TREATMENT OF DEPRESSION, ANXIETY, AND BIPOLAR DISORDER AMONG ADULTS IN A PRIMARY CARE SETTING
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INTRO
• 17 years in mental health
• 12 years as Professional Clinical Counselor
• 3 years as psychiatric nurse practitioner
• NAMI Board Member for Hancock County

ASSESSMENT OF DEPRESSION (MDD) DSM-V

2 WEEK PERIOD OF DEPRESSED MOOD OR LOSS OF INTEREST OR PLEASURE
JUINED WITH DEPRESSION BUT NOT PERSISTENT鋡

- Most of the day, nearly every day
- Diminished pleasure in activities
- Significant weight loss or increase in weight
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness
- Decreased ability to think or concentrate
- Recurrent thoughts of death
MDD CONTINUED

- B. Symptoms cause clinically significant distress or impairment in social, occupational, or other areas of functioning
- C. Not attributable to physiological effects of a substance or another medical condition (alcohol, marijuana, etc.)
- D. Not better explained by another psychiatric disorder
- E. THERE HAS NEVER BEEN A MANIC OR HYPOMANIC EPISODE

DIFFERENTIAL DIAGNOSES- MEDICAL

- Hypothyroidism
- Blood sugar issues/diet/exercise
- Medication side effects (steroids, BP meds)
- Sleep Disorders
- MS

SUICIDE RISK ASSESSMENT

- Any thoughts of harming yourself?
- Passive – it crossed my mind, wonder if people would be better off without me, thoughts about who would attend funeral, take care of kids, etc.
- Active – intent and plan. I want to kill myself, and here is what I have thought about
- Hospitalizations – risk of harming self or others, psychosis
- Risks: previous attempts, plan, access to plan, substance abuse, family history of suicide, proximity of means, limited support, age, gender
- Don’t let them leave without a crisis hotline number in their phone or list of resources
ANXIETY DISORDERS

• Generalized Anxiety
• Social Anxiety
• Phobias
• Panic Disorder
• Obsessive Compulsive Disorder

GENERALIZED ANXIETY DISORDER

• Excessive anxiety and worry occurring more days than not for at least 6 months about a number of activities
• Individual finds it difficult to control the worry
• Anxiety is associated with at least 3 of these symptoms:
  - restlessness/on edge, easily fatigued, difficulty concentrating, irritability, muscle tension, sleep disturbance
• Anxiety causes clinically significant distress or impairment in areas of functioning
• Not attributable to physiological effects of a substance or medical condition
• Not better explained by another mental health disorder

PANIC ATTACKS

• Palpitations/pounding heart/accelerated heart rate
• Sweating
• Trembling
• ICK/smothered
• Chest pain
• Nausea/GI issues
• Dizzy/light-headed
• Chills or overheated
• Numbness or tingling
• Feelings of unreality/detachment
DIFFERENTIALS

- High/low blood sugar
- Thyroid issues
- Tumor
- Too much caffeine
- Sleep disturbances
- Cigarette/marijuana/drug use
- Eating Disorders
- Parkinson's Disease
- Cardiac (arrhythmias), vestibular dysfunctions, seizure disorders, COPD, asthma
- Distinguish "physical/physiological symptoms" from "cognitive" symptoms

BIPOLAR DISORDER

- Manic Episode:
  - A distinct period of persistently elevated or irritable mood and increased goal-directed activity or energy, lasting at least one week
  - B. Three of the following are met:
    1. Inflated self-esteem or grandiosity
    2. Decreased need for sleep
    3. More talkative or pressure to keep talking
    4. Flight of ideas/racing thoughts
    5. Distractibility
    6. Increase in goal-directed activity (socially, work, school, sexually) or psychomotor agitation (purposeless non-goal-directed activity)
    7. Excessive involvement in activities that have a high potential for consequences (buying sprees, sexual activities, business investments)

BIPOLAR CONTINUED

- C. Causes marked impairment in social or occupational functioning
- D. Not attributable to physiological effects of substance (stimulants, other medications or drugs)

**Use Mood tracking/apps if unsure**
HYPOMANIC EPISODE

- Same as Manic episode except on a “lesser” scale, not severe enough to cause impairment
- Bipolar I vs. Bipolar II

MAJOR DEPRESSIVE EPISODE

- See previous criteria for MDD – need to be present during the same 2 week period and represent a change from previous functioning

DIFFERENTIAL DIAGNOSES

- ADHD
- Panic Disorder
- Substance Abuse
- PTSD
- Personality Disorders
- Schizophrenia/Delusional Disorder
SCREENING TOOLS

- Depression: Hamilton Depression Rating Scale, Beck Depression Inventory
- Anxiety: GAD-7, Hamilton Anxiety Rating Scale
- Bipolar Disorder: The Mood Disorder Questionnaire, Young Mania Rating Scale

* These are screening tools, not diagnostic tools, good conversation starters.

INITIAL APPOINTMENT

- History of Present Illness:
  - Onset
  - Sleep (history of sleep apnea, too much, too little)
  - Appetite changes
  - Mood – Depression, Anxiety, Irritability
  - Energy level
  - Suicidal/homicidal ideations

INITIAL APPOINTMENT (HPI CONTINUED)

- Delusions/visual/auditory hallucinations
- Substance Abuse
- Risky behaviors/impulse control/anger issues
- OCD
- Manic episodes
- Eating Disorder
- Trauma
INITIAL APPOINTMENT CONTINUED

- Past Psychiatric History:
  - Previous diagnosis and/or treatment (just because they were previously diagnosed with something does not always mean correct diagnosis. Do your own assessment)
  - Meds that you have already tried AND response to them. Was it a therapeutic dose? Was it a long enough trial? Gives clues into diagnosis and if you need to move to a different family of medications. Hand them sheet to look at.
  - Hospitalizations
  - OASIS report

INITIAL APPOINTMENT CONTINUED

- Family Psychiatric History:
  - What runs in the family?
  - Parents, grandparents, aunts, uncles, cousins, siblings
  - Any meds they are on, if so, what?

INITIAL APPOINTMENT CONTINUED

- Past Medical History
  - Cardiac issues (prolong QT), seizures, cholesterol, recent labs, allergies, caffeine use (anxiety, sleep disturbances), cigarette use, surgical, etc
INITIAL APPOINTMENT CONTINUED

- Social History:
  - Living arrangements, chance of pregnancy, breastfeeding, future plans for pregnancy, employed, legal issues, cultural/religious background, firearms, developmental, support system, learning disabilities

MEDICATIONS

- Which one do I choose?
- Think of variety of factors:
  - Financial situation
  - Likelihood of compliance
  - Side effects
  - Insurance
  - Number of “tried and failed” meds
  - Age
  - General health
  - Other meds they are on (serotonin syndrome)

MEDICATIONS FOR DEPRESSION AND ANXIETY

- SSRI’s first line treatment: Citalopram, Lexapro, Luvox, Parnix, Prozac, Zoloft, Trintellix
- SNRIs: Cymbalta, Effexor, Pristiq
- “Other”: Wellbutrin, Våbryl, Remeron
- Anxietiy adjuncts: Buquepar, Neurontin, Vistaril, Minipress, Propranolol, Clonidine
- Depression adjuncts: Abilify, Seroquel, Haldol
MEDICATIONS CONTINUED

• Celexa: Depression. Caution: multiple interactions with other meds.
• Lexapro: MDD, GAD. Also good for elderly.
• Paxil: MDD, OCD, Panic Disorder, Social Anxiety, PTSD, GAD, PMDD. Caution: weight gain, sedation, dry mouth.
• Prozac: MDD, OCD, PMDD, Bulimia nervosa, Panic Disorder Side note: increased energy
• Zoloft: MDD, Panic Disorder, PTSD, Social Anxiety, OCD Side note: either causes sedation or restlessness

First week: start with 25% of starting dose, then see back every 4-6 weeks to re-evaluate and titrate.

MEDICATIONS CONTINUED

• Other meds to look out for: pain med, NSAIDS, dose differently if renal or hepatic impairment
• Blackbox warning under the age of 25: increased suicidal ideation
• Always caution about activation of mania/irritability
• Never abruptly stop or switch med

MEDICATIONS CONTINUED:

• SNRI’s:
  • Cymbalta: MDD, diabetic peripheral neuropathic pain, generalized, GAD, chronic musculoskeletal pain. Side note: expensive, very hard to come off it
  • Effexor: Depression, GAD, Social Anxiety, anxiety disorder. Side note: does not work well with other meds, bad side effects if dose not titrated, very hard to come off it
  • Priprax: MDD, side note: marketed for fatigue and concentration, samples from pharma reps
  • Fetzima: MDD. Side note: marketed for time around side effects, samples from pharma reps
  • Pristiq: MDD. Side note: marketed for time around side effects, samples from pharma reps

• This category of meds can sometimes make anxiety worse
• Never abruptly stop or switch med

• Goodrx.com - coupons
**MEDICATIONS CONTINUED**

- Viibryd (SSARI serotonin partial agonist): MDD. Side note: takes with food. Marketed for anxious depression and less sexual side effects. Samples from pharm reps.

**MEDICATIONS CONTINUED**

- Buspar: anxiety. Side note: 2-3 times/day dosing, may take awhile to take effect, good adjunct.
- Neurontin: not FDA indicated for anxiety but used. Side note: 2-3 times per day dosing, abuse potential.
- Propranolol, Clonidine: off-label for physiological effects of anxiety. Side note: check BP/HR.

**BENZOS**

- When to use them – panic attacks
- Contraindications: elderly, opiates, any history of substance abuse
- Benzoh contract
- Short-term use
- Educate them about long-term side effects (may be linked to memory loss)
- Educate about addiction potential/tolerance/dependence
- Use responsibly, use your best judgment
- Analogy: asthma attack
OTHER TREATMENTS FOR ANXIETY AND DEPRESSION

- Counseling
- Support groups
- Holistic approach - diet, exercise, stress management, etc.
- Cognitive Behavioral Therapy
- Meditation/Relaxation Techniques
- Sleep hygiene
- Reduce caffeine consumption
- Reduce substances – cigarettes, marijuana, alcohol, etc.

MEDICATION FOR BIPOLAR DISORDER

- Depakote: Acute mania, mixed episodes. Side note: platelet counts, LFT’s, weight gain, sedation, regular lab draws
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- Lithium: Manic episodes, maintenance for manic-depressive patients. Side note: regular lithium levels, kidney function, thyroid function, EKG over 50 yrs old, weight gain, sedation, no NSAIDS
  Side note: regular lithium levels, kidney function, thyroid function, EKG over 50 yrs old, weight gain, sedation, no NSAIDS
- Lamictal: maintenance tx of Bipolar I. Side note: slow titration, rash/SJ Syndrome, need 100% compliance
  Side note: slow titration, rash/SJ Syndrome, need 100% compliance
- Trileptal: not FDA indicated but used off-label. Side note: monitor Na levels
  Side note: monitor Na levels

BIPOLAR MEDICATIONS CONTINUED

- Vraylar: Acute and mixed mania in Bipolar I. Side note: insurance, samples
  Side note: insurance, samples
  Side note: monitor glucose, lipids, BP, weight. Unusual for weight gain or sedation.
- Latuda: Schizophrenia, Bipolar Depression. Side note: insurance, samples, labs
  Side note: insurance, samples, labs
- Seroquel: Schizophrenia, acute mania, Bipolar maintenance, Bipolar Depression, Depression. Side note: sedation, weight gain, labs
  Side note: sedation, weight gain, labs
MONITORING OF MEDICATIONS

- Weight and BP on all patients
- Antipsychotics: lipid, glucose, CBC, prolactin, CMP, caution with dementia
- Cymbalta: liver function
- Depakote, Lithium, Trileptal: medication levels, CMP, CBC
- Lamictal: Rash
- SSRI's: generally no monitoring

SIDE EFFECTS

- What to do about side effects?
  - Wait…wait…wait… and refer to Stahl's book
  - Lower the dose
  - Change the time of day they are taking the med
  - Split the dose between AM and PM
  - Change the med
  - Give temporary medication to help until side effects subside
  - Note: sexual side effects: add Buspar or Wellbutrin or switch family of meds

SIDE EFFECTS OF ANTI-PSYCHOTICS

- Tardive Dyskinesia (permanent): repetitive, involuntary, purposeless movements such as facial grimacing, tongue movements, lip smacking, difficulty not moving. Use AIMS scale. Switch med, lower dose, manage side effects, add Vitamin E. May be permanent. Weight pros/cons.
- Extrapyramidal symptoms: akathisia, akinesia, dystonia, dyskinesia. Use Cogentin or other anticholinergic, sometimes benzene or beta blockers.
- Neuroleptic Malignant Syndrome: serious, hot, stiff and out of it, muscle rigidity, muscle cramps, tachycardia, autonomic instability, delirium. Go to hospital.
INSURANCE ISSUES

- Get to know the meds and insurances, typically need to try and fail certain meds first
- Prior authorizations
- Samples
- Pharm reps
- Coding properly
- Consider long-term management of meds, financial situation, compliance

TIPS FOR INCREASING COMPLIANCE

- Give patients appropriate timeframe of when to feel effects of medications. Goal is to manage the symptoms not make the “diagnosis” go away.
- Encourage them to call with any questions or side effects
- Give them expected side effects and timeframe of how long they last
- Encourage them to give a “fair” 4-6 week trial
- Treatment should include more than just medications – counseling, groups, etc.
- Include family or friends to increase compliance

TIPS FOR INCREASING COMPLIANCE CONTINUED

- Include family or friends to increase compliance
- Normalize mental health issues and praise for getting help
- Appropriate level of care
- Appropriate timeframe of follow up and titrating up appropriately
- Provide realistic expectations – this didn’t develop overnight so we’re not going to fix it overnight
- Educate the patient on mental health diagnosis / reduce stigma
**FOLLOW UP QUESTIONS**

- Use rating scales – 1-10
- Any change in sleeping or eating?
- How are you functioning?
- Have others noticed a change?
- Compliance?
- What else have you done/changes have you made? Follow up on suggestions?
- Change in number of panic attacks? Have you used your “rescue” medication?
- Suicidal ideation?
- “They don’t tell unless you ask”

**“OTHER” ISSUES**

- Rule of thumb for SSRI’s and how many to try
- Taper med before switching
- Don’t be afraid to use antipsychotics/adjunct meds/benzos
- How many failed med before I refer to psych?
- How do I manage my patient in the mean time?
- Chemical vs. behavioral/personality/environment
- What do I do if I inherit a patient on benzos?

**REFERRALS**

- When to refer to Psych?
- Case management – SPMI, history of inpatient admissions, need more resources
- Drug treatment/dual diagnoses
- Mental health counseling/individual/marriage
- Several failed medication trials
- Try to form relationship with local mental health providers so they can either get your patient in sooner or help you with the medication selection process
- Counselor referral may get foot in the door and help stabilize patient
RESOURCES

- DSM-V
- Stahl’s Prescriber’s Guide
- Handout of medications
- Local mental health providers
- List of all resources and groups in your county – NAMI, Hospice, etc.
- Beam Contract

REFERENCES