Depression & Anxiety

Score it, exclude bipolar and the mimics, pick the drug by its side effects · and give every trial an adequate dose for an adequate time

Ask about suicide
directly, every time

SCREEN, SCORE, AND TWO QUESTIONS FIRST *the number guides treatment; two questions prevent disasters*

SCREENING AND SCORING

USPSTF 2023: screen all adults for depression (including pregnancy/postpartum) **and adults up to 64 for anxiety.** PHQ-2 gates to PHQ-9: bands at 5/10/15/20, **≥ 10 is the usual treatment trigger**, remission < 5, response = 50% drop. GAD-7 bands 5/10/15. **Re-score at every visit**: treating without trending is titrating insulin without glucose values.

⚠ BIPOLAR SCREEN FIRST

Antidepressant monotherapy in unrecognized bipolar disorder can precipitate mania, and bipolar illness usually debuts as a depressive episode: the patient asking for help with depression is exactly the one who might be bipolar. Ask about **decreased need for sleep with increased energy, racing thoughts, pressured speech, impulsive spending or sexual behavior**, plus family history (or use the MDQ). Positive = mood-stabilizer pathway with psychiatry, not an SSRI.

⚠ SUICIDE: ASK DIRECTLY

"Are you having thoughts of killing yourself?" **does not plant the idea**: that fear is disproven and is the main reason clinicians under-ask. Any PHQ-9 item-9 positive gets the same-day conversation: **ideation, plan, intent, means, protective factors**. **Ask about firearms by name**: means restriction is one of the few interventions proven to prevent deaths. Active ideation with plan and intent is an emergency, not a referral.

CHOOSE THE DRUG BY ITS SIDE EFFECTS *efficacy is comparable, so the profile is the selection tool*

Agent	Dose and the reason to pick (or avoid) it
Sertraline / escitalopram *the defaults*	Sertraline 25-50 → 50-200 mg; escitalopram 5-10 → 10-20 mg. Best tolerated, safe in cardiac disease; sertraline is the usual choice in pregnancy and lactation. Class effects: early GI upset and activation, sexual dysfunction, hyponatremia in the elderly, bleeding with NSAIDs/anticoagulants
⚠ Citalopram	**FDA QT cap: max 40 mg/day, 20 mg if elderly or hepatic impairment.** ECG with cardiac disease or other QT drugs. "Failed citalopram 40" means switch agents, not push the dose
Duloxetine	30 → 60 mg. SNRI that also treats **neuropathic pain and fibromyalgia**: the rational pick when depression and chronic pain coexist. Avoid in heavy alcohol use and hepatic disease
Venlafaxine XR	37.5-75 → 75-225 mg. Effective in depression and anxiety; **dose-dependent hypertension** (check BP at titration) and one of the harshest discontinuation syndromes: always taper
Bupropion	150 → 300-450 mg XL. **No sexual dysfunction, no weight gain**, activating; the switch or add-on when SSRIs cause either, and it aids smoking cessation. **Contraindicated in seizure disorders and active eating disorders**; not for prominent anxiety
Mirtazapine	7.5-15 → 15-45 mg qHS. **Sedation + appetite stimulation ARE the therapy** in the depressed elderly patient with insomnia and weight loss; more sedating at LOWER doses; minimal sexual dysfunction
Fluoxetine / paroxetine	Fluoxetine's long half-life **self-tapers** (best for dose-missers, useful to bridge hard tapers); activating. Paroxetine: most weight gain, most anticholinergic, **worst discontinuation syndrome**, avoided in pregnancy: rarely the answer. Low-dose trazodone is a sleep aid, **not an adequate antidepressant**

RUN THE TRIAL PROPERLY *most "failures" were underdosed, under-timed, or not taken*

Rule	Detail
Adequate trial	**Therapeutic dose for 4-6 weeks minimum (full effect 8-12) before judging.** Warn about the first two weeks (GI upset, jitteriness before benefit): patients who expect it stay on the drug. **Under-25s: boxed warning for early emergent suicidality**, so see or contact them within 1-2 weeks of starting
Ask what they will not volunteer	**Sexual dysfunction is the leading silent adherence killer**: ask at follow-up. Bupropion (switch or add-on) is the usual answer. Prior response to a specific agent is the best predictor of response now: ask what worked before
Inadequate response	Optimize dose → **switch** (within class, or SNRI/bupropion/mirtazapine) or **augment** (bupropion, mirtazapine, or an atypical antipsychotic). **Two adequate failed trials = treatment-resistant: refer**, where esketamine and ECT live. **ECT remains the most effective treatment** for severe, psychotic or catatonic depression
The calendar	**Continue 6-12 months after remission for a first episode** (stopping at "I feel better" roughly doubles relapse); maintenance after two episodes. **Taper on the way out**: discontinuation syndrome (days: dizziness, "brain zaps," flu-like) is not relapse (weeks: the original symptoms), and misreading one for the other re-anchors the drug
Mimics and severity	TSH, CBC, B12 where the picture fits; **quantify alcohol, screen OSA**. Mild disease (PHQ-9 5-9): CBT, behavioral activation and exercise before medication. Moderate-severe: **combination beats either alone**. Psychosis, catatonia, or refusing intake: psychiatry now

ANXIETY: SAME DRUGS, GENTLER START *and the benzodiazepine trap*

GAD AND PANIC DISORDER

SSRIs/SNRIs first-line for both, started at HALF the usual dose (sertraline 12.5-25, escitalopram 5): anxious patients are exquisitely sensitive to early activation and a bad first week ends treatment. Say the timeline out loud: benefit at 2-4 weeks, mature at 8-12. **CBT equals medication with more durable benefit.** Buspirone adjuncts GAD (not panic; needs 2-4 weeks, BID-TID). Propranolol 10-40 mg covers performance situations only. For panic, name the physiology: **the attack peaks and passes within minutes and cannot hurt you**: that sentence alone reduces attack frequency.

⚠ BENZODIAZEPINES: THE IMMEDIACY IS THE TRAP

They work instantly, **which is how they entrench**: a PRN dose during a panic attack teaches the patient the pill ended an event that would have self-terminated anyway, avoidance is reinforced, and tolerance and dependence develop within weeks. Elderly patients add falls and cognitive harm. **Bridge use only (2-4 weeks while the SSRI takes hold), with the end date written into the first prescription.** Never with opioids (boxed warning: fatal respiratory depression) or substance-use history. Long-term users taper slowly: withdrawal seizures are real.

PEARLS & PITFALLS

- **Anhedonia counts even when sadness is denied.** "Nothing is enjoyable anymore" satisfies the cardinal criterion in the patient who insists they are not depressed.
- **Alcohol quietly defeats the antidepressant.** Nightly drinking is both depressogenic and the cause of the 3 AM awakenings: quantify it and name it as part of the prescription.
- **A first "panic attack" in an older patient gets the organic workup**: hyperthyroidism, arrhythmia, PE and hypoglycemia all masquerade as anxiety, and the mislabel runs in both directions.
- **Discontinuation symptoms arrive in days with brain zaps; relapse arrives in weeks with the original symptoms.** Teaching the difference prevents both unnecessary restarts and false "treatment failures."

References: USPSTF 2023 recommendations on screening for depression and for anxiety disorders in adults · APA practice guideline for major depressive disorder · FDA drug safety communication on citalopram and QT prolongation · FDA boxed warnings on antidepressants in young adults and benzodiazepine-opioid co-prescribing.

Educational aid; verify against current guidance, local formulary and patient factors.

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