Anxiety & Depression: Case Studies in Management 2024

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Disclosure

- Neither Dr Emmerich nor her spouse have any financial disclosures to report related to the content of the current presentation.

Agenda

- Guiding Principles of Psychiatric Treatment
- Suicide Risk Assessment
- Anxiety
- Depression
- Impact of Bipolar Disorder on Tx
- Answers to the most common questions

Educational Goals

At the end of this session participants will be able to:

- Perform Suicide Risk Assessment.
- Determine when “prn” vs maintenance medication is indicted for Anxiety Disorders.
- Suggest treatment options for Treatment Resistant Depression.

Management Plan for Psychiatric Conditions

- *Diagnosis*
- *Risk Assessment*
- *Education*
- *Medication*
- *Psychotherapy*
- *Somatic therapies/newer treatment options (if indicated*)

Guiding principles

- *Some patients get a cure; some need a chronic care model to ↓ risk of, and manage, recurrences.*

- *Important to assess what stage of illness pt is in currently and context (prior history, triggers, medical status, substances).*

- *Is there any information that suggests a comorbid untreated/under-treated diagnosis?*

High % recurrence – 4 year follow up

- **Diagnostically stable recurrence** - recurrence of the specific index disorder (anxiety 23.8%, depression 37.6%, comorbid 54%)
- **Diagnostically unstable recurrence** - newly arisen anxiety or depressive disorders that are different from the index episode (for instance new panic attacks in pt with prior episode depression) (anxiety 54.8%, depression 49.7%, comorbid 66.3%)

- Scholten et al, 2016

Chronic Care Model

- Providers need to be pro-active:
  - *Recognition of triggers:*
    - Not taking meds
    - Losses/anniversaries of losses
    - Lack of attainment of goals
    - Increase in stress
    - ***Seasonal pattern***
  - *Early warning signs:*
    - Sleep changes
    - Isolating
    - Missed appts
    - Increase in use of substances

Suicide Risk Assessment

- ***Suicidal thoughts? Access to firearms or other means?***
- ***Static risk factors*** – recent inpatient admission, prior suicide attempts, h/o head injury, h/o psychosis, family h/o completed suicide, etc.
- ***Modifiable risk factors*** – depression, anxiety, grief, lack of supports, housing/financial insecurity, no day structure, substance use, etc.
- ***Protective factors*** – engagement in tx, support system, absence of SI, no prior attempts, religious beliefs, sense of responsibility to others, connection to work/school, connection to pets, etc.
- ***Appropriate for outpt level of care (loc) or in need of higher loc?***

Suicide Prevention Hotlines

- **“988”** nationwide, 24/7, 365 days/year, call or text
  - Veterans press 1
  - Spanish speaking press 2
  - LGBTQIA youth press 3
  - Deaf, hard of hearing access
- **866-4-U-TREVOR (866-488-7386)**: for LGBTQIA youth and young adults or text “START” to 678-678.

Anxiety

US Preventive Services Task Force

- Sept 2022 – new recommendations
- Under age 65: screen for Anxiety as well as Depression
- Over age 65: screen for Depression

“Racism and structural policies have contributed to wealth inequities in the United States, which also affects mental health in underserved communities,” the recommendation states. “For example, wealth inequities may result in barriers to receiving mental health services, such as treatment costs and lack of insurance, which tend to have a greater impact on Black persons and other racial and ethnic groups than on White persons. The misdiagnosis of mental health conditions occurs more in Black and Hispanic/Latino patients compared with White patients.”

US Preventive Services Task Force, Sept 2022

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ____ = Add Columns ____ + ____ + ____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

GAD – 7 scoring

- 0–4: minimal anxiety
- 5–9: mild anxiety
- 10–14: moderate anxiety
- 15–21: severe anxiety

Screens for Generalized Anxiety Disorder (GAD), Panic Disorder (PD) and Social Anxiety Disorder

Case 1

- 22 yo male, new to your practice
- H/O severe anxiety, school avoidance, failure to launch
- Multiple residential programs in teens
- Therapist x 10 years
- Meds included Ativan, high dose antipsychotic, antidepressant
- Several hospitalizations
- Agoraphobic – afraid to go places alone due to fear he would faint from anxiety
- No substances. No psychosis. No mood swings. No Suicidality. ‘
- Medically healthy.
- GAD-7 score: 21 (severe anxiety)

Cognitive Behavioral Therapy (CBT)

First line treatment for Anxiety Disorders.

What you think impacts your emotions (If you think elevators are dangerous & avoid them, your brain will feel anxious when you see an elevator & your body will manifest physical sx of anxiety)

“Cognitive behavioral therapy (CBT) is well suited for the primary care setting due to its short-term structure and skills-based approach….The primary finding from this study is that CBT delivered to individuals with anxiety disorders in primary care resulted in significant improvements in self-reported anxiety symptoms.”

(*Bogucki, 2021*)

SMART
Stress Management and Resiliency Training

- Mind Body Program
- Trainees learn to focus the mind on the present moment through practices such as meditation, yoga, tai chi.
- ↓healthcare utilization.

(*Stahl, 2017*)

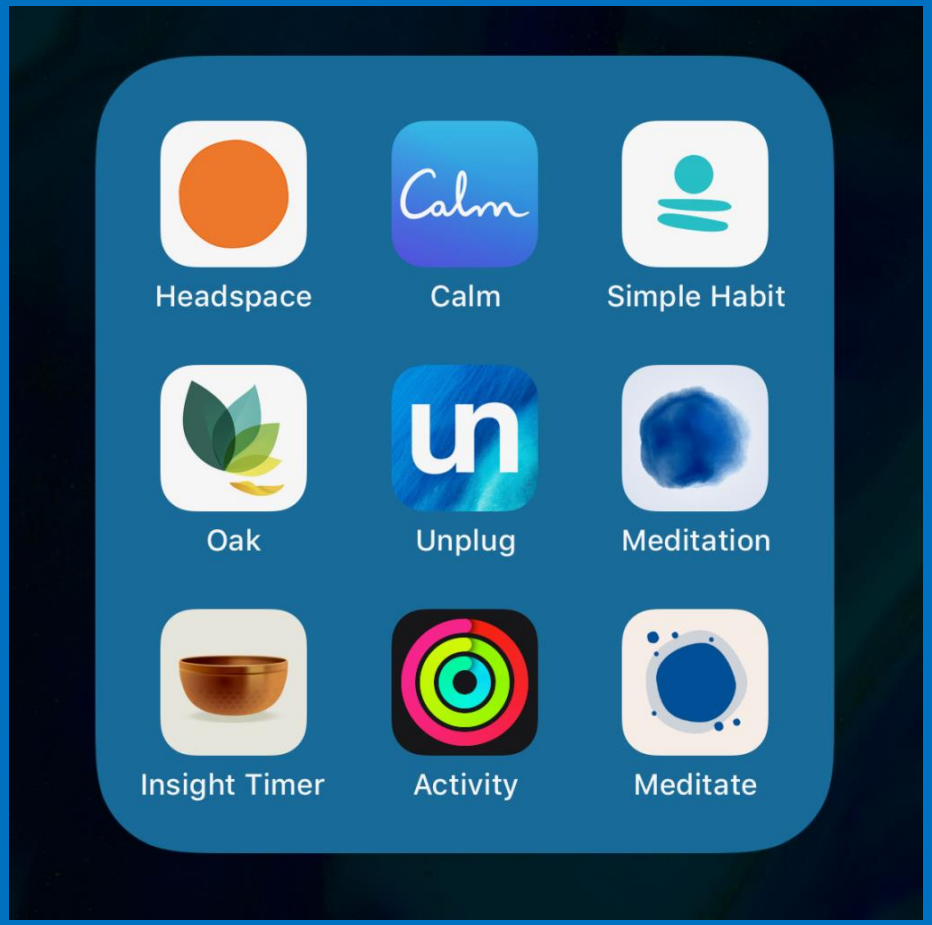
5 senses grounding technique for severe anxiety

- Helps re-direct attention from panic state to present moment
- Notice:
  - 5 things you can see
  - 4 things you can touch
  - 3 things you can hear
  - 2 things you can smell
  - 1 thing you can taste

5 Finger Breathing Technique

- Stretch out the fingers of your left hand
- Place the index finger of your right hand on the palm of your left hand
- As you inhale move that finger slowly up the thumb of your left hand
- As you exhale move that finger slowly down the thumb
- Repeat this with each of the fingers of the left hand, moving the index finger of the right hand up the finger as you inhale and down the finger as you exhale
- Repeat this a few times until you are feeling calmer

Mindfulness apps



Pharmacology – Anxiety Disorders

- Selective Serotonin Reuptake Inhibitors (SSRI) (some off label)
- Serotonin Norepinephrine Reuptake Inhibitors (SNRI)
- Tricyclic Antidepressants (TCA)
- Mono-amine Oxidase Inhibitors (MAOI)
- Benzodiazepines
- Pregablin

- ***For GAD (generalized anxiety): above + buspirone, gabapentin (off label), hydroxyzine.***
- ***For social anxiety: propranolol (off label), benzos.***

Atypical Antipsychotics

- **LAST CHOICE** for sleep or anxiety (off label)
- Risperdone (Risperdal)1-4 mg, Quetiapine (Seroquel) 25-100 mg, others
- Risk of metabolic syndrome. Monitor lipids, glucose.
- Risk of movement disorders.
- Use only when all others have failed or short term if high risk and rapid response needed.
- Document that you discussed off label use and risk of side effects and gave instructions for pt to call you for any unusual motor movements.

PRN vs daily medication

Choose medication based on frequency/severity of symptoms

- ***Infrequent sxs (social anxiety/rare panic attacks/phobias):*** **PRN medication**: B-blocker (off label), benzodiazepine, hydroxyzine
- ***Frequent sxs***: **Daily med**: SSRI/SNRI (some off label), gabapentin (off label), buspirone, pregabalin
- ***Panic disorder:*** **Rescue meds and maintenance meds:** ("if you need to use a benzodiazepine 2 or more times per week for panic attacks, it is an indication to me that it is time for us to talk about a daily preventive med such as an SSRI")

SSRI/SNRI doses are the same as for depression.

Same time to onset of effect , 4-8 weeks.

Q - Does dx matter when SSRIs are indicated for so many psych conditions?

- **YES** – diagnosis does matter. Meds are only part of the tx plan.

Case 1 continued

- *MD recognized that fear of fainting was an obsessive thought and explored whether pt had other obsessions and compulsions.*
- *Dx of Obsessive Compulsive Disorder was made. Tx plan was adjusted.*
- CBT for anxiety is different than Exposure and Response Prevention Treatment (ERP) for OCD. When comorbid OCD is present, tx plan should include OCD specialist therapist who can offer ERP (may be 12-18 month wait for appt).
- 8 years later, pt lives independently with girlfriend and owns his own business. He is asymptomatic, off all benzos and antipsychotic meds, remains on SSRI and Gabapentin.

Anxiety Summary

- Offer evidence-based treatment options: CBT, SMART, pharmacology.
- Treatment outcomes improve if the correct diagnosis is made & the correct treatment plan is implemented. **Anxiety is highly comorbid with OCD, depression, SUDs (substance use disorders).**

Depression

Case #2

- 50 yo woman, lives alone, teacher.
- Several prior episodes of depression, through the years has transitioned from sertraline (Zoloft) to citalopram (Celexa) to duloxetine (Cymbalta) with relief of sxs each time but continued recurrences of depression
- Comes in to see pcp for urgent appointment – depression has returned in aftermath of dog's death and neighbor she was friendly with moving away.
- Dysporic, crying, poor sleep, poor concentration, negative ruminations, has missed a few days of work, low interest, no suicidal thoughts.

Mild-moderate depression 2024

- No changes in treatment recommendations
- SSRIs- fluoxetine, sertraline, citalopram, escitalopram, paroxetine
- SNRIs – venlafaxine, desvenlafaxine, duloxetine
- Wellbutrin (stimulant type action, give early in day, less risk of weight gain, less risk of sexual dysfunction, may ↑ BP, seizure risk)
- Mirtazapine (more sedating at lower doses, risk of weight gain, less risk of sexual dysfunction)
- Psychotherapy: CBT or psychodynamic (“traditional talk therapy”)
- Augmentation or combination treatment if needed
- Assess for comorbidities (anxiety, substances, medical)
- TMS – transcranial magnetic stimulation (36 sessions over 6 weeks)

Q – "Which SSRI do you like best?"

My personal answer:

I like them all because I know the difference between them and that helps guide my choice for each patient.

SSRIs

- *Citalopram (Celexa)* – QTc ↑ with dose ↑. FDA Dose limits: ≤ 20 mg/day over age 60 or with meds that ↑QTC. EKG at baseline and at full dose, monitor for palpitations, dizziness, chest pain etc.
- *Escitalopram (Lexapro)* – no FDA warning re QTc but showed this potential in large chart review (Castro, et al, 2013). Prudent to check EKG.
- Fluoxetine (Prozac) – many med interactions (incl TCAs), 5 weeks to fully eliminate from body, better for younger patients who take fewer meds.

SSRIs

- *Fluvoxamine (Luvox)* – niche as first line tx for OCD
- *Paroxetine (Paxil)* – less stimulating which may have advantage for pts with anxiety but most apt to cause withdrawal sxs (flu type sxs, electric zap sensations).
- *Sertraline* – the fewest med interactions (but not okay for women on tamoxifen), no QTc issues, may have more GI side effects in early days.

SSRI side effects/instructions

- GI side effects ---- “take with food” to diminish these
- Insomnia ---- “take early in the day but if you are one of the 20% of people who find SSRIs sedating, take in evening”
- Sexual dysfunction --- “please let me know if you are experiencing this so we can discuss adding a dose of Wellbutrin or adjusting dose schedule which might help offset this”
- Increased risk of GI bleeding if SSRIs used in patients who regularly use NSAIDs (Alam et al, 2022)

SNRIs

- Usually tried after failed trial of SSRI, can be first agent.
- Titration crucial. Rapid titration = nausea, headache, often leads to patient terminating trial.

Side effects:

- *Venlafaxine* – hypertension, cardiovascular fatalities reported in overdose especially with alcohol, headaches, GI distress
- *Duloxetine* – hepatotoxicity (fatalities reported, avoid use in heavy drinkers), tachycardia, nausea, fatigue, sweats.

Q- how slowly should I titrate?

Examples for outpatient setting:

Citalopram (pt under age 60) – “10 mg per day for one week then 20 mg per day for one week then 30 mg per day for one week then 40 mg per day”

Duloxetine – “20 mg per day for one week then 40 mg per day for one week then 60 mg per day”…. Hold at 60 mg for a couple of weeks and then titrate by 20 mg per week to 120 mg per day if needed

Early treatment guidelines

Start low and titrate up with ALL antidepressants - to diminish side effects and improve compliance.

Contact in 2 weeks (sooner for more severe depression) *"I don't expect you to be feeling better in 2 weeks but I do want to know how you are tolerating the medication*".

DON'T LOSE FOCUS. Goal is to get to full dose and achieve remission.

Set expectations

4-6 weeks for onset of action.

Response is not linear. *“There will be a phase of good days and bad days before you feel truly well. This does not mean the medicine is not working or that you will not get better”.*

Combination Therapy

- Two anti-depressants: from different categories to reduce risk of side effects and serotonin syndrome
  - SSRI/SNRI with Wellbutrin
  - SSRI with Trazodone
  - Venlafaxine/Duloxetine with Mirtazapine

Augmentation Therapy

- Adding a second agent that is not an antidepressant.
- Sequenced Treatment Alternatives to Relieve Depression (STAR-D) Study

Traditional Augmenting Agents & (their side effects)

- *Mood stabilizers*:
  - *Lithium 300-600 mg:* (monitor TSH, creatinine, diarrhea, tremor, ataxia)
  - *Lamotrigine 100-200 mg:* (slow titration to reduce risk of SJS, ↓ dose in combo with Depakote)
- *Buspirone 30-60 mg:* (slow titration to ↓ risk of GI distress)
- *Atypical neuroleptics*:
  - *Aripiprazole 2-15 mg:* (metabolic syndrome, movement issues)
  - *Quetiapine 25-150 mg:* (metabolic syndrome)
- *Psychostimulants:* (HR, blood pressure, feeling hyper)
- T3, SAMe, modafinil, Deplin (l-methyl folate)

Case #2 continued

- Pt cannot tolerate duloxetine higher than 80 mg – headaches
- You add aripiprazole (Abilify) & titrate to 10 mg/day.
- Pt responds well, soon feels much better, but 6 weeks later you notice involuntary chewing motions and excessive eye blinking. You taper off the aripiprazole and the movement issues resolve.
- Depression sxs again increase. Pt agrees to lithium augmentation, you taper up to 600 mg/day, a typical augmentation dose.
- No response after several weeks, now having some passive SI.
- Pt declines further augmentation meds

Case #2 continued

- Pt's history suggests further med trials will show diminishing results.
- You discuss somatic therapy options with her – ECT and TMS.
- Pt agrees to trial **TMS,** has good outcome, is sx free after 6 weeks.
- Pt starts to work again, starts mindfulness program to manage stress and ACT (acceptance and commitment therapy) to begin working on life vision that includes activities outside of work to reduce risk of depression recurrence.

Treatment Resistant Depression

FDA definition: Failure to respond to two antidepressants in the same episode.

Insurance companies: Usually require failure or intolerance of at least 4 meds from two different categories before they will pay for other options

Case #3

- 55 yo executive. Chronic depression, stable on Fluoxetine and Bupropion with psychotherapy for years. Lives alone. No local family.
- Comes in for urgent appt with pcp. Has lost 10 lbs (weight at baseline was 115 lbs), severely depressed x several months. Trigger = loss of valued job, lack of day structure.
- Over next 6 months, multiple med changes, side effects, inability to get some meds due to formulary restrictions, sxs worsen.
- Weight drops to 90 lbs. Pt is hospitalized.

Treatment Resistant Depression Tx Options

- New agents
- New augmentation strategies
- Somatic therapies (TMS, ECT)
- Ketamine
- Psychedelics?
- Precision Psychiatry?
- Skills Based Therapies – DBT (dialectical behavioral therapy) & ACT (acceptance and commitment therapy)

Newer Agents

- **Levomilnacipran (Fetzima):** SNRI, NE>SER; HTN, ↑ HR, szs, angle closure glaucoma, urinary issues
- **Vilazodone (Vibryyd**): SSRI + partial 5HT agonist; 20-40 mg/d, diarrhea, n/v, insomnia, risk of bleeding.
- **Vortioxetine (Trintellix**): SSRI + direct agonist/antagonist impact on receptors; 5-20 mg/d, n/v, diarrhea, headache, dizziness, hyponatremia, eye/vision problems, ↓sexual dysfunction.
- **Auvelity**: Dextromethophan + Bupropion (Wellbutrin), NMDA + NE mechanism of action; headaches, dizziness, diarrhea, dry mouth

Augmentation strategies

- **Memantine (Namenda)** (NMDA receptor antagonist, off label) -- meta-analysis showed no benefit for unipolar depression however case reports of benefit for bipolar depression (Krzystanek et al, 2021)
- **Pramipexole (Mirapex)** (dopamine agonist, off label) (Tundo et al, 2019)
- **Brexpiprazole (Rexulti)** (combo of 5 HT1A and D2 agonist activity and 5-HT2A antagonist activity) (FDA approved)

Somatic Therapies

- **ECT (electroconvulsive therapy**): 8-15 sessions, maintenance monthly therapy needed for some pts. Transient memory loss and H/As most common side effects. **Remains most effective and accessible treatment for severe TRD.**
- **TMS (Transcranial Magnetic Stimulation)**: FDA approved, no anesthesia, approx. 30 mins per day for 36 days. (O'Reardon et al, 2007). Evidence for reduction in suicidal ideation (Cui et al, 2022)
- **VNS (Vagal Nerve Stimulation)** – MGH study enrolling patients who have Medicare.

Ketamine – NMDA receptor antagonist

- Increasing evidence for reduction of suicidality in patients with severe treatment refractory depression.
- March 2019 – FDA approved use of esketamine nasal spray for TRD.
- Only available through a restricted distribution system, under a Risk Evaluation and Mitigation Strategy (REMS).
- Only in-office administration, pt must be observed for 2 hours in office for any emergence of sedation or dissociation.
- Pts who might not be eligible – prior h/o psychosis, asthma/COPD, uncontrolled HTN or CV disease.

(*Corriger & Pickering, 2021*)

Case #3 continued

- ECT commences in hospital. 20+ sessions, suicidal thoughts remit but mood remains dysphoric, weight increases to 95 lbs.
- Pt goes home with 24 -hour support from family, slow progress, many weeks and weight still not at 100 lbs.
- Family persuades pt to borrow money from them and try IV Ketamine.
- 10 sessions – rate of recovery increases, mood improves, weight returns to baseline, several months later patient takes a new job. She continues monthly IV ketamine infusions that she can now afford as she is working again.

Psychedelics

- The most common question patients now have: “where can I get psychedelic treatment”
- No treatment outside of studies -Imperial College, London; Johns Hopkins; MAPS; many others soon (MGH starting soon to enroll for study of psychedelics and IBS as well as study for depression).
- Two approaches:
  - Full dose psychedelic guided therapeutic experience
  - Micro-dosing

(Artin, 2021)

Q – What about genetic testing?

- NO clinically available testing to tell us what the DIAGNOSIS IS.
- NO clinically available testing to tell which TREATMENT the patient will RESPOND TO.
- Currently available testing evaluates Cyt P450 metabolic profiles, suggests whether pt might need higher or lower dose or might have more or less side effects.
- Cyt P450 profile does not always correlate with whether pt has side effects.

Use as Directed	Moderate Gene-drug Interaction		Significant Gene-drug Interaction
amitriptyline (Elavil®)	**bupropion** (Wellbutrin®)	1	
citalopram (Celexa®)	**fluoxetine** (Prozac®)	1	
clomipramine (Anafranil®)	**selegiline** (Emsam®)	1	
desipramine (Norpramin®)			
desvenlafaxine (Pristiq®)			
doxepin (Sinequan®)			
duloxetine (Cymbalta®)			
escitalopram (Lexapro®)			
fluvoxamine (Luvox®)			
imipramine (Tofranil®)			
levomilnacipran (Fetzima®)			
mirtazapine (Remeron®)			
nortriptyline (Pamelor®)			
paroxetine (Paxil®)			
sertraline (Zoloft®)			
trazodone (Desyrel®)			
venlafaxine (Effexor®)			
vilazodone (Viibryd®)			
vortioxetine (Trintellix®)			

Anxiolytics and Hypnotics

Use as Directed	Moderate Gene-drug Interaction		Significant Gene-drug Interaction
alprazolam (Xanax®)	**diazepam** (Valium®)	1	
buspirone (BuSpar®)			
chlordiazepoxide (Librium®)			
clonazepam (Klonopin®)			
clorazepate (Tranxene®)			
eszopiclone (Lunesta®)			
lorazepam (Ativan®)			

Genetic testing and MTHFR mutation

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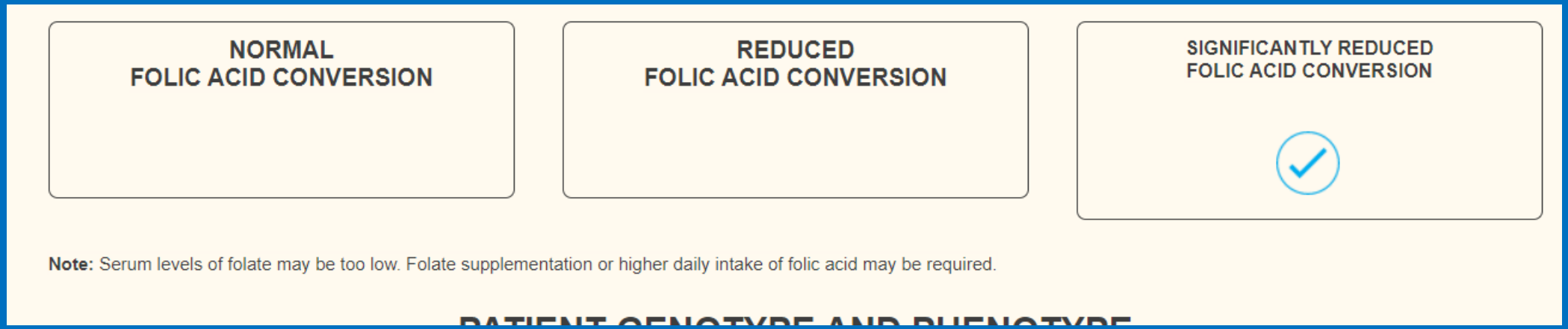

Deplin (l-methylfolate)

- Deplin = increased penetration of blood-brain barrier
- If genetic testing result available, proof of MTHFR mutation will usually result in approval of prior auth.
- Dose:
  - Adults – 7.5 mg for 1-2 weeks then 15 mg
  - Do not use in children under age 6

Seasonal Affective Disorder

- Campbell, 2017:
  - Efficacy of bright light therapy for SAD.

- What should pts buy?
  - 10,000 Lux seasonal light box.

- How should they use it?
  - 30 mins each morning, October through March.
  - Place on desk approx 24 inches from face.
  - Eat, read, use computer – light shining on face but not looking directly at light.

Pregnancy/Post-partum

- High % relapse in women who discontinue meds, particularly those with h/o bipolar or psychotic episodes.
- No psych meds actually FDA approved for use during pregnancy but many women need to stay on meds.
- Useful website to learn what is known about med safety: MGH Center for Womens' Mental Health.

Brexanolone

- Brexanolone approved by FDA for post partum depression March 2019.
- Only available via Risk Evaluation and Mitagation Strategy Program.
- IV administration.
- GABA-A modulator.

(***Azhar Y, Din AU, 2021)***

Impact of Bipolar Disorder on Tx of Depression

Q- Is unrecognized bipolar disorder a contributor to apparent treatment resistant depression?

A- Maybe

(Correa et al, 2010)

Case #4

- 58 yo woman, referred by pcp – euphoria, speech more rapid than usual, increase in spending on clothes and gifts for family, more irritable, waking a few times each night but returning to sleep. No psychosis. No suicidal thoughts. No physical aggression.
- No prior psychiatrist.
- Tx by pcp for several episodes of what seemed to be unipolar depression since age 50, with escalating doses of sertraline. At onset of hypomania, was taking sertraline 175 mg per day.
- Medical workup was negative. No evidence of dementia.
- After onset of sxs, aunt told her of family h/o bipolar disorder.

Bipolar Disorder Diagnosis

- Bipolar I – one episode of full mania, +/- depression.
- Bipolar II – hypomanic episodes (“little manias”), mood variability not reaching level of mania.
- Hypomania/mania: euphoria OR irritability/aggression.
- Some episodes can be “mixed” – elements of both mania and depression.

Mania

2 weeks + of:

- Not sleeping.
- Rapid speech/thoughts.
- ↑ spending
- Unusual use of alcohol/drugs
- Irritability or euphoria.
- Can include psychosis

A full manic episode is a psychiatric emergency.

Bipolar Disorder - Major Tx Issues

- Mood stabilizer vs atypical neuroleptic vs both?
- If pt stabilized with atypical on inpatient unit, do you try to switch to mood stabilizer later?
- Might the patient benefit from ECT? (Bahji, 2019)

Weigh the side effects of these options, what is best choice for this patient? Is treatment working? Are you monitoring for side effects?

Mood Stabilizers (FDA approval status)

- *Lithium (mania) (off label for depression).
- *Valproic Acid (manic or mixed episodes).
- Carbamazepine (manic and mixed episodes).
- Trileptal (off label).
- Topiramate (off label, especially for pts who refuse meds that might cause weight gain, watch for cognitive side effects that might mimic depression).
- Lamotrigine (maintenance phase tx of bipolar disorder, all phases, often used for bipolar depression)

(*major mood stabilizers)

FDA approved atypical neuroleptics

- Manic/Mixed Episode
  - Aripiprazole (Abilify) (manic or mixed episodes of bipolar, adjunctive treatment for depression)
  - Cariprazine (Vraylar) (manic, mixed or depressive episodes, Bipolar I)
  - Quetiapine (acute manic episodes, adjunctive tx for depression)

- Bipolar Depression
  - Lumateperone (Caplyta) (Bipolar depression, monotherapy or adjunctive with Lithium or Depakote)
  - Lurasidone (Latuda) (Bipolar depression, monotherapy or adjunctive to lithium or Depakote)

Should you prescribe an antidepressant if pt is in depressed phase and is known to have BD type I?

- Patients spend more time in depressed phase than manic phase across lifetime.
- Bipolar D = ↑↑ risk of suicide in both phases.
- Antidepressant use -- risks switch to mania.
- Antidepressant use – risks triggering more cycling of mood.
- Study results vary, often mix Bipolar I and II together.

Bipolar I recommendations

- Avoid antidepressants if at all possible to reduce risk of more frequent cycling.
- Antidepressant use **only** if pt is on effective mood stabilizing regimen.
- If patient has had known swing to mania in past with antidepressants while on mood stabilizer, consider ECT for severe depression not able to be managed with mood stabilizers and atypical neuroleptics.

Bipolar II - What do psychiatrists do?

- “Majority of psychiatrists prefer to have some kind of mood stabilizer in place to reduce risk of triggering more frequent or worse cycling – Gabapentin and Lamotrigine* are common choices for Bipolar II where risk of Depakote and Lithium may not be warranted.”

***** *Lamotrigine is a common choice for depression in both Bipolar I and Bipolar Bipolar II disorders due to its mood stabilizing and antidepressant impact. impact. (titrate slowly to reduce risk of rash and dose adjustment if given given with valproic acid).*

(https://psycheducation.org/blog/antidepressants-in-bipolar-ii-what-the-experts-do/)

Case #4 continued

- Sertraline was discontinued, sxs resolved.
- Over next year mood up and down, pt reluctant to start mood stabilizer and MD reluctant to give antidepressant without this.
- Pt eventually agreed to mood stabilizer.
- Lithium - caused significant tremor. Decision to not use atypicals.
- Lamotrigine ---Pt developed rash and depression was worsening.
- Depakote – well tolerated, has been able to start antidepressant without hypomanic mood swing, remains sx free on this combo.

Key Points

- Anxiety and depression are unique issues with need for unique treatment plans.
- It is important to always consider possibility of comorbid dx or dx which has not fully revealed itself.
- The pillars of management are risk assessment, education, medication, psychotherapy (both psychodynamic and skills-based therapies such as CBT, DBT, ACT), somatic therapies (ECT &TMS), ketamine.
- PCP has a vital role in supporting the tx, encouraging compliance, monitoring for side effects and recurrences, even if pt is seeing a psychiatrist.

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