Depression and Anxiety Disorders: Diagnosis and Treatment

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Overview

- In 2021, at least 21 million adults experienced a major depressive episode
- Prevalence was higher in 18-25 year olds
- Over 20% of US adolescents ages 12-17 had a major depressive episode
- Prevalence higher in females
- Anxiety Disorders often coexist with depressive disorders
- Major increase in adolescent and young adults since the pandemic, including increased illnesses and suicidality

Major Depressive Disorder

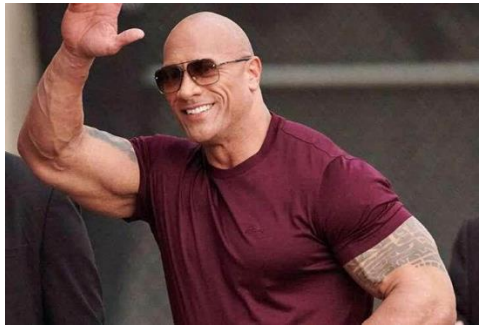
- SLEEP
- INTEREST
- GUILT
- ENERGY
- CONCENTRATION
- APPETITE
- PSYCHOMOTOR RETARDATION
- SUICIDALITY

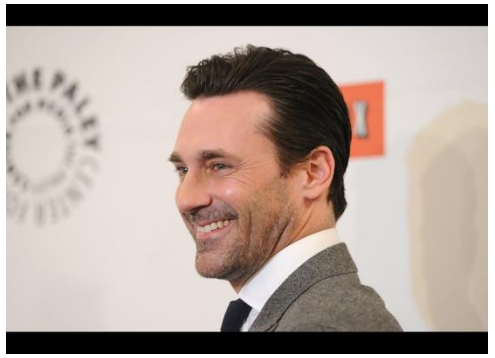
Major Depressive Disorder

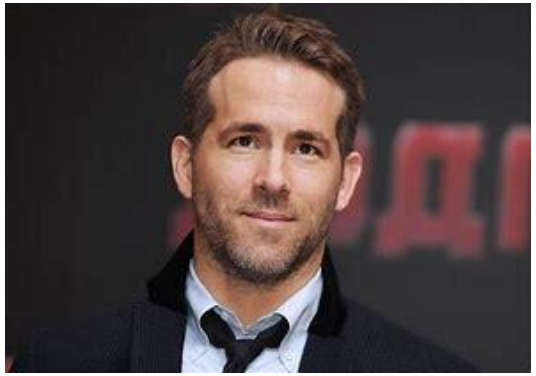
- 5 SYMPTOMS FOR AT LEAST 2 WEEKS
- DEPRESSED OR ANHEDONIA
- GENERALLY LAST LONGER THAN 2 WEEKS
- MORE OFTEN MULTIPLE EPISODES THROUGHOUT LIFE

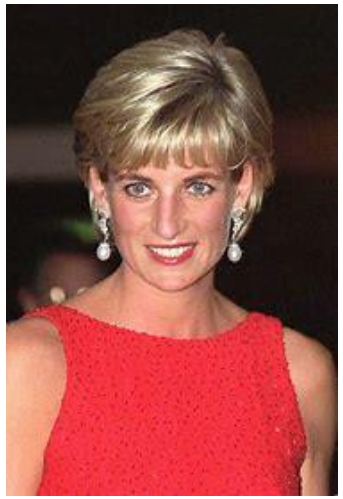
Major Depressive Disorder

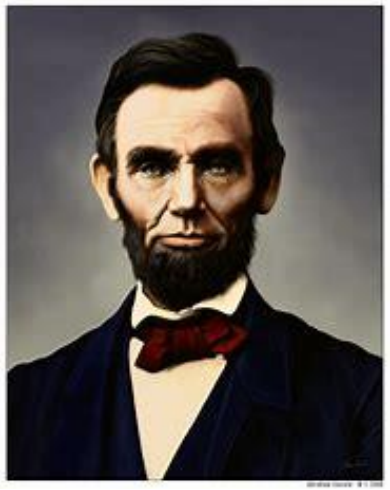
- MILD, MODERATE, SEVERE
- COMMON SPECIFIERS:
  - PERIPARTUM
  - SEASONAL PATTERN
  - ATYPICAL

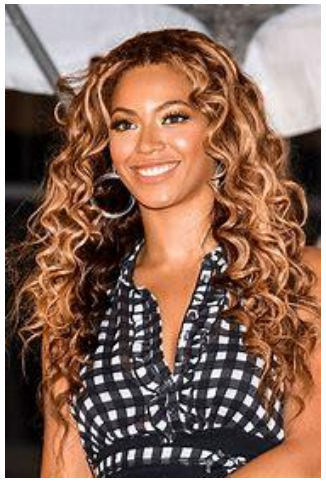


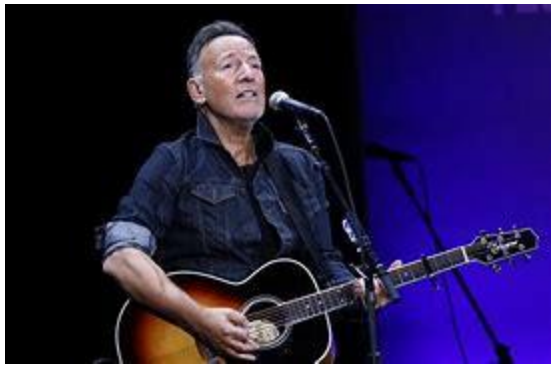












Persistent Depressive Disorder (Dysthymia)

- DEPRESSED MOOD FOR 2 YEARS
- NOT SYMPTOM FREE FOR MORE THAN 2 MONTHS
- APPETITE
- SLEEP
- ENERGY
- SELF ESTEEM
- CONCENTRATION
- HOPELESSNESS

MORE LIKELY TO MEET MDD THAN THIS

Generalized Anxiety Disorder

- EXCESSIVE ANXIETY OR WORRY FOR 6 MONTHS
- 3 OR MORE SYMPTOMS:
  - RESTLESSNESS
  - FATIGUED EASILY
  - CONCENTRATION
  - IRRITABILITY
  - MUSCLE TENSION
  - SLEEP
- ONLY ONE IN CHILDREN

Panic Disorder

- PANIC ATTACK: SURGE OF INTENSE FEAR, PEAKS IN MINUTES, AND 4 OR MORE:

  HR, SWEATING, TREMBLING, SOB, CHOKING, CHEST PAIN, GI, DIZZY, TEMP, PARASTHESIAS, DEREALIZATION, FEAR OF LOSING CONTROL, FEAR OF DYING

- RECURRENT PANIC ATTACKS
- 1+ MONTH OF PERSISTENT WORRY ABOUT NEXT PANIC ATTACK, AND/OR MODIFY BEHAVIORS (AVOIDANCE, ETC)

AGORAPHOBIA

- MARKED ANXIETY IN 2+
  - PUBLIC TRANSPORTATION
  - OPEN SPACES
  - ENCLOSED SPACES
  - CROWDS
  - OUTSIDE OF HOME
- FEEL ESCAPE IS DIFFICULT
- 6 MONTHS

SPECIFIC PHOBIA

- MARKED ANXIETY ABOUT SPECIFIC OBJECT OR SITUATION

- ANIMALS
- ENVIRONMENT
- BLOOD/NEEDLES
- SITUATIONAL (AIRPLANES)
- OTHER

- ALMOST ALWAYS PROVOKES ANXIETY RESPONSE

SOCIAL ANXIETY DISORDER

(SOCIAL PHOBIA)

- MARKED ANXIETY TO SITUATIONS EXPOSED TO POSSIBLE SCRUTINY
- PUBLIC SPEAKING

OBSESSIVE-COMPULISVE DISORDER (OCD)

- OBSESSIONS, COMPULSIONS, OR BOTH
- OBSESSIONS: THE REPETITIVE THOUGHTS
- COMPULSIONS: THE ACTION TO NEUTRALIZE THE THOUGHTS
  - HAND WASHING
  - ORDERING
  - COUNTING
  - CHECKING
- TAKE 1+ HOURS DAILY

POSTTRAUMATIC STRESS DISORDER (PTSD)

- EXPOSURE TO ACUTAL/THREATENED DEATH, INJURY, VIOLENCE
- FLASHBACKS, DREAMS, DISSOCIATION, SYMBOLISM
- AVOIDANCE
- NEGATIVE MOOD
- HYPERVIGILANCE
- AT LEAST 1 MONTH
- ACUTE STRESS DISORDER (<1 MONTH)

ADJUSTMENT DISORDERS

- EMOTIONAL/BEHAVIORAL SYMPTOMS WITHIN 3 MONTHS OF A STRESSOR
- DISTRESS OUT OF PROPORTION
- CAUSES IMPAIRMENT
- DOES NOT MEET CRITERIA FOR OTHER DISORDERS OR EXACERBATION OF OTHER DISORDERS
- VERY COMMON IN YOUNGER POPULATION (ED VISITS)

BIPOLAR I DISORDER

- MANIA

- PERSISTENT ELEVATED, EXPANSIVE (3) OR IRRITABLE (4) MOOD, AND
- DISTRACTIBILITY
- IMPULSIVITY
- GRANDIOSITY
- FLIGHT OF IDEAS
- ACTIVITIES INCREASED
- SLEEP DEFICIT
- TALKATIVENESS

- AT LEAST 1 WEEK, LESS IF HOSPITALIZATION IS DONE SOONER

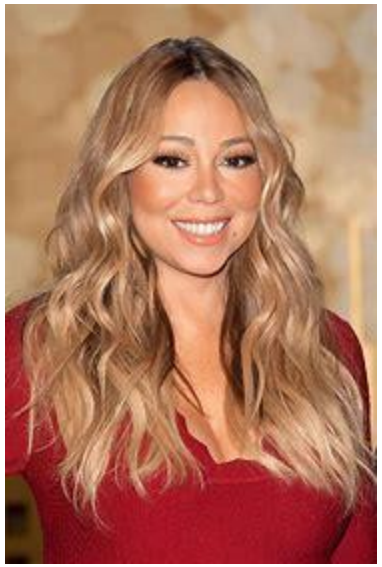
- CAUSED MARKED IMPAIRMENT AND NEEDS HOSPITALIZATION

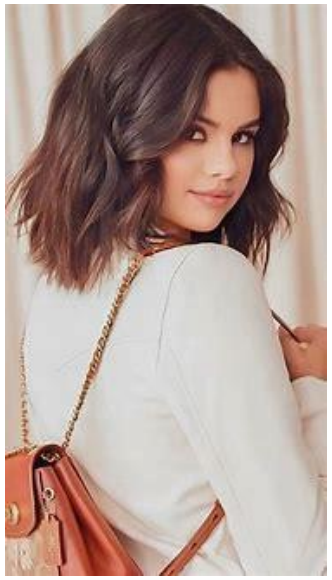
BIPOLAR I DISORDER

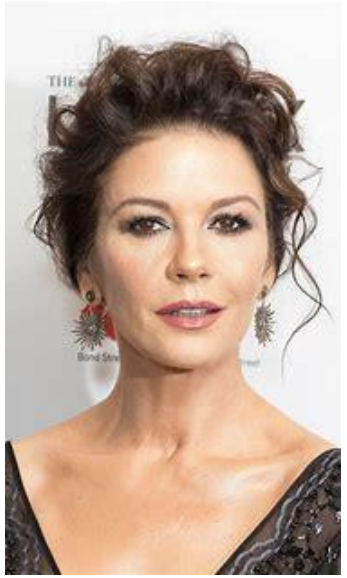
- NEEDS AT LEAST ONE MANIC EPISODE
- CAN HAVE A SEPARATE MDD EPISODE, BUT NOT NEEDED FOR CRITERIA
- NEEDS HOSPITALIZATION, BE CAREFUL IN YOUR NOTES

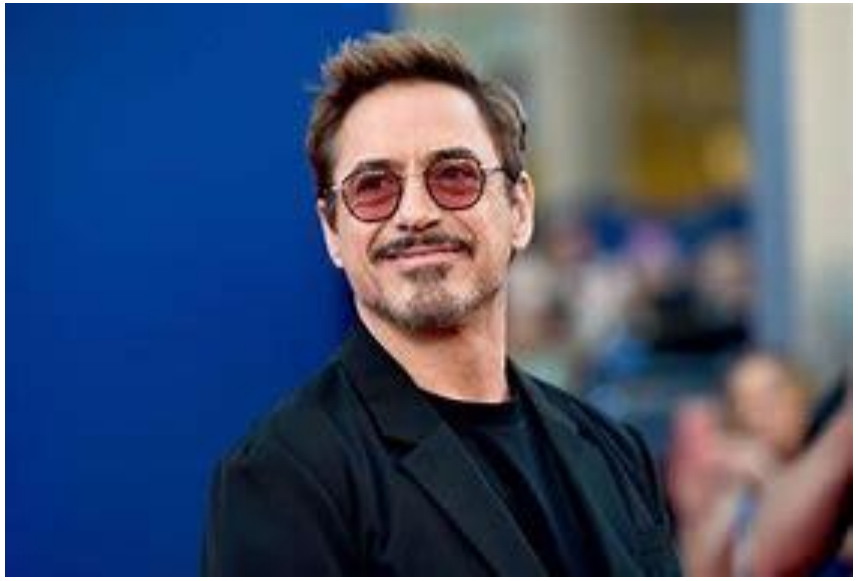
BIPOLAR II DISORDER

- MDD EPISODE
- HYPOMANIA
  - SAME MANIA DIGFAST, BUT DOES NOT CAUSE SEVERE IMPAIRMENT
  - AT LEAST 4 DAYS
  - NEVER HAD MANIA
  - AT LEAST ONE HYPOMANIC AND ONE MDD EPISODE
  - CAN FUNCTION BUT STILL NEEDS TREATMENT










NEVER, NEVER,
NEVER GIVE UP!

DYSRUPTIVE MOOD DYSREGULATION DISORDER

- TEMPER OUTBURTSTS (VERBAL AND/OR PHYSICAL) NOT CONSISTENT WITH DEV. LEVEL
- 3+ WEEK FOR AT LEAST 12 MONTHS
- DX STARTS AT 6-18 YO
- NEW DX DUE TO OVERDIAGNOSIS (MISDIAGNOSIS) OF BIPOLAR DISORDER IN CHILDREN

PREMENSTURAL DYSPHORIC DISORDER (PMDD)

- 1 OR MORE:
  - LABILITY
  - IRRITABILITY
  - DEPRESSED MOOD
  - ANXIETY
- 1 OR MORE:
  - DECREASED INTEREST
  - CONCENTRATION
  - FATIGUE
  - APPETITE
  - SLEEP
  - OVERWHELEMED
  - PHYSICAL SYMPTOMS
- AT LEAST 5 TOTAL IN FINAL WEEK BEFORE MENSES, START TO IMPOVE WITHIN ONSET OF MENSES, AND BECOME ABSENT OR MINIMAL IN THE WEEK POSTMENSES

MEDICATION MANAGEMENT

THE ANTIDEPRESSANTS

- **SSRI**
- PROZAC (10-80mg)
- PAXIL (10-50mg)
- LEXAPRO (5-20mg)
- CELEXA (10-40mg)
- ZOLOFT (25-200mg)
- LUVOX (50-300mg)

- **SNRI**
- EFFEXOR (37.5 – 225mg sometimes 300)
- CYMBALTA (20-120mg, can do bid)
- PRISTIQ (25-100mg sometimes 150mg)

OTHER ANTIDEPRESSANTS

- **TRINTELLIX** (5-20mg): serotonin reuptake inhibitor, plus 5-HT3 blocker, 5HT 1A agonist, 5-HT 1A agonist, 5-HT 1B partial agonist, 5-HT 1D and 7 blocker
  - Wellbutrin increases Trintellix, so reduce Trintellix by half

- **VIIBRYD** (10-40mg): serotonin reuptake inhibitor, 5-HT 1A partial agonist

- **BUSPAR** (5-60mg in bid or tid): partial 5-HT 1A
- **REMERON** (7.5-45mg): boosts serotonin and NE, alpha 2 blocker, H1 blocker
- **WELLBUTRIN** (75-450mg in bid/tid, SR 100-400mg, in bid, XL 150-450mg qd)

  Boosts NE and Dopamine (reuptake inhibitors)

IMPORTANT NOTES

- ALWAYS SCREEN FOR BIPOLAR D/O, CAN INDUCE MANIA
- NEVER EVER MIX SSRIs or SNRIs TOGETHER (DANGEROUS AND INEFFECTIVE)
- START LOW AND GO SLOW
- SIDE EFFECTS: COMMON ONES ARE WT GAIN, GI, SEXUAL DYSFUNCTION
- ZOFRAN MOA: BLOCKS 5-HT 3

- TRYCYCLICS:
  - AMITRIPTYLINE, NORTRIPTYLENE, DOXEPIN, DESIMPRAMINE, ETC
  - STILL USED FOR HA, IBS, PAIN, AND IT'S OK TO HAVE THIS WITH OTHERS, BUT BE CAREFUL – GET AN ANNUAL EKG, WATCH OUT FOR TACHYCARDIA
  - CAUTION IF CARDIAC HX

AUGMENTATION AGENTS

- CAN ADD **BUSPAR**, **WELLBUTRIN**, AND **REMERON** TO SSRI OR SNRI

- **LAMICTAL**: GREAT AUGMENTATION AGENT WITHOUT THE WEIGHT GAIN
- SJS RASH RISK, START WITH 25MG QD AND INCREASE EVERY TWO WEEKS

- **Lithium:** LIFE SAVING, BEST FOR REDUCING/STOPPING SI
- CBC, CMP, LITHIUM LEVEL, TSH, EKG,
- DOES NOT HAVE TO BE IN THERAPEUTIC RANGE TO BE EFFECTIVE FOR DEPRESSION (NON BIPOLAR)

- **ANTIPSYCHOTICS**

TYPICAL ANTIPSYCHOTICS (1ST GENERATION)

- DO NOT USE FOR DEPRESSION AUGMENTATION
- HIGHER RISK OF TD AND CARDIAC SE
- HALDOL, THORAZINE, MELLARIL, ETC.

ATYPICAL ANTIPSYCHOTICS
2ND GENERATION)

- ABILIFY, ZYPREXA, GEODON, RISPERDAL, SEROQUEL
- NEW ONES: REXULTI, VRAYLAR, LATUDA
- PARTIAL D2 AND 5-HT1A AGONIST AND 5-HT2A BLOCKER
- MONITOR METABOLIC PARAMETERS (CBC, CMP, HBG A1C, FLP)
- MONITOR FOR EPS AND TD NO MATTER HOW LOW THE DOSE
  - Dystonia, Akathisia, Parkinsonian symptoms, TD
- CAN CYCLE THESE IN TIMES OF NEED TO MINIMIZE LONG TERM SE
- CAN WORK FASTER AND EFFECTIVELY

ACUTE SIDE EFFECTS TO KEEP IN MIND

- **AMS**
- **FEVER**
- **DYSAUTONOMIA**
- **MUSCLE RIGIDITY**

- SEROTONIN SYNDROME
- NEUROLEPTIC MALIGNANT SYNDROME
- MALIGNANT HYPERTHERMIA

- SEROTONIN SYNDROME: DIARRHEA AND SEROTONERGIC DRUGS
- NMS: ELEVATED CK AND ANTIPSYCHOTIC USE
- MH: FAMILY HISTORY AND OR SETTING
- ALL 3 ARE EMERGENCIES

Other Treatments

- AUVELITY
- NEWEST DRUG
- DEXTROMETHORPHAN/WELLBUTRIN
- NMDA ANTAGONIST
- FAST ACTING

- KETAMINE (SPRAVATO)
- NMDA ANTOGONIST
- SCHEDULE III
- VERY NEW, MIXED RESULTS, HAS SHOWN PROMISE
- HIGH ABUSE POTENTIAL

- ZURZUVAE
- POSTPARTUM DEPRESSION TX
- STEROID MODULATES GABA-A RECEPTORS

- ZULRESSO
- IV FOR PPD, GABA-A MODULATOR

OTHER TREATMENTS

- TMS
- MAY BENEFIT, SERIOUS TIME COMMITMENT/COST

- ECT
- STILL THE MOST EFFECTIVE TX
- NOT A FIRST LINE
- MAY HAVE PERMANENT RISKS, BUT ALSO CAN BE LIFE SAVING

AS NEEDED TREATMENT FOR ANXIETY

- DO NOT START WITH BENZOS, ONCE STARTED CAN BE HIGHLY ADDICTIVE AND DIVERSION INTO THE COMMUNITY
- PROPRANOLOL
  - CAREFUL IF DM, ASTHMA, OR LOWER HR
- HYDROXYZINE
- NEURONTIN
- BUSPAR

THANK YOU!!