Depression

A family physician refers a 34-year-old married female with an 8-month history of depression. She is an accountant, but currently is on disability leave for the last three months. She has been treated with Zoloft® (sertraline) 100 mg daily for 8 weeks but continues to be quite depressed with the following features: Dysphoric mood, 29-pound (13 kg) weight loss, Disturbed sleep pattern with early a.m. awakening, Low energy, Agitation, Social withdrawal

She describes feelings of low self-worth and feels like a failure due to her inability to function as a parent and professional. She is otherwise medically healthy and has never been treated for any other psychiatric disorder. She has also been treated with Fluoxetine at doses of up to 60mg daily for 8 weeks prior to the current medication trial, but again with minimal results.

In the past few weeks she has expressed fleeting suicidal thoughts but hasn't acted on these feelings. The patient feels she is to blame for her current dilemma due to past "indiscretions" but is not prepared to discuss them now. Patient has not had a past history of psychoses, substance abuse, PPD, or mania. Family history is strongly positive for mood disorders. All lab parameters including thyroid screen,

EEG, LFTs, CBC and glucose show no abnormalities. She has been compliant with treatment but has had minimal results and reports no side effects.

MSE Features: Dysphoric mood, hopeless, refuses to talk about past indiscretions, feels bad, guilty. No cognitive impairment. Fleeting suicidal thoughts.

Q1 Based on the above information, list your provisional and differential diagnoses?

A1 Provisional

- Major Depressive Disorder, recurrent, severe, with Melancholic Features

Differential

- Depression with Psychotic Features
- Bipolar Disorder, Most Recent Episode Depressed
- Substance/medication-induced depressive disorder
- Depressive Disorder Due to AMC

Melancholic Features

At least one of:

- Loss of pleasure in almost all activities
- Lack of reactivity to pleasurable stimuli, and

At least three of:

1. Despair, despondent, morose mood
2. Depression worse in the morning
3. Early morning awakening (at least 2 hours prior to regular time of awakening)
4. Marked psychomotor changes
5. Significant anorexia/weight loss
6. Excessive or inappropriate guilt

Q2 Outline your approach to assessing this patient - what additional information would you like to obtain in order to confirm the diagnoses and develop a treatment plan?

A2 Assessment

- Verify diagnoses and severity of condition
- Do MSE and review for safety issues, suicidality and possibility of psychotic depression and need for hospitalization
- Explore compliance issues and response to current and past treatment
- Explore possible co-morbid factors that may contribute to "treatment resistance" (e.g. anxiety disorders, history of untreated depression, mania, substance abuse, personality disorders).

· Explore psychiatric and psychosocial history
· Review medical history, obtain physical exam
· Explore family history
· Obtain collateral information

Q3 You decide that it is safe to treat this patient on an outpatient basis ¯ outline your approach to proceeding with pharmacotherapeutic treatment.

A3 Pharmacotherapy

Approach (based on CanMat 2016)

1 – Select and initiate a 1st line antidepressant
2 – If early improvement after 2-4 weeks, continue x 6-8 weeks
if sx remit then maintain for 6-9 months (no RF for recurrence) or 2+ year (if there ARE RF for recurrence)
3 – If NO improvement after 2-4 weeks then consider factors for SWITCH vs. ADJUNCT
4 – SWITCH to antidepressant with superior efficacy → 2nd line → 3rd line
If first AD trial, initial AD NOT well-tolerated/no response, more time to wait for response, pt preference
5 – ADD adjunctive medication
If 2+ AD trials, initial AD well-tolerate/partial response, residual sx/SE of initial AD can be targeted, less time/more severe, pt preference

In this case:

· Determine compliance, tolerance (side effects - GI, headache, sexual), and effectiveness of current regimen and past trials →option to optimize vs. switch vs. augment
· Provide psychoeducation on medication, including regimen, titrate, side effects, interactions
· **NO** specific AD have demonstrated superiority in melancholic ft
· Consider non-medication interventions: rTMS, ECT
· Treatment of comorbidities: Short-term benzodiazepines for sleep disturbance and anxiety

Q4 Outline your approach to proceeding with psychotherapy:

A4 Psychotherapy

Indications (based on CanMAT 2016) – pt attitude/preference, availability
Suitable for ALL ages, education, cultures, genders and depression subtypes
Magnitude of benefit from psychological treatment INCREASES with more severity
Time-course with meds FASTER – preferred in severe/high risk cases

In this case

· Review prior exposure to psychotherapy (effectiveness, modality), current motivation/preferences, and severity of current illness. Review comorbidities. Also consider availability of specific tx modalities.
· Depressed phase -1st line: CBT/IPT/BA; 2nd line: MCBT, CBASP, STPT, PST, tele/internet, 3rd line: ACT, MI, PDT
· Maintenance – 1st line: CBT/MBCT; 2nd line: IPT, BA, CBASP; 3rd line: PDT
· **Discussion of at least one psychotherapeutic modality in detail
CBT – time-limited (~12 weeks), structured, present-oriented;
Focus on relationship btw thoughts/feelings/behaviours
Goal – modify dysfunctional thoughts/behaviours to tx current depressive sx
Automatic thoughts (reflect cognitive distortions) → intermediate beliefs (attitudes, rules, assumptions) → core beliefs (I am_)
Identify and modify ATs using Thought Change Records
Behavioural experiment: establish hierarchy of difficult situations→ graded exposure

Shared components of most psychological treatments:
· Establish a working alliance
· Set GOALS with pt (alleviate depressive sx)
· Provide psychoeducation to pt/family about depression and tx
· Focus on current problems/sx
· Establish structure – i.e. homework, time-limited
· Monitoring of sx (including SI and psychotic ft)

Depression-2

Dr. Z is a family physician/primary care provider and would like to discuss a case with you. Dr. Z's patient is Harpo, a 38-year-old man who works as a computer technician. He lives alone, having been separated from his wife for the last six months.

He has been given the following diagnoses (which you are to assume have been correctly made):
Major Depressive Disorder, single episode, moderate severity

Please let the examiner know when you are ready to begin.

Ask the candidate the following questions:

1. Harpo asked me for a referral to a cognitive therapist. He has a friend who received cognitive therapy (CBT) for depression and found it to be helpful. Can you tell me at least FOUR basic things about CBT?

CBT – time-limited (~12 weeks), structured, present-oriented;
· Developed for tx of depression by Aaron Beck in 1960s
· Focus on relationship btw thoughts/feelings/behaviours
· Goal – identify and modify dysfunctional thoughts/behaviours to tx current depressive sx

Beck 2011: 10 basic principles

1. Based on evolving formulation of pt & problem in cognitive terms
2. Requires therapeutic **a**lliance
3. Emphasizes collaboration and active participation
4. **G**oal-oriented and problem-focused
5. Initially emphasizes the present (**c**urrent sx)
6. Psycho**E**ducative (teach pt to be their own therapist)
7. Time-limited
8. **S**tructured
9. Identify, evaluate and respond to dysfunctional thoughts/beliefs
10. Uses various techniques to change thinking, mood and behaviour

2. What is Beck's COGNITIVE TRIAD of depression?

Negative thinking regarding self (worthless), world (unfair) and the future (hopeless)

3. Give FOUR examples of dysfunctional thinking/cognitive distortions?

· Jumping to conclusions, All or nothing thinking, Magnify/Minimize, Mental filter, Emotional reasoning, Discounting positives, Selective abstraction/Shoulds, Labeling, Overgeneralization, Personalization
· Others = Excessive responsibility, Assuming temporal causality, Self-references, Catastrophizing, Dichotomous thinking

4. Can you give me FOUR reasons why you would pick CBT for someone with depression?

· Patient preference
· Specific patient populations with mild to moderate depression – peripartum, child & adolescents
· Inability to tolerate/partial/no response to pharmacotherapy
· In combo with meds for PDD
· Variable mood reactive to environmental events; variable mood that correlates with negative

5. Name FOUR conditions OTHER THAN DEPRESSION that can be treated effectively with CBT?

· CBT - Anxiety disorders - Panic disorder, GAD, SAD
· CBT-ERP - Obsessive-compulsive disorder
· TF-CBT - Posttraumatic stress disorder
· Eating disorders (esp BN/BED)

· CBT-RP - Substance use disorders
· Personality disorders
· CBT-psychosis - Schizophrenia
· Bipolar disorder (2nd line depressed/maintenance)

6. I've heard that CBT includes homework. Can you give me TWO examples of homework assignments?

· Behavioural activation (increase activity level)
· Thought records
· SMART goals
· Reviewing the past therapy session
· Preparing for the next therapy session

7. Describe the components of a typical session.

1. Brief weekly update and check-in re: mood
2. Bridge from previous session
3. Setting the agenda
4. Review of homework
5. Discussion of issues on the agenda and teach CBT skills
6. Final summary, assign HW, and feedback from patient regarding the session

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Depression-3

You are a consultant psychiatrist with Consultation-Liaison service at a general hospital. The GP Hospitalist, Dr. S has asked you to provide a consultation regarding an inpatient on his service.

The patient is Mr. Charles Brown. He is a 45-year-old gentleman who is currently living with his wife and two children. He works as an electrician, but is on short-term disability for his medical illness (he has a high resistance to working at this time).

Mr. B was admitted to hospital 3 days ago with acute pyelonephritis. He has been on IV antibiotics since admission. Mr. B has done well and Dr. S will be changing his medication to p.o. tomorrow and he will likely be discharged the day after that.

Dr. S would like your advice regarding management of Mr. B's depression. Dr. S did some extra training in psychiatry and has done a thorough psychiatric history, mental status examination, physical examination, and laboratory testing. He has given Mr. B the following diagnoses (which you are to assume are accurate):

- Major Depressive Disorder, Recurrent, Moderate, with melancholic features
- Narcissistic Traits: often envious of others and shows arrogant, self-aggrandizing behaviors
- Acute Pyelonephritis, Acute Nephrolithiasis

Mr. B's depression began approximately 2 months ago after a customer complained to a manager about his work. Mr. B had been having difficulty concentrating at work after an argument he had with his wife. He began to feel increasingly depressed, with a worsening of his mood in the morning. He began to have terminal insomnia and would wake up at 5 a.m. He would feel restless and would go for long walks until it was time for him to get ready for work. He lost his appetite and began to lose weight. He stopped golfing, which he usually enjoys, because it just wasn't fun anymore. He felt easily teed off. He has never had suicidal thoughts or plans.

He went to see his family doctor, Dr. S, about a week into his depression. He had been depressed before and knew that he needed help. Dr. S recognized the melancholic features and prescribed Venlafaxine beginning at 37.5mg per day for the first week, 75mg a day for the second week, and then 150mg per day after that. Mr. B has tolerated the medication well.

Unfortunately, Mr. B's physical health began to worsen and he developed kidney (nephrolithiasis). He had to take some time off work and required pain medication. He developed a secondary pyelonephritis and is being treated as mentioned above. He is on the following medications:

Venlafaxine 150mg po od
Zopiclone 7.5mg po qhs
Ampicillin 500mg IV q6h
Gentamicin 80mg IV q8h
Meloxicam 15mg po od
Tylenol #3 (acetaminophen 325mg and codeine 30mg) 1 to 2 tablets p.o. q4h prn, max 6 in 24 hours

Mr. B does not drink alcohol, does not smoke cigarettes, and has never used street drugs.

Mr. B has had one previous episode of depression. This occurred 10 years ago following the death of his father, who died suddenly of a cardiac event. Mr. B was treated with Fluoxetine and did well on this occasion.

Mr. B was born and raised in this city and is the oldest of three children. His father was an electrician and suffered from depression and alcohol dependence. His mother was a homemaker. Mr. B was an average student and completed his electrician's apprenticeship program after graduation from grade 12. He has been working for a large company for the past 25 years.

Mr. B married at the age of 20. He and his wife have a reasonably good marriage. She stayed at home to raise their son and daughter. They have recently been arguing about her wish to return to work.

Ask the candidate the following questions:

1. Mr. B does not appear to be responding to the antidepressant I prescribed for him. Did I pick the wrong one?
No – Venlafaxine is a 1st line tx option for MDD

b. Is there any possibility that the Effexor® (venlafaxine) caused his kidney stones?
No – this is not a typical SE of Venlafaxine.

c. How do I know if he had an adequate trial of the Venlafaxine?
An adequate trial = optimal dose x 6-8 weeks

d. What should I do now?
Determine medication compliance, diagnostic accuracy, and if there are additional comorbidities.
Can then consider dose optimization (if safe and tolerated well) to 225mg po daily then reassess in 2 weeks. OR consider switch to another 1st line agent (SSRI, other SNRI, Bupropion, Mirtazapine) if not effective. OR consider augmentation with 1st line augmenting agent per CANMAT (Risperidone, Aripip, Quetiapine).

2. Mr. B.s GFR is reduced to 50% of normal. Should I be concerned about this? Is there anything I should do?
Yes. Venlafaxine is cleared by the kidney – the t1/2 is affected in those with moderate to severe impairment of renal function. Mr. B's dose should be reduced by 25% to 50% (half of optimal dose 225mg = 112mg daily)

3. If he doesn't respond to an adequate trial of the Effexor, is there another medication I can try? Please give me at least three options.
MONOTHERAPY options
1st line: SSRIs – Sertraline, Escitalopram, Citalopram; other SNRI – Duloxetine; Bupropion, Mirtazapine
2nd line: TCAs – Amitriptyline, Nortriptyline, Desipramine, Clomipramine; RIMA – Moclobemide; MAO-Bi - Selegiline; Trazodone; Quetiapine
3rd line: MAOi – Phenelzine, Tranylcypromine

4. I am wondering about psychotherapy for Mr. Brown. What are the options?
Yes - for moderate depression, a combination of pharmacotherapy and psychotherapy may result in higher remission and lower relapse rates than meds alone.
1st line for acute depression CBT, IPT, BA.
2nd line MBCT, CBASP, Tele/internet assisted, PST, STPT
3rd line ACT, MI, LTPDT

5. I've heard about IPT (interpersonal therapy). Is it indicated for depression? Who developed it? On whose theories is it based? What does it address specifically in depression?
· Indicated for treatment of depression when related to interpersonal issues.
· Developed by Klerman and Weissman in the 1970s
· Time-limited: 12-16 weekly sessions
· Focused: on present
· Principles: Bidirectional rel'ship between social interactions and depressive sx – w
· Goal: improve depressive sx by improving the quality of patients' interpersonal relationships and social fn
· Four areas of focus: Grief, role dispute, role transition, interpersonal deficits/sensitivity

6. What are the phases of IPT?
· Beginning: sessions 1-3; psych **a**ssessment, set framework, give **s**ick role, do interpersonal **i**nventory, offer interpersonal **f**ormulation (linked with one of 4 focal areas)
· Middle: sessions 4-9; communication analyses (mood-interpersonal events), role plays, decisional analysis (pro/cons), track mood w/ scale
· Termination: sessions 10-12; consolidate skills, relapse prevention, emphasize competence/success

Depression-4

Richie Tenenbaum was born in NYC to Royal and Etheline Tenenbaum. He was the youngest of three children. He had an older, adopted sister named Margot and an older brother named Chas. Royal Tenenbaum was a litigation attorney. He favoured Richie above his other children and would often take him to events such as dog fights. Chas and Margot were left at home on these occasions, and often blamed Richie as much as their father for being left out. Richie felt caught in the middle. He loved his father and was close to him, but also felt a loyalty to his brother and sister.

Etheline Tenenbaum was a homemaker. She stayed at home with the children until they had finished high school. Her life revolved around them, and she brought out the best in each of them. She published a book about her children titled A Family of Geniuses and took them on a publicity tour. After her childrens' graduations, she returned to school and completed a degree in Archaeology. She obtained employment with the Department of Housing and the Transit Authority. Her work often took her abroad. Richie was close to his mother, who understood his conflicted loyalties.

The relationship between Etheline and Royal was filled with conflict and deception. Royal had a number of extramarital affairs. When Richie was 10 years old, Etheline asked Royal for a separation. He left the family home and took up residence in a hotel, where he lived for the next 22 years. Richie remained close to his father, seeing him whenever he could, and continued to buffer the conflict between Royal and the other family members. Richie also felt especially close to Margot. One year, when he was in 5th Grade, he and Margot ran away from home and camped out in the public archives (library), staying in the same sleeping bag and consuming only root beer and crackers.

Richie's best friend was Eli Cash who lived across the street from the Tenenbaums in an apartment with his aunt. Eli took part in the Tenenbaum family gatherings and holidays, and was at their home mornings before school and most afternoons. Richie had a number of interests including playing the drums, painting, and training and flying his falcon, Mordecai. He was especially talented in sports. and became a professional tennis player at 17. He won the U.S. Nationals three years in a row.

Unfortunately, Richie's career as a professional tennis player suddenly ended at the age of 26 after he had terrible match. When he found out that Margot had, just the day before, married a neurologist named Raleigh St.Clair. Richie lost his focus, made a number of mistakes and broke down crying on national television. He was shamed before the entire nation. Even his father was ashamed of him. He retired his racket and set off on a worldwide cruise to get away from his humiliation. He hid behind his headband, sunglasses, and beard. He corresponded only with his mother and Eli. He ate very little, slept poorly, and although he had a number of exciting expeditions, he never really enjoyed himself. He became increasingly depressed. After cruising around the world and being alone with his thoughts for two years, he realized that he was still in love with Margot and he confided his feelings to Eli.

Shortly thereafter, he was informed by his mother that his father was terminally ill with stomach cancer. He immediately sailed for home, meeting up with Margot at the harbour. On arrival at his mother's home, he discovered that both Margot and their brother Chas felt depressed and had also moved back home. Richie gave up his room for his ailing father and slept in a tent in the spare room. It was a difficult time for him, reliving his shame and feeling caught between his difficult father and brother. He was then unexpectedly informed that Margot was having an affair with Eli, that Eli had a drug addiction, and that his father had been feigning illness to break up his mother's relationship with her new fiancé, Henry Sherman. He felt betrayed by everyone. Richie began to re-examine himself. He went into the bathroom and took off his headband and his sunglasses. He cut his long hair and shaved his beard. As he began to see himself more clearly, Richie became increasingly distressed. He made a suicide attempt by cutting his wrists and forearms. He was found in his bathroom by a family friend and taken to the hospital. While there, he reflected on all of his conflicting emotions. He realized that he was angry with his family, particularly with Margot. He left the hospital against medical advice and went home. He talked about his feelings for Margot with her. He also confided in his father, who was surprisingly supportive. He confronted Eli, who admitted that he became involved with Margot because he wanted so much to be a part of the Tenenbaum family. Richie no longer knew what he wanted, but knew that he now at least had the support of his family.

Ask the candidate the following questions:

1. Please present your synthesized understanding of Richie Tenenbaum.

	Predisposing	Precipitating	Perpetuating	Protective
BIO	Age – late 20s Gender – males (higher risk of suicide) Medical – none Psych – depressive ep Genetic vulnerability – sibling depressed, father antisocial	Depressive sx – poor appetite, sleep, self-care Subs – none Med issues – none Physical sx - none	Untreated depressive sx	Normal dev hx Lack of med illness, substances Only 1 dep episode, late onset with clear ppt
Psycho	*Attachment* – insecure, having to mediate btw parents, btw dad and sibs *Temperament* – reward dependent (please others), harm avoidant	*IPT areas* – grief (father's illness), role transition (being a son and same family dynamic; lose tennis star title) *Attachment* – loss of sister's affection	*Cognitive distortion*s – personalization, magnifying, catastrophizing *Coping style* - avoidance *Defense mech* – Regression, displacement (anger > self harm)	Reflective, insight capacity Attached to family members Ego strength – able to admit feelings for sis
Social	Parental separation Parental conflict Critical father Complicated family relationships	Betrayal by father and siblings Father's illness Change in living situation Loss of career/$	Sleeping in a tent Refusing hospital care (AMA) $ instability?	Past high fn – employment, hobbies, social Has social supports (mom)

2. Please present your complete diagnostic formulation and differential diagnosis for Richie Tenenbaum.
Provisional dx: PDD, with persistent MDE (not enough info to determine if pure dysthymic syndrome)
DDx: Adjustment d/o with depressed mood
MDD, current MDE
Bipolar d/o, current MDE
Depressive d/o 2ary to AMC; sub/med-induced depressive d/o
Avoidant PD

In formulating Richie Tenenbaum's case, it is important to consider the significant biological and psychosocial factors leading him to present with depression and a suicide attempt at this particular time.

- . From a biological perspective, the patient is vulnerable towards depression/anxiety given the family history of depression and sociopathy. Other important biological predisposing factors include the patient's depressive hx.
- . Given this biological vulnerability certain psychosocial factors may also predispose him towards difficulty in forming attachments.
- . The patient's early developmental years suggest a primary caregiver who was critical, punitive, and created schisms in the family leading Richie to experience himself as a mediator and outsider, and others as disapproving of him, making him vulnerable to conflicted, limited, and painful relationships.
- . Additional family factors that may have reinforced these experiences include his unfulfilled longing for his (adopted) sister.
- . Social factors that may have contributed to his vulnerability include his loss of status and income as a tennis star, widespread knowledge of his emotional difficulties, and his anguish and the loss of his sister's affection.
- . Occupationally he also appears to have struggled with unemployment, which may have further reinforced his sense of worthlessness, shame, and being unlovable.

- . Given this developmental course and underlying biological vulnerability, the recent occurrence of his father's malingered illness and revelation of his sister's affair with his best friend may have precipitated this disorder.
- . Once precipitated, the disorder was likely maintained by his disconnection from his family and public shame.
- . However, protective factors that may buffer the course of the disorder include his renewed relationship with his father and chance to discuss matters with his sister.
- . It seems that up to now the patient has been able to cope with this condition by avoiding and denying, suggesting a passive and avoidant coping-response style.

Therefore, treatments to consider include: psychotherapy (IPT, CBT, BA) and pharmacotherapy (1st line for MDD); combo is better for PDD. Could also benefit from family therapy re: longstanding family conflicts.

Bereavement/Depression-5

In this station, you are a psychiatrist working in the community. A family physician that shares a patient with you would like to ask you some questions regarding a family member of your patient.

Let the examiner know when you are ready to begin.

Mr. and Mrs. Rolo had been patients of Dr. Lecter since the good doctor finished his residency. Their previous family physician mysteriously vanished, and Dr. Lecter took over the practice. Mr. Rolo died three months ago from a stroke. You had been following Mr. Rolo over the last two years for progressive dementia, likely related to Alzheimer's disease. You had only met Mrs. Rolo on a couple of occasions. Mrs. Rolo is 72 years old. She had been happily married for 28 years (and unhappily for about 10). The Rolo's have three children, all of whom live outside of the city. Mrs. Rolo was a homemaker and was the primary care giver for her husband, since his ability to manage IDLs and IADLs deteriorated prior to his passing. Mr. Rolo's death came unexpectedly.

Mrs. Rolo and her daughter scheduled an appointment one month after her husband's death with Dr. Lecter to thank him for all the support, and in particular, the delicious meals that he provided during this difficult time. At one month's time, Mrs. Rolo appeared to have been coping reasonably well with the death of her husband. But that was about to change. Recently, Mrs. Rolo came to the office alone for a routine visit. Her attention to self-care had deteriorated and she was quite tearful. Dr. Lecter was unsure how to proceed further.

Q1. I am unsure of what to expect in this situation. Can you tell me five manifestations of a normal grief reaction?

Mood – empty, loss, pangs of grief associated with thoughts of deceased
Reactivity – can have positive emotions/humour
Preoccupied = with thoughts/memories of the deceased
Self-esteem = preserved
Thoughts = of death focused on deceased/joining them
Stages of grief (DABDA) – denial, anger, bargaining, depression, acceptance…

Q2. Generally how long after the loss do symptoms persist before the diagnosis of Major Depressive Disorder can be given?

- OUTDATED Q – no timeframe in DSM-5
- Better answer – WHY would you suspect MDD (Vs grief)?
    - Mood = depressed, anhedonia that is persistent and not tied specifically to thoughts of deceased
    - Reactivity = minimal positive emotion/humour
    - Preoccupied = self-critical/pessimistic ruminations
    - Self-esteem = poor, may feel worthless, self-loathing
    - Thoughts of death = focused on suicide due to worthlessness, undeserving, unable to cope

Q3. Are there certain symptoms that are not characteristic of a normal grief reaction that may be helpful in differentiating bereavement from a Major Depressive Episode?

a) Guilt about actions taken or not taken by the survivor at the time of death.
b) Thoughts of death (other than survivor feeling they would be better off dead or should have died with the deceased person).
c) Morbid preoccupation with worthlessness.
d) Marked psychomotor retardation.
e) Marked functional impairment.
f) Hallucinating experiences other than thinking he/she hears the voice or transiently sees the image of the deceased person.

Q4. I don't know Mrs. Rolo that well, what further questions should I ask?

a) Past psychiatric history (specifically depression) b) Medical history
c) Current medications d) Substance history (current use)
e) Family psychiatric history f) Social supports

Case Scenario, Second Course

Mrs. Rolo reported feeling depressed over the last month, which she feels is a normal response to her husband's death. Her daughter insisted that she see her Dr. Lecter because she (Mrs. Rolo) had run out of her blood pressure medication two weeks ago and had not refilled it. In fact, she has not left her home at all in the last three weeks. She smells bad. Her sleep, appetite, energy and concentration are low. She mainly feels guilty that she will be a burden on her family and wishes people would stop fussing over her. She states her children are successful and live on their own and therefore no longer need her. She feels little purpose in her life now that her husband is gone. She denies having a plan to harm herself. She has not been consuming any alcohol and very little caviar. Mrs. Rolo had one previous episode of depression when her husband was laid off from work many years ago and there was significant financial strain. She was not treated with any medications. She denied symptoms of depression prior to her husband's death, however, you suspect she was under a great deal of stress with the additional responsibilities taking care of her husband.

Q5. What percentage of widows and widowers will experience a major depression during the first year of bereavement?

45-50% (range 40 to 60% for the mark)

Q6. How should I treat Mrs. Rolo?

BIO:
1st line LLD: Level 1 - mirtazapine, duloxetine, nortriptyline; level 2 – bupropion, SSRIs (escit, cit, sertraline), SNRIs
2nd line: Quetiapine, trazodone; adjunct LAM (Li, abilify, mph)
Psychotherapy:
1st line: CBT, IPT, BA; 2nd line: MBCT, TIPS (PST may be better for elderly)
Social:
Referral to Bereavement Group
Community Resources such as Home Care, CCAC.

Q7. What are some of the negative health outcomes associated with untreated depressive symptoms in the elderly?

a) Increased use of health care and/or home care
b) Increased mortality (i.e. cardiovascular disease, nutritional deficiencies, falls)
c) Increased disability d) Functional and cognitive decline
e) Increased social isolation f) Increased risk of suicide

Depression - 6

Woman comes to the ER with feelings of sadness. Husband very concerned that she's suicidal. Cries for no reason. Feels worse in the mornings but improves as the day goes by. No joy. On Effexor 112.5 mg for 2 months. She's suicidal and agrees to voluntary admission via the ER. You see her for the first time the next day on the ward. Has lost about 20 lbs. Doesn't enjoy visits by her children like she used to. No psychotic symptoms.

1) **What's your primary diagnosis?**
   Major depressive disorder. Single episode. Severe with melancholic features.

2) **What would you do in the first 48 hours?**
   Assessment: Full psychiatric hx, including safety and MSE (to confirm dx)
   Safety: Determine if suitable to be a voluntary patient vs having to certify them (already hospitalized)
   Determine patient's capacity to provide informed consent
   Collateral: from husband
   Investigations: labs (CBC, lytes, extended lytes, TSH, B12, urinalysis, renal function, liver fn); ECG
   Physical exam: including WC, BMI, vitals
   Scales: pt – PHQ9; md – HAM-D
   Collaborate: Psychoeducation to her and her family

   BIOPSYCHOSOCIAL: Regular vitals; F/U daily; optimize Venlafaxine to 150mg then 225mg as tolerated (after providing psychoed); therapeutic alliance; plant seed re: psychological tx (CBT, IPT, BA)

3) **You increase her Effexor to 300 mg, she gets a bit better but not completely resolved. How do you assess if she's ready for discharge from hospital?**

   -Use of weekend/overnight LOAs, community passes to assess stability and improvement of mood.
   -Examine suicidality
   -Examine patient and husbands concerns
   -Outpatient F/U
   -Contingency plan if symptoms get worse or suicidality increases (ie come to ER, call me)
   -Possible involvement of the husband to monitor symptoms
   -Optimize (Biopsychsocial)

4) **You see her as an out pt. She's still not doing very well. She wants to stay on monotherapy. You change her to Paxil. After 6 weeks of optimized use she's still not great. Now what?**
   Re-evaluation if you have the correct diagnosis
   Examine co-morbidities (including personality disorder, cognitive impair, OSA, low B12, fast metabolizer, hypothyroid, substances)
   Optimize dose (already done)
   Consider SWITCH vs AUGMENT
   Add psychotherapy; consider ECT or rTMS

5) **You're a staff psychiatrist and an R1 asks you what are the pros and cons of switching meds vs. augmentation. What do you tell them?**
   Benefits of augmentation: build on partial response, rapid onset of effect, allow longer trial on initial antidepressant and maintaining therapeutic optimization with patients. Pt preference.
   Benefits of change: simpler treatment, less side effects, no concerns with drug-drug interactions, better compliance (but switch may lead to delay in response). Pt preference.

6) **You decide to augment with CBT and agree upon 16 sessions. How would you structure the sessions?**
   Initially – establish rapport, psychoeducation, set goals, educate about CBT triangle
   Skills – thought records, SMART goals, downward arrow, behavioural experiments, relaxation techniques

Termination – relapse prevention and contingency planning

Early (sessions 1-4) establish therapeutic relationship and provide education on the cognitive model, influence of cognitions on emotions, set goals, illicit and evaluate automatic thoughts
Middle (sessions 5-12) identify dysfunctional beliefs and compensatory strategies, identify core beliefs
End (sessions 13-16) prepare for termination, look at situations around recurrence, consolidate learning

Each session:

1. Brief weekly update and check-in re: mood
2. Bridge from previous session
3. Setting the agenda
4. Review of homework
5. Discussion of issues on the agenda and teach CBT skills
6. Final summary, assign HW, and feedback from patient regarding the session

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Depression-7

Mrs. Q is an 85 year old woman referred to a tertiary hospital from a hospital in a small community. In March of the previous year Mrs. Q had run out into the snow yelling that she was evil. She asserted that her goal was to run into the hellfire that she saw outside. Within a month she had become completely unable to manage her affairs and agreed to let her family take over. Mrs Q then began to focus on all the trouble she was causing her family, and why they even bothered to be around her. She did not want to kill herself, but did not care if she lived or died. Mrs Q started to hear voices on the radio, and TV repeating her name over and over. They asked her why she was blowing up all the churches, and said she was responsible for all the wars on earth. She believed in God and Jesus, but couldn't see how they could possibly love her.
Mrs Q's family gave some of the history. Mrs Q had been admitted to a psychiatric hospital twice in the past, the last one being 40 years ago. She had been followed by various psychiatrists but had been well for many years, this is why her behaviour was shocking them so.
Medical history is positive for aortic stenosis, diverticulosis, atrial fibrillation, HTN, and TIA's from about last March. There has never been any substance abuse and family Hx is not known.

MSE showed a casually dressed, kempt, white female looking her stated age. She made no eye contact and had motor retardation. There was constant self depreciation, she was co-operative. Speech was slow in tempo, not pressured. Thought content was delusional with focus on guilt, worthlessness, and nihilistic thought. Thought form was tangential, but no loosening of associations. Affect was very flat, and mood very depressed. Perception involved mainly auditory hallucinations. LOC was normal, insight and judgement poor. MMSE score was 18/30. She was not actively suicidal, but did not care if she lived or died.

Question # 1 List 3 possible diagnoses giving the preferred diagnosis first.

1. MDD with psychotic features
2. Major neurocognitive disorder
3. Schizophrenia
4. Substance/med-induced psychotic disorder
5. Psychotic disorder 2ary to AMC
6. Bipolar disorder, current episode depressed
7. SCZA, depressed type

Question # 2 Give a possible course of pharmaceutical treatment for this woman's depressive illness. If all fails what would the next step be?

Assuming MDD + psychosis = antidepressant (mirtazapine, SSRIs, SNRIs, bupropion, TCAs) + antipsychotic
i.e. Mirtazapine 7.5mg po od (titrate up to 15mg > 30 > 45 mg)
i.e. Escitalopram 5mg po od (titrate up to 10mg > 15 > 20 mg daily – careful bc old)
Risperidone 0.25mg po qhs (titrate up to 0.5mg > 1mg – be careful thereafter bc old)
Consider ECT

Question # 3 Give 3 other conditions in the elderly ECT could be used for.

Indications in MDD (that make ECT 1st line):
- acute SI, psychotic ft, TRD, repeat medication intolerance, catatonia, pregnancy, rapidly declining physical status, pt preference, past good response
Indications in mania: above features, extreme/sustained agitation, manic delirium
Indications in SCZ: abrupt/recent onset positive sx, catatonia, past good response

Other indications: catatonia, parkinson's disease (esp on/off motor sx), NMS, intractable seizures

Question # 4 You believe ECT is the best course of action. Name 2 things you would do next.

Determine if pt VOLUNTARY vs INVOLUNTARY

- if VOL = capacity assessment re: informed consent if NOT then seek SDM if none then PGT
  - Renew consent q6mo or 15 tx
- if inVOL similar pathway

STEPS – capacity assessment, call family meeting, get informed consent (after explaining procedure, risks/benefits)

Question #5 Name at least 4 adverse effects/risks of ECT. Name 2 benefits.

1. Adverse effects/risks

a) headaches, muscle soreness and nausea
b) risk of MANIC switch
c) immediately after seizure - disorientation, poor attention, praxis
d) transient retro and anterograde amnesia
e) mortality 1/73k (due to GA)
f) Relative CI – space occupying lesion, recent stroke/MI, increased ICP, unstable vascular aneurysm, pheo, unstable CVD (RECENT MI, unstable angina, HF, severe valve dz or AoS),
g) effects cardiac function therefore cardiac disease must be carefully monitored or a consultation with a cardiologist made. This risk is minimized with good medical care.
h) poor respiratory function may affect how anaesthesia is used thus it would have to be assessed
i) possible vertebral fractures thus extra care in osteoporosis

2. Benefits

a) High response rate – 70-80% (compared to meds)
b) Quick response, usually within 6-12 tx (as early as 2-3 weeks)
c) reasonably quick resolution of adverse effects without being permanent
d) return to premorbid functioning

Question#6 *If the family is still nervous, what else would help them to deal with the situation?*

Psychoeducation – Pamphlets, Video presentation

Offer 2nd opinion

Question#7 What is the most important requirement before starting?

Informed consent

Question#8 Name at least 8 things you would do in a pre-ECT workup for <u>this</u> patient?

Full medical history with focus on:
- Current medical status (stable/unstable)
- Neuro/cardiac/resp systems and previous response to anesthesia
- Psych hx including dx, past meds, past ECT and response
- Physical exam – vitals, dentition (may affect bite block)
- Bloodwork – CBC, lytes, BUN/Cr (typical for procedures involving GA)
- ECG; consider CXR (cardiopulm issues), C-spine XR (if c-spine instability), EEG
- Other consults if needed (cardio, pulm, anesthesia, OB etc)

Question #9 ***Name at least 6 medications would you continue, and at least 4 you would stop?***

Generally continue meds for medical illnesses – 1hr before with sips of water or afterwards

- Favourable to stop as many psychotropics as possible
- SSRIs – ok to continue (consider d/c if high risk of post-ECT delirium, i.e. dementia)
- MAOis – ok to continue
- TCAs – ok to continue (consider d/c anticholinergic TCAs if at high risk of post-ECT delirium)
- Bupropion **– STOP (**spontaneous sz, lower threshold)
- SNRIs – ok to continue?
- Anticonvulsants – **consider d/c** (higher threshold, decr sz time, dec ECT efficacy); should hold night before and AM before UNLESS EPILEPSY
- Benzos – **consider d/c** (higher threshold, decr sz time, dec ECT efficacy); should hold morning of ECT
- Lithium – **consider d/c (**risk of delirium, prolonged sz, decr threshold); hold night and morning of
- Antipsychotics – okay to con't, but FGA may lower sz threshold and risk of post-ECT delirium if more anticholinergic

Question#10 Name at least 4 parameters that need to be set for ECT?

Current (milliamperes)
Charge (coulombs --# of electrons flowing)
Brief pulse (tiny doses of current sent at regular intervals –milliseconds- through scalp)
Frequency (# of cycles of pulses/second)
Duration (#of seconds)

Question#11 ECT was a success. What do you suggest to the family now?

Index course – 2-3x/week x 6-15tx
Maintenance ECT – qweek x 4 weeks, biweekly x 8 weeks, qmonth

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