ANXIETY AND DEPRESSION

Maria Sonnack, MPAS, PA-C
Inpatient Psychiatry
Genesis Medical Center
Davenport, IA

LEARNING OBJECTIVES

• Understand general effect of anxiety and depression on quality of life and course of medical disorders.
• Understand basic information about gold standard, 1st line treatment of anxiety and depressive disorders.
• Understand basic differences in diagnosing and treating the different anxiety and depressive disorders.
• Know when to refer to psychiatry for management of anxiety and/or depression.

BASIC INFORMATION/STATISTICS

• Anxiety and depression are amongst the most common mental health disorders in the US.
• Approx 18% of the population over the age of 18 y.o suffers from an anxiety disorder.
• Although treatable, only about 36% receive treatment.
• Those with anxiety are 3-5xs more likely to seek medical attention, and 6xs more likely to be hospitalized.

BASIC INFORMATION/STATISTICS

• Depression is the leading cause of disability worldwide.
• Nearly 1/3 of those with depression also suffer from anxiety.
• Depression associated with several chronic health conditions:
  - CAD, stroke, gastrointestinal issues, MS, PD, fibromyalgia, and others.
BASIC INFORMATION/STATISTICS

- Of those 13-18 y.o., approx. 25% are affected by anxiety.
- Poor school performance.
- Less social interactions.
- Increased substance abuse.
- Major depressive episodes and suicidal ideation on the rise in youth.
- Depressive episodes increased by nearly 4%.
- Suicidal ideation increased by 1%.
- Estimated 62% of youth with depressive episode not receiving treatment.

ANXIETY DISORDERS

- Generalized anxiety disorder
- Panic disorder
- Obsessive compulsive disorder
- Post traumatic stress disorder
- Social anxiety disorder
- Specific phobias

DSM-5 CRITERIA FOR GENERALIZED ANXIETY DISORDER

- A. Excessive anxiety and worry occurring more days than not for at least 6 months about a number of events or activities.
- B. Individual finds it difficult to control worry.
- C. Anxiety and worry are associated with three or more of the following (with at least some present for more days than not in the past 6 months):
  1. Restlessness or feeling keyed up or on edge
  2. Being easily fatigued
  3. Difficulty concentrating or mind going blank
  4. Irritability
  5. Muscle tension
  6. Sleep disturbance

DSM-5 CRITERIA FOR GENERALIZED ANXIETY DISORDER

- D. Anxiety, worry, or physical symptoms cause clinically significant distress or impairment.
- E. Disturbance not attributable to substance or another medical condition.
- F. Not better explained by another mental disorder: social phobia, panic disorder, OCD, separation anxiety disorder, obsessive-compulsive, somatic symptom disorder, body dysmorphic disorder, illness anxiety disorder, delusions.

GENERALIZED ANXIETY DISORDER (GAD)

- Excessive worry about life circumstances such as health, finances, social acceptance, job performance etc.
- 4.3-7.6% lifetime prevalence
- Early onset, under the age of 30
- Onset tends to be in early 20s
- Few seek treatment within psychiatry
- Plans likely to be seen by PCP for muscle tension, insomnia, upset stomach, etc.
- Tends to be chronic
- May later develop panic disorder
- Restless, distracted, fatigued
- Higher co-occurrences of MDD, and substance use disorders

GAD INTERVIEW QUESTIONS

- What types of things make you feel anxious?
- Do you feel that your worry is excessive or out of proportion to what you are worried about?
- Does your worrying/anxiety cause you problems with focus or to have problems completing tasks.
- In what ways does your worrying impact your quality of life/keep you from doing your usual day-to-day activities?

GAD

- Etiology and Pathophysiology:
  - Runs in families
  - NE, GABA, and 5HT systems all implicated within the frontal lobe and limbic system
- DDX:
  - Similar to panic disorder
  - Important to rule out drug induced conditions (including caffeine intake) as well as withdrawal syndromes.
  - Panic disorder, specific phobias, social anxiety disorder (CDD), substance and MDD

GAD CLINICAL MANAGEMENT

- Psychotherapy combined with pharmacotherapy = gold standard
- Gold standard, 1st line treatment SSRI (selective serotonin reuptake inhibitors)
- SNRIs (serotonin norepinephrine reuptake inhibitors) typically second line.
- TCAs or MAOIs may be indicated
- Bupropion (Wellbutrin)
- Hydroxyzine (Vistaril)
- Gabapentin (Neurontin)
DSM-5 CRITERIA FOR PANIC DISORDER

• A. Recurrent unexpected panic attacks. A panic attack is abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which 1 or more sympotms occur:
  • 1. Palpitations
  • 2. Sweating
  • 3. Trembling or shaking
  • 4. Sensations of shortness of breath or smothering
  • 5. Feeling of choking
  • 6. Chest pain or discomfort
  • 7. Nausea or abdominal distress
  • 8. Feeling dizzy, unsteady, light-headed, or faint
  • 9. Chills or heat sensations
  • 10. Paresthesias
  • 11. Derealization or depersonalization
  • 12. Fear of losing control or “going crazy”
  • 13. Fear of dying

Diagnostic and statistical manual of mental disorders (5th ed.), 2013

• B. At least one of the attacks has been followed by 1 month or more of one or both of the following:
  • Persistent concern or worry about additional panic attacks or their consequences
  • A significant maladaptive change in behavior related to the attacks

• C. Disturbance not attributable to substance or another medical condition

• D. Not better explained by another mental disorder; social anxiety disorder, specific phobia, OCD, PTSD, separation anxiety disorder

Diagnostic and statistical manual of mental disorders (5th ed.), 2013

PANIC DISORDER

• Characterized by recurrent unexpected panic (and/or anxiety) attacks.
• Persistent concern about having another attack.
• May include avoidance of public places.
• May avoid places/situations where past attacks occurred.
• May be accompanied by generalized worrying, although this is NOT the prominent complaint.
• Majority of panic attacks accompanied by physical symptoms.
• Unrelated fear that you are dying/having a heart attack.
• Racing heart, shortness of breath, numbness/tingling in extremities, palpitations, dizziness, lightheadedness, shaking/shivering.
• Rule out substance induced panic/anxiety (caffeine is common), or medical condition (hyperthyroidism)

PANIC DISORDER EPIDEMIOLOGY

• 5% F and 2% M have met criteria at some point in their life
• Prevalence higher in some subgroups.
• In patients experiencing cardiac type symptoms and seeking evaluation panic attacks may be present in up to 50% or more of those found to have a negative cardiac workup.
• Onset in mid-20s
• 8/10 develop prior to age 30
• Some may develop after specific events (breakup, accident or illness, or postpartum) or after using drugs
• Tend to be a diagnosis of exclusion within emergency settings
• Attacks develop suddenly, peak within 10 min and last 5-20 min total
• Feelings of anxiety/worry may persist after an attack for days
EPIDEMIOLOGY

- Full remission uncommon.
- 70% may see improvement with treatment.
- Associated with increased risk for PUD, CVC (htn), and have increased rates of death than expected.
- Associated with several physical conditions: joint hypermobility syndrome, mitral valve prolapse, migraines, fibromyalgia, chronic fatigue syndrome, IBS, asthma, allergic rhinitis, and sinusitis.
- Increased risk of suicide due to co-occurring depression and substance abuse.
- MDD and ETOH abuse most common to co-occur.
- MDD occurs in up to 50%.
- ETOH abuse in up to 20%.

PANIC DISORDER ETIOLOGY AND PATHOPHYSIOLOGY

- Hereditary.
- 20% amongst 1st-degree relatives.
- Twin studies show higher concordance with MZ twins vs. DZ twins.
- Likely related to increased concentrations levels in the CNS, abnormality in the locus coeruleus, and C2 hyperreactivity, a decrease in tissue metabolism, and abnormalities of GABA.
- None alone explains all of the symptoms although each has been supported by research.
- ??? Are panic attacks conditioned responses?"?
- DDX:
  - R/O other medical disorders such as hyperthyroidism, pheochromocytoma, disease of the vestibular nerve, hypoglycemia, and SVT.
  - R/O MDD, GAD, schizophrenia, depersonalization disorder, somatization disorder, or borderline personality disorder.
  - R/O adjustment disorder.
OBSESSIVE COMPULSIVE DISORDER (OCD)

• Characterized by intense obsessions and compulsive behaviors.
• Thoughts are intrusive and cause significant distress.
• Intrusive thoughts and compulsive behaviors inhibit patient from completing necessary tasks (is a tertiary factor).
• Anxiety is “relieved” in completing the compulsory act.
• Re-categorized in DSM-5 as “Obsessive-Compulsive and Related Disorders" rather than in the Anxiety Disorder as the pathophysiology, course, and treatment is different.

DEPRESSIVE DISORDERS

• Major depressive disorder
• Persistent depressive disorder
• Seasonal affective disorder
• Bipolar depression
• Disruptive mood dysregulation disorder
• Premenstrual dysphoric disorder

DSM-5 CRITERIA FOR MAJOR DEPRESSIVE EPISODE

• A. Five or more of the following symptoms, present during the same 2-week period and represent a change from previous functioning, or at least one of the symptoms is either depressed mood or loss of interest or pleasure.
  1. Depressed mood most of the day, feels sad, empty, hopeless, or observation by others. Children and adolescents can be irritable mood.
  2. Markedly diminished interest or pleasure in all, or almost all activities most of the day.
  3. Significant weight loss when not dieting or weight gain. Children consider failure to make expected weight gain.
  4. Insomnia or hypersomnia nearly every day.
  5. Psychomotor agitation or retardation nearly every day. (observable by others, not merely subjective feelings of restlessness or being slowed down).
  6. Fatigue or loss of energy nearly every day.
  7. Feelings of worthlessness or excessive or inappropriate guilt (may be delusional).
  8. Diminished ability to think or concentrate, or indecisiveness.
  9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Diagnostic and statistical manual of mental disorders (5th ed.), 2014
**DSM-5 CRITERIA FOR MAJOR DEPRESSIVE EPISODE**

- **A.** The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- **B.** The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- **C.** The episode is not attributable to the physiological effects of a substance or to another medical condition.
- **D.** The occurrence is not better explained by another disorder such as schizoaffective disorder.
- **E.** There has never been a manic episode or a hypomanic episode.

*Note: Responses to a significant loss may resemble a depressive episode.*

**MAJOR DEPRESSIVE DISORDER (MDD)**

- Feelings of worldlessness, hopelessness, inadequacy and guilt are also frequent.
- Inhibited cognition seen as lack of focus, difficulty completing tasks, slower thought processes, difficulty with short-term memory.
- Difficulty watching a full TV show/movie, difficulty participating in conversation.
- Suicide ideation: passive vs. active.
- Diurnal variation.
- Decrease in sex drive, impotence or anorgasmia.
- Masked depression: patient denies a depressed mood but admits to several other symptoms consistent with depression.
- Elderly patients may present complaining of non-organic symptoms.
- MDD will experience psychotic symptoms: typically mood congruent.
- Automatically classify the episode as "severe" if psychosis is present—par DSM-5.
MDD DDX

- Persistent depressive disorder
- Manic episodes with irritable mood or mixed episodes
- Cyclothymia and other mood disorders
- Mood disorder due to another medical condition
- Substance/medication-induced depression or bipolar disorder
- ADHD
- Adjustment disorder with depressed mood: response to stressor doesn’t meet MDD criteria
- Sadness/Normal periods of grief/sadness

MDD COURSE AND OUTCOME

- Sudden or gradual
- Duration = 2 weeks—months or even up to 2 years
- Prognosis of any one episode is typically good as far as effective treatment options
- Many will have a subsequent episode in their life
- 25% will develop a chronic form
- Most serious complication is suicide
- 10-15% of hospitalized patients for depression eventually complete suicide
- Risk factors: drug or ETOH abuse, age>40, history of prior SA, M>F, divorced or living alone

MDD ETIOLOGY AND PATHOPHYSIOLOGY

- Lifetime prevalence: 7%
- F>M 2:1
- Median age of onset: 30 years
- Men tend to have an earlier onset
- Runs in families
- Remember this genetics is not the only contributor to familiality (role modeling, learned behaviors, social environmental factors—emotional depression, physical environment factors present and prior birth complications due “deleted genes” through family)
- Increased risk of mood disorders (eg bipolar disorder) if 1 degree family member
- Tend to breed true (unipolar within unipolar and bipolar within bipolar, but not as much unipolar within family of bipolar)
- 5HT (serotonin), DA (dopamine) and NE (norepinephrine) all involved.

MDD SOCIAL AND ENVIRONMENTAL FACTORS

- Normal response to a stressful situation vs. clinically significant depression
- Loss or significant stress typically results in similar symptoms in patients, although not clinically significant
- Look at the timing
- Look at the severity of symptoms (out of proportion to the stressor?)
- Stressful events induce a biological reaction??
- Tendency to be neurobiologically oversensitive to the effects of psychosocial stress a contributor to depression???
MDD CLINICAL MANAGEMENT

- Encourage optimism and hopefulness.
- Assess for severity of symptoms; take into account individual and cultural differences.
- Routine probing may not be indicated when patient is significantly depressed.
- Extensive probing may not be ideal when the patient is significantly depressed.
- Determine suicidal risk and reassess frequently.
- Moderate to severe depression should be treated more aggressively with somatic therapy.
- May require hospitalization.
- May require more frequent, brief checks for support and medication management.
- Adjustment of antidepressant approx. every 4-6 weeks, but may want to visit between then as well for support and encouragement as antidepressants take time to be effective.
- 16-20 weeks of maintenance suggested prior to attempting taper following an INITIAL episode.
- After 2-3 episodes consider lifelong treatment with antidepressant medication. (with each episode the risk for developing a subsequent episode increases exponentially).

MDD PHARMACOLOGIC MANAGEMENT

- 1st line = SSRIs
- SNRIs
- Wellbutrin (bupropion)
- TCAs
- MAOIs
- Several options for augmentation of 1st line medications if indicated.
- Buspirone (Buspar), lamotrigine (Lamictal), aripiprazole (Abilify), exogenous thyroid hormones (levothyroxine, liothyrine), mirtazapine (Remeron), dual antidepressant treatment, psychostimulants in appropriate candidates (methylphenidate or amphetamine salts), etc.

ECT AND RTMS FOR MDD

- ECT (electroconvulsive shock therapy)
- FDA approved
- Indications: severe depression (high potential for suicide or cardiovascular disease which may preclude use of other antidepressants), and psychosis.
- May be effective in depression resistant to antidepressants, but such studies are not yet available.
- Monitoring AD after ECT is completed.
- tDCS (transcranial direct current stimulation) and vagal nerve stimulation (VNS)
- FDA approved
- Not as widely available as ECT (newer, more expensive, not well covered by insurance).
- Magnetic pulses applied to the scalp using a handheld coil depolarizes neurons.
- Thought to alter levels of NTs and functional activity of the CNS that is dysregulated in depressed patients.

SSRIS

- Fluoxetine (Prozac)
- Sertraline (Zoloft)
- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Paroxetine (Paxil)
- Fluvoxamine (Luvox)
SSRI SIDE EFFECTS

• Transient:
  • Nervous system: N/V, diarrhoea
  • Sedation (usual) or agitation (infrequent)
  • Appetite change (increase or decrease)
  • Weight gain or loss
  • Sexual dysfunction
• Uncommon: agitation, restlessness, impulsivity, irritability, constipation, tremor
• Black box warning: increased/new suicidal ideation or worsened depression—debunked in most studies
• Exception: PAXIL, especially in KIDS!!
• Rare: hyponatremia and SIADH (most common over the age of 60), serotonin syndrome (rare, rare, RARE), easy bleeding, mania (mostly in bipolar patients), prolonged QT syndrome
• Positive: ESTABLISHES NEW CONNECTIONS BETWEEN NEURONS—PROCOGNITIVE!
• Safe in pregnancy and breastfeeding, EXCEPT PAXIL

SSRI DOSING

• Fluoxetine (Prozac)
  • Available dosing:
    • 10 mg, 20 mg, 40 mg
  • Typical max: 80 mg QD
• Sertraline (Zoloft)
  • Available dosing:
    • 25 mg, 50 mg, 100 mg
  • Typical max: 200 mg QD
• Citalopram (Celexa)
  • Available dosing:
    • 10 mg, 20 mg, 40 mg
  • Typical max: 40 mg QD
• Escitalopram (Lexapro)
  • Available dosing:
    • 5 mg, 10 mg, 20 mg
  • Typical max: 20 mg QD
• Paroxetine (Paxil)
  • Available dosing:
    • 10 mg, 20 mg, 30 mg, 40 mg
    • CR: 12.5 mg, 25 mg
  • Typical max: 50-62.5 mg QD
• Fluvoxamine (Luvox)
  • Available dosing:
    • 25 mg, 50 mg, 100 mg
    • CR: 100 mg, 150 mg
  • Typical max: 300 mg QD

SNRIS

• Venlafaxine (Effexor)
• Desvenlafaxine (Pristiq)
• Duloxetine (Cymbalta)
• Milnacipran (Savella)
• Levomilnacipran (Fetzima)
### SNRI SIDE EFFECTS

- Same as the SSRIs, but now add in the role of NE
- Dizziness
- Hypertension (Effexor)
- + pain relief (Cymbalta)
- + helps with hot flashes (improves vasomotor symptoms)
- More likely to have withdrawal effects
- Less apathy
- Less sexual side effects
- More dizziness and headaches

### SNRI DOSING

<table>
<thead>
<tr>
<th>SNRI</th>
<th>Available dosing</th>
<th>Typical max</th>
<th>QD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venlafaxine (Effexor)</td>
<td>25 mg, 75 mg, 150 mg, 300 mg capsule and tablets available</td>
<td>300 mg</td>
<td></td>
</tr>
<tr>
<td>Desvenlafaxine (Pristiq)</td>
<td>50 mg, 100 mg</td>
<td>100 mg</td>
<td></td>
</tr>
<tr>
<td>Duloxetine (Cymbalta)</td>
<td>20 mg, 40 mg, 60 mg, 120 mg</td>
<td>120 mg</td>
<td></td>
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<tr>
<td>Milnacipran (Savella)</td>
<td>12.5 mg, 25 mg, 50 mg, 100 mg</td>
<td>200 mg</td>
<td></td>
</tr>
<tr>
<td>Levomilnacipran (Fetzima)</td>
<td>20 mg, 40 mg, 80 mg, 120 mg</td>
<td>120 mg</td>
<td></td>
</tr>
</tbody>
</table>

### OTHER ANTIDEPRESSANTS

- Vortioxetine (Trintillex)
- Selective serotonin reuptake inhibitor (SSRI)
- Multimodal—primarily serotonin, but also has DA and NE involvement
- Vilazodone (Viibryd)
- Multimodal
- Serotonin partial agonist reuptake inhibitor (SPARI)
- Serotonin partial agonism at 5HT1A theoretically diminishes sexual dysfunction caused by serotonin reuptake inhibition
- Bupropion (Wellbutrin)
- Dopamine reuptake inhibitor and releaser, also norepinephrine dopamine reuptake inhibitor (NDRI)
- Antidepressant, weight loss, smoking cessation
- Bartram (Wellbutrin)
- Nausea
- Weight loss, anorexia
- Insomnia
- Tremor
- Headache
- Agitation
- Anxiety
- Hypertension
- Rare seizures—decreases the seizure threshold
- 2D6 inhibition
OTHER ANTIDEPRESSANTS DOSING

• Vortioxetine (Trintillex)
  - Available dosing:
    • 5 mg, 10 mg, 15 mg, 20 mg
    • Typical max: 20 mg QD
  - Available dosing:
    • 10 mg, 20 mg, 40 mg
    • Typical max: 40 mg QD

• Bupropion (Wellbutrin)
  - Available dosing:
    • IR: 75 mg, 100 mg
    • SR: 150 mg, 300 mg
    • XL: 150 mg, 300 mg
    • Typical max: 450 mg QD, in one dose or divided

TRICYCLIC ANTIDEPRESSANTS (TCAS)

• Amitriptyline (Elavil)
• Nortriptyline (Pamelor, Aventyl)
• Desipramine (Norpramin)
• Imipramine (Tofranil)
• Clomipramine (Anafranil)
• Trimipramine (Surmontil)
• Protriptyline (Vivactil)
• Doxepin (Sinequan)
• Clorpropamine (Akvist)

TCA MECHANISM OF ACTION

• Serotonin, NE multimodal
• Serotonin and NE/noradrenaline reuptake inhibitor
• Similar to SSRIs
• Very potent serotonergic and NE agent
• Higher risk for serotonin syndrome than the SSRIs or other SNRIs
• Anticholinergic actions as well

TCA SIDE EFFECTS

• Blurred vision
• Constipation
• Urinary retention
• Increased appetite
• Dry mouth
• N/V/D
• Heartburn
• Weight gain
• Fatigue
• Weakness
• Dizziness
• Sedation
• Headache
• Anxiety/hypersensitivity
• Restlessness
• Sexual dysfunction
• Lowered seizure threshold
• Orthostatic hypotension, tachycardia, syncope, sudden death (BAD in overdose)
• QTc prolongation
TCA DOSING AND INDICATION

- Depression
  - Serotonin reuptake depression
  - Anxiety
  - Neuropathic pain/chronic pain
  - Headache
  - Low back/neck pain
  - Enuresis (Imipramine)
  - OCD (Clomipramine)

  - Amitriptyline (Elavil)
    - Available dosing:
      - 25 mg, 50 mg, 100 mg
      - Typical max: 150-300 mg (depends on indication etc)

- Nortriptyline (Pamelor, Aventyl)
  - Available dosing:
    - 10 mg, 25 mg, 50 mg, 75 mg
    - Typical max: 150-300 mg

- Doxepin (Sinequan)
  - Available dosing:
    - 10 mg, 25 mg, 50 mg, 75 mg, 100 mg, 150 mg
    - Sleep: 10-50 mg

MONOAMINE OXIDASE INHIBITORS (MAOI)

- Phenelzine (Nardil)
- Isocarboxazid (Marplan)
- Tranylcypromine (Parnate)
- Selegeline transdermal (EMSAM)

  - Remember that these medications require a special diet that lacks/is low in tyramine due to severe and potentially life threatening side effect.
  - Not likely to be utilized by anyone other than a psychiatric provider
  - Use caution in primary care when you see patients on this medication—it does NOT play well with other drugs—NUMEROUS interactions that are dangerous and potentially fatal

ANXIOLYTIČS

- 1st line is SSRI or SNRI
  - Sedation, sexual dysfunction, weight gain
  - May reduce sexual dysfunction with SSRIs
  - Monomanic atypical medications in public speaking
  - Check with physician
  - Secondary (fluoxetine)
  - Citalopram
  - Escitalopram
  - Olanzapine (Seroquel)
  - Quetiapine (Seroquel)
  - Propranolol

BUSPIRONE

- Serotonin receptor 1A partial agonist
- May reduce sexual dysfunction with SSRIs
- Indications: anxiety disorders, treatment resistant depression (adjunctive)

  - Side effects:
    - Distress, headache, dizziness, excitement, nausea

  - Available dosing:
    - 5 mg, 10 mg, 20 mg
    - Sleep: 10-50 mg QD usually in divided doses BID or TID

  - Not as effective as BZs or ADs
**BENZODIAZEPINES**

- Alprazolam (Xanax)
- Lorazepam (Ativan)
- Clonazepam (Klonopin)
- Diazepam (Valium)
- Others

**BZ SIDE EFFECTS**

- Sedation
- Disorientation (+/-)
- Increased risk for falls
- Decreased fine motor coordination (ataxia)
- Decreased respiratory drive
- Dependence
- Delirium
- Depression
- Slurred speech
- Forgetfulness/memory impairment (INCREASED RISK FOR DEMENTIA)
- Dizziness
- Confusion
- Hypotension

**POTENCY AND HALF LIFE MATTERS WITH BZS!!!**

- Most commonly prescribed
  - Alprazolam (Xanax)
    - 3-5x more potent than lorazepam
    - Onset: 0.5-1 hour
    - Lasts 1-4 hours
- Lorazepam (Ativan)
  - Similar potency to alprazolam
  - Onset: 1-2 hours
  - Lasts 4-8 hours
- Clonazepam (Klonopin)
  - 2x more potent than lorazepam (similar in potency to alprazolam)
  - Onset: 0.5-1 hour
  - Lasts 4-8 hours
- Diazepam (Valium)
  - Onset: 0.5-1 hour
  - Lasts 4-8 hours
  - Onset: 1-2 hours
  - Lasts 4-8 hours

**BZ DOSING**

- Alprazolam (Xanax)
  - 0.25 mg up to QID, PRN
- Lorazepam (Ativan)
  - 0.5 mg up to TID or QID, PRN
- Clonazepam (Klonopin)
  - 0.25 mg up to BID or TID, PRN
- Diazepam (Valium)
  - 2 mg up to BID or TID, PRN
PHOTOTHERAPY

- Traditionally used to treat seasonal affective disorder (SAD).
- Fatigue, oversleeping, overeating with weight gain and craving for carbs, hypersomnia in the dark or high (r)ed blood pressure, poor concentration, difficulty concentrating, irritability—all worse in the winter months.
- Also helpful as an augment for MDD and other depressive disorders.
- Lights should provide 10,000 lux.
- Titrate gradually up to 30-90 minutes each morning.
- 2 feet from the face.
- Tanning beds are NOT the same.

REFERENCES

- U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health.
- World Health Organization (WHO).