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?

Feel Bad

Do Less
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
Behavioral Activation
set of strategies at the beginning of CBT treatment

Cognitive
dysfunctional cognitions or “automatic thoughts” → increase flexibility and decrease depressed way the thoughts function

Good evidence for C, B, and C+B
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

1. Increase adaptive activities, preferably for mastery and pleasure
2. Decrease activities that maintain depression
3. Problem solve barriers to rewarding things
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

Life Events

- loss of friendships, conflict with supervisor at work, financial stress, poor health, etc.

- sad, tired, worthless, indifferent, etc.

stay home, stay in bed, watch TV, withdraw from social contacts, ruminate, etc.
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
Divorce, pain onset, unemployment, child with learning disability, marital conflict

Staying in bed, napping, shutting down emotionally with kids and husband

Guilty, ashamed, frustrated, angry, scared, helpless

loss of marital intimacy, loss of fun activities with kids, loss of sense of self efficacy with marriage and mothering

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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?
Staying in bed, napping, shutting down emotionally with kids and husband

Guilty, ashamed, frustrated, angry, scared, helpless

Loss of marital intimacy, loss of fun activities with kids, loss of sense of self efficacy with marriage and mothering

Divorce, pain onset, unemployment, child with learning disability, marital conflict

What is she Avoiding???

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Staying in bed, napping, shutting down emotionally with kids and husband

Guilty, ashamed, frustrated, angry, scared, helpless

Loss of marital intimacy, loss of fun activities with kids, loss of sense of self efficacy with marriage and mothering

Divorce, pain onset, unemployment, child with learning disability, marital conflict

She’s avoiding: Emotional expression, engaging kids, acknowledging her positives

Staying in bed, napping, shutting down emotionally with kids and husband

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3 Goals of BA

1. Mastery and pleasure targets: Parenting and Marriage

2. Decrease activities that maintain depression: Napping and emotional disengagement

3. Problem solve barriers: communication skills, activity pacing, relaxation training
Selecting RB’s BA targets:

- **What she worked on…**

<table>
<thead>
<tr>
<th>Won’t talk to husband, avoiding emotional expression with her partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Talk to husband about frustrations</td>
</tr>
<tr>
<td>- Take timeouts but plan when you will re-engage when fights happen</td>
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<tr>
<td>- Try reflective listening</td>
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<tr>
<td>- Increase physical intimacy</td>
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<table>
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<tr>
<th>Stopped activities with kids</th>
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<tbody>
<tr>
<td>- Pace activities with kids</td>
</tr>
<tr>
<td>- Dance with them, moving her neck especially; reduce guarding activity</td>
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</table>

<table>
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<tr>
<th>Won’t acknowledge her accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Internal validations for her motherhood and accomplishments</td>
</tr>
<tr>
<td>- She chose to:</td>
</tr>
<tr>
<td>- Organize and decorate her house</td>
</tr>
<tr>
<td>- Improve her attire, put on make-up, do her hair</td>
</tr>
</tbody>
</table>
RB’s Symptoms: 8 visits over 4 mos
Typically we think of acting from the “inside → out” (e.g., we wait to feel motivated before completing tasks)

In BA, we ask people to act according to a plan or goal rather than a feeling or internal state

Approach: Outside → In

Maximizing Activation
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?

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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
Problem-Solving Treatment (PST):

Introduction
Problem-Solving Treatment (PST):

FAST

• Engage patient in what they care most about

FOCUS ATTENTION

• Training brain to solve problems

UNIVERSE OF PROBLEMS

YOU ARE FIRED
Problem-Solving Process

- Problem Definition
- Realistic Patient Goal
- Brainstorming
- Pros and Cons
- Choosing a Solution
- Action Plan
- Outcome Evaluation

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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

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Medications

Feel Bad

Do Less
Role for Care Managers in Medication Treatment

Opportunity

• Time
• Different relationship

Skills

• Engaging patients
• Assessing patients
• Supporting patients
Antidepressants 101

The Beginning
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?
## Antidepressant Medications*

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOSAGE</th>
<th>KEY CLINICAL INFORMATION</th>
</tr>
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<tbody>
<tr>
<td>Bupropion (Wellbutrin)</td>
<td>Start: IR-100 mg bid, X 4d then ↑ to 100 mg tid. SR-150 mg qm X 4d then ↑ to 150 mg bid X-150 mg qm X 4d then ↑ to 300 mg qm. Range: 300-450 mg/day.</td>
<td>Contraindicated in seizure disorder because it decreases seizure threshold stimulating, not good for treating anxiety disorders; second line TX for ADHD; abuse potential. (SSRI, S DL)</td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
<td>10-20 mg qd X 1 w, then ↑ to 60 mg qd. Range: 60-120 mg/day.</td>
<td>More GI side effects than SSRIs; tx neuropathic pain: Need to monitor BP; 2nd line TX for ADHD.</td>
</tr>
<tr>
<td>Doxepin (Sinequan)</td>
<td>Start: 5-10 mg qd X 4d then ↑ to 10 mg qd. Range: 10-30 mg/day.</td>
<td>More activating than other SSRIs; long half-life reduces withdrawal 1/2 + 4-5 d.</td>
</tr>
<tr>
<td>Escitalopram (Lexapro)</td>
<td>Start: 5 mg qd X 4d then ↑ to 10 mg qd. Range: 10-20 mg/day.</td>
<td>Contraindicated in seizure disorder because it decreases seizure threshold stimulating, not good for treating anxiety disorders; second line TX for ADHD; abuse potential.</td>
</tr>
<tr>
<td>Fluoxetine (Prozac)</td>
<td>20-40 mg qd X 4d then ↑ to 20 mg qd. Range: 20-40 mg/day.</td>
<td>Best tolerated of SSRIs; very few and limited CYP 450 interactions; good choice for anxious pts.</td>
</tr>
<tr>
<td>Mirtazapine (Remeron)</td>
<td>Start: 15 mg qd X 4d then ↑ to 30 mg qd. Range: 30-60 mg/day.</td>
<td>Sedating and appetite-promoting. Neutropenia risk (1 in 1000) so avoid in immunosuppressed patients.</td>
</tr>
<tr>
<td>Paroxetine (Paxil)</td>
<td>Start: 10 mg qd X 4d then ↑ to 20 mg qd. Range: 20-60 mg/day.</td>
<td>Anticholinergic: sedating; significant withdrawal syndrome.</td>
</tr>
<tr>
<td>Sertraline (Zoloft)</td>
<td>25-50 mg qd X 4d then ↑ to 50 mg qd. Range: 50-150 mg/day.</td>
<td>More limited CYP 450 interactions; mildly activating.</td>
</tr>
<tr>
<td>Venlafaxine (Effexor)</td>
<td>Start: 37.5 mg qd bid X 4d then ↑ to 75 mg bid, SR-75 mg qm X 4d then ↑ to 150 qm. Range: 150-375 mg/day.</td>
<td>More agitation &amp; GI side effects than SSRIs; tx neuropathic pain above 150 mg qd; need to monitor BP; 2nd line TX for ADHD. Significant withdrawal syndrome. (SSRI, S CR)</td>
</tr>
</tbody>
</table>

*Warning 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 often occurs with abrupt cessation (especially with SSRIs and SNRIs), Increased risk of bleeding with SSRIs and SNRIs (especially in combination with NSAIDs). 5) Risk for Serotonin Syndrome (except bupropion), 6) Contraindication of drugs including benzodiazepines; 7) Hypertension sometimes seen with SSRIs and SNRIs.

## Antianxiety and Sleep (Hyponotic) Medications

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<tr>
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<tr>
<td>Alprazolam (Xanax)</td>
<td>Start: 0.25 mg – 0.5 mg bid. Usual MAX: 4 mg/d.</td>
<td>Equally effective 0.8-0.9 mg. Onset immediate (1-2 hrs). T1/2: 11 hrs. More addictive than other benzos and has uniquely problematic withdrawal syndrome. Try to avoid as 1st line tx.</td>
</tr>
<tr>
<td>Chlordiazepoxide (Librium)</td>
<td>Start: 10-20 mg qd X 3-4x daily. Usual MAX: 200 mg/day.</td>
<td>Equally effective: 25 mg bid. Onset immediate (0.5-2 hrs). T1/2: 10-14 hrs (parent compound). 14-15 hrs (metabolites). Useful for treating outpatient ETOH withdrawal because of prolonged T1/2.</td>
</tr>
<tr>
<td>Clonazepam (Klonopin)</td>
<td>Start: 0.25 mg bid or tid. Usual MAX: 3 mg/d.</td>
<td>Equally effective: 0.52 mg. Onset immediate (1-4 hrs). T1/2: 40-50 hrs. Helpful in mania.</td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>2-10 mg bid or tid with doses depending on symptoms severity. Usual MAX: 30-40 mg/day.</td>
<td>Equally effective: 4 mg. Onset immediate (highly lipophilic). T1/2: 20-50 hrs. Note: the presence of liver disease will significantly lengthen half-life.</td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>Start: 0.5-1 mg bid. Usual MAX: 6 mg/d.</td>
<td>Equally effective: 1 mg. Onset immediate (1/2-1 hr). 12 hrs: No active metabolites, so safer in liver.</td>
</tr>
<tr>
<td>Buspirone (Buspar)</td>
<td>Start: 7.5 mg bid. Range: 10-30 mg bid.</td>
<td>Nonbenzodiazepine drug FDA approved for anxiety. May take 4-6 weeks to become fully effective.</td>
</tr>
<tr>
<td>Hydroxyzine (Vistaril)</td>
<td>Start: 25-100 mg 3 X qd per day. Usual MAX: 400 mg/day.</td>
<td>Antihistamine/anticholinergic drug FDA approved for anxiety. Consider in pts w/ hx of substance abuse.</td>
</tr>
<tr>
<td>Prazepam (Minipress)</td>
<td>Start: 1 mg qd. Increase q 2-3d until symptoms abate. Usual MAX: 10 mg qd.</td>
<td>Old antihypertensive used for nightmares and night sweats in pts w/ PTSD. Need to warn about orthostasis particularly in AM after first dose and after each new dosage change.</td>
</tr>
<tr>
<td>Temazepam (Restoril)</td>
<td>Start: 15 mg at bedtime. MAX: 45 mg qd.</td>
<td>T1/2: 1.9 hrs. Older benzodiazepine. No P450 metabolism. More potential for physical dependence than Ambien/Sonata.</td>
</tr>
<tr>
<td>Zolpidem (Ambien)</td>
<td>Start: 5-10 mg qd. MAX: 30 mg qd.</td>
<td>T1/2: 2.5 hrs. Older benzodiazepine. No P450 metabolism. More potential for physical dependence than Ambien/Sonata.</td>
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## Mood Stabilizers

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<td>Lithium</td>
<td>Start: 300 mg bid to target plasma level: acute mania: bipolar depression: 0.6-1.2 mEq/L. Maintenance: 0.8-0.9 mEq/L. Available in CR form dosed once daily (usually at HS). Lithium is Efficacy. Plasma levels related to renal clearance.</td>
<td>Black box warning for toxicity. Teratogenic (cardiac malform). Need to inform women of childbearing age of this risk. Check TSH and BUN before starting and q4-12 months thereafter. Advise of abrupt discontinuation of NSADS and HIN meds can cause acute renal failure. Lithium strongly anti-psialid. (Lithium carbonate, citrate &amp; S R), (Lithium, Eskalith)</td>
</tr>
<tr>
<td>Divalproex (Depakote)</td>
<td>Start: 750 mg daily (bid or tid). Dose: ETOH, RPS; increase dose as quickly as tolerated to achieve effective target plasma level: 75 to 100 mg/dL (ER) &amp; 80-125 mg/dL (ER).</td>
<td>Multiple black box warnings including for hepatotoxicity, pancreatitis, and teratogenicity (need to inform women of childbearing age of this risk). Add Clonazepam to ER as an adjunct to LS levels and apercular initially and qd. Acute. Significant weight gain common. (Black box warning for serious, life-threatening rash requiring hospitalization and ofc of TX (Steven Johnson syndrome @ approx. 1-1 to 2000). No drug level monitoring typically required. Need to strictly follow published titration schedule. Fewer cognitive and appetite stimulating side effects.</td>
</tr>
</tbody>
</table>

## Antipsychotics/Mood Stabilizers**

<table>
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<td>Olanzapine (Zyprexa)</td>
<td>Bipolar: Start: 10 mg qd X 1w then ↑ to 20 mg qd. MAX: 40 mg/day.</td>
<td>EPS: Low. Metabolic side effects: High weight gain and sedation common. Do not prescribe to diabetes. Need to screen glucose and lipids regularly.</td>
</tr>
<tr>
<td>Risperidone (Risperdal)</td>
<td>Start: 0.5-5 mg qd. Target: 4-6 mg qd.</td>
<td>EPS: highest. Metabolic side effects: moderate. Hyperprolactinemia and sexual side effects common. Need to screen glucose and lipids regularly.</td>
</tr>
</tbody>
</table>

**Antipsychotic mood stabilizer warning precautions:** 1) Increased risk of death related to psychiatric 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).
Major Depression Medication Treatment

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

**SNRI**
- Venlafaxine/ Effexor
- Duloxetine/Cymbalta

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

**Common Augmentation**
- Buspirone /Buspar
- Antipsychotic medications (ex. Abilify or Seroquel)
Anxiety

Antidepressants
- SSRI
- SNRI
- Wellbutrin

Benzodiazepines
- Lorazepam / Ativan
- Xanax / Alprazolam
- Clonazepam / Klonopin

Other
- Prazosin
- Buspirone
- Hydroxazine
Bipolar Depression

- Antipsychotics
  - Seroquel
- Lithium
- Lamictal
- Depakote

ANTI-DEPRESSANTS
Common Side Effects for SSRI/SNRIs

Short term:
• GI upset / nausea
• Jitteriness / restlessness / insomnia
• Sedation / fatigue

Long term:
• Sexual dysfunction (up to 33%)
• Weight gain (5 – 10%)
Effects of antidepressant treatment

Time in weeks

Therapeutic effects

Side effects
Response Rates

Antidepressant response
~50-60%

Real-world effectiveness
~28%
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

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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

Enhancing medication adherence = Support behavioral change
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)
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?
Elizabeth Video