet counts, and coags initially and q3-6 mo. Significant weight gain common. $
Lamotrigine (Lamictal)	Start: 25 mg daily for weeks 1 & 2, then 50 mg daily for weeks 3 & 4, then 100 mg qday for week 5, and finally 200 mg qday for week 6+ (usual target dose). Dosage will need to be adjusted for patients taking enzyme-inducing drugs or Depakote.	**Black box warning** for serious, life-threatening rashes requiring hospitalization and d/c of TX (Stevens Johnson syndrome @ approx. 1: 1-2000). No drug level monitoring typically required. Need to strictly follow published titration schedule. Fewer cognitive and appetite stimulating side effects. ¢
Antipsychotic/Mood Stabilizers**		
Aripiprazole (Abilify)	**Mania.** Start: 15 mg qday; Range: 15-30 mg/day. **MDD adj tx.** Start: 2-5 mg/day; adjust dose q 1+ weeks by 2-5 mg. Range: 5-10 mg/day. MAX: 15 mg qday. **Schizophrenia.** Start: 10-15 mg/day; ↑ at 2 week intervals; rec. dose: 10-15/day. MAX: 30 mg/day	EPS: moderate (especially akathisia); Metabolic side effects: low. Very long half-life: 75 hrs. Least amount of sexual side effects. FDA indication for adjunctive treatment of MDD. Potential increased suicidality in first few months. Need to screen glucose and lipids regularly. $
Olanzapine (Zyprexa)	Start: 5-10mg daily titrating to 15-30 mg daily once or divided bid.	EPS: Low; Metabolic side effects: high. Weight gain and sedation common. **Do not prescribe to diabetics.** Need to screen glucose and lipids regularly. $
Quetiapine (Seroquel)	**Bipolar Dep:** Start: 50 mg qhs; Initial target: 300 mg qhs; Range: 300-600 mg/d **Mania.** Start: 50 mg bid; Initial target: 200 mg bid. Range: 400-800 mg/d. **MDD adj tx.** Start: 50 mg qhs; Initial target: 150 mg qhs. Range: 150-300 mg/day. **Schizophrenia.** Start: 25 mg bid and increase by 50-100 mg/d (bid/tid). Initial target: 400 mg/d. Range: 400-800 mg/d	EPS: Lowest (except for Clozaril); Metabolic side effects: moderate. Highly sedating. FDA indication for bipolar depression and adjunctive treatment of MDD. Potential increased suicidality in first few months. Need to screen glucose and lipids regularly. **Abuse potential.** Available in an extended release form: Seroquel XR. **$ (IR & XR). Avoid or use alternative in combination with methadone due to QTc prolongation.$**
Risperidone (Risperdal)	Start: 0.5 – 1mg qhs or bid titrating to 4-6 mg daily or bid. Available as long-acting injectable given q 2 weeks called Risperdal Consta.	EPS: highest; Metabolic side effects: moderate. Hyperprolactinemia and sexual side effects common. Need to screen glucose and lipids regularly. ¢
Ziprasidone (Geodon)	Start: 40 mg bid titrating quickly to 60–80 mg bid. Needs to be taken w/ food (doubles absorption).	EPS: moderately high (especially akathisia); Metabolic side effects: lowest. Need to screen glucose and lipids regularly. Lower dosage can be more agitating than higher doses. **Contraindicated in combination with methadone due to QTc prolongation.$**
**Antipsychotic/mood stabilizer warnings/precautions: 1) Increased risk of death related to psychosis and behavioral problems in elderly patients with dementia, 2) Increased risk of QTc prolongation and risk of sudden death (especially in combination with other drugs that are known to prolong the QTc).		

po = by mouth; prn = as needed; qday = 1x/day; bid = 2x/day; tid = 3x/day; qid = 4x/day; qod = every other day; qhs = at bedtime; qac = before meals. ¢ = generic available. $ = Not available as generic or expensive. SSRI = Selective Serotonin Reuptake Inhibitor. SNRI = Serotonin Norepinephrine Reuptake Inhibitor. Developed by David A. Harrison, MD, PhD ©University of Washington V2.2 September 2010.

Major Depression Medication Treatment

SSRI

- Fluoxetine/Prozac
- Sertraline/Zoloft
- Citalopram/Celexa
- Escitalopram/Lexapro
- Paroxetine/Paxil
- Fluvoxamine/Luvox

SNRI

- Venlafaxine/ Effexor
- Duloxetine/Cymblta

Other

- *Newer:*
  - Bupropion / Wellbutrin / Zyban,
  - Mirtazapine / Remeron
- *Older:*
  - TCA (Amitriptyline, Nortriptyline)
  - MAOI

Common Augmentation

- Buspirone /Buspar
- Antipsychotic medications (ex. Abilify or Seroquel)

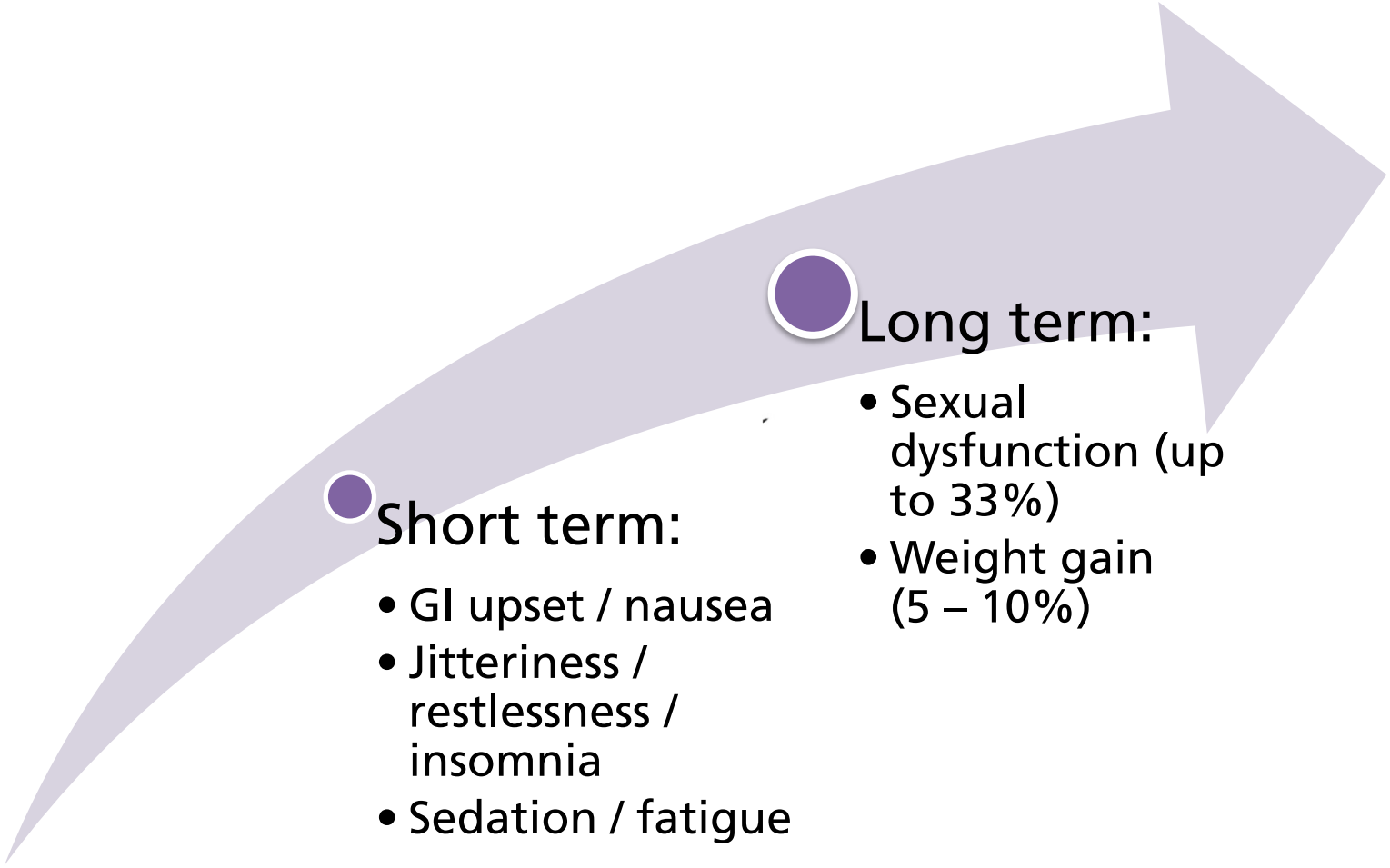
Anxiety

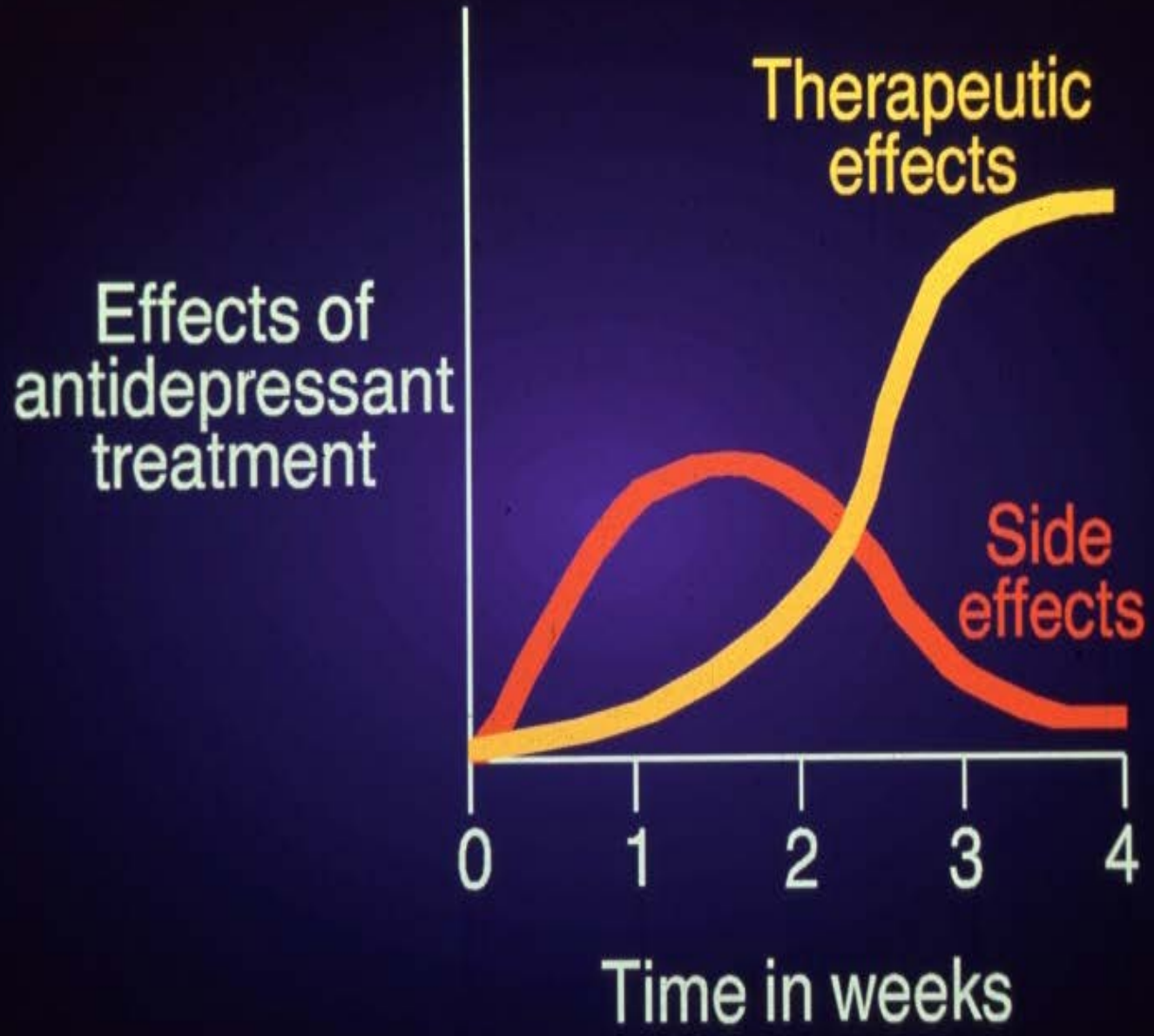
Antidepressants	Benzodiazepines	Other
• SSRI • SNRI • Wellbutrin	• Lorazepam / Ativan • Xanax / Alprazolam • Clonazepam / Klonopin	• Prazosin • Buspirone • Hydroxazine

Bipolar Depression

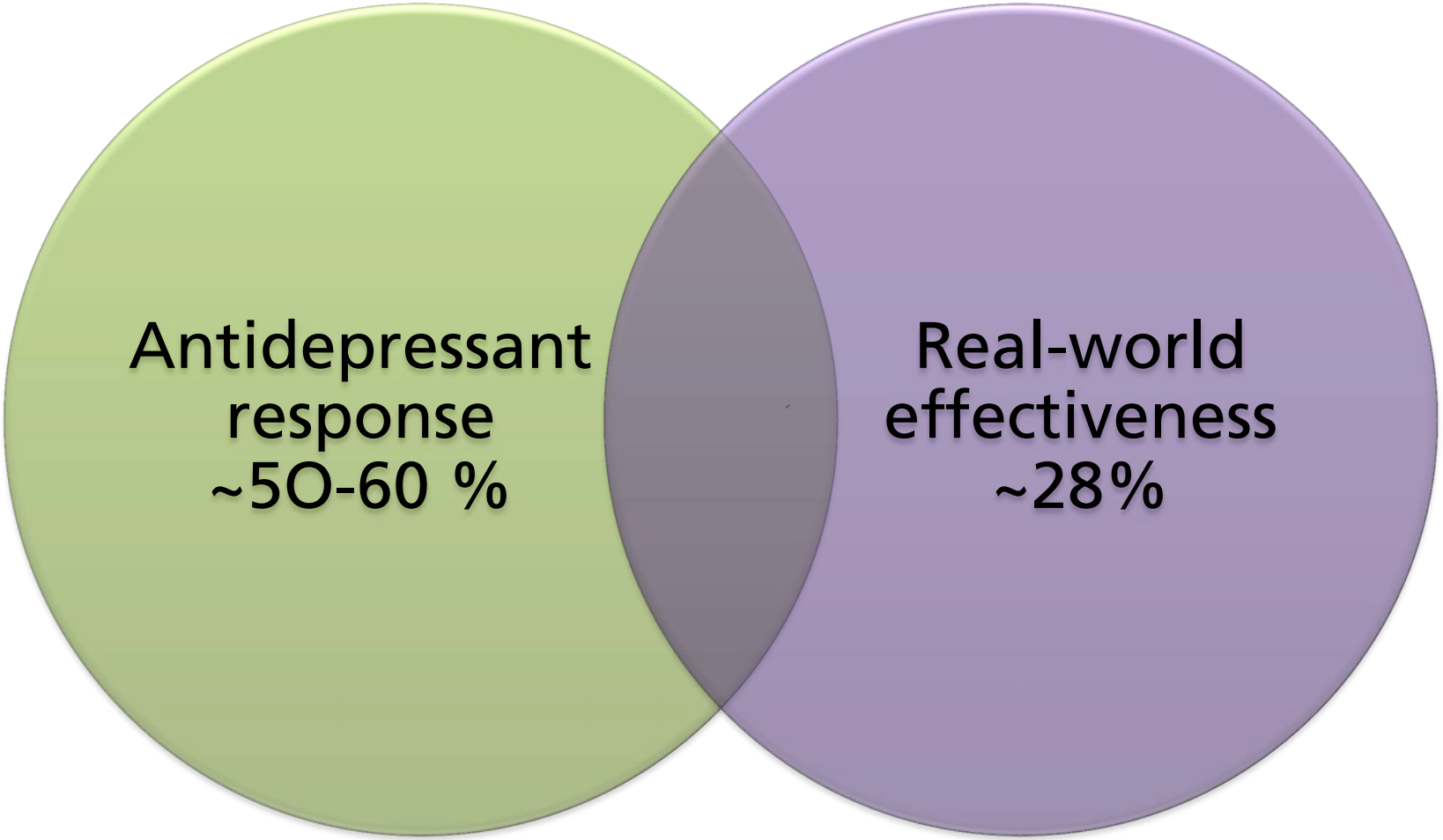
- Antipsychotics
  - Seroquel
- Lithium
- Lamictal
- Depakote

Common Side Effects for SSRI/SNRIs




Therapeutic effects
Effects of antidepressant treatment
Side effects
0
1
2
3
4
Time in weeks

Response Rates



Patient Education About Antidepressants

Anticipate

- Patient concerns about medications
- Side effects (these can be managed)
- Problems with adherence

Reinforce

- Do not stop medications without talking to prescriber
- May need continuation or maintenance treatment to prevent relapse

Managing Misconceptions

"Medications are addictive - I will become dependent on them"

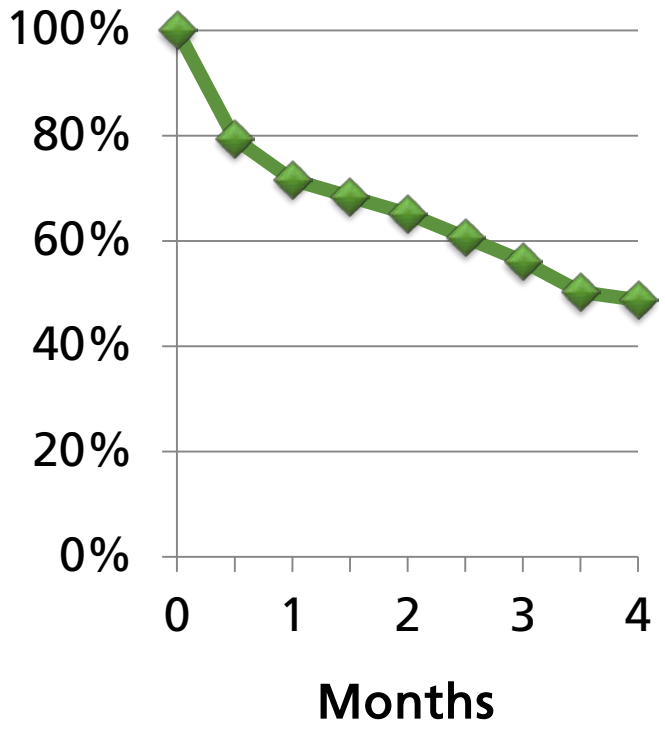
"Medications are mind-altering drugs"

"Medications are 'happy pills' or 'will make me a zombie'"

"Once I get better, I won't need medication any more"

"I only take medication when I have symptoms"

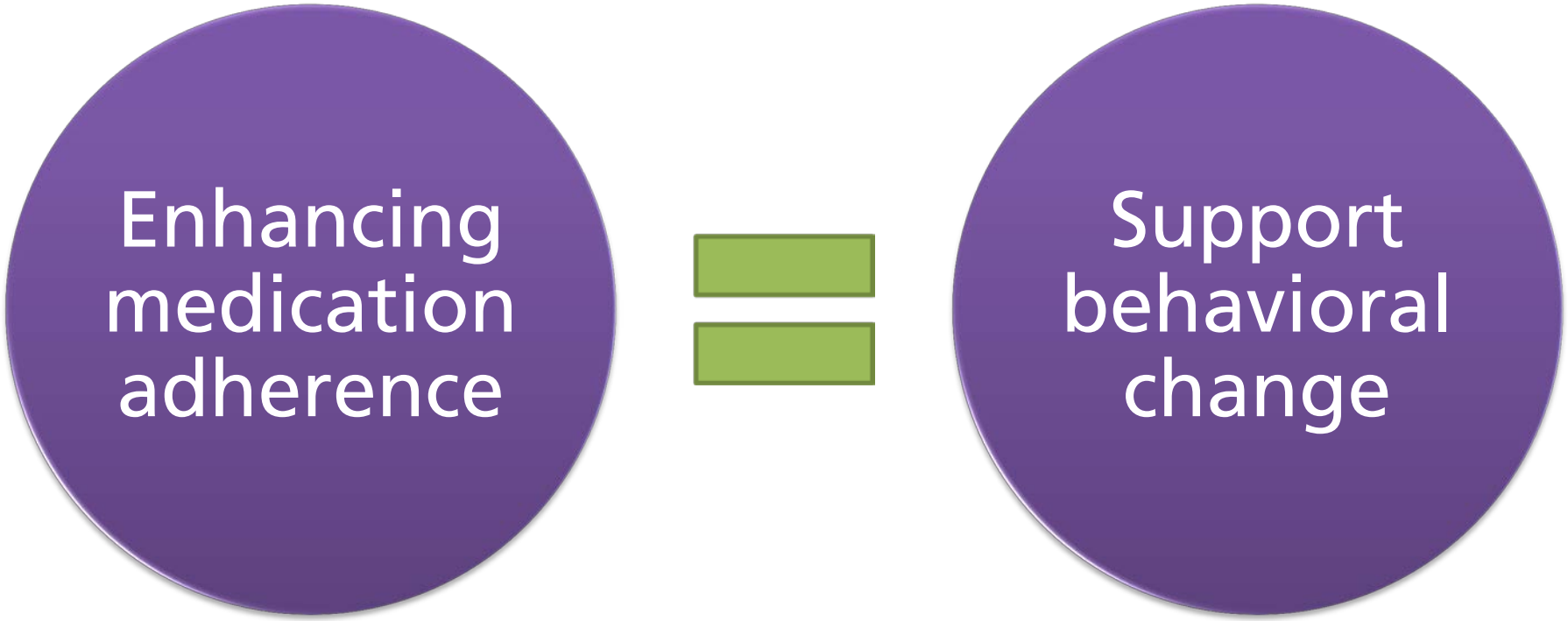
Antidepressant Adherence



- 1 mo → 28% stopped
- 4 mo → 44% stopped

Lin EH. *Med Care* 1995;33:67

What's missing?
Behavior Change Specialists



Optimizing Adherence

- Provide rationale for use
- Careful attention to side-effects
- Counter demoralization (CM)
- Address fear of dependence and loss of control
- Enlist family/spousal support (CM)
- Address concerns in relation to patient's or significant other's prior experience with medication (CM)
- Increase contact with brief phone check-ins (CM)
- Specific instructions (take regardless of symptom change, don't stop on own)
- Use symptom scale (e.g., PHQ-9) (CM)

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Video Clip: Follow-up

What if Patients Don't Improve?

- Is the patient adhering to treatment?
- Is the dose high enough?
  - See max dose guidelines
- Is the diagnosis correct?
  - ? Bipolar depression
  - ? Medical conditions (hypothyroidism, sleep apnea, pain)
  - ? Meds: steroids, interferon, hormones
  - ? Withdrawal: stimulants, anxiolytics
- Are there untreated comorbid conditions / life stressors?

Good Reasons to Stop a Medication

- Intolerable side effects
- Dangerous interactions with necessary medications
- The medication was not indicated to start with (e.g., bipolar depression)
- Medication has been at maximum therapeutic dose without improvement for 4-8 weeks

When and How to Stop Antidepressants?

- Treat all adults for 9-18 months after initial response
- Treat those at high risk for relapse for 2 years or longer; Some may need lifetime treatment
- Maintenance treatment should be at full dose
- Make a relapse prevention plan
- Taper antidepressants slowly to avoid discontinuation syndrome

→ TEAM EFFORT!

Reflection

How will we take what we learned and provide better care to our patients?

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Elizabeth Video