Treating co-occurring generalized anxiety disorder and depression: Expert tips to keep your clients from getting stuck

Brett Johnson, MD, and Stacy Shaw Welch, PhD

Thursday, March 25, 2021

ROGERS Behavioral Health

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Quick overview of logistics

Our speakers will give a 75-minute presentation.

Following the presentation, there will be a dedicated time to answer your questions.

- Please use the **Q&A feature**, located in the toolbar at the bottom of your screen, to send your question to the moderator.
- The moderator will review all questions submitted and select the most appropriate ones to ask the presenter.

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Disclosures

Brett Johnson, MD, and **Stacy Shaw Welch, PhD,** have each declared that they do not, nor does their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation. The presenters have each declared that they do not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Summarize two risk factors common to both GAD and MDD.
2. Identify at least two psychopharmacological strategies that can be used to help patients with co-occurring GAD and MDD.
3. Describe two ways to incorporate elements of exposure and behavioral activation treatments strategically to help clients with co-occurring GAD and MDD.

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What we'll cover in this webinar

- Co-occurring generalized anxiety and depression: Common elements and challenges
- Using medicines to support therapeutic targets
- Weaving exposure and behavioral activation together

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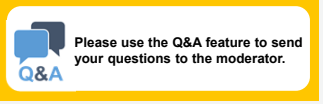
Co-occurring GAD and depression: Common elements and challenges



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Depression and generalized anxiety co-occur at extremely high rates

- Since the pandemic began, CDC reports rates of anxiety and depression have quadrupled with the **burden disproportionately born by women and people of color** (Czeisler, Lane, Petrosky et al, 2020).
- Depression and anxiety rates are as high as 60% (Goldstein-Piekarski, Williams & Humphreys, 2016).
- Clinicians can not treat their clients in a vacuum; if commonly applied exclusion criteria were applied in practice, up to 92% of patients seeking treatment for anxiety would be left behind
- Co-morbidity matters and can cut the rate of response to treatment by up to half (Bruce et al, 2005); however, treatments tend to be mono-focused

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GAD and MDD

While there are differences, GAD and MDD are both characterized by pervasive and dysregulated negative affect:

- **Depressive rumination:** Tends to focus on the past, and on a firm sense of a negative past and future. Themes of grief, sadness, hopelessness, and loss are central.
- **Anxious worry:** Tends to focus on the future, and often has a more somatic/physical component. Themes of fear and threat are central.

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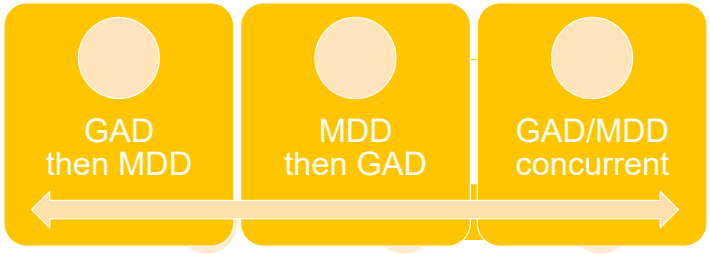
Risk factors



Experience of disorder may leave "scars" that create more vulnerability to future disorder

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We have good* treatments for both depression and generalized anxiety

Cognitive behavioral therapy (CBT) is well-established for both anxiety and depression (van Dis et al, 2020; Cuijpers et al, 2013; Perrin et al, 2019).

- In CBT we try to:
  - Help depressed patients "activate" towards healthy and enjoyable routines and valued activities – **Behavioral Activation**
  - Help anxious patients "expose" themselves to previously feared and avoided situations that limit their ability to enjoy happy and productive lives – **Exposure Therapy**

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The flip side of risk factors – perseverance and optimism

Similar themes are helpful for both depressed and anxious patients, and these can be emphasized in CBT.

Goal persistence is key; positive reappraisal is also helpful (more than self-mastery; Zainal & Newman, 2019).

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Co-occurrence presents challenges for the patient and the clinician

- Patients who start to work on behavioral activation often become fearful / anxious
- Patients who begin exposure therapy are often so depressed it is hard to motivate
- Patients are sometimes confused by the distinction between "activation hierarchies" and "exposure hierarchies" when tackling their depression and anxiety concurrently

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Conceptualizing treatment:

Taking the co-occurrence of anxiety and depression into account can help maximize the chance for success.

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Case example

Adrian is a 35-year-old, non-binary Latinx individual. They experienced early childhood abuse leading to placement within the foster care system. As one of the few non-white students in school, they experienced rejection and teasing in school. They were socially anxious and never dated or had many friends. They eventually dropped out of school and obtained a GED.

In adulthood, Adrian has had success in their career in as an electrician. However, they were laid off due to the pandemic and have struggled financially. They present to treatment with depressed mood, anxiety about the future, and low social support. Primary worries are about never having a relationship and not being able to support themselves. They spend most of the day in bed and are quite isolated. They feel that they never developed social skills and feel worried "all the time."

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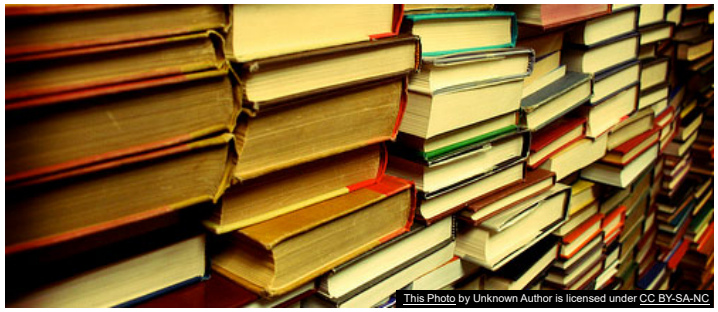
Traditional CBT models



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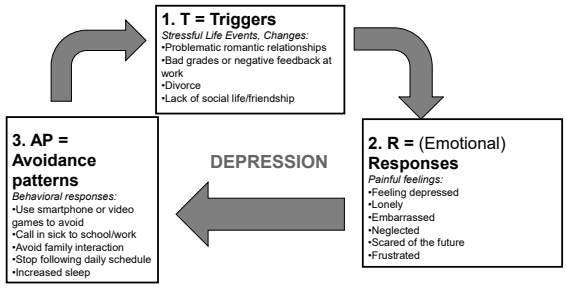
Rationale: How do people become depressed?



Main point: **Your depression makes sense.**

Adapted from Martell et al., 2001; Kanter et al., 2009

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Rationale for BA: TRAC

1. T = Triggers
Stressful Life Events, Changes

2. R = (Emotional) **Responses**
Painful feelings

3. AC = Active coping
Behavioral responses

3. AP[illegible] patte[illegible]s
Behavio[illegible]

Main point: **There are specific things we can do to reduce your depression.**

Goal: **Diverse, stable sources of + reinforcement.**

Purported mechanism of action: **Activation**

(e.g., Santos et al., 2019)

Martell et al., 2001

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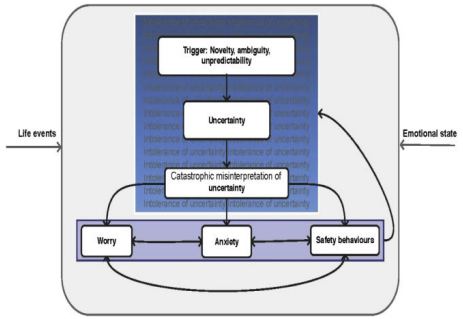
CBT for GAD: Learning to tolerate uncertainty



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CAUTION

This is a lot for a new client!

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Idea 1: Streamline and simplify with goals

1. Take extra time to understand the client's goals and perspective before launching in with psychoeducation or intervention
2. This will take more time initially, but will save you and the client much time and effort in the long run
3. Start with the client's goals for their **life** (not just treatment goals)

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Client's goals for their life

- **Ideas for clients who have trouble identifying life goals:**
  - Remember they may never have had a peaceful or happy life: you will need to help them! It is ok to start small – e.g., start with what they **don't** want
  - Remember they have trouble seeing a positive future and believing they can get to it by definition – part of your job is to help model goal persistence
  - Resources: values sorts, "vision statements", positive psychology blogs, visual cues, characters who have what they want (or don't want)

- **Ideas for clients who have trouble identifying treatment goals:**
  - As you begin to introduce behavioral activation and exposure, it is critical to make sure you articulate how these therapy goals will help the client achieve their life goals

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Idea 2: "Common factors" to help build your alliance and help your client hold hope

1. Normalize the experience of experiencing both generalized anxiety and depression, and validate the difficulty of it
2. Let your client know that while it is difficult, people do recover from anxiety and depression
3. If possible, help your client imagine themselves feeling negative emotion **and** having power to persevere until they get the life they want
4. Take time to get buy-in to the treatment process; it will help clients to know that the process will involve many steps and is rarely linear

- A friend to talk to
- A few hobbies that I like
- Financial stability
- Feeling comfortable in my own skin

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Using medicines to support therapeutic targets

Q&A Please use the Q&A feature to send your questions to the moderator.

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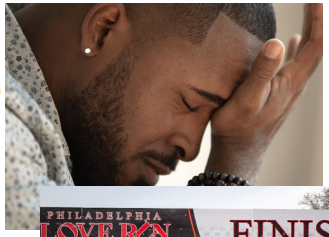
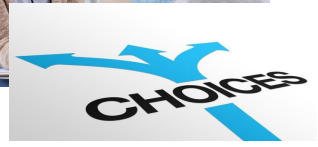
Why pharmacotherapy?





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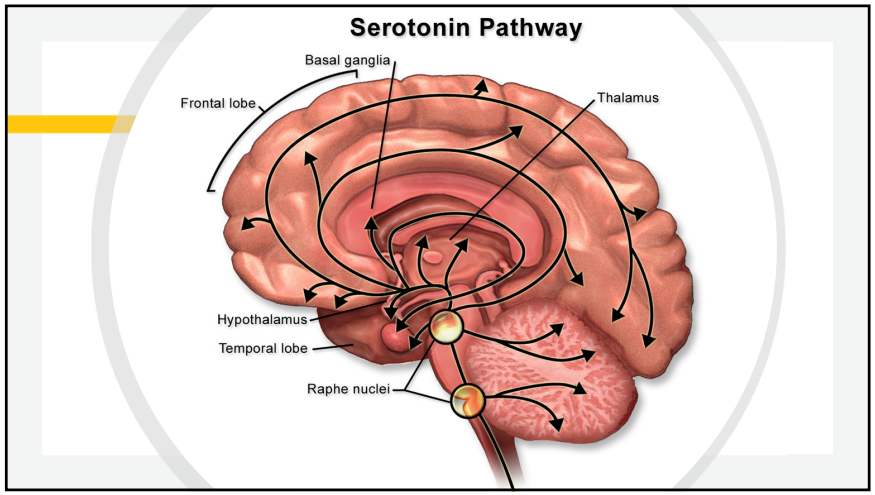

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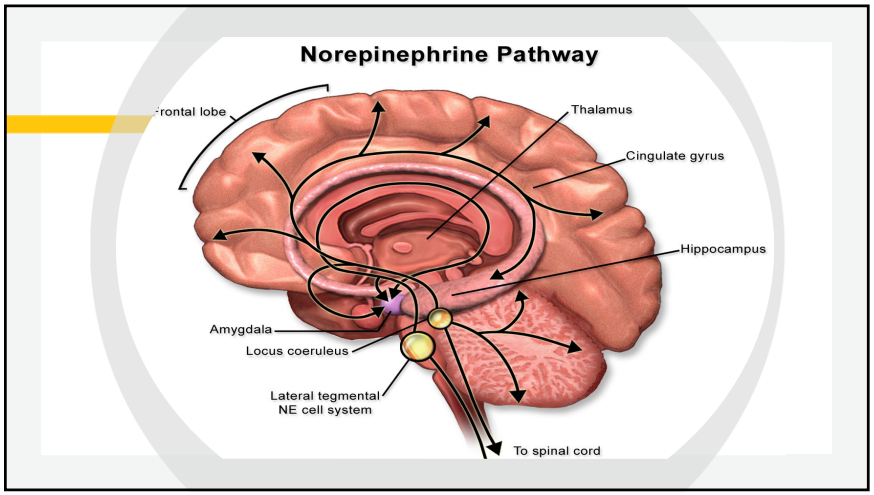

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Fluoxetine
Levomilnacipran
Tranylcypromine
Escitalopram
Isocarboxazid
Clomipramine
Sertraline
Nortriptyline
amoxapine
Nefazodone
Duloxetine
Fluvoxamine
Bupropion/budeprion
Trazodone
desipramine
Paroxetine
Mirtazapine
Selegiline
Trimipramine
Protriptyline
Vortioxetine
Venlafaxine
Maprotiline
Citalopram
Vilazidone
Phenelzine
Desvenlafaxine
doxepin
Amitriptyline

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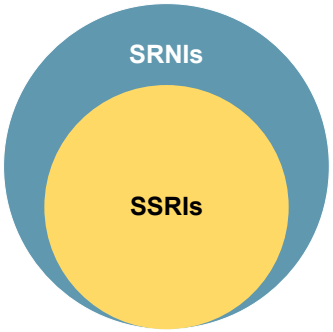
Most common medications for MDD and GAD

SSRIs
- Fluoxetine (MDD)
- Sertraline (MDD)
- Citalopram (MDD)
- Escitalopram (MDD, GAD)
- Paroxetine (MDD, GAD)
- Fluvoxamine (OCD)

SNRIs
- Venlafaxine (MDD, GAD)
- Desvenlafaxine (MDD)
- Duloxetine (MDD, GAD)



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Additional agents

Combination agents

- Mirtazapine
- Vortioxetine
- Vilazidone
- Bupropion/budeprion
- Nefazodone
- trazodone

Tricyclic antidepressants

- Amitriptyline
- Clomipramine
- Imipramine
- Desipramine
- Trimipramine
- Protriptyline
- nortriptyline

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Monoamine oxidase inhibitors (MAOIs)

- Isocarboxazid
- Phenelzine
- Tranylcypramine

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Anxiolytics and hypnotics

Anxiolytics

- Benzodiazepines
  - Alprazolam
  - Clonazepam
  - Lorazepam
  - temazepam
- Buspirone
- Gabapentin
- Pregabalin

Hypnotics

- Trazodone
- Antihistamines
- Z-drugs
  - Zolpidem
  - Zaleplon
  - Eszopiclone
- TCAs
- melatonin

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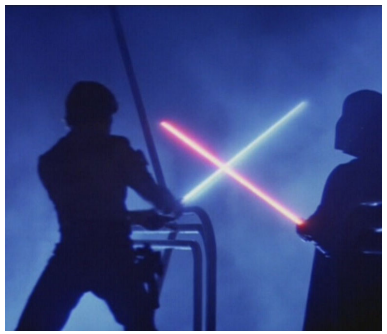
Battle of the benzos

Pros:

- Very effective
- Facilitate therapeutic alliance
- Bridge until other medications take effect

Cons:

- Sedation
- Misuse
- Overdose
- Falls
- May be difficult to discontinue
- Controlled medication



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Nonbenzodiazepine alternatives

- Buspirone
- Gabapentin
- Pregabalin
- Beta-blockers
- Antihistamines
- TCAs
- Atypical antipsychotics

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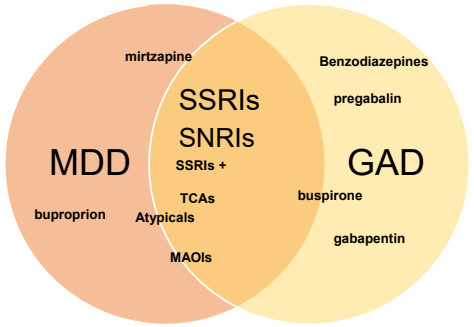
Combination treatment



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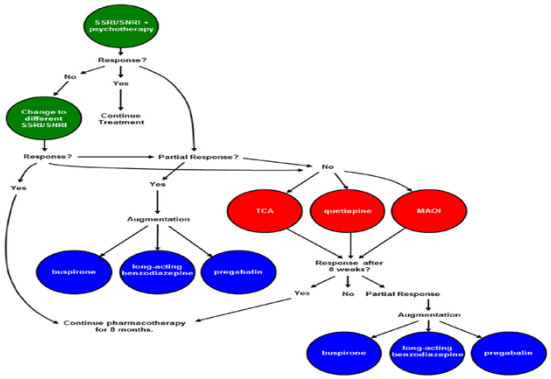

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Treating children and adolescents

Considerations

- Black box warning for suicidal thoughts and behaviors
- Closer monitoring required
- Dosing starts lower
- Final dose often may be quite robust
- Differences in metabolism
- Changing doses based on growth, pubertal status, and brain development
- Generally avoid paroxetine and venlafaxine

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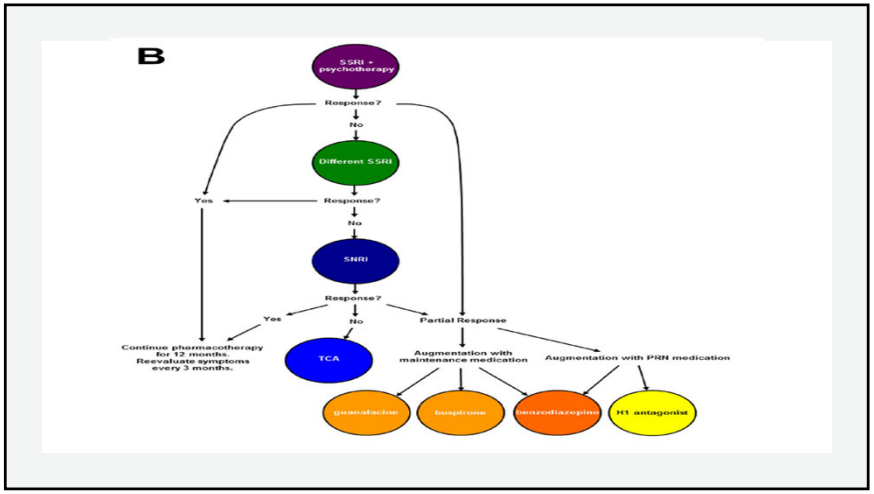

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Weaving exposure and behavior activation together

Please use the Q&A feature to send your questions to the moderator.

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Idea 3: Build a personalized treatment plan by categorizing emotional reactions to each goal and overall

- A friend to talk to
- A few hobbies that I like
- Financial stability
- Feeling comfortable in my own skin

Makes me anxious; needs its own exposure hierarchy

I don't know what I like to do but can "sample" once I make a list – think it's just getting out of bed

Makes me anxious and depressed to even think about this

I don't even know what that means for me really – maybe looking better

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Personalized treatment plan

Behavioral Activation

Talk in therapy about finances – practice tolerating uncertainty

Exposure

Hobbies

- Book up a book on hobbies at the library and try one thing (2)
- Try drawing (4)**
- Cook something for dinner (5)
- Take a walk outside (6)

Friends

- Text my old co-worker to say hi (2)
- Text my old friend back (3)
- Text my old friend back and think "they might not want to talk to me, I'll never know for sure" (5)
- Call Starbucks and ask for the hours in a friendly way (4)
- Practice small talk in therapy (5)
- Practice small talk with someone at the grocery store (6)
- Record myself practicing a video chat to see how I'd look on zoom (7)

Exposure

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Re-orient to goals consistently

1. **Now that you have treatment goals, a therapeutic alliance, and the start of a treatment plan….go back to goals!**
   Clients with co-occurring GAD and MDD will typically need help re-focusing on the big picture until they get some traction and success. Constantly link what you are working on in the session (and their homework) to their big-picture goals.
2. **Avoid a disappointed, punitive, or overly clinical tone at all costs.**
   Strive to model persistence towards the goal no matter what and model an optimistic tone that shows you believe in them.

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Think strategically about sequencing

Exposure first:

- High-value targets or goals that the client is likely to experience quick success or learning to (phobic stimuli) for quick success
- If the client is very motivated to work on a fear
- If the fear is preventing the client from engaging in other valued routines, activities, etc.
- When the client becomes anxious related to BA targets

Behavioral Activation first:

- If the client is so depressed they are likely to lack energy to engage in exposure
- If the client's relationships will be impaired by their lack of ADLs
- If the client is motivated to work on BA
- If the client's anxiety is more "free form" and unlikely to interfere with their BA targets

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Weave BA and exposure together if needed

BA target		Exposure
Make a friend	→	Talk to people, eye contact, small talk, etc.
Apply for jobs	→	Tolerate the uncertainty involved in the process; tolerate the social exposure; learn I can tolerate the feeling of "putting myself out there"
Go hiking	→	Practice going places without constant connection with parents through text

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role play

/ˈrōl ˌplā/

verb

1. Act out or perform the part of a person or character, for example as a technique in training or psychotherapy.

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A last hopeful data point

- Shamblaw, Rumas & Best (2021) examined 797 participants cross-sectionally and longitudinally (n=395) to determine what was the most helpful coping
- 14 different coping strategies were categorized as “approach” or “avoidance” based.
- Avoidance coping was associated with higher depression, higher anxiety, and lower quality of life at baseline, and increased depression and anxiety over time.
- Approach coping was associated with lower depression and better quality of life at baseline but not over time.
- Further, depression and anxiety significantly mediated the association between coping and quality of life. Of the specific coping strategies examined, “positive reframing” was the most beneficial, suggesting that interventions focusing on reframing negative aspects of the pandemic may be most beneficial to improve general well being.

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A nod to our colleagues studying integrated models

- Unified Protocol for Emotional Disorders (Barlow, Farchinoe, Bullis et al, 2017)
- Modular Treatment protocols for youth (Chorpita et al, 2013).

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Time for questions and answers…

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Where to get additional information…

ANXIETY AND DEPRESSION ASSOCIATION OF AMERICA

www.adaa.org

ABCT ASSOCIATION for BEHAVIORAL and COGNITIVE THERAPIES

www.abct.org

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About the presenters….

Brett Johnson, MD
Psychiatrist, San Diego
Dr. Johnson is board-certified in both child and adolescent and adult psychiatry. He is trained and has treated many patients with both cognitive-behavioral therapy and exposure and response prevention; he firmly believes in combination treatment, integrating both therapy and medications, when indicated. Dr. Johnson has trained residents and fellows, including leading the advanced psychopharmacology seminar for trainees for many years..

Stacy Shaw Welch, PhD
Clinic Director, Seattle
Dr. Welsh provides clinical leadership and direction for Rogers Behavioral Health's Seattle area location. She has extensive clinical experience working with children, adolescents, and adults with obsessive compulsive disorder (OCD), anxiety disorders, trauma (PTSD), depression, body focused repetitive behaviors, tic disorders, and Tourette Syndrome. Dr. Welch is also an Adjunct Assistant Professor at the University of Washington, where she teaches on child and adolescent anxiety and provides didactics.

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