A brief guide to anxiety and depression

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thepsychiatrists.co.uk

Depression in Primary Care

- What is Anxiety?
- What is Depression?
- Suicide Risk?
- Risk of Aggression?
- In each disorder I want you to think of examples of this disorder and the impact on that seafarer.


StupidVideos.com

Anxiety

- So What Symptoms do you see in a pt with with anxiety?

When Anxiety Becomes a disorder

Free Floating Anxiety, Excessive Worry

Months of prominent tension

Autonomic Arousal Sx

Chest and Abdominal Sx

Mental State Changes

General Sensations

Poor Sleep

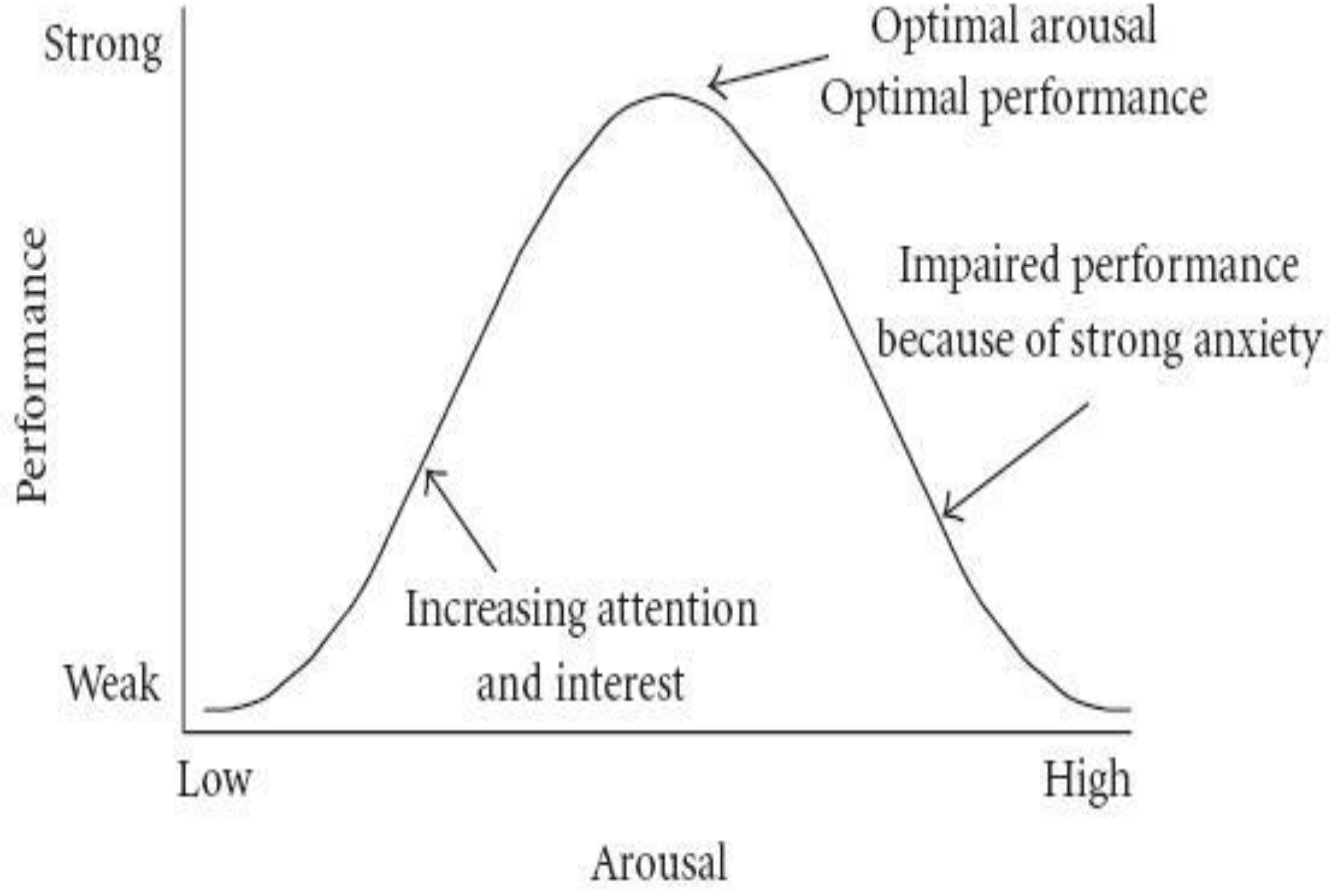
Poor Concentration

Irritability

Exaggerated startle

Loss Of Function

Anxiety vs Function



Investigating a suspected anxiety disorder: useful questions to consider

- Does the patient suffer from normal, appropriate anxiety or excessive worry?
- Is there an underlying organic illness?
- Is there a co-occurring psychiatric condition?
- Any use of medications known to cause/exacerbate anxiety?
- Has the patient made multiple visits to their physician with medically unexplained symptoms?

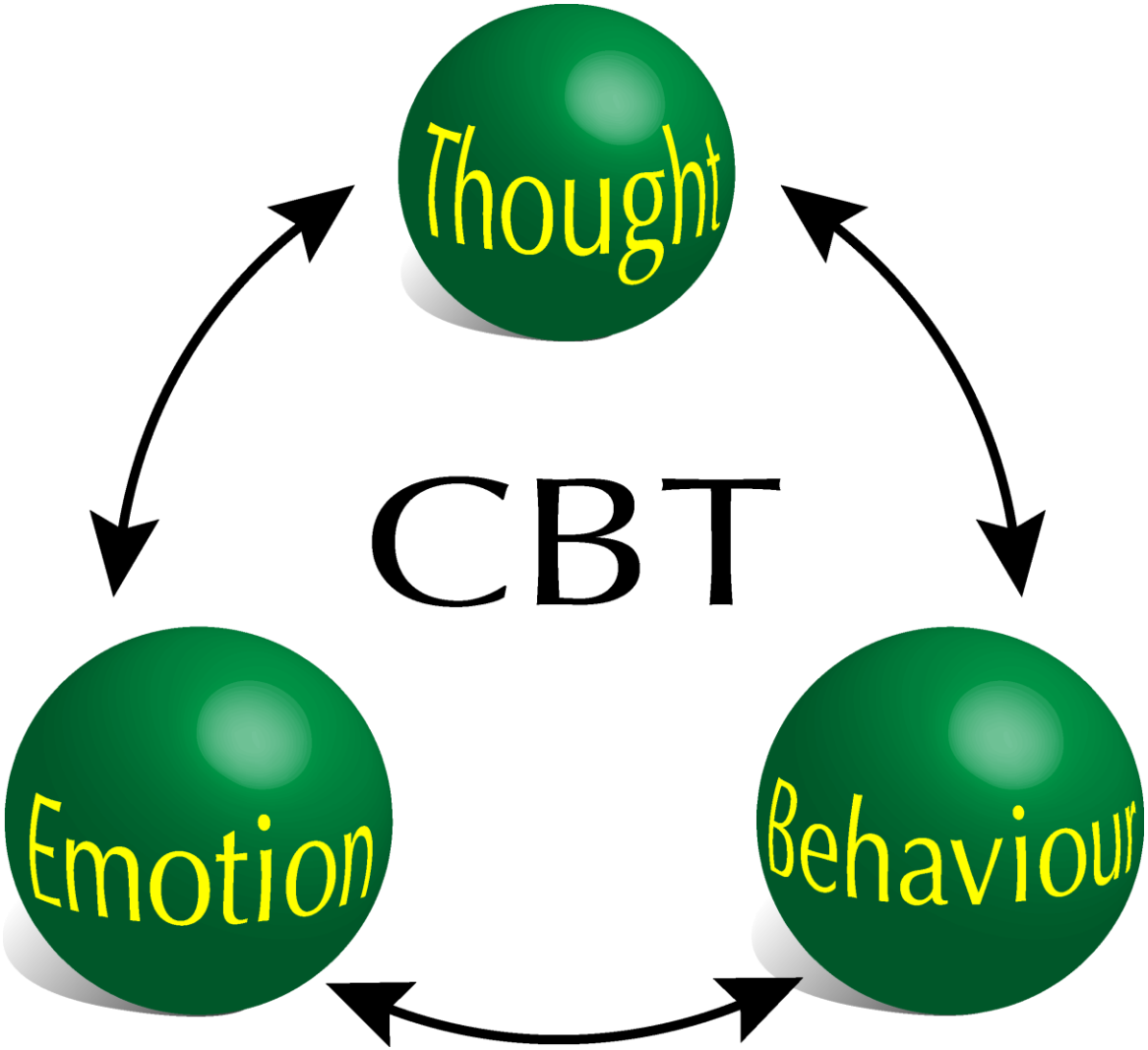
Anxiety

Pharmacological Anxiety Treatment

Available pharmacological treatments for generalised anxiety disorder

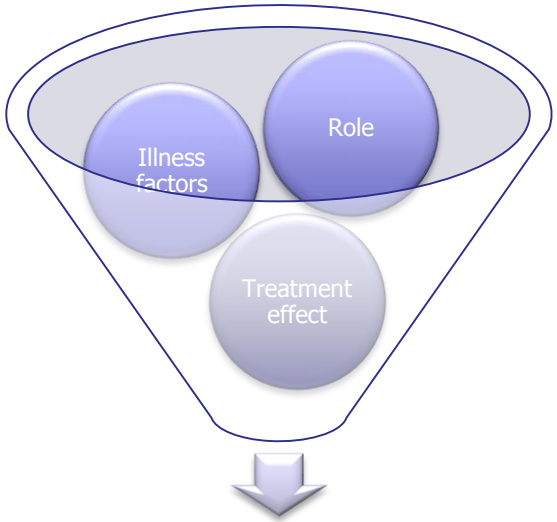
Treatment	Mechanism of action
Selective serotonin reuptake inhibitors (SSRIs)	• Inhibits reuptake of serotonin by pre-synaptic neurones[1]
Selective serotonin and norepinephrine reuptake inhibitors (SNRIs)	• Inhibits reuptake of serotonin and norepinephrine by pre-synaptic neurones[2]
The tricyclic antidepressant (TCA), imipramine*	• Inhibits reuptake of serotonin and norepinephrine, and to a lesser extent , dopamine[3]
Calcium channel modulator (pregabalin)	• Binds to the α2-δ subunit protein of voltage-gated calcium channels[1] • Associated with decreased synaptic release of neurotransmitters from hyperexcited neurones
Benzodiazepines*	• Act by enhancing γ-aminobutyric acid (GABA) function[3]

Psychological



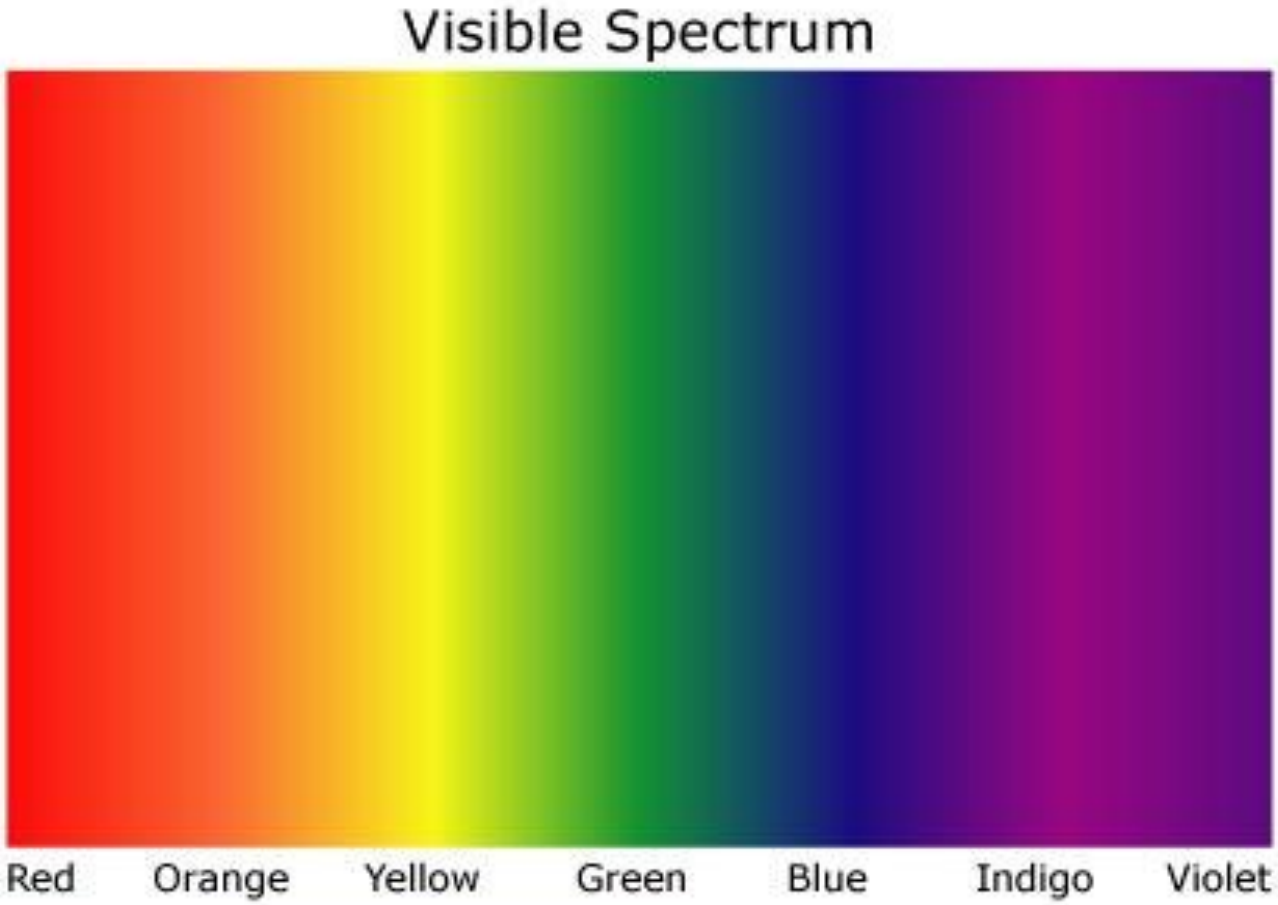
What is the impact on seafarers?

What is the impact on Seafarers?



Fitness

Depression


Visible Spectrum
Red
Orange
Yellow
Green
Blue
Indigo
Violet

Depression

Biological	Cognitive
Changed Sleep	Dec'd Concentration
Changed Appetite	Dec'd Attention
Changed Energy	Dec'd Confidence
Changed Mood	Guilt/Self Blame
Physical slowing	Suicidal Thoughts
	Loss of enjoyment
	Loss of libido
	Suicidal thoughts/acts

2 weeks
(14 days)
(336 hours)

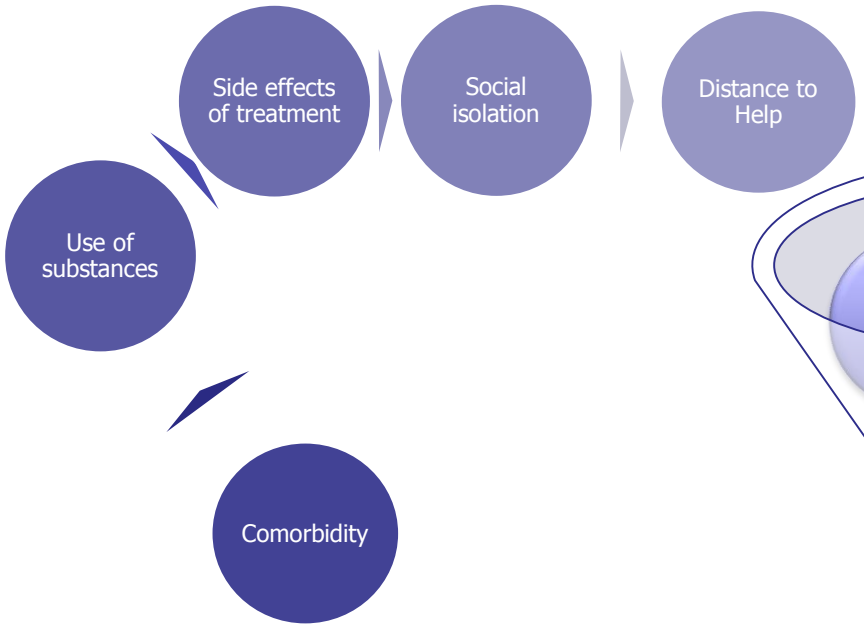
Loss Of Function

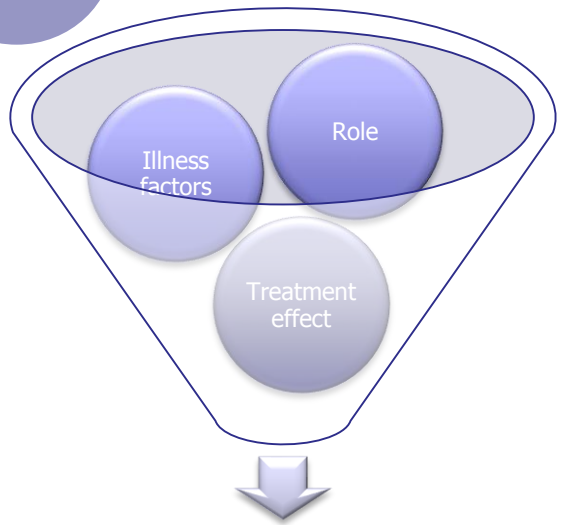
Depression in Primary Care

- 5% of general population
- Women more than men
- May well present with something other than low mood

What is the impact on seafarers?

What is the impact on Seafarers?





Fitness

Nice Guidelines

Step 1: recognition and diagnosis

↓

Step 2: treatment in primary care

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Step 3: review and consideration of alternative treatments

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Step 4: review and referral to specialist mental health services

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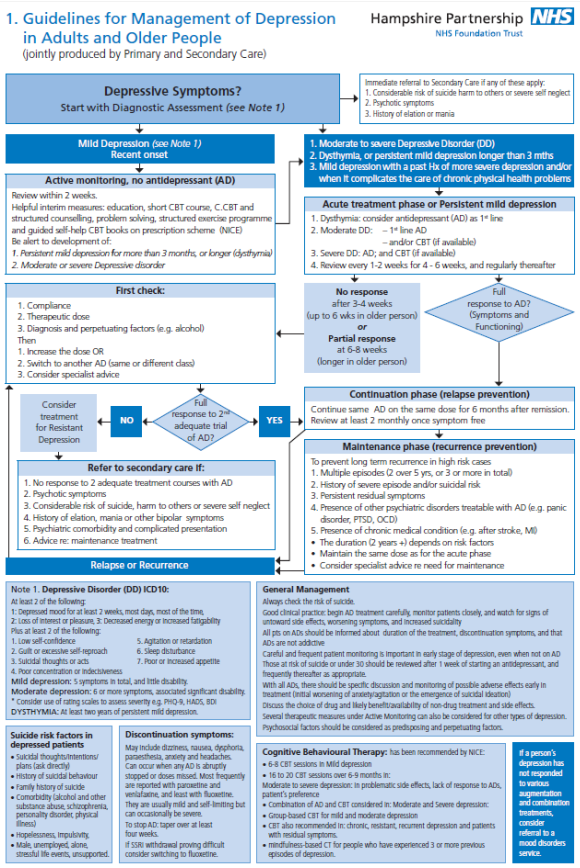
Step 5: care in specialist mental health services

Depression treatment algorithm

Offering Treatment



1. Guidelines for Management of Depression in Adults and Older People
(jointly produced by Primary and Secondary Care)

Hampshire Partnership NHS
NHS Foundation Trust

Depressive Symptoms?
Start with Diagnostic Assessment *(see Note 1)*

Immediate referral to Secondary Care if any of these apply:
1. Considerable risk of suicide harm to others or severe self neglect
2. Psychotic symptoms
3. History of elation or mania

Mild Depression *(see Note 1)*
Recent onset

Active monitoring, no antidepressant (AD)
Review within 2 weeks.
Helpful interim measures: education, short CBT course, C.CBT and structured counselling, problem solving, structured exercise programme and guided self-help CBT books on prescription scheme (NICE)
Be alert to development of:
1. Persistent mild depression for more than 3 months, or longer (dysthymia)
2. Moderate or severe Depressive disorder

First check:
1. Compliance
2. Therapeutic dose
3. Diagnosis and perpetuating factors (e.g. alcohol)
Then
1. Increase the dose OR
2. Switch to another AD (same or different class)
3. Consider specialist advice

Consider treatment for Resistant Depression

NO

Full response to 2nd adequate trial of AD?

YES

Refer to secondary care if:
1. No response to 2 adequate treatment courses with AD
2. Psychotic symptoms
3. Considerable risk of suicide, harm to others or severe self neglect
4. History of elation, mania or other bipolar symptoms
5. Psychiatric comorbidity and complicated presentation
6. Advice re: maintenance treatment

Relapse or Recurrence

1. Moderate to severe Depressive Disorder (DD)
2. Dysthymia, or persistent mild depression longer than 3 mths
3. Mild depression with a past Hx of more severe depression and/or when it complicates the care of chronic physical health problems

Acute treatment phase or Persistent mild depression
1. Dysthymia: consider antidepressant (AD) as 1st line
2. Moderate DD: – 1st line AD
– and/or CBT (if available)
3. Severe DD: AD; and CBT (if available)
4. Review every 1-2 weeks for 4 - 6 weeks, and regularly thereafter

No response after 3-4 weeks (up to 6 wks in older person)
or
Partial response at 6-8 weeks (longer in older person)

Full response to AD? (Symptoms and Functioning)

Continuation phase (relapse prevention)
Continue same AD on the same dose for 6 months after remission.
Review at least 2 monthly once symptom free

Maintenance phase (recurrence prevention)
To prevent long term recurrence in high risk cases
1. Multiple episodes (2 over 5 yrs, or 3 or more in total)
2. History of severe episode and/or suicidal risk
3. Persistent residual symptoms
4. Presence of other psychiatric disorders treatable with AD (e.g. panic disorder, PTSD, OCD)
5. Presence of chronic medical condition (e.g. after stroke, MI)
- The duration (2 years +) depends on risk factors
- Maintain the same dose as for the acute phase
- Consider specialist advice re need for maintenance

Note 1. Depressive Disorder (DD) ICD10:
At least 2 of the following:
1: Depressed mood for at least 2 weeks, most days, most of the time,
2: Loss of interest or pleasure, 3: Decreased energy or increased fatigability
Plus at least 2 of the following:
1. Low self-confidence
2. Guilt or excessive self-reproach
3. Suicidal thoughts or acts
4. Poor concentration or indecisiveness
5. Agitation or retardation
6. Sleep disturbance
7. Poor or increased appetite

Mild depression: 5 symptoms in total, and little disability.
Moderate depression: 6 or more symptoms, associated significant disability.
* Consider use of rating scales to assess severity e.g. PHQ-9, HADS, BDI
DYSTHYMIA: At least two years of persistent mild depression.

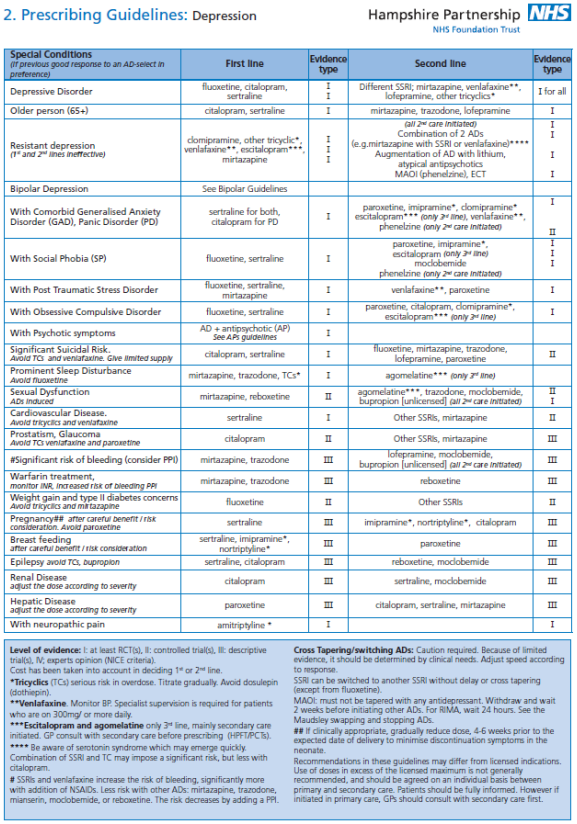
General Management
Always check the risk of suicide.
Good clinical practice: begin AD treatment carefully, monitor patients closely, and watch for signs of untoward side effects, worsening symptoms, and increased suicidality
All pts on ADs should be informed about duration of the treatment, discontinuation symptoms, and that ADs are not addictive
Careful and frequent patient monitoring is important in early stage of depression, even when not on AD
Those at risk of suicide or under 30 should be reviewed after 1 week of starting an antidepressant, and frequently thereafter as appropriate.
With all ADs, there should be specific discussion and monitoring of possible adverse effects early in treatment (initial worsening of anxiety/agitation or the emergence of suicidal ideation)
Discuss the choice of drug and likely benefit/availability of non-drug treatment and side effects.
Several therapeutic measures under Active Monitoring can also be considered for other types of depression.
Psychosocial factors should be considered as predisposing and perpetuating factors.

Suicide risk factors in depressed patients
- Suicidal thoughts/intentions/plans (ask directly)
- History of suicidal behaviour
- Family history of suicide
- Comorbidity (alcohol and other substance abuse, schizophrenia, personality disorder, physical illness)
- Hopelessness, impulsivity.
- Male, unemployed, alone, stressful life events, unsupported.

Discontinuation symptoms:
May include dizziness, nausea, dysphoria, paraesthesia, anxiety and headaches. Can occur when any AD is abruptly stopped or doses missed. Most frequently are reported with paroxetine and venlafaxine, and least with fluoxetine. They are usually mild and self-limiting but can occasionally be severe.
To stop AD: taper over at least four weeks.
If SSRI withdrawal proving difficult consider switching to fluoxetine.

Cognitive Behavioural Therapy: has been recommended by NICE:
- 6-8 CBT sessions in Mild depression
- 16 to 20 CBT sessions over 6-9 months in:
Moderate to severe depression: in problematic side effects, lack of response to ADs, patient's preference
- Combination of AD and CBT considered in: Moderate and Severe depression:
- Group-based CBT for mild and moderate depression
- CBT also recommended in: chronic, resistant, recurrent depression and patients with residual symptoms.
- mindfulness-based CT for people who have experienced 3 or more previous episodes of depression.

If a person's depression has not responded to various augmentation and combination treatments, consider referral to a mood disorders service.



2. Prescribing Guidelines: Depression

Hampshire Partnership NHS
NHS Foundation Trust

Special Conditions *(If previous good response to an AD-select in preference)*	First line	Evidence type	Second line	Evidence type
Depressive Disorder	fluoxetine, citalopram, sertraline	I I	Different SSRI; mirtazapine, venlafaxine**, lofepramine, other tricyclics*	I for all
Older person (65+)	citalopram, sertraline	I	mirtazapine, trazodone, lofepramine	I
Resistant depression *(1st and 2nd lines ineffective)*	clomipramine, other tricyclic*, venlafaxine**, escitalopram***, mirtazapine	I I I	*(all 2nd care initiated)* Combination of 2 ADs (e.g.mirtazapine with SSRI or venlafaxine)**** Augmentation of AD with lithium, atypical antipsychotics MAOI (phenelzine), ECT	I I I I
Bipolar Depression	See Bipolar Guidelines			
With Comorbid Generalised Anxiety Disorder (GAD), Panic Disorder (PD)	sertraline for both, citalopram for PD	I	paroxetine, imipramine*, clomipramine*, escitalopram*** *(only 3rd line)*, venlafaxine**, phenelzine *(only 2nd care initiated)*	I II
With Social Phobia (SP)	fluoxetine, sertraline	I	paroxetine, imipramine*, escitalopram *(only 3rd line)* moclobemide phenelzine *(only 2nd care initiated)*	I I I
With Post Traumatic Stress Disorder	fluoxetine, sertraline, mirtazapine	I	venlafaxine**, paroxetine	I
With Obsessive Compulsive Disorder	fluoxetine, sertraline	I	paroxetine, citalopram, clomipramine*, escitalopram*** *(only 3rd line)*	I
With Psychotic symptoms	AD + antipsychotic (AP) *See APs guidelines*	I		
Significant Suicidal Risk. *Avoid TCs and venlafaxine. Give limited supply*	citalopram, sertraline	I	fluoxetine, mirtazapine, trazodone, lofepramine, paroxetine	II
Prominent Sleep Disturbance *Avoid fluoxetine*	mirtazapine, trazodone, TCs*	I	agomelatine*** *(only 3rd line)*	
Sexual Dysfunction *ADs induced*	mirtazapine, reboxetine	II	agomelatine***, trazodone, moclobemide, bupropion [unlicensed] *(all 2nd care initiated)*	II I
Cardiovascular Disease. *Avoid tricyclics and venlafaxine*	sertraline	I	Other SSRIs, mirtazapine	II
Prostatism, Glaucoma *Avoid TCs venlafaxine and paroxetine*	citalopram	II	Other SSRIs, mirtazapine	III
#Significant risk of bleeding (consider PPI)	mirtazapine, trazodone	III	lofepramine, moclobemide, bupropion [unlicensed] *(all 2nd care initiated)*	III
Warfarin treatment, *monitor INR, increased risk of bleeding PPI*	mirtazapine, trazodone	III	reboxetine	III
Weight gain and type II diabetes concerns *Avoid tricyclics and mirtazapine*	fluoxetine	II	Other SSRIs	II
Pregnancy## *after careful benefit / risk consideration. Avoid paroxetine*	sertraline	III	imipramine*, nortriptyline*, citalopram	III
Breast feeding *after careful benefit / risk consideration*	sertraline, imipramine*, nortriptyline*	III	paroxetine	III
Epilepsy *avoid TCs, bupropion*	sertraline, citalopram	III	reboxetine, moclobemide	III
Renal Disease *adjust the dose according to severity*	citalopram	III	sertraline, moclobemide	III
Hepatic Disease *adjust the dose according to severity*	paroxetine	III	citalopram, sertraline, mirtazapine	III
With neuropathic pain	amitriptyline *	I		I

Level of evidence: I: at least RCT(s), II: controlled trial(s), III: descriptive trial(s), IV: experts opinion (NICE criteria).
Cost has been taken into account in deciding 1st or 2nd line.
***Tricyclics** (TCs) serious risk in overdose. Titrate gradually. Avoid dosulepin (dothiepin).
****Venlafaxine**. Monitor BP. Specialist supervision is required for patients who are on 300mg/ or more daily.
*****Escitalopram and agomelatine** only 2nd line, mainly secondary care initiated. GP consult with secondary care before prescribing (HPFT/PCTs).
****** Be aware of serotonin syndrome which may emerge quickly. Combination of SSRI and TC may impose a significant risk, but less with citalopram.
# SSRIs and venlafaxine increase the risk of bleeding, significantly more with addition of NSAIDs. Less risk with other ADs: mirtazapine, trazodone, mianserin, moclobemide, or reboxetine. The risk decreases by adding a PPI.

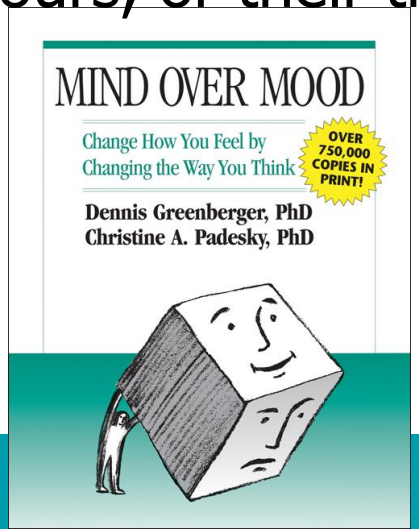
Cross Tapering/switching ADs: Caution required. Because of limited evidence, it should be determined by clinical needs. Adjust speed according to response.
SSRI can be switched to another SSRI without delay or cross tapering (except from fluoxetine).
MAOI: must not be tapered with any antidepressant. Withdraw and wait 2 weeks before initiating other ADs. For RIMA, wait 24 hours. See the Maudsley swapping and stopping ADs.
If clinically appropriate, gradually reduce dose, 4-6 weeks prior to the expected date of delivery to minimise discontinuation symptoms in the neonate.
Recommendations in these guidelines may differ from licensed indications. Use of doses in excess of the licensed maximum is not generally recommended, and should be agreed on an individual basis between primary and secondary care. Patients should be fully informed. However if initiated in primary care, GPs should consult with secondary care first.

Approved Medicines Management Committee – December 2010
Basingstoke, Southampton & Winchester DPC
Approved Portsmouth and S.E. Hampshire – December 2010
Review Date – December 2013

http://www.southernhealth.nhs.uk/EasysiteWeb/getresource.axd?AssetID=43735&type=full&servicetype=Inline&filename=/SHFT_Prescribing_Guidelines_Depression_V5_-_March_2016.pdf

What is CBT

- "problem focused‟ and "action oriented‟.
- Developed from purer Cognitive therapies and Behaviour therapies.
- focus on the "here and now‟.
- The therapist and client work together in changing the client’s behaviours, or their thinking patterns.
- Classic Text



Concept

Figure: The "hot cross bun" model. (Adapted from Greenberger D, Padesky CA[21])

Predicting Suicide following Self harm

Systematic review of Risk factors and risk scales

"The four risk factors that emerged , although of interest, are unlikely to be of much practical use because they are comparatively common in clinical populations. **No scales have sufficient evidence to support their use.** The use of these scales, or an over reliance on the identification of risk factors in clinical practice may provide false reassurance and is therefore , potentially dangerous.

Comprehensive psychosocial assessments of the risks and needs that are specific to the individual should be central to the people who have self harmed."

Chan et al: BJPysch Jun 2016

Risk Factors for Suicide

- Male
- Increasing Age
- Low socioeconomic status
- Unmarried separated or widowed
- Living alone
- Unemployed

Demographic factors

- DSH with high intent
- Childhood adversity
- Family history of suicide
- Family history of suicide

Background History

- Hopelessness
- Impulsiveness
- Low self esteem
- Life event
- Relationship Instability
- Lack of social support

Psychological and Psychosocial Factors

- Mental illness diagnosis e.g. depression, bipolar disorder, schizophrenia
- Personality disorder diagnosis e.g. EUBPD
- Physical illness, especially chronic conditions and or those associated with functional impairment e.g. MS Malignancy, Pain
- Recent contact with psychiatric services
- Recent discharge from psychiatric in patient facility.

Clinical History

- Suicidal Ideation
- Suicide Plans
- Availibility of Means
- Lethality of Means

Current "context"

Risk Factors for Aggression

- Male
- Young
- Socially disadvantaged neighborhoods
- Lack of social support
- Unemployment problems
- Criminal peer group

Demographic factors

- Childhood maltreatment
- History of violence
- First violence at young age
- History of childhood conduct disorder
- History of non violent criminality

Background History

- Anger
- Impulsivity
- Suspiciousness
- Morbid jealousy
- Criminal/violent attitudes
- Command Hallucinations
- Lack of insight

Psychological and Psychosocial Factors

- Psychopathy
- Substance abuse
- Personality disorder
- Schizophrenia
- Executive dysfunction
- Non compliance with treatment

Clinical History

- Threats of violence
- Interpersonal discord/instability
- Availability of weapons

Current "context"

Depression in Primary Care

- What is Anxiety?
- What is Depression?
- Suicide Risk?
- Risk of Aggression?
- In each disorder I want you to think of examples of this disorder and the impact on that seafarer.

Depression and Anxiety

Locations

Below is details of the locations of where we currently practice, to contact one of our psychiatrists please click here.

- The Manor Clinic - Mansbridge Road, Southampton, Hampshire, SO18 3HW
- Hampshire Health - 97 Havant Road, Emsworth, Portsmouth, PO10 7LF
- Chilworth Office - Draycott, Chilworth Road, Southampton, SO16 7LA

Visit us online