Psychiatry for Primary Care

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Disclosures

I have no disclosures

Objectives

- Review diagnostic criteria for common psychiatric disorders
- Address psychiatric disorders that lend themselves to primary care treatment
- Treatment suggestions for primary care
- Disorders best left to the psychiatrist
- Disorders to refer for therapy

Depressive Disorders

- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)
  - 2 or more symptoms for at least 2 years
- Premenstrual Dysphoric Disorder
- Substance – Induced Depressive Disorder

Risk Factors for Depression

- Loss of parent before age 11
- Childhood abuse
- Unemployment
- Retirement
- Loss of Spouse
- Genetics: 2-3X increase in relatives with depressive disorders
  - Twin concordance: Monozygotic 50% vs 20% dizygotic twins
- Adoption studies:
  higher concordance related to biologic vs adoptive parents

Statistics

- Lifetime prevalence: 17% 1.7:1 female to male
- Average onset: 29 years
- Severe role impairment: 60%
- Eventually develop Bipolar Disorder: 5-10%
- Complete suicide: 7-15%
- Duration:
  - Average episode 3 months
  - Full recovery in 6 months: 60% In 2 years: 80%
- Risk of recurrence:
  - One major depressive episode: 50%
  - After 3 episodes: 80%
- 75% comorbidity with other mental health disorders (Anxiety 70%)

Major Depressive Disorder

- 5 symptoms persistent for at least 2 weeks
  1. Depressed mood most of the day (sadness)
  2. Decreased interest in pleasurable activities (anhedonia)
  3. Change in appetite (can't eat or over eat)
  4. Sleep disturbance (too little or too much)
  5. Psychomotor retardation or agitation
  6. Fatigue
  7. Worthless feeling or self critical (are you good at beating yourself up?)
  8. Poor concentration
  9. Passive thoughts of death or suicidal ideas (do you hate the circumstances or do you hate living)
- Clinical Distress and impairment in function – change from the person's normal functioning

Hamilton Rating Scale for Depression

- Depressed mood
- Feeling of guilt
- Suicide
- Insomnia
- Work and Activities
- Weight change
- Agitation
- Anxiety
- Somatic symptoms
- Libido
- Psychomotor retardation

Questions to ask

- When you get depressed, are you down for hours, days, weeks or months?
- Do you go through times when you are having more down days than good days? If yes, can that last weeks or months?
- Do you have more trouble with sad and blue than no energy, no motivation, can’t get going or are they equal?
- Is it just that nothing is fun?
- How much anxiety do you have when you are depressed?
- Consider checking thyroid functions: 10% patients hospitalized to depression have hypothyroidism

Treatment Options

- Serotonin agents treat sad, blue and anxiety symptoms best
  - Any of the SSRI work about the same
  - Escitalopram (Lexapro) tends to have less side effects
- Norepinephrine treats no energy, no motivation = SNRIs
  - Venlafaxine (Effexor), duloxetine (Cymbalta), desvenlafaxine (Pristiq)
  - Levomilnacipran (Fetzima) $400
- Dopamine agents treat anhedonia – nothing is fun – and low energy
  - Bupropion (Wellbutrin) – dopamine & NE reuptake inhibitor

Suggested Dosing

- Starting doses
  - Prozac 20 mg
  - Paxil 10 mg
  - Zoloft 50 mg
  - Lexapro 10 mg
  - Trintellix 10 mg
  - Viibryd 10 mg
  - Effexor ER 75 mg
  - Pristiq 50 mg
  - Cymbalta 30 mg
  - Fetzima 20 mg x 2 days
  - Wellbutrin 150 mg
- Maintenance Doses (minimum/maximum)
  - 20 mg to 40 mg/80 mg
  - 20 mg
  - 100 mg
  - 20 mg if anxiety present
  - 20 mg/20 mg
  - 20 mg/40 mg
  - 150 mg/300 mg
  - 50 mg/200 mg
  - 60 mg/120 mg (pain = 120 mg)
  - 40 mg/120 mg
  - 300 mg/450 mg

FOLLOW UP APPOINTMENT

- While you are waiting for the 3 to 6 months before your patient can get a psychiatry appointment
- See the patient in follow up between 4 and 6 weeks
- Keep in mind some patient will never go to a psychiatrist
- May need to increase the dose or change meds

Combination Therapy

- Abilify (aripipraxole) 2 to 5 mg qhs – best first adjunct med
  - Seroquel (quentiapine) 50-300 mg qday
  - Rexulti (brexpiprazole) 0.5 – 1 mg qday ($1,200)
- SSRI or SNRI plus Wellbutrin
- Provigil (modafinil) 200 mg – fatigue & sedation
- L-methyl folate 15 mg (crosses BBB)
- BusPar (buspirone) total dose 15 mg to 30 mg qday
- Remeron (mirtazapine) 15-30 mg qhs plus SSRI or SNRI (sedating and weight gain)
- Lithium: only medication effective for suicidal ideations (Serum lithium level 0.5 to 1.0)

How long to treat

- Adequate trial for an antidepressant: 6 to 8 weeks
- Minimum duration: 6 months (one year recommended – stop if symptoms resolved and home life is stable) “When you’re doing well, give the meds 6 more months.”
- Treatment resistant depression: about one third of patients
  - Commonly accepted definition = failure of 2 different antidepressants – preferably of different mechanisms of action (ex. Not 2 SSRIs)
  - Refer for psychiatric consult
- Maintenance therapy recommended for:
  - 3 major depressive episodes
  - 2 episodes + family history, early onset, severe episodes
  - Use the same dose that achieved good results

Bipolar Depression

- Same diagnostic criteria for a Major Depressive episode
- Medications approved by FDA
  - Olanzapine/fluoxetine (Symbyax) start with 6mg/25mg, max 12/50mg
  - Quentiapine (Seroquel) 300-600 mg
  - Lurasidone (Latuda) 20 to 80 mg, max 120 mg
- SSRIs can help with anxiety, but may cause switch to mania
- Lamotrigine (Lamictal) target dose 200 mg, max 400 mg
  - 25 mg qday X 14 days, then
  - 50 mg qday X 14 days, then
  - 100 mg qday X 7 days, then
  - 200 mg qday
- Combination of Lamictal and Latuda works well – start both

Bipolar Manic Episode

- Distinct period of abnormally elevated/agitated mood
- Must last 7 days NON-STOP (not mood swings)
  - Inflated self esteem or grandiosity
  - Decreased need for sleep (not tired but can’t sleep)
  - Talking more, louder and faster than normal
  - Racing thoughts or flight of ideas
  - Distractibility (irrelevant external stimuli) usually reported by others
  - Increased goal directed activity (but getting nothing done)
  - Excessive high-risk behavior (spending, sex, business deals)
- Marked social and occupational impairment
- Psychotic symptoms: hallucinations, delusions, paranoid ideas
- (send them to the hospital, get them out of your office!!!)

Pre-Menstrual Dysphoric Disorder

- 5 or more symptoms in the pre-menstrual phase
  - Mood swings, sadness, tearfulness, rejection sensitivity
  - Irritability, anger, interpersonal conflict
  - Hopelessness or self-deprecating thoughts
  - Marked anxiety
- One of the following symptoms (as one of the 5 symptom total)
  - Decreased interest in usual activities
  - Poor concentration
  - Change in appetite
  - Insomnia or hypersomnia
  - Feeling overwhelmed
- Most cycles over a one-year period

PMDD treatment

- SSRI – sertraline (Zoloft may be most effective) – one week prior to onset of menses or continuous
- Contraceptive medications
- Lifestyle changes:
  - Relaxation – stress management therapy
  - Exercise
  - Reduction of caffeine, alcohol and tobacco
  - Cognitive behavioral therapy
  - Family therapy

Generalized Anxiety Disorder

- True anxiety disorder starts very young – evident by 5-7 years
- Excessive anxiety/worrying for at least 6 months (3 symptoms)
  - Restless, keyed up or on edge feeling
  - Fatigue
  - Difficulty concentrating
  - Muscle tension (neck/shoulders/back)
  - Difficulty falling asleep
- Ask: Do you have anxiety in excess of what others would have under your circumstances?
- It’s normal to have anxiety under stressful situations

Social Anxiety Disorder

- Fear in social situations that exposes one to scrutiny (meeting unfamiliar people, eating in public, performing)
- Fear that one will be observed as anxious & judged negatively
- Social situations always produce severe anxiety
- Social situations are avoided or endured with extreme anxiety
- Fear of embarrassment (do something stupid)
- Must last for at least 6 months
- Specify if: performance only = restricted to public speaking, etc.
- Mean age of onset: 13 years

Panic Disorder

- Recurrent unexpected abrupt surge of intense fear
- Peaks within minutes, 4 or more symptoms
  - Palpitations – tachycardia
  - Shortness of breath
  - Trembling
  - Diaphoresis
  - Chest discomfort – pain or tightness
  - Nausea or abdominal distress
  - Light headed or dizzy
  - Feeling that things are closing in
  - Paresthesia
  - Fear of going crazy
  - Fear of death
- First episode: think they are having a heart attack

Treatment of Anxiety Disorders

- DO NOT USE BENZODIAZIPINES !!!!!!
- First line medications SSRIs – use slightly higher doses
  - Virtioxetine (Trintellix) may be more effective - 20 mg or SNRIs
- Be patient – 6-8 weeks for full effect
- Gabapentin (Neurontin) start with 100 to 300 mg tid, but can go as high as 3600 mg in divided doses
- Pregabalin (Lyrica) 50 mg tid, max 600 mg divided doses
- Atenolol – 25 to 50 mg bid (doesn't cross BBB)
- Propranolol 10 to 20 mg bid (don't use in depressed patients)
- Buspirone (BusPar) 30 to 60 mg qday
- Quentiapine (Seroquel) 25 mg tid

Obsessive Compulsive Disorder

- Obsessions (contamination, somatic, symmetry, sexual)
  - Recurrent, persistent thought or impulses
  - Person attempts to ignore or suppress obsessions
- Compulsions (checking, washing, counting, hoarding)
  - Repetitive behavior that person is driven to perform
  - Aimed to reduce distress, but not connected in realistic way
- Must take at least one hour per day
- Causes distress to person
- Onset generally in adolescence
- Prevalence 2.5% across the world
- Monozygotic twin concordance 80%

Treatment of OCD

- Fluvoxamine (Luvox) 200-300 mg
- Sertraline (Zoloft) 100-200 mg
- Fluoxetine (Prozac) 40-80 mg
- Paroxitine (Paxil) 40-60 mg
- Clomipramine (Anafranil) 100-300 mg
- Augmentation:
  - Risperidone (Resperdal) 2 mg qhs
  - Olanzapine (Zyprexa) 5-10 mg ahs
  - Pindolol (**B1 & B2 antagonist) 7.5 mg qday**
- Cognitive Behavioral Therapy!

For all Mood and Anxiety Disorders

Medications plus Therapy

works better than medication or therapy alone!

Post Traumatic Stress Disorder

- Exposure to actual or threatened death, serious injury or sexual violence
  - Directly experienced or witness to others
  - Can be perpetrated on a family member
  - Experiencing repeated traumatic events (first responders)
- Intrusive thoughts, destressing dreams, flashbacks
- Avoidant behavior – anything that reminds one of trauma
- Negative alterations of cognitions or mood
  - Negative self assessment, guilt, shame, detached, anhedonia
- Alterations in arousal & reactivity
  - Hypervigilance, exaggerated startle, sleep disturbance

PTSD Treatment

- Refer for therapy!!! CBT & EMDR (eye movement desensitization and reprocessing)
- DO NOT USE BENZODIAZIPINES – contraindicated
- SSRIs (Zoloft/Paxil) or SNRIs (Effexor)
- Mirtazapine (Remeron)
- Prazosin (Minipress) for nightmares (alpha 1 adrenergic antagonist) – start at 1 or 2 mg, max. 10 mg
- Alpha 2 agonists: clonidine and guanfacine
- Buspirone (BusPar)
- Same type doses for depression and anxiety disorders

Substance Use Disorder and Mental Health

- By the time patients get to treatment their brain chemistry is SCREWED UP!!!
- Everyone is depressed and anxious
- Everyone is on the “emotional roller coaster”
- If you are drinking a lot or using drugs – MEDS DON’T WORK!
- Psychiatric diagnoses are hard to establish – drugs can mimic most psychiatric disorders
- Symptoms generally clear within a few weeks of abstinence
- However, about half will have comorbid psychiatric disorders

Insomnia (I can’t sleep Doc)

- Try trazodone first: 50 mg, max. 300 mg (antihistamine)
  - Be careful with the dose if on a SSRI – serotonin syndrome
- GABA-BZD receptor agonist
  - eszopiclone (Lunesta) 3 mg
  - zaleplon (Sonata) 5-10 mg (for problem with sleep onset)
  - zolpidem (Ambien) 3 mg
- Mirtazapine (Remeron) 15 mg (higher doses less sedating)
  - Weight gain
- Quentiapine (Seroquel) 25-50 mg, max sedation 300 mg
  - Weight gain
- Doxepin 25-50 mg
- Amitriptyline 10-50 mg
- Suvorezant (Belsomra) orexin receptor antagonist: 5-20 mg ($350)
- Can combine 2 or 3 agents for severe insomnia (melatonin)

Attention Deficit Hyperactivity DO

- 3 – 7% of children
- Males 2-4: 1 females
- 4% of adults
- Half of children with ADHD have symptoms that persist in adulthood
- If one family member has the diagnosis of ADHD, 25-35% chance another family member has the disorder
- Monozygotic (identical) twins = 65% concordance

Incidence of ADHD

- Prevalence 3 – 7% of children
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Causes of ADHD

- Genetics: ADHD is the most highly inherited psychiatric disorder (1/3 of children of fathers with ADHD)
- Dopamine and norepinephrine dysregulation in area of the brain involved with attention, activity and impulse control
- Increased incidence if mother uses alcohol, drugs or smokes during pregnancy

Symptoms Involve

- Regulating psychomotor activity (hyperactive):

  Prefrontal deficit in dopamine neurotransmission

- Attending to tasks (inattention):

  Frontal cortex deficit/ineffective NE transmission

- Inhibiting behavior (impulsivity): Norepinephrine

DSM V Diagnosis

- Symptoms must persist for 6 or more months to a degree that is maladaptive & inconsistent with developmental level **prior to age 12**
- Not due to oppositional behavior or failure to understand (overall intelligence)
- 6 or more symptoms of inattention or hyperactivity or impulsivity (over age 17 = 5 sx)
- Impairment present in 2 or more settings, i.e. school (or work), home, etc.
- Clear evidence of significant impairment in social, academic, or occupational functioning

Psychological Testing

- T.O.V.A. – Test of Variable Attention
  - Accuracy: 90% for hyperactive,
    84% for inattentive type, 87% for non-ADHD (false positive)
- Connors Continuous Performance Test:
  - Very boring computer test
  - Measures attention span – errors of omission
  - Impulsivity - errors of commission
- Immediate & Delayed Memory Task
  - Computer gives 5 digits
  - Teste must match the 5 digits – attention
  - Omission errors = clicking on 4 matching digits and thinking that's all 5 of them

ADHD Treatment

- Medication:
  - Psychostimulants (increases DA & NE transmission)
  - Antidepressants: TCAs, SSRIs (fluoxetine), buproprion (Wellbutin), atomoxetine (Strattera), especially inattentive type
  - Antihypertensives: Clonidine, Guanfacine (a-2 adrenergic agonist)
- Cognitive-Behavioral Therapy
  - Coping/organizing strategies
  - Negative impact on life issues
  - FAMILY therapy (especially parents & spouses)

Psychostimulants in Primary Care

- Get familiar with some basic medications
- Adderall: most adults respond well
  - Start with 20mg bid or tid (tid used for work in the evening or to preserve sanity in the home)
  - If patient feels revved up = dose too high
  - If patient feels irritable or no response = too low
- Methylphenidate: children respond well
  - Let the peds or psychiatrists handle them!
  - Adults: 5-10 mg bid or tid, can increase 10 mg q7days

Response to Psychostimulants

- Normal people who are not ADHD
  - Speeds them up
  - Gives them energy
  - Will not sleep until psychostimulant wares off
  - Looks like they are on speed
- Clear ADHD diagnosis
  - Slows and calms them down
  - Can take psychostimulant and then take a nap
  - Can do twice the work with half the effort
  - Must do something to remind themselves to take the mid-day dose
- Recommendation: neuropsych testing, let the psychiatrist adjust dosing, then you can refill Rxs.

Elderly Issues

- Elderly with depression can look like dementia
- Are often dealing with losses
  - Death of friends or relatives
  - Loss of heath
  - Loss of independence
- Therapy can help as much or more than medications
- Antidepressant medication: start low and go slow
- But, primary care is often the MD that hears about symptoms of dementia

Dementia

- Up to 20% after age 65
- 45% after age 80
- Etiology:
  - Alzheimer's Disease 66%
  - Lewy Body Disease 20%
  - Cerebrovascular Disease 15%
  - All other causes 19%
    - Frontal-temporal lobar degeneration
    - Chronic alcoholism
    - Infectious diseases
    - Neoplastic diseases
    - Huntngtion's Chorea

Today – 5 million

By 2050 – 14 million

Dementia vs. Depression

	Depression dementia	Dementia
Onset	Well demarcated	Indistinct
History	Short	Long
Course	Rapid progression	Long progression
Cog. complaints	Frequent	Often absent
Psychiatric complaints	Often	Generally absent
Behavior	Adaptive function OK	Disinhibited – no insight

Basic Labs

• Complete CBC	• Anemia, infection
• Electrolytes	• Hyponatremia/SIADH
• Glucose	• Hypoglycemia/DM
• BUN/Creatinine	• Renal failure
• Thyroid Functions	• Hypothyroidism
• Liver Enzymes	• Hepatic encephalopathy
• Vitamin B12	• B12

Treatment

- Cholinesterase Inhibitors
- Donepezil (Aricept)
- Rivastigmine (Exelon)
- Galantamine (Razadyne)
- NMDA Receptor Agonist
- Memantine (Namenda, Namenda XR

- Start with 5 mg – increase to 10 mg
- 1.5 mg bid, up to 6 mg bid
  patch 4.6 mg, max 13.3 mg
- 8 mg ER, max 24 mg
- IR: 5 mg bid, increase to 10 mg bid
  XR 7mg qday, increase to 28 mg

Behavioral Symptoms

- Mood: depressions, elation, anxiety, irritability
- Thoughts: hallucinations, delusions
- Activity: apathy, vocalizations, aggression disinhibition, sexual inappropriate behavior
- Disordered sleep
- Disordered appetite/eating
- Average work for caregivers: 60-100 hours

Managing Behavior

- Depression & anxiety: SSRIs, Wellbutrin may help apathy
- Do not use benzodiazepines (falls, cognitive impairment, confusion, disinhibition)
- Agitation and aggression:
  - Divalproex – 250 mg bid, max 1,250 mg qday
  - Carbamazepine – 300 mg qday
  - Prazosin – 1 mg to 5 mg
- Hallucinations/psychotic symptoms:
  - No FDA approved medications
  - Increased mortality 1.6-1.7 higher than placebo
  - Atypical antipsychotics at low doses
    - Risperdal, Ability, Seroquel, Rexulti, Vraylar, Saphris, Fanapt

Benzos Started by Someone Else

- Especially a problem in the elderly on benzos for years
- Guaranteed short term memory loss
- Sell the idea that eventually “If you don’t write it down, you won’t remember it, you will look like you have Alzheimer’s”
- Think of tapering the benzo over 6 or more months
- Start Neurontin or Lyrica when you start the benzo taper
  - Start at a low dose
  - Taper Neurontin or Lyrica up as you taper benzo down
- Most people recover most of their short term memory functions by one year after being benzodiazepine free
- BusPar is not effective for anxiety if patient has been on a benzo

Personality Disorders: WARNING

- Borderline Personality Disorder
  - If a patient tells you that you are the best doctor ever – watch out!!!
- Narcissistic Personality Disorder
  - No matter what you do, no matter what you do not do, it's not good enough or right enough, or fast enough
  - They know more than you = "Web MD"
  - They are smarter than you (in their opinion)
- Antisocial Personality Disorder (Sociopath)
  - Will try to con you, often drug seeking

Patients to refer for therapy

- Patients who don’t say “I’m fine” but actually tell how bad their life is going (want a 60-minute therapy session in your 15 minutes)
- Life events for which they are having difficulty coping
- Significant losses
  - Loss of family member
  - Job loss
  - Serious medical problem – loss of health
  - Divorce
- May or may not need medications
- Goal: learn coping skills, come to resolution of problems

For all psychiatric problems

Exercise until

the Day You Die