Strategies for Managing Depression

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Presenter Disclosures

Dr. Karen Anderson

The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

Lundbeck
Teva
Overview

• Symptoms of depression
• Depression versus apathy
• Nonpharmacological treatments
• Medication treatments
• Suicide
Depression

- Common in early stages of disease
- May worsen as condition progresses
- May be confused with apathy—by families and clinicians
FIGURE 1. Prevalence of Depressed Mood

Craufurd (23)
Kulisevsky (17)
Leroi (19)
Murgod (20)
Paulsen (18)
Paulsen (21)

Percent

van Duijn et al, 2007
Depression

• Losses may contribute- loss of loved ones, home, independence

• Caregiver depression can be “projected” as patient depression
Depression

• Besides sadness:
  - decreased appetite
  - feel life not worth living
  - poor concentration
  - low energy
  - sleep changes
Depression

- Does not always look like Sadness:

May appear more like:
- Irritability
- Anxiety
- Anger
- Resenting Care partners

Cummings et al, 1999
Impact of Depression

- **Faster progression**
- Greater memory decline
- Lower quality of life
- Increased burden
- Decreased ability to care for self
- Negative focus

“You can wrap it up in a pretty package, but it's still life.”
Depression-Evaluation

• Low mood, feelings of guilt, tearfulness, hopelessness, irritability, loss of interest in activities, loss of enjoyment

• Appetite and sleep (both may be increased or decreased)

• Has patient’s personality changed?
Depressed Mood - Other Factors

• Sleep disorder in HD causing low mood

• Recent “loss” such clinician telling them can no longer drive, work, care for family

• Death of affected family member/anniversary of parent’s death from HD

• Participation in treatment study ending
Depression versus Apathy

• Sad mood?

• Loss of enjoyment versus enjoys once starts an activity?

• Consider trial of an antidepressant?

• Some antidepressants can make apathy worse
Tetrabenazine and Depression

• Used to treat chorea in HD

• Tetrabenazine (TBZ) interferes with dopamine, serotonin, norepinephrine in the brain

• If depression or suicidal thinking occurs, TBZ should be reduced

• Depression can be delayed effect, weeks or months
Nonpharmacological therapies

- Not everyone tolerates antidepressants
- Not everyone responds to antidepressants
- Polypharmacy is an issue
- Patients and families may desire counseling to help with coping with illness
Nonpharmacological therapies

• More activities/more structure

• Exercise

• Hobbies that are able to do

• Outdoor time

• Supportive Talk Therapy
Cognitive Behavioral Therapy

- Thoughts cause feelings and behaviors, NOT external things (people, situations, and events)

- Catch, label and re-evaluate negative feelings

- Thoughts of dependency, being a burden, isolation are common targets

- May be extremely helpful for carepartner
Mindfulness

• Goal- reduce physical and emotional stress, and enhance day-to-day well-being

• Mindfulness = paying attention on purpose, non-judgmentally, to the present moment, internally and externally
Mindfulness Based Stress Reduction

• Be aware of experiences, rather than becoming consumed by them

• More purposeful choices, instead of reacting automatically (often with adverse consequences) to things you cannot control
Depression Treatment

• Choice of treatment depends on side effect profile for particular individual

• Response to treatment is not always steady, never immediate
Antidepressants

- **SSRIs** - more (paroxetine, fluoxetine, citalopram) versus less sedating (sertraline)

- **Vilazodone** - selective serotonin reuptake inhibitor (SSRI) and a 5-HT1A receptor partial agonist - reduce sexual side effects

- **SNRIs** (e.g. venlafaxine) - cognitive effects

- **Bupropion** - activating, may worsen irritability, anxiety and insomnia
Antidepressants

• **Mirtazepine**- noradrenergic and specific serotonergic antidepressant - sedating, increase appetite

• **Tricyclics**- cognitive effects, sedating, weight gain

• **Augmenting**- adding one antidepressant to another or adding another type of medication to help antidepressant work better (for example, adding a mood stabilizer)
Antidepressant Treatment Notes

- Time course of 4-6 weeks for efficacy
- MUST be taken REGULARLY
- Continue meds for 9-12 months AFTER sx in remission
- May stay on meds long term if history of severe depression, relapses
Suicide

• Elevated risk of suicide attempts and suicide completion in HD
  – Fourfold increase from the rate in the general population

• Suicide may be viewed as an “option” if a close relative has taken his/her own life

• Asking about suicidal thoughts does NOT cause someone to attempt suicide
Suicide

- Usual risk factors are important (childless, single, substance abuse, owning weapons)

- BUT- often impulsive, unpredictable
Suicide- Means Reduction

• Keep guns and bullets separated and locked up, remove guns from home if possible

• Have family members keep medications and dispense only daily doses

• Example: Golden Gate Bridge- side with lower vs higher barrier

• Reduce opportunities for IMPULSIVE attempts
Team Based Care for Depression

- Multiple clinicians with differing specialties
- Communication between different doctors/other clinicians is key
Georgetown HD Care, Education and Research Center
Resources

- HDSA Guide Understanding Behavior

- HDSA Center of Excellence, MedStar Georgetown: Hope Heller, LICSW, (202) 444-0816 or (202) 687-1366
  [hope.heller@medstar.net](mailto:hope.heller@medstar.net)

[https://neurology.georgetown.edu/research/hdcerc](https://neurology.georgetown.edu/research/hdcerc)
Resources

• Cognitive Behavioral Therapy

• Mindfulness