General Psychiatry in Primary Care: Depression and Anxiety

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Learning Objectives

1. Appreciate the continued expanding role of primary care providers in screening, diagnosis, and treatment of mental illness.
2. Understand best practices for treating depression and anxiety.
3. Discuss referring to mental healthcare, setting boundaries, and crisis planning.

Primary Care as the Front Line

USPSTF Recommends:

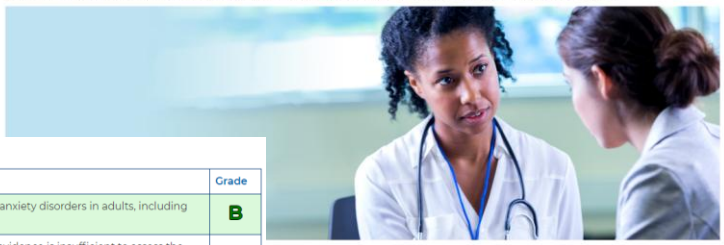
- **2011: Depression Screening**
- **2023: Anxiety Screening**

Final Recommendation Statement

Anxiety Disorders in Adults: Screening

June 20, 2023

Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.



Recommendation Summary

Population	Recommendation	Grade
Adults 64 years or younger, including pregnant and postpartum persons	The USPSTF recommends screening for anxiety disorders in adults, including pregnant and postpartum persons.	B
Older adults 65 years or older	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for anxiety disorders in older adults.	I

Pathway to Benefit

To achieve the benefit of screening for anxiety disorders and reduce disparities in anxiety disorder--associated morbidity, it is important that persons who screen positive are evaluated further for diagnosis and, if appropriate, are provided or referred for evidence-based care.

https://www.uspreventiveservicestaskforce.org

Primary Care as the Front Line

DUH, BUT WHY?!?!

- Limited insurance coverage for mental healthcare
- Shortage of psychiatric clinicians (regardless of quality)
- Stigma
- Improvement in treatments
  - SSRIs are safer and more tolerable
- The internet, always the internet.

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Common Questions/Concerns

- What medication to start?
- When to change?
- When to augment?
- When to refer?
- How to not exhausted myself caring for these patients?

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First some background….

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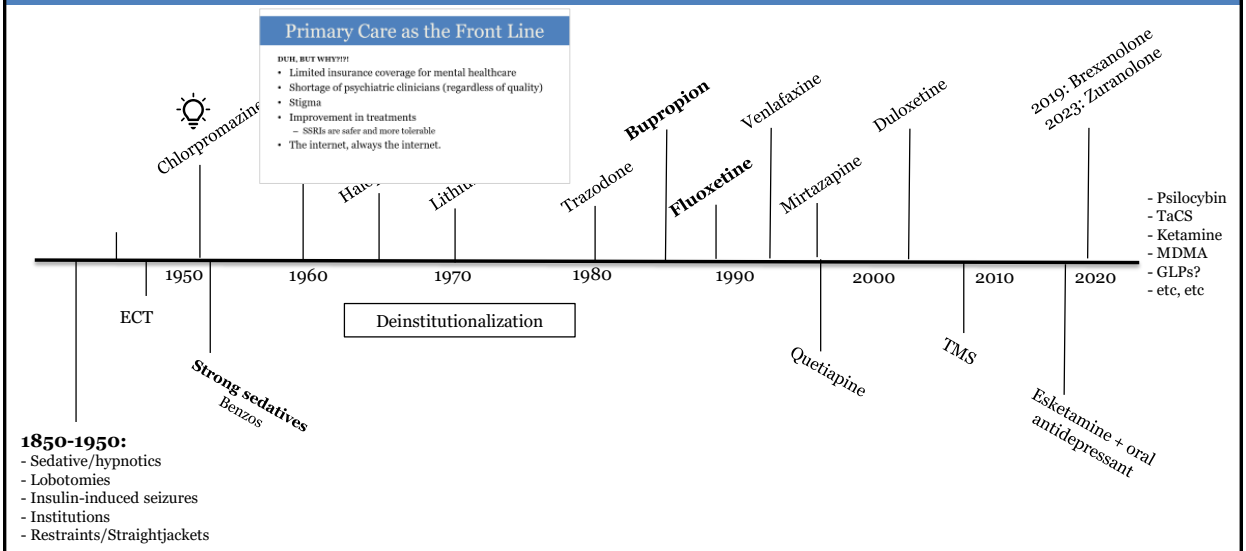
Timeline



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Epidemiology

Disorder/Syndrome	12 month - Men	12 month - Women	Lifetime
Major Depressive Disorder (MDD) - Men	7%	13%	15-26%
Suicide attempts w/in an MDD episode	13.62%		4.77%
Anxiety Disorders (GAD, PD, OCD, PTSD, etc)	14.3%	23.4%	19.1%
Bipolar Disorder	2.9%	2.8%	4.4%
Schizophrenia and related psychotic dis.			0.25 – 0.64%
ADHD – Adults			4.4% (or… 14-26%)

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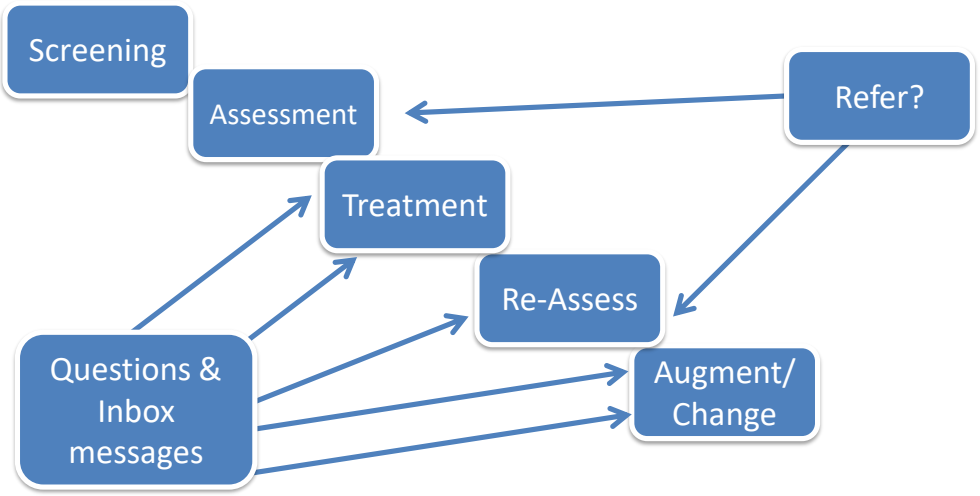
The Process



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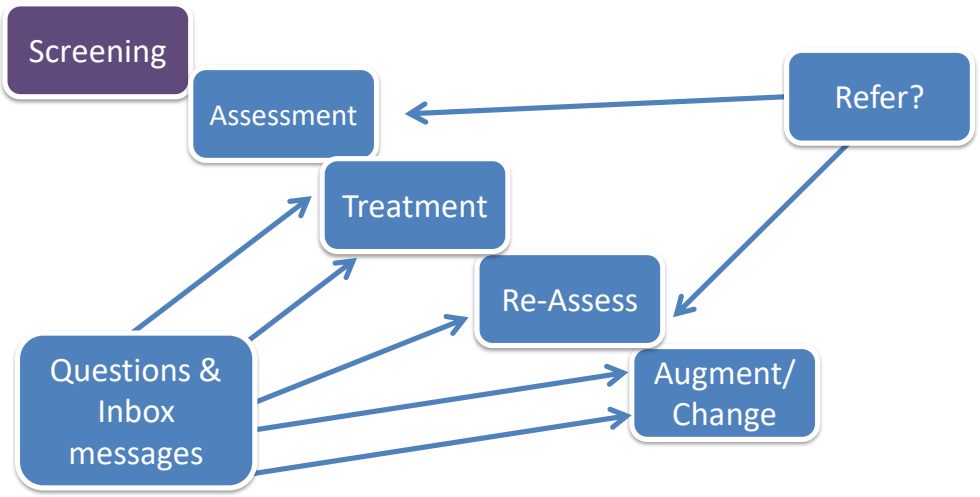
The Process



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Screening

Depression

- Patient Health Questionnaire – (PHQ-9)
- Quick Inventory of Depressive Symptomatology – Self-Report (QIDS-SR)
- Edinburgh Postnatal Depression Scale (EPDS)

Anxiety

- Generalized Anxiety Disorder Scale – 7 (GAD-7, GAD-2)
- Geriatric Anxiety Scale (GAS)
- Edinburgh Postnatal Depression Scale (EPDS, qs 3-5)

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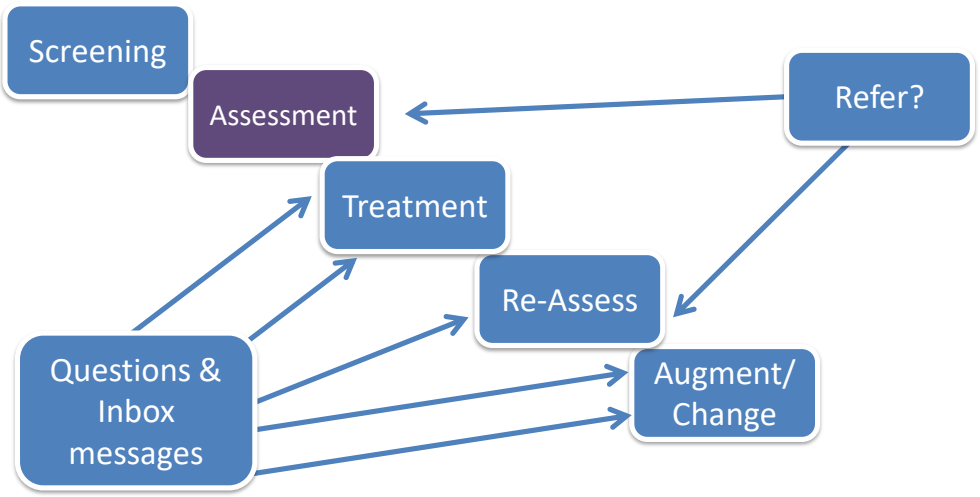
The Process



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Assessment

History

- Family History
- Medication History
- Hospitalizations
- Suicide Attempts
- Trauma History

Physical Work-Up/Baseline

- Weight
- BP
- TSH
- CBC/CMP
- EKG/Qtc

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Assessment

- Appearance
- Behavior
- Mood
- Affect
- Motor
- Speech
- Thought process and content
- Perception
- Cognition
- Insight
- Judgment

Assessment Is Not the Same as Recording a Patient Report.

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Diagnosis: Perspectives

- Disease: what someone *has*
- Dimension: who someone *is*
- Behavior: what someone *does*
- Life Story: what someone has *experienced*

- Developmental?

Peters ME, Taylor J, Lyketsos CG, Chisolm MS. Beyond the DSM: the perspectives of psychiatry approach to patients. Prim Care Companion CNS Disord. 2012;14(1):PCC.11m01233. doi: 10.4088/PCC.11m01233. Epub 2012 Feb 23. PMID: 22690367; PMCID: PMC3357579.
McHugh, Paul R., and Phillip R. Slavney. *The perspectives of psychiatry*. JHU Press, 1998.

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Diagnosis: Perspectives

Consider:
- Suicidal ideation
- Changes in concentration/distraction

- Disease: what someone *has*
- Dimension: who someone *is*
- Behavior: what someone *does*
- Life Story: what someone has *experienced*

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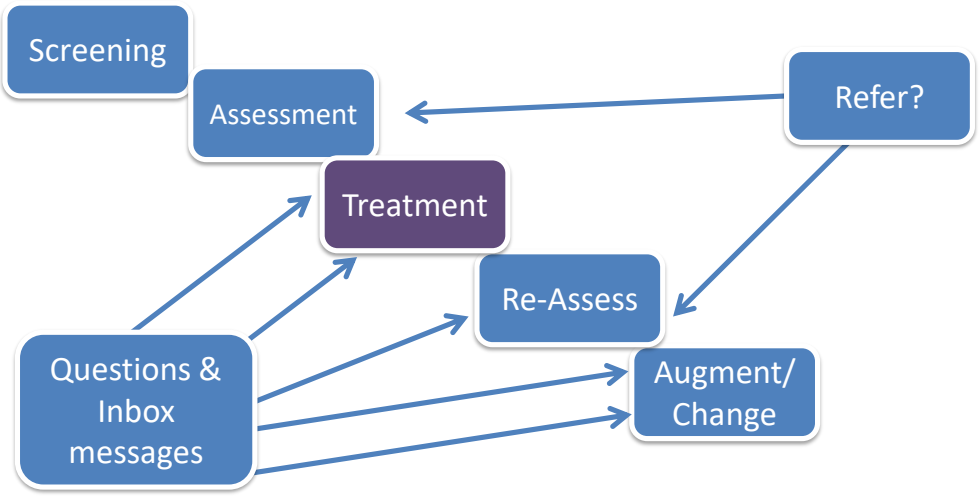
The Process



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Before Treatment: Setting Expectations

- Medication doses
- Early side effects
- Role of therapy
- Early referral
- Follow-up
- Crisis Planning

Boundaries & Expectations

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Treatment Dose Ranges- SSRI

	Starting Dose (to mitigate side effects)	MDD/PPD*	Anxiety Disorders***	OCD***
Sertraline	25-50 mg	100 – 200 mg	100-200 mg	200-400 mg
Fluoxetine	10 mg	20 – 60 mg	20-60 mg	40-100 mg
Escitalopram	5-10 mg HS	10-20 mg	20-40 mg	20-60 mg**
Citalopram	10 mg	20-40 mg	20-40 mg	20-80 mg**
Fluvoxamine	50-100 mg HS	----------	--------	100-300 mg
Paroxetine	10-20 mg	50 mg	60 mg	60 mg

*No SSRI/SNRI has been FDA approved for PPD/PPA
**Off-label use
***Often above FDA-approved maximum recommended dose

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Side Effects - SSRI

	Most Common Side Effects (>5% and 2x placebo)
Sertraline	Nausea, diarrhea, tremor, dyspepsia, sweating, low appetite, ejaculation failure (ED), decrease libido (>5%)
Fluoxetine	Nausea, diarrhea, constipation, insomnia, low appetite, dry mouth, **increased anxiety early on**, sweating, ED, tremor
Escitalopram	Fatigue/somnolence, insomnia, decreased libido, anorgasmia, nausea, sweating, **QTc prolongation (over others)**
Citalopram	Insomnia, ED, sweating, fatigue/somnolence, decreased libido, anorgasmia, **more QTc prolongation than others**
Fluvoxamine	nausea, somnolence, insomnia, nervousness, dyspepsia, ED, sweating, tremor, vomiting, anorgasmia, decreased libido, dry mouth, rhinitis, taste perversion, and urinary frequency in patients with OCD

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Treatment Dose Ranges- More

	Starting Dose (to mitigate side effects)	MDD	Anxiety Disorders
Bupropion XL	150 mg	300 – 450 mg	
Venlafaxine	37.5-75 mg	150 – 225 mg	225 mg
Duloxetine	30 – 60 mg	60 – 120 mg	60 - 120 mg
Vilazodone	10 mg	40 mg	
Nortriptyline	10-25 mg	75 – 100 mg (level)	

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Side Effects - SSRI

	Most Common Side Effects (>5% and 2x placebo)
Bupropion XL	Insomnia, slight QTc prolongation
Venlafaxine	Drowsiness, insomnia, GI, sexual side effects
Duloxetine	Insomnia/agitation, GI, unclear weight gain, sexual dysfunction
Vilazodone	Insomnia/agitation, GI, sexual dysfunction
Nortriptyline	Anticholinergic, drowsiness, orthostatic hypotension, slight weight gain

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Tell Me More: Libido

- Most SSRIs are equal in sexual side effects (paroxetine worse)
- Venlafaxine more sexual side effects
- Mirtazapine, duloxetine, vilazodone, vortioxetine all low sexual SE
- Bupropion almost none (never say never)

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Tell Me More: Weight Gain

- Paroxetine and mirtazapine = more
- SSRIs (except fluoxetine) = slight
- Duloxetine, venlafaxine = slight
- Bupropion: None

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Setting Expectations: SSRI

- Why we start low (tolerance of side effects)
- Expected dose
- Dose increase plan
- Common side effects: nausea, headache, increased anxiety usually subside after 3-4 days
- Start in morning initially
  - Change to night if needed

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Therapy + Meds = More Effective

- Behavioral Therapy
- Cognitive Behavioral Therapy (CBT)
- Interpersonal Psychotherapy (IPT)
- Psychodynamic Therapy
- Dialectical Behavioral Therapy (DBT)
- Exposure Response Therapy
- Supportive Therapy

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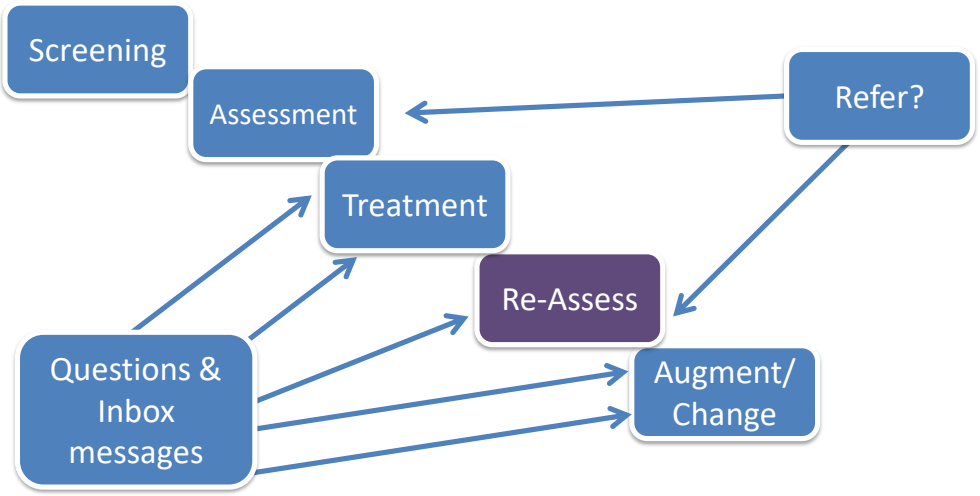
The Process



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Re-Assessment

- Get to optimal dose (not starting dose) x 6-8 weeks
- Compare screening scales
- Bring a partner/friend to visit to provide real-time collateral
- Reinforce therapy
- Refer

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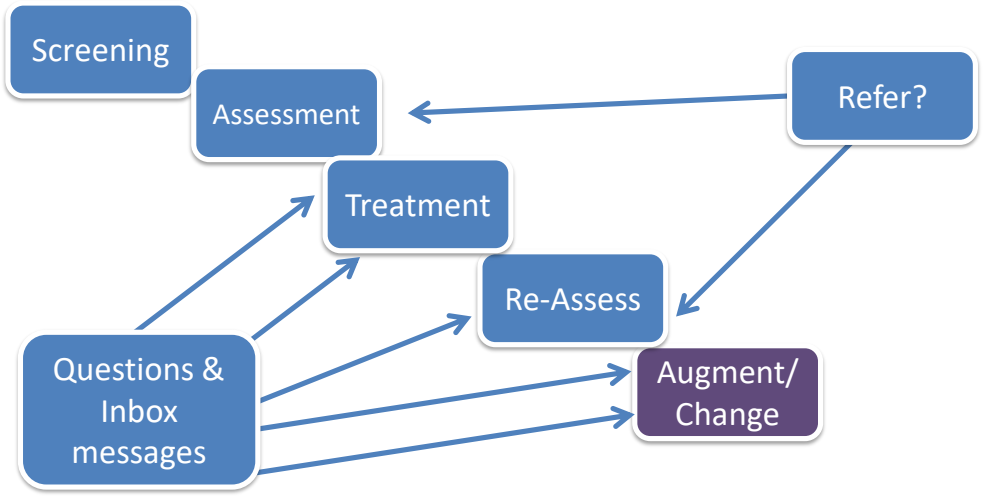
The Process



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Augmentation

- Bupropion
- Trazodone
- Second generation antipsychotics
  - Aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone
- Buspirone
- Lamotrigine
- Lithium

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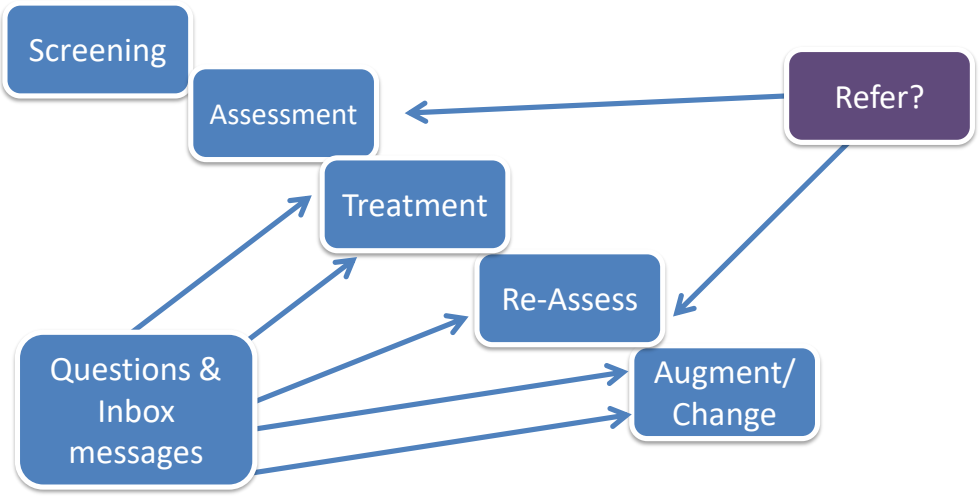
The Process



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Referral/Structure

- If moderate-severe symptoms: refer early
- Access to more treatment modalities
- Communication/relationship with mental health providers
- Collaborative Care Models
- Imbedded Consultation Models

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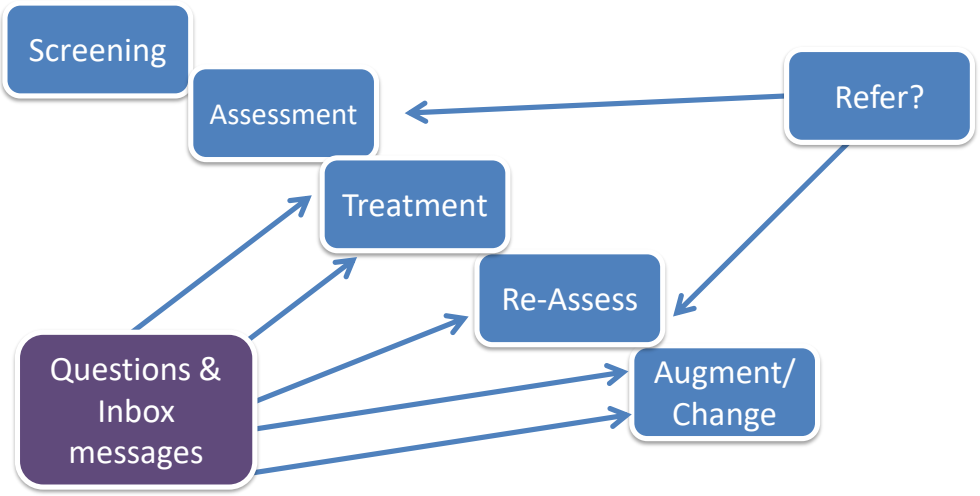

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Setting Boundaries

- Do not fear setting boundaries!
- Vital for patient's care and your own
- We can't leave Freud completely out:
  - Transference
  - Countertransference
- Expectations around when to message and when you will respond
- Reinforce to patient (and yourself) that remission takes time
- Crisis plan for psychiatric emergency

"And you're honestly not feeling any transference?"

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Crisis Plan

- Create a smartphrase/print out
  - Suicide Hotline: 988
  - Chat: www.988lifeline.org
  - Local emergency rooms
  - Link to a safety planning tool: Stanley – Brown Safety Plan
  - Starter instructions for finding therapist
    - Get list from insurance
    - PsychologyToday.com
    - Info for local mental health care

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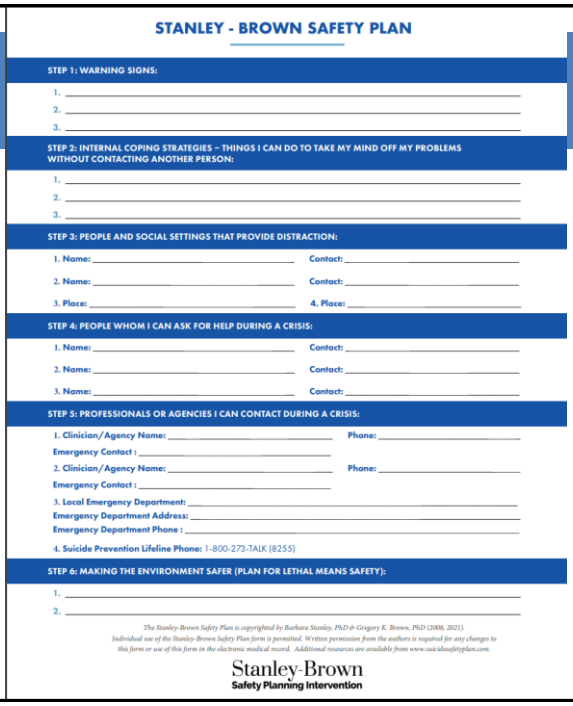

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Place: _____ 4. Place: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
2. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
3. Local Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone : _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

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Other Treatments

- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Esketamine (intranasal)
- Zuranolone
- Transcranial alternating current stimulation (tACS)

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What Percentage of Patients with Depression Receive Psychiatric Medications from Their PCP?

A. 30%
B. 55%
C. 75%
D. 90%

1987 to 1997:
37.3% → 74.5%
-Faghri, et al. 2010

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Key References

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