Behavioral Medicine I: Mood Disorders

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Learning Objectives

1. Recognize the differential diagnosis and clinical presentation of:
   a. Major depressive disorder
   b. Dysthymia
   c. Anxiety disorders
   d. Bipolar disorder
2. List the pharmacotherapeutic options for treatment of these conditions.

1. According to the DSM-IV multiaxial model for diagnosing mental health disorders, developing psychiatric diseases are coded on which axis?
   A. Axis I
   B. Axis II
   C. Axis III
   D. Axis IV
   E. Axis V

Most of what follows is true...
1. According to the DSM-IV multiaxial model for diagnosing mental health disorders, developing psychiatric diseases are coded on which axis?

A. Axis I 45%
B. Axis II 19%
C. Axis III 14%
D. Axis IV 22%
E. Axis V 2%

2. Which of the following is NOT true about screening for depression?
A. Brief, 2-question screens for depression are discouraged compared to longer instruments 48%
B. The Edinburgh Postnatal Depression Scale should be routinely used at the first postpartum visit 19%
C. There are multiple standardized scales that can be used for screening for depression 15%
D. The USPSTF recommends screening adults and adolescents for depression 29%

Depression Screening
- USPSTF guidelines recommend screening adults for depression.
- Can use following scales:
  - Zung Self-Rating Depression Scale
  - Beck Depression Inventory
  - General Health Questionnaire, Center for Epidemiologic Studies Depression Scale
  - SelfCARE (D)
  - Geriatric Depression Scale
- But …

Multiaxial Approach to Diagnosing Mental Disorders
- **Axis I: Clinical Syndromes**
  - i.e., depression, anxiety, OCD, bipolar disorder
- **Axis II: Developmental & Personality Disorders**
  - Includes autism and mental retardation
- **Axis III: Physical Conditions**
  - Conditions that play a role in the development, continuance, or exacerbation of Axis I & II Disorders
- **Axis IV: Psychosocial Stressors**
  - Events which can impact the Axis I & II
- **Axis V: Global Assessment of Functioning (GAF)**
  - Rating of patient's level of function, both at the present time and the highest level within the previous year (0-100)

Depression Screening
- A "yes" response to the following 2 questions may be as effective as using longer screening tools. (USPSTF, 2002)
  - Over the past 2 weeks, have you ever felt down, depressed, or hopeless?
  - Have you felt little interest or pleasure in doing things?
Depression

• Effective management strategies
  – Collaborative care between primary care MD, psychiatrist, psychologist (cognitive therapy)
  – Combining patient education, automated pharmacy data, & psychiatric intervention
  – Medication counseling by non-MDs (nurses, pharmacists, counselors)
  – Nurse case management (general support, medication counseling, telephone follow-up)

Depression: Screening

• USPSTF found evidence is insufficient to recommend for or against routine screening of children (7-11 years old) for depression
• USPSTF recommends screening adolescents (12-18 years old) and adults for depression in clinical practices with systems in place for diagnosis, treatment, follow-up
  – First postpartum evaluation should include screening for depression
    – Routine use of the Edinburgh Postnatal Depression Scale improves diagnosis rates

3. Which of the following is NOT true about depression and dysthymia?

A. The depression associated with dysthymia is not as severe as that of major depressive disorder (MDD)
B. Lifetime risk is twice as great for women than men
C. Depression is more common in medically ill patients
D. Dysthymic patients may have periods of “normal” mood that can last for ≥1 year

Diagnosis of Major Depression

• Requires either depressed mood or loss of enjoyment (anhedonia)
• Along with 3 or 4 of:
  – Appetite or sleep changes
  – Decreased energy or concentration
  – Thoughts of guilt or death
  – Psychomotor changes (restlessness or slowing)

Diagnosis of Dysthymia

• Requires depressed mood for at least two years with no symptom-free period lasting longer than two months
• Along with 2 or more of:
  – Appetite or sleep changes
  – Decreased energy or concentration
  – Thoughts of guilt or death
  – Psychomotor changes (restlessness or slowing)
Epidemiology of Depression

• Depression is common.
• Lifetime risk greater for women (20%-25%) than for men (10%)
• Community prevalence is about 5%
• Prevalence is higher (15%) in the medically ill.

4. Which of the following is true about treating depression?

A. If a patient does not respond to an SSRI within 2 weeks of starting it, the dose should be increased or a second antidepressant should be added
B. The medication of choice for depressed patients with seizures is bupropion
C. Memory loss caused by ECT is often short term & reversible
D. Antidepressants are contraindicated if the patient is breastfeeding

Features of Effective Clinical Management

• Patient education (the diagnosis, treatment options, duration of treatment and costs, side effects, goals of the treatment, recurrence and relapse, etc.)
• Reassurance (such as, “depression is a medical illness, not a character defect or weakness; recovery is the rule, not the exception; treatments are effective; an effective treatment can be found for nearly all patients,” etc.)
• Regular monitoring for symptoms and adverse effects
• Adjustments or changes in the treatment plan if response is lacking or suboptimal

Choice of Antidepressant

• All modern antidepressants are equally effective.
• Patient preference
• Cost
• History of prior response to specific medication
• Response of first-degree relative to specific medication
• Use one antidepressant.

Treatment of Depression

• Usually begin with selective serotonin reuptake inhibitors (SSRIs)
  – Once-a-day dosing
  – No titration 80% of the time
  – Few side effects (GI, sexual)
  – Safe in overdose
Other Antidepressants

- Bupropion (Wellbutrin) 150-450 mg
  - No sexual side effects, not with seizures
- Venlafaxine (Effexor XR) 75-225 mg
  - Mixed nor-epi & serotonin
- Nefazodone (Serzone) 50-100 mg
  - No sexual side effects, sedating
- Mirtazapine (Remeron) 15-45 mg
  - At low doses, sedating, appetite increased
- Duloxetine (Cymbalta) 40-60 mg
  - May be useful if chronic pain is present
- Vilazodone (Viibryd) 20-40 mg
  - Serotonin agonist and reuptake blocker

Treatment (cont)

- If no response to any newer agents, or if chronic pain is a large issue in the depression, consider a tricyclic antidepressant

Tricyclic Antidepressants

- Desipramine (Norpramin) 50-150 mg
  - Less sedation
  - Maximum dosage up to 300 mg/day
- Nortriptyline (Pamelor) 50-100 mg
  - More sedation
  - Maximum dosage up to 125 mg/day
- Serum levels available

Monoamine Oxidase Inhibitors (MAOIs)

- Generally not used
- Dietary restrictions; if patients eat foods with tyramine, will get hypertensive crisis
- Problematic in acute medical crises or emergency room settings
- Oral drugs are phenelzine (Nardil) and tranylcypromine (Parnate)
- Transdermal patch – Emsam (selegiline)

Antidepressant Side Effects

- Tricyclics: anticholinergic effects, narrow-angle glaucoma, caution in bundle branch blocks, weight gain
- SSRIs: sexual dysfunction; hyponatremia
- SNRIs: anticholinergic, narrow-angle glaucoma, hepatic dysfunction
- Bupropion: seizure induction (0.4%)

Depression: Terms

- Response: at least a 50% reduction in symptoms of depression as assessed by rating scale
- Remission: resolution of essentially all symptoms
- Recovery: remission lasting for 6 to 12 months
- Relapse: worsening before achieving recovery
- Recurrence: new depressive episode within a few months of recovery
Duration of Treatment

- For 1st episodes of depression, treat for 9-12 months.
- For recurrent depression, treat for at least 2 years.
- If patient relapses after successful treatment, >90% will respond to the same antidepressant.

Augmentation of Antidepressants

- Cytomel (T-3) 25-50 mcg qam
- Lithium carbonate 300-600 mg daily
- Response usually rapid, 7-9 days
- Bupropion (STAR*D Study)
- Buspirone (STAR*D)

Treatment of Depression

- If no response to multiple antidepressants, consider a trial of electroconvulsive treatment (ECT)
- ECT: most effective treatment in patients with severe resistance or psychotic depression
  - Safe; memory loss is short-term, reversible

Depression: Special Groups

- Geriatrics
  - Treat for longer period than younger adults
  - SSRIs better tolerated (↓ sedation, anticholinergic)
- Pediatrics
  - Fluoxetine only one FDA-approved (7-17 years)
- Lactation
  - Antidepressants are NOT contraindicated!
  - In most cases, infant blood concentrations of TCAs and SSRIs have been below the detection limit of commercial labs & well tolerated
  - Fluoxetine: check infant blood levels at 6 weeks

Antidepressants: Use in the Pregnant Patient

- Relapse risk 5x higher if antidepressant is stopped
- SSRIs are first-line
  - Risk of PPHN with SSRI use in late pregnancy
  - Paroxetine: changed to pregnancy category D
  - TCAs also considered safe and effective
  - SSRIs appear to have a more favorable side-effect profile than TCAs
  - One small study supports the use of venlafaxine
  - Informed consent is key

5. Which of the following is NOT true of postpartum depression?

A. The “baby blues” typically resolve spontaneously by the 1st or 2nd postnatal week
B. Patients are predisposed by prior history of depression
C. Therapy is more effective than medications
D. A history of bipolar disorder is a risk factor for the development of postpartum psychosis

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Postpartum Depression

- “Baby blues”
  - Frequency range: 26 to 85%
  - Characterized by mild depressive symptoms
  - Lasts 1-2 weeks
  - Treatment: supportive care
  - Increases risk for postpartum major depression (PMD) later in the postpartum period, especially if symptoms were severe

Postpartum Depression: Treatment

- Treatment is the same as that for major depression
- Psychotherapy or pharmacotherapy may be used alone or in combination
  - No single modality has been shown to be superior

Postpartum Psychosis

- Postpartum psychosis: a medical emergency
  - 0.2% occurrence
  - Onset within the first month of delivery
  - Manic in nature; bipolar disorder is a risk factor
  - Inability to sleep, agitation, expansive or irritable mood, avoidance of the infant
  - Delusions or hallucinations often involve the infant; auditory hallucinations "telling" mother to kill her infant are possible
  - May require inpatient treatment with ECT, neuroleptic agents and/or mood stabilizers

Anxiety Disorders

- Panic Disorder with or without agoraphobia
- Specific phobia
- Social phobia
- Generalized anxiety disorder
- Post-traumatic stress disorder
- Obsessive-compulsive disorder
**Panic Disorder**
- Can occur with or without agoraphobia
- Is a discrete, unprovoked psychophysiological event
- Almost always (90%) comorbid with another illness
- Female: male ratio is 2:1

**Symptoms of Panic Attacks**
- Sudden onset and escalation of extreme anxiety, fear and apprehension
- Accompanied by somatic complaints such as feeling dizzy, lightheaded, faint, tremulous, short of breath, and sweating
- Patients often state, “I am about to die,” or “I am going crazy.”
- 25% will have **nocturnal** attacks

**Treatment of Panic Disorder**
- **SSRIs**
  - Best tolerated
  - Good response reported with all SSRIs
- **Venlafaxine (Effexor)**
- **Tricyclics (imipramine & desipramine)**
  - Patients sensitive to activating effects
  - Start with “geriatric” doses, 10-25 mg

**Treatment of Panic Disorder**
- **MAOIs**
  - May be more effective than tricyclics
  - 3rd or 4th line due to Dietary restrictions and risk of hypertensive crisis
- **Buspirone (Buspar)** is not effective
- Should treat for at least 12 months
- Psychotherapy helpful if agoraphobia does not respond to drug treatment of actual Panic attacks

**Specific Phobia**
- 11% lifetime prevalence
- Some phobias common and culturally or family related
- Little comorbidity
- Often don’t seek help
- Treated with cognitive behavioral therapy and graded desensitization

**Social Phobias**
- Fear of “performance” situations
  - Speeches and presentations
  - Meeting new people
  - Eating in crowded places
- May affect 2% of the population
Treatment of Social Phobia

- SSRIs surprisingly effective
- Phenelzine (MAOI)
- Buspirone not effective
- Beta blockers reduce tremors, sweating, etc., but do not help subjective anxiety

6. Based on RCTs vs. placebo, which of the following has not been shown to be beneficial in the treatment of generalized anxiety disorder?

A. Beta blockers
B. Benzodiazepines
C. Antidepressants
D. Cognitive therapy

Generalized Anxiety Disorder (GAD)

- Involves excess anxiety and worry for more than 6 months
- Accompanied by at least 3 physical symptoms: restlessness, fatigue, poor concentration, muscular tension, irritable bowel symptoms, etc.

Female:Male ratio is 2:1
GAD patients say they have been anxious all of their lives and that they “worry about everything”
Many GAD patients are shy, compliant, perfectionist, and are concerned with their own failures and imperfections.

Generalized Anxiety Disorder (GAD)

- Major differential diagnosis involves major depression, frequently comorbid
- Is chronic, 50% still diagnosed GAD at 5 year follow-up
Treatment of GAD
• Must individualize treatment
• SSRIs effective for generalized anxiety
• Venlafaxine also useful
• Benzodiazepines useful for immediate relief, or if above meds fail.
• Beta blockers do not relieve generalized anxiety

Other Treatments for GAD
• Buspirone (Buspar) may be effective, especially if used as a 1st agent
  – Not a controlled substance, does not prevent ETOH or BZD withdrawal
  – Delayed action, 1-2 weeks
  – Daily BID dosing, not prn

Obsessive-Compulsive Disorder (OCD)
• Obsessions – Recurring, unwanted thoughts
• Compulsions – Repetitive behaviors that reduce anxiety caused by obsessive thoughts
• Occurs in 1% of adults
• Obsessions (trains of thought) produce anxiety, leading to repetitive actions (compulsions) that reduce anxiety
• Patients are aware that these are irrational, but if stopped will lead to incapacitating anxiety

Common Symptoms
<table>
<thead>
<tr>
<th>Obsessions</th>
<th>48%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contamination</td>
<td></td>
</tr>
<tr>
<td>Doubt</td>
<td>47%</td>
</tr>
<tr>
<td>Symmetry</td>
<td>45%</td>
</tr>
<tr>
<td>Fear of aggression</td>
<td>36%</td>
</tr>
<tr>
<td>Somatic obsessions</td>
<td>35%</td>
</tr>
<tr>
<td>Sexual obsessions</td>
<td>22%</td>
</tr>
<tr>
<td>Compulsions</td>
<td></td>
</tr>
<tr>
<td>Checking</td>
<td>62%</td>
</tr>
<tr>
<td>Washing</td>
<td>46%</td>
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<tr>
<td>Need to confess</td>
<td>41%</td>
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<tr>
<td>thoughts or guilt</td>
<td></td>
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<tr>
<td>Need for symmetry</td>
<td>40%</td>
</tr>
<tr>
<td>Counting</td>
<td>30%</td>
</tr>
<tr>
<td>Hoarding</td>
<td>25%</td>
</tr>
</tbody>
</table>

Treatment of OCD
• Use high-dose SSRIs first
• If SSRIs fail, use clomipramine (Tricyclic)
• 50% symptom relief is a good medication response
• Behavioral and Cognitive therapies may help
• 90% of patients relapse if treatment is stopped

Key Points for the Exam
• Screening for depression:
  • Children = no
  • Adolescents and adults = yes, if systems in place to monitor
• Recovery from first MDD: can discontinue medications
• Adequate trial of antidepressant: 4-6 weeks
• ECT: memory loss short-term, reversible
• Lithium: mania without rapid cycling
• Lactation: antidepressants OK, lithium not
• Pregnancy: continue treatment to avoid relapse; SSRIs first-line therapy, but avoid paroxetine

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Answers

1. A
2. A
3. D
4. C
5. C
6. A