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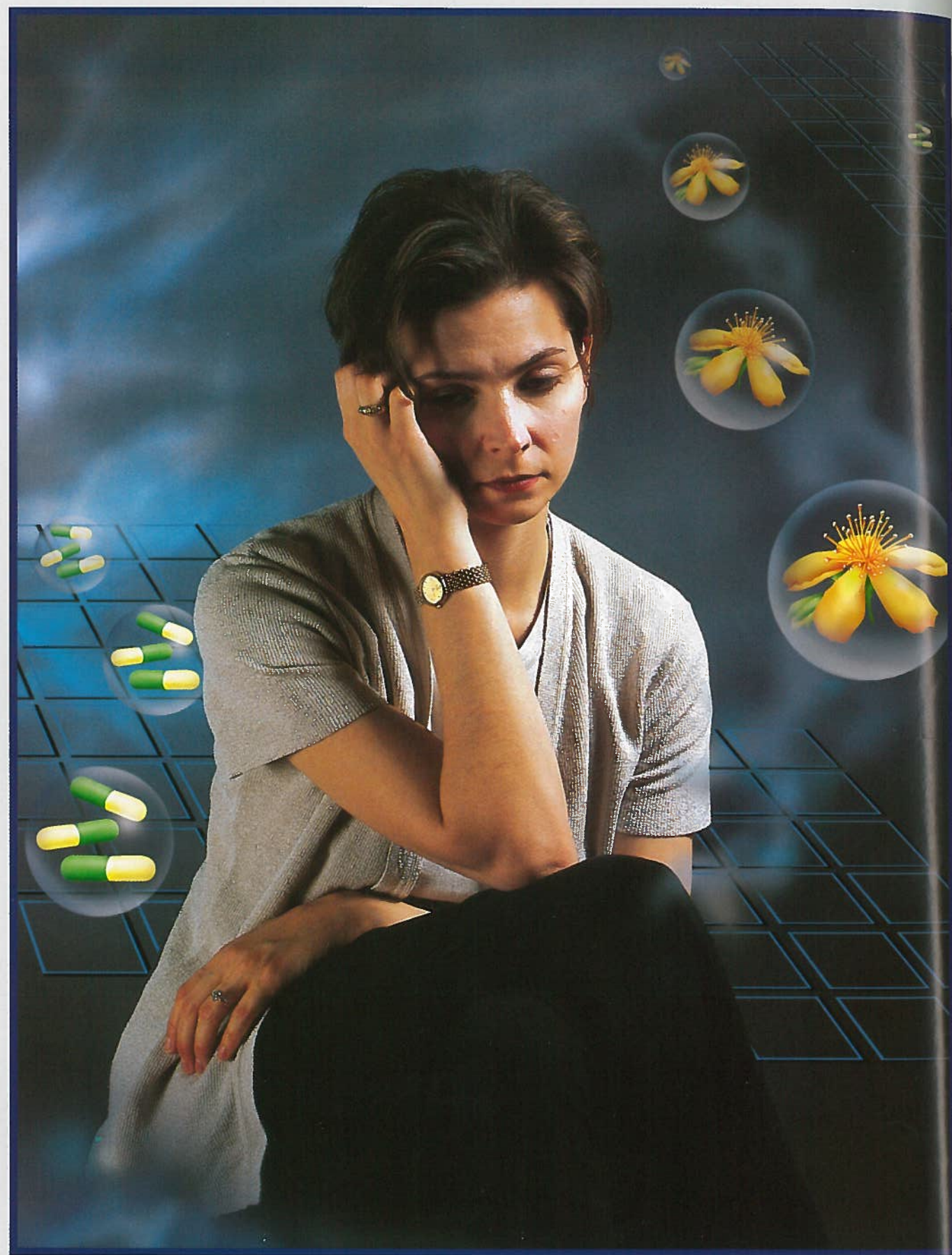


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Prescribing Medications for Mood Disorders

BY JUDITH SHANNON LYNCH, MS, APRN

You are finishing a school physical on a 17-year-old girl. You note throughout the encounter that she has a depressed affect and has made little eye contact. You gather almost no information from either indirect or direct questioning. Finally, you ask her if there is anything wrong and, if so, what you can do to help. Slowly, she looks at you and begins to sob. The story emerges. She witnessed her mother shoot her father to death 6 months ago. Her mother is in prison and the patient is living with maternal relatives. She is unable to eat, sleep or concentrate on school or sports. She has never spoken to anyone at school or on her basketball team about this incident. She visits her incarcerated mother each week. She denies any suicidal ideations.

Nurse practitioners in primary care should be prepared to evaluate and treat

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Primary Care Strategies

patients such as this young woman. Although it would be essential to refer this particular patient to a mental health setting for trauma counseling, the basic assessment and management must remain with the primary care provider. The trust between provider and patient will contribute to the optimal healing of mood disorders commonly seen in the primary care setting.

Mood Disorders in Primary Care

Depression and anxiety disorders have become the "common cold of psychiatry," with as much as 4% of the general population affected by significant depression at any given time and 20% seeking care for anxiety disorders.^{1,2} Of patients diagnosed with depression, 15% commit suicide.³ Despite this grave consequence, 50% of all cases of depression are undiagnosed in

the primary care setting.⁴ Between 50% and 70% of patients with major depression also experience significant anxiety symptoms, and up to one-third have anxiety attacks.⁵ Finally, although 4 million Americans suffer from generalized anxiety or panic disorders, only one in four is ever correctly diagnosed and treated in the primary care setting.⁶

Diagnostic criteria for mood disorders are available in the *Diagnostic and Statistical Manual of Mental Disorders IV*.⁷ Criteria for major depressive episodes, dysthymic disorders, generalized anxiety disorders and panic disorders allow for an accurate and valid assessment during the basic encounter with a depressed or anxious patient. Taken together with a comprehensive history, physical examination, appropriate laboratory testing and the use of valid screening tools such as the Beck Depression Inventory or the Anxiety Inventory, a definitive assessment can be reached in one to two ambulatory visits.⁸

Although the clinical interview lends much to the diagnosis of mood disorders, it is essential to support clinical intuition

Key Points

PRESCRIBING MEDICATIONS FOR MOOD DISORDERS

- **Both nonpharmacologic and pharmacologic modalities are important to the successful management of any patient with a depressive or anxiety disorder, so consider a combined treatment plan.**
- **Consider the following before instituting any drug therapy: adverse effects, cost, effectiveness and safety in overdose situations. Assess suicide risk at each visit and prescribe necessary medications accordingly.**
- **Because many psychotropic medications have serious side effects, follow patients closely. Inform them of the possible side effects associated with the various drug classes, and allow them to take an active part in choosing the specific medication.**
- **When a patient shows only a partial response to an antidepressant, a second drug may be added to the treatment regime.**
- **After you initiate a course of pharmacotherapy, continue it until the patient has been asymptomatic for approximately 6 to 12 months. A gradual tapering may be started after 6 months of therapy and continued over a period of 2 to 3 months.**



with an objective database to rule out medical and other psychiatric health problems. This is easily accomplished through an in-depth physical examination and a set of screening laboratory tests that should include, but not be limited to, a complete blood count with differential, chemistry profile, venereal disease research laboratory test, thyroid screen, urinalysis, toxicology screen and electrocardiogram.

Multidimensional Treatment Plan

Both nonpharmacologic and pharma-

colgic modalities are important to the successful management of any patient with a depressive or anxiety disorder, so consider a combined treatment plan. Appropriate counseling measures should be immediately instituted, and you can play an integral part in seeing that the patient receives counseling pertinent to the health problem. You should serve as a counselor in the context of helping the patient clarify, define and reflect feelings and set realistic goals for the future. While seeing the patient on a regular schedule, you should be constantly alert to the risk of suicide in people who are depressed or anxious. Of course, the nonpharmacologic treatment should be multidisciplinary, since counseling and psychotherapy will often be implemented by colleagues in the mental health system.

The effectiveness of any treatment plan will rest on a cooperative effort between

from pharmaceutical companies and knowing about various plans for uninsured patients, as well as being aware of what drugs are covered by Medicare and Medicaid plans, are helpful ways to decrease direct cost to the patient.

Effectiveness and safety profiles of various psychotropic medications differ according to specific drug classifications. Assess suicide risk at each visit and prescribe necessary medications accordingly.

Prescribing for Depressive Disorders

Many options are available for the pharmacologic management of depression (Table 1). The oldest drugs are the tricyclic antidepressants (TCAs), which inhibit the neuronal intake of serotonin and norepinephrine but do not target a specific neurotransmitter. This is known as the "shotgun approach" to therapy. These drugs, of which amitriptyline (Elavil) is the most popular, are inexpensive and have been

It is absolutely essential that you educate patients about all options for treatment and allow them to choose, with your input, the general course of treatment.

the provider and the patient.⁴ A careful, accurate and comprehensive explanation of the patient's specific problem, repeated over many visits, will help provide an understanding and acceptance of the complexities of depression and anxiety. The better patients' understanding of the interplay between the pathophysiology and psychology of these disorders, the better they will be able to comply with the pharmacologic management plan, as well as with the long-term nature of counseling or psychotherapy. It is absolutely essential that you educate patients about all options for treatment and allow them to choose, with your input, the general course of treatment.

General Pharmacologic Plans

Consider the following before instituting any drug therapy: adverse effects, cost, effectiveness and safety in overdose situations.

Because many psychotropic medications have serious side effects, follow patients closely. Inform them of the possible side effects associated with the various drug classes, and allow them to take an active part in choosing the specific medication.

Cost is an issue for many patients in a managed care system. Selecting an inexpensive drug may be the only way you can implement a management plan. Stocking supplies of sample starter doses

used in the relief of chronic pain and migraine headache prophylaxis, as well as in the treatment of depressive disorders. TCAs often cause toxicity (especially anticholinergic side effects) before a therapeutic dosing schedule can be reached. TCAs interact with antiarrhythmic agents, must be used with caution in elderly patients (they may cause excessive somnolence), and patients on certain TCAs must be monitored with frequent blood tests. Dose must be slowly titrated and tapered before discontinuing therapy. Only weekly supplies should be given for the first 2 months of therapy, especially if there is any potential for suicide.

Because of the issues associated with TCAs, another class of drugs, the selective serotonin reuptake inhibitors (SSRIs), has become first-line treatment for depressive disorders. These medications, popularized by fluoxetine (Prozac), inhibit the neuronal reuptake of serotonin only, thus having a more specific effect on neurotransmission. These medications have a wide therapeutic range and safety margin and can be used in dysthymic and obsessive-compulsive disorders, as well as in depression. Fluoxetine has also been used to treat eating disorders. These medications have few side effects (insomnia and restlessness are the most commonly reported) and do not need to be titrated.

They should be tapered before discontinuing therapy, however, and are generally far more expensive than TCAs.

Second-line drugs used to treat depressive disorders are also important to consider in certain clinical situations. Trazodone (Desyrel) has a high sedative effect and can be successfully used with a small number of patients who have sleep disorders. Although trazodone has minimal anticholinergic side effects, it is very expensive and should be used with caution in the majority of patients due to its sedating effect.

Bupropion (Wellbutrin), which inhibits dopamine and norepinephrine uptake, may be used when a patient is unresponsive to a first-line drug. This medication is especially useful when a patient is sleeping excessively, since a major side effect is insomnia. This drug is contraindicated in patients with a past history of eating disorder or seizure disorder, but is otherwise well-tolerated and has been recently marketed as a smoking cessation adjunct under the name Zyban.⁹

Venlafaxine (Effexor), a structurally novel antidepressant, is similar to SSRIs in its effect and may also be used with unresponsive patients. An ascending dose response occurs with this drug and, in high doses, it has been reported to cause a blood pressure rise in susceptible patients. Nefazodone (Serzone), a serotonin-2 antagonist, is an analogue of trazodone. It is more sedating than the SSRI medications and is most successful in patients who have a comorbid anxiety or agitation disorder. It potentiates the plasma concentrations of commonly used benzodiazepine medications, however, and should be used cautiously with Halcion or Xanax.

Another important classification of drugs used to treat depressive disorders is the monoamine oxidase inhibitors (MAO

TABLE 1
Common Medications for Depression

DRUG NAME	USUAL DAILY DOSE
Amitriptyline (Elavil)	200 mg once daily
Bupropion (Wellbutrin)	100 mg t.i.d. (SR = 150 mg tid)
Desipramine (Norpramin)	200 mg once daily
Fluoxetine (Prozac)	20 mg once daily
Imipramine (Tofranil)	200 mg once daily
Nefazodone (Serzone)	200 mg b.i.d.
Nortriptyline (Pamelor)	100 mg once daily
Paroxetine (Paxil)	20 mg once daily
Sertraline (Zoloft)	100 mg once daily
Trazodone (Desyrel)	300 mg in daily doses
Venlafaxine (Effexor)	75 mg b.i.d.

inhibitors). Since these medications should be used only after consultation with a psychiatric specialist, they are not included in this discussion. You should become familiar with the pharmacology of these agents, however, since psychiatric patients taking MAO inhibitors may present in primary care settings for other medical problems. ▽

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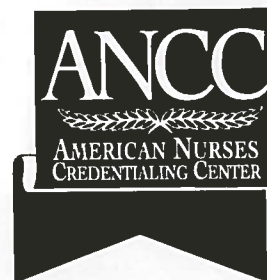
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TABLE 2
Common Medications for Anxiety

DRUG NAME	USUAL DAILY DOSE
Alprazolam (Xanax)	0.5 mg q.i.d.
Clonazepam (Klonopin)	0.5 mg b.i.d.
Diazepam (Valium)	10 mg b.i.d.
Lorazepam (Ativan)	1 mg t.i.d.
Oxazepam (Serax)	15 mg t.i.d.
Buspiron (BuSpar)	15 mg b.i.d.

When a patient shows only a partial response to an antidepressant, a second drug may be added to the treatment regime. This is called "augmentation" and is often attempted in consultation with a psychiatric specialist. Commonly used medications include lithium, bupropion (BuSpar) or a second antidepressant medication.¹⁰

Prescribing for Anxiety Disorders

The two anxiety disorders most commonly seen in primary care are generalized anxiety disorder and panic disorder. For treatment of chronic, generalized anxiety, the serotonergic anxiolytic bupropion can be successfully used. This is a non-sedating

The goal of treatment in panic disorder is to successfully block recurrent and unexpected panic attacks.¹¹ These attacks may be treated with SSRIs in low doses to avoid an initial increase in anxiety. TCAs may also be used, but patients will experience the usual side effects at therapeutic doses, and titration must occur slowly.

All benzodiazepine drugs are useful in the treatment of generalized anxiety and panic disorder. Clonazepam (Klonopin) and alprazolam (Xanax) are generally considered most effective, but have also received the most intense study.¹⁰ These medications may be used safely for short

and expensive medication that achieves its full effect in about 4 weeks (Table 2). Many NPs choose benzodiazepines as anxiolytics, but bupropion has an advantage in the patient who has a current or past history of alcohol or substance abuse. Bupropion has no abuse potential.

periods, but patients may become dependent after long-term use. Their advantages include a rapid onset, high tolerability and few side effects. Prescribe these drugs cautiously for elderly patients, who experience excessive drowsiness; tapering is necessary to avoid seizures.

If a patient has a combination of depression and anxiety, the SSRI class of drugs should be prescribed as first-line therapy.

Maintenance and Follow-Up

After you initiate a course of pharmacotherapy, continue it until the patient has been asymptomatic for approximately 6 to 12 months.⁵ A gradual tapering may be started after 6 months of therapy and continued over a period of 2 to 3 months. Encourage the patient to report any symptom recurrence. After the patient is finished with all medication and remains asymptomatic, maintain contact, through three to four visits each year, to monitor progress and avoid exacerbations. Often this can be achieved in the context of routine health maintenance and the monitoring of other health problems.

In summary, the nurse practitioner plays a vital role in the treatment of mood disorders in the primary care setting. The NP has the primary responsibility to diagnose both depression and anxiety disorders and to treat all such health problems in a comprehensive and holistic manner. This includes recommending psychiatric consultation and referral for various counseling and therapy modalities, as well as the direct provision of care. An important part of the primary care of these patients will require the accurate prescribing of common psychotropic medications and the monitoring and follow-up of a holistic management plan. ♦

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