Psychiatric Corner: Ripping the Veil

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Objectives:

1. Participants will be able to identify symptoms of different mood and anxiety disorders commonly seen in a primary care setting.
2. Participants will be able to understand how mental health disorders affect medical treatment and health outcomes
3. Participants will learn different treatment considerations for common problems seen in mentally ill populations.

What is the Adverse Childhood Experiences (ACE) Study?

- Decade long, 17,000 people involved.
- Looked at effects of adverse childhood experiences over the lifespan
- Largest study ever done on this subject

Adverse Childhood Experiences are Common

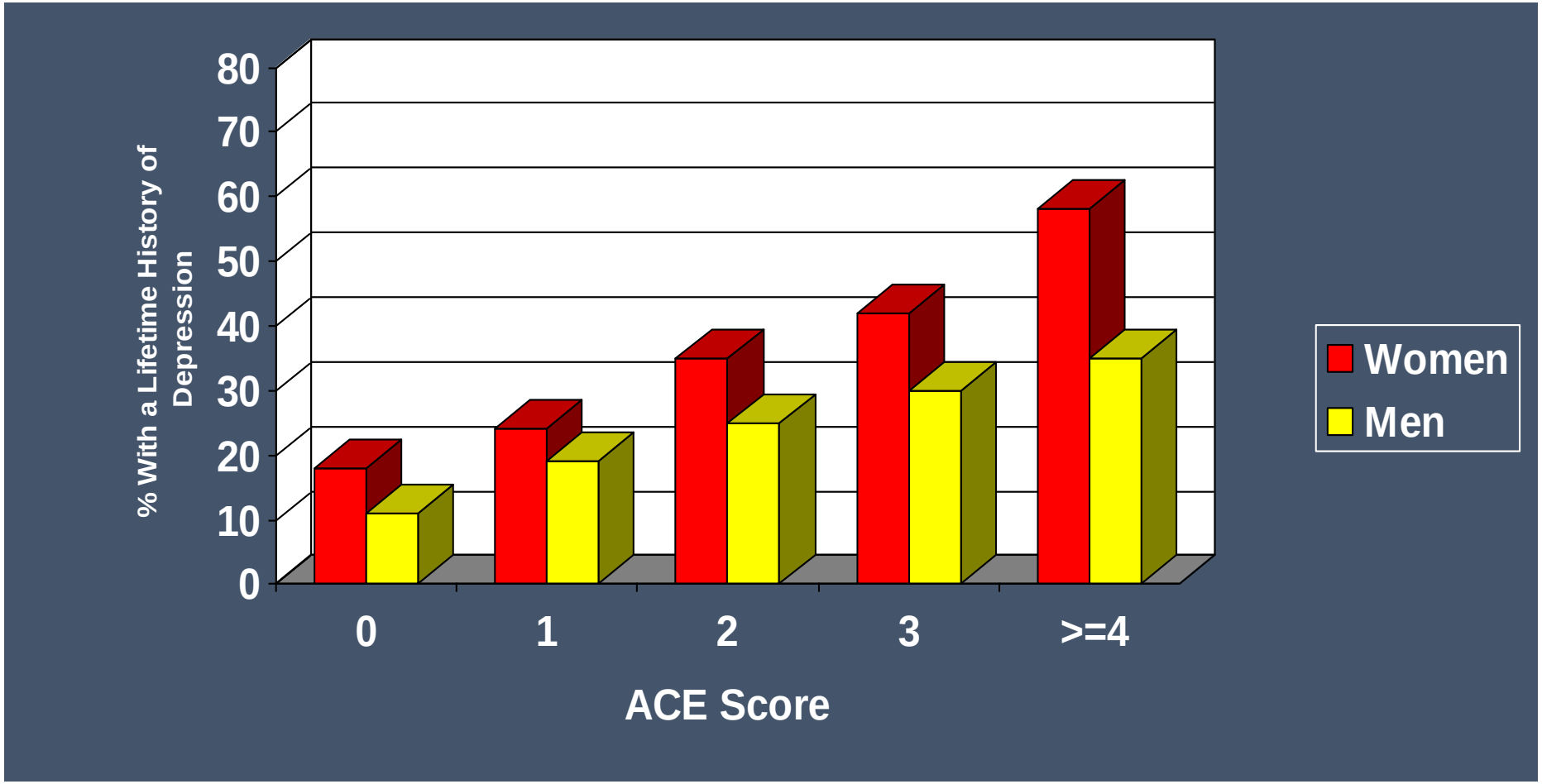
Of the 17,000 HMO Members:

- 1 in 4 exposed to 2 categories of ACEs
- 1 in 16 was exposed to 4 categories.
- 22% were sexually abused as children.
- 66% of the women experienced abuse, violence or family strife in childhood.

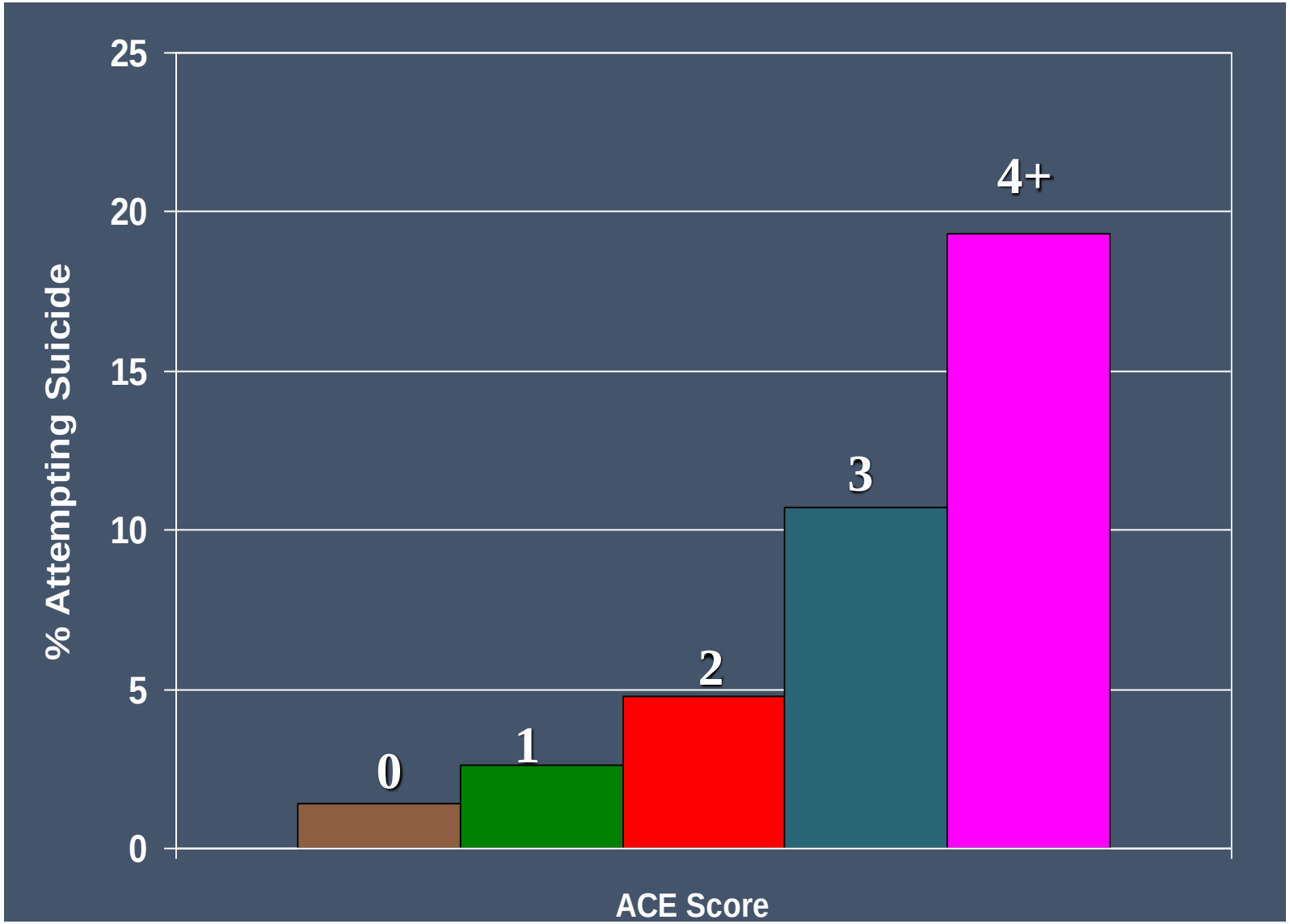
The higher the ACE Score, the greater the likelihood of :

- Severe and persistent emotional problems
- Health risk behaviors
- Serious social problems
- Adult disease and disability
- High health and mental health care costs
- Poor life expectancy

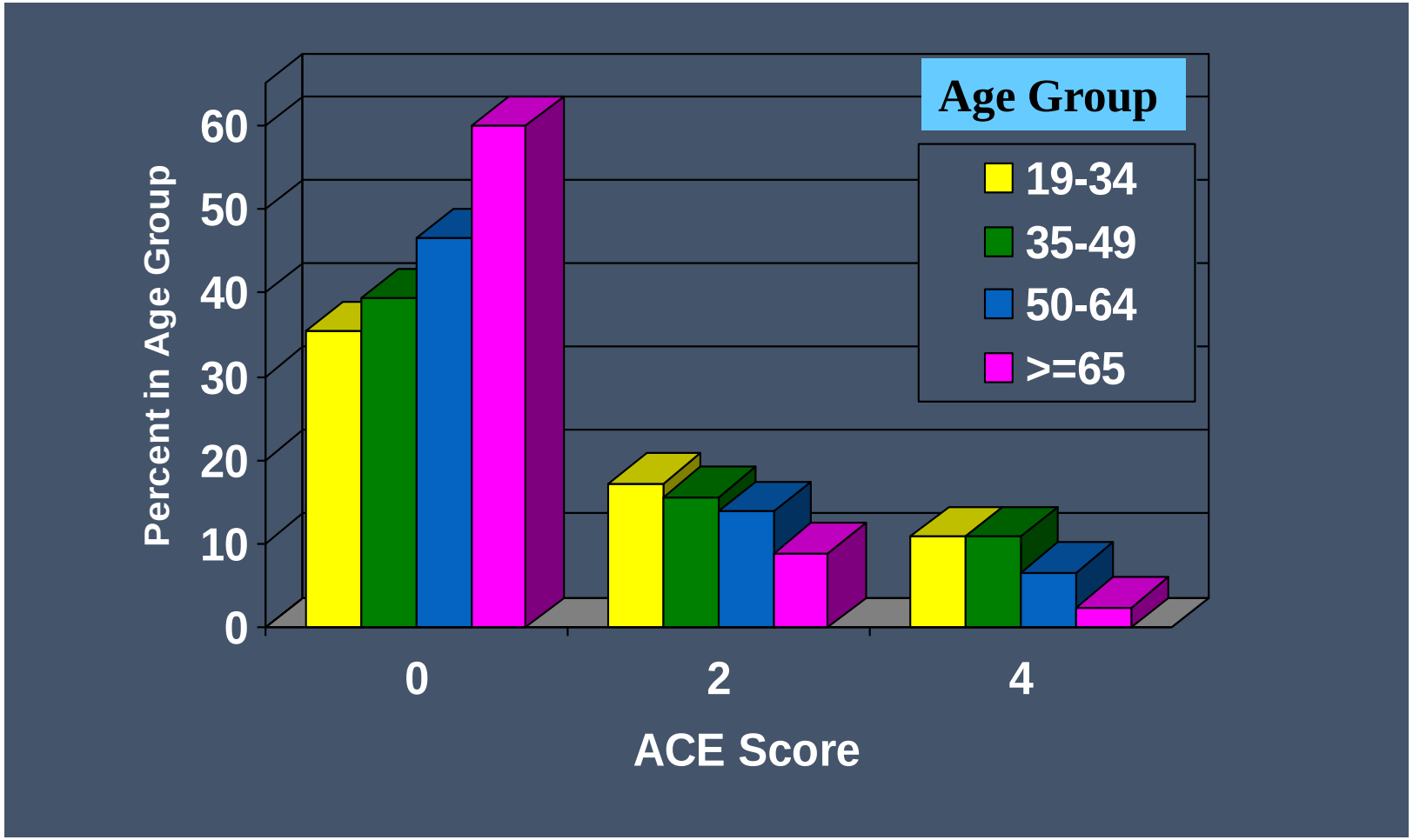
Childhood Experiences Underlie Chronic Depression

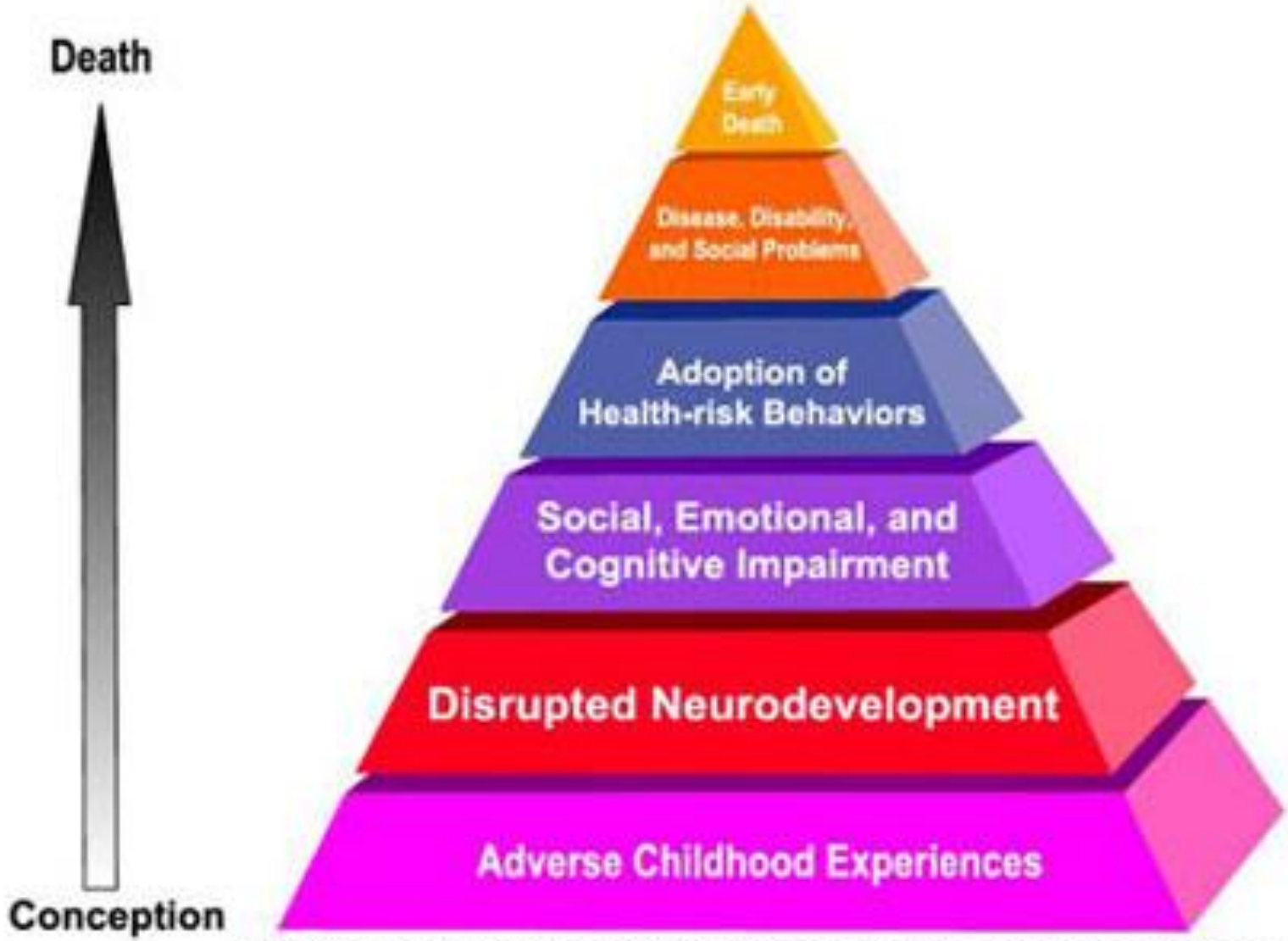


Childhood Experiences Underlie Suicide



Effect of ACEs on Mortality





Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

ACE Study

- www.cdc.gov/nccdphp/ace
- www.acestudy.org

The Need for Mental Health Promotion & Services

An estimated 9 to 13% (ages 9-17) have serious diagnosable emotional or behavioral health disorders (Friedman, 2002)

Strong need for early intervention programs:

- Children who are identified as hard to manage at ages 3 and 4 have a high probability (50:50) of continued behavioral difficulties in adolescence (Campbell & Ewing, 1990; Egeland et al., 1990; Fischer, Rolf, Hasazi, & Cummings, 1984)
- When aggressive and antisocial behavior has persisted to age 9, further intervention has a poor chance of success (Dodge, 1993)

Low Rates of Treatment Delivery

- Of the young children who show *early signs* of challenging behavior, fewer than 10% receive services for these difficulties (Kazdin & Kendall, 1998)
- Of the children and adolescents with a *diagnosable condition*, less than a third actually receive any type of treatment (Leaf et al., 1996)

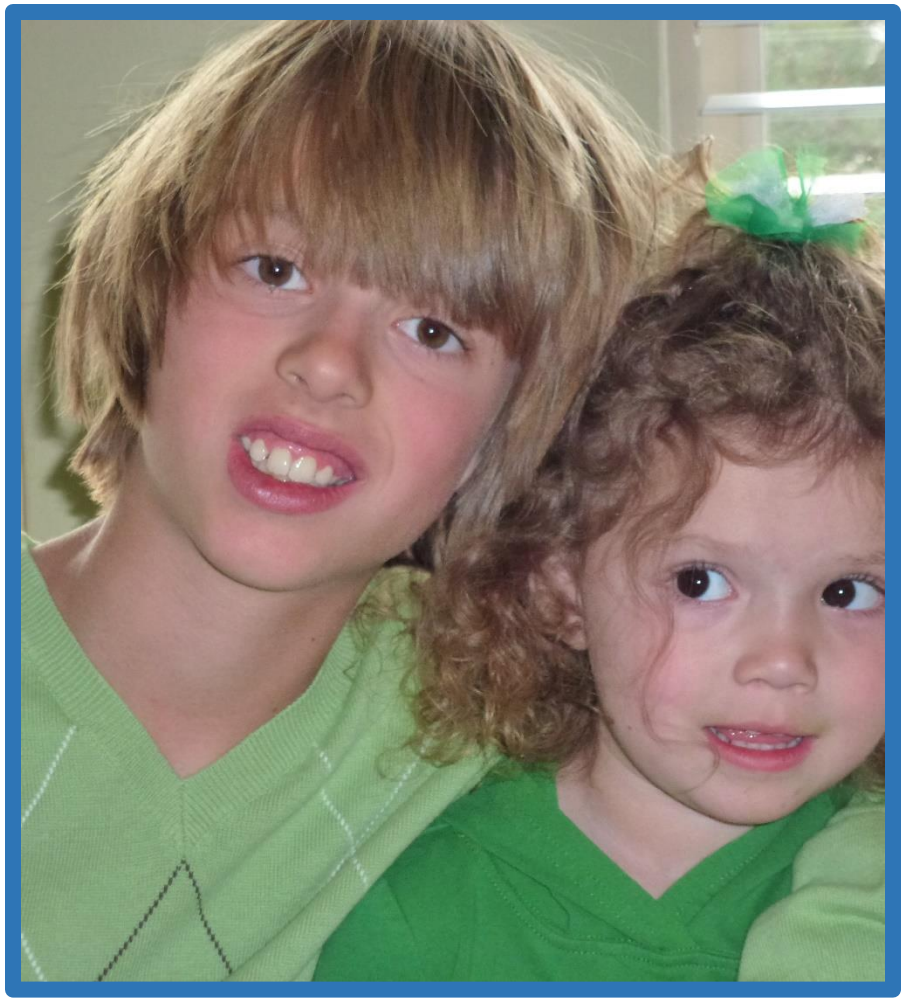
The 20/20 Problem

Up to 20% of children have diagnosable problems

Only about 20% of those having a problem receive services

The situation has not changed in 25 years

There are evidence based practices that are effective in changing this developmental trajectory…the problem is not what to do, but rests in where and how we can support children and help families access services



Social Programs that work in Early Childhood

- Nurse-Family Partnership (A nurse home visitation program for low-income, pregnant women)
- Triple P System (A system of parenting programs for families with children age 0-8)
- Abecedarian Project (High-quality child care/preschool for children from disadvantaged backgrounds)
- Perry Preschool Project (High-quality preschool for children from disadvantaged backgrounds)

http://evidencebasedprograms.org/wordpress/

Infants/Toddlers

For Infants- dysregulation of physiologic function

fussiness/colicky behavior

feeding and sleeping problems

failure to thrive

For Toddlers- behavioral disturbances

aggression/ defiance

impulsivity/ over activity

developmental delays

subtle physiologic, sensory, motor-processing problems

In other words

Infants and Toddlers

- Displays very little emotion
- Does not show an interest in sights, sounds or touch
- Rejects or avoids being touched or held or playing with others
- Unusually difficult to soothe or console
- Unable to comfort or calm self
- Extremely fearful or on-guard
- Does not turn to familiar adults for comfort or help
- Exhibits sudden behavior changes

In other words

Preschool Children

- Cannot play with others or objects
- Absence of language or communication
- Frequently fights with others
- Very sad
- Unusually fearful
- Inappropriate responses to situations

In other words

Preschool children

- Withdrawn
- Extremely active
- Loss of earlier skills
- Sudden behavior changes
- Very accident prone
- Destructive to self and/or others

Causes of Disruptive Behavior Problems in Childhood

- All disorders are on a continuum ranging from normal variation in behavior to a clinically significant problem
- No single cause for any disorder
- No single treatment for any disorder

Signs of Depression

- Frequent sadness, tearfulness, crying
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Hopelessness
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self esteem and guilt
- Extreme sensitivity to rejection or failure

Signs of Depression

- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self destructive behavior

Anxiety

Symptoms of separation anxiety include:

- constant thoughts and intense fears about the safety of parents and caretakers
- refusing to go to school
- frequent stomachaches and other physical complaints
- extreme worries about sleeping away from home
- being overly clingy
- panic or tantrums at times of separation from parents
- trouble sleeping or nightmares

Anxiety

Symptoms of phobia include:

- extreme fear about a specific thing or situation (ex. dogs, insects, or needles
- the fears cause significant distress and interfere with usual activities
- *Symptoms of social anxiety include:*
- fears of meeting or talking to people
- avoidance of social situations
- few friends outside the family

Anxiety

- many worries about things before they happen
- constant worries or concerns about family, school, friends, or activities
- repetitive, unwanted thoughts (obsessions) or actions (compulsions)
- fears of embarrassment or making mistakes
- low self esteem and lack of self-confidence

What we see:

24% of patients presenting to a primary care provider have a well defined ICD-10 mental disorder

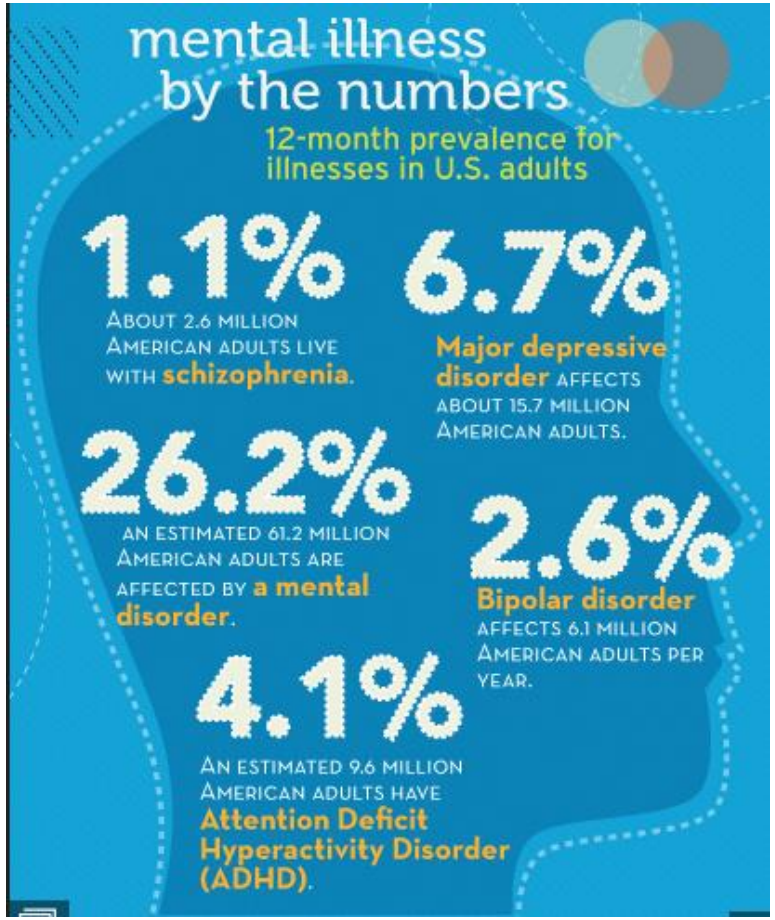
- 69% of these patients present with physical symptoms

Common mental health issues include:

- Depression
- Anxiety
- Alcohol use disorder
- Sleep problems
- Chronic tiredness
- Unexplained somatic complaints

Interactions between Mental Health and Physical Health

- Poor mental health is a risk factor for chronic physical conditions
- People with serious mental health conditions are at high risk of experiencing chronic physical conditions
- People with chronic physical conditions are at risk of developing poor mental health



Mental Illnesses are risk factors that affect the incidence and prognosis of diseases

- Patients with type II diabetes mellitus are twice as likely to experience depression as the general population
  - patients with diabetes who are depressed have greater difficulty with self-care
  - depression is associated with poorer glycemic control
- Patients suffering from mental illness are twice as likely to smoke cigarettes as other people
- In patients with chronic obstructive pulmonary disease, mental illness is linked to poorer clinical outcomes
  - Anxiety is the strongest predictor of poor functional outcomes and quality of life in COPD
- Up to 50% of cancer patients suffer from a mental illness, especially depression and anxiety
  - treating symptoms of depression in cancer patients may improve survival time
- In patients who are depressed, the risk of having a heart attack is more than twice as high as in the general population
  - Treating the symptoms of depression after a heart attack has been shown to lower both mortality and re-hospitalization rates
- Depression increases the risk of death in patients with cardiac disease
- Up to 20% of all patients presenting with a diagnosed depressive syndrome may also have OSA, and vice versa

Chronic medical morbidities are more common in those with mental health problems

Table 1. Risk of People with a Mental Illness Developing Specified Chronic Physical Conditions

Chronic Physical Condition	Relative Risk (RR) or Odds Ratio (OR) or Standardized Incidence Ratio (SIR)	Type of Study and Source
Diabetes	RR = 1.6 for people with depression	Meta-analysis B. Mezuk, W.W. Eaton, S. Albrecht and S. Hill Golden, "Depression and Type 2 Diabetes over the Lifespan," *Diabetes Care* 31, no. 12 (2008): 2383-2390.
Heart Disease	RR = 1.6 for people with depression	Meta-analysis R. Rugulies, "Depression as a Predictor for Coronary Heart Disease: A Review and Meta-Analysis," *American Journal of Preventive Medicine* 23 no. 1 (2002): 51-61.
Stroke	RR = 3.1 for people with depression	Prospective study S.L. Larson, P.L. Owens, D. Ford and W. Eaton, "Depressive Disorder, Dysthymia, and Risk of Stroke: Thirteen-Year Follow-Up from the Baltimore Epidemiologic Catchment Area Study," *Stroke: Journal of the American Heart Association* 32, no. 9 (2001): 1979-1983.
COPD	OR = 3.8 – 5.7 for people with schizophrenia, schizoaffective disorder, major depressive disorder or bipolar disorder	Cross-sectional study S. Himelhoch et al., "Prevalence of Chronic Obstructive Pulmonary Disease among Those with Serious Mental Illness," *American Journal of Psychiatry* 161, no. 12 (2004): 2317-2319.
Breast Cancer	OR = 1.5 for people with schizophrenia	Retrospective Study J. Hippisley-Cox, Y. Vinogradova, and C. Coupland, "Risk of Malignancy in Patients with Schizophrenia or Bipolar Disorder," *Archives of General Psychiatry* 64 no. 12 (2007): 1368-1376.
	SIR = 1.2 for people with schizophrenia	Retrospective study D. Lichtermann et al., "Incidence of Cancer among Persons with Schizophrenia and Their Relatives," *Archives of General Psychiatry* 48, no. 6 (2001): 573-578.
Colon Cancer	OR = 2.9 for people with schizophrenia	Retrospective Study (Hippisley-Cox et al., 2007)
	SIR = 0.9 for people with schizophrenia	Retrospective study (Lichtermann et al., 2001)
Lung Cancer	OR = 0.59 for people with schizophrenia	Retrospective Study (Hippisley-Cox et al., 2007)
	SIR = 2.2 for people with schizophrenia	Retrospective study (Lichtermann et al., 2001)

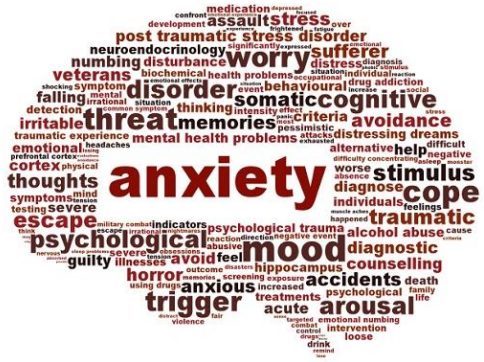
Depression

- Is there:
  - Low mood/sadness
  - Loss of interest or pleasure
  - Decreased energy or increased fatigue
- If Yes to any above, ask about
  - Sleep disturbance
  - Appetite disturbance
  - Concentration difficulty
  - Increased or decreased motor activity
  - Decreased libido
  - Loss of self confidence/esteem
  - Thoughts of death/suicide
  - Increased Guilt

- Indicates clinical depression if:
  - Positive for any of first three
  - PLUS at least 5 of the remaining
  - At least two week duration
  - Most of the time

Anxiety

- Is there:
  - 1) Feeling tense or anxious
  - 2) Worrying about a lot of things
- If yes to the above, ask about:
  - 3) Symptoms of arousal and anxiety
  - 4) Unclear cause of intense or unexpected fear:
    - Dying
    - Losing control
    - Pounding heart
    - Trembling/shaking
    - Chest pain/difficulty breathing
    - Feeling dizzy, lightheaded or faint
    - Numbness or tingling sensations
    - Feelings of unreality
    - Nausea



- 5) Experience of fear or anxiety in specific situations
  - Leaving familiar places
  - Traveling alone
  - Public/confined places
- 6) Experience of fear/anxiety in social situations
  - Speaking in front of others
  - Social events
  - Eating in front of others
  - Worry a lot about that others think/self conscious

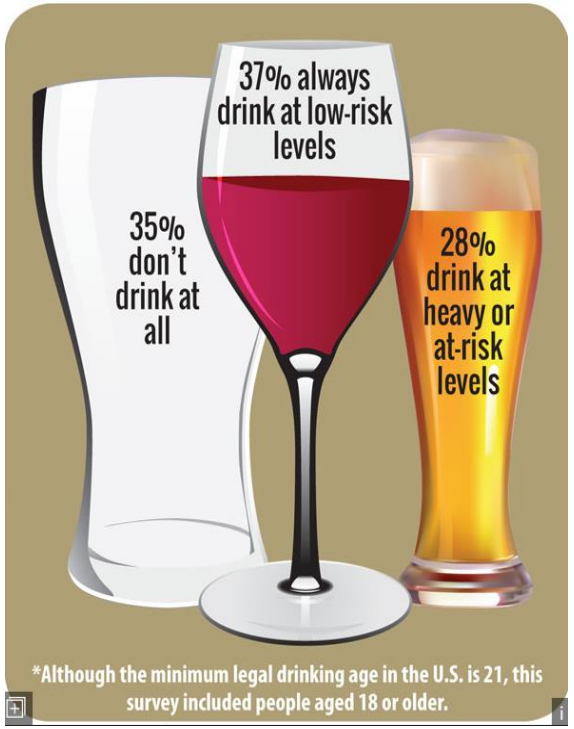
- Positive for 1 and 2 only: Generalized Anxiety disorder
- Positive for 1 and 3: Panic Disorder
- Positive for 1 and 4: Agoraphobia
- Positive for 3 and 6: Social Phobia

Random Phamacotherapy Pearls:

- SSRIs are beneficial for depression and anxiety
  - Lower doses may enough to target depression
    - ex: 50mg of sertraline
  - Higher doses may be needed to target anxiety
  - ex: 150mg -200mg of sertraline
- Effexor can be helpful for pain, but may need to be in higher doses than often prescribed
  - “true” SNRI activity around 150mg -225mg of Venlafaxine
- Mirtazapine is a better sleep aid at 7.5-15mg compared to higher doses better for mood.
  - Causes RLS in 30% of patients
  - Does not have anticholinergic effects
  - Can be a good adjunct in PTSD treatment
- Wellbutrin is the antidepressant least likely to cause RLS, excessive limb movements in sleep, or REM sleep behavior disorder (acting out dreams)
  - Less likely to cause fatigue or GI side effects
  - May increase insomnia if taken after 3pm
- If a patient has RLS symptoms, check ferritin.
  - If less than 50, given iron supplementation with vit C for better absorption x 3 months then recheck.
- Gabapentin and lyrica can be anxiolytic, decrease neuropathic pain, and increases slow wave (deep sleep)
- Benzodiazapines increase brain activity associated with wakefulness during sleep.
- Antidepressants may not be as effective when there is an active inflammatory process present
- Abilify has unique properties compared to other antipsychotics
  - Partial dopamine agonist/antagonist
  - Does not clearly prolong Qtc like other antipsychotics
  - Can be helpful adjust for treatment resistant depression

Alcohol Use Disorder

- Ask About:
  - 1) Number of standard drinks in a typical day when drinking
  - 2) Number of days per week having alcoholic drinks
- If 1) x 2) above is greater than 14 drinks/week for men and greater than 7 drinks/week for women:
  - 3) Have you been unable to stop, reduce, or continue your drinking?
  - 4)Have you ever had such a strong urge to drink that you could not resist it?
  - 5)Did stopping or cutting down on your drinking cause you problems such as:
    - The shakes
    - Being unable to sleep
    - Feeling nervous or restless
    - Sweating
    - Heart beating fast
    - Headaches
    - Fits or seizures
  - 6) Have you ever continued to drink when you know that you had problems that can be made worse by drinking?
  - 7) Has anyone expressed concern about your drinking?
- Is there an alcohol use problem?
  - If 1) x 2) is greater than 14 drinks/week for men and greater than 7 drinks/week for women:
    - Possible alcohol problem
  - If positive to 1) and any of 3) through 7):
    - Likely alcohol use problem



Sleep Problems

- First ask about:
  - Difficulty falling asleep
  - Restless or unrefreshing sleep
  - Frequent or long periods of being awake
- If yes:
  - 1) Do you have medical problems or physical pains
  - 2) Do you take any medication
  - 3) Do any of the following apply:
    - Drink alcohol, coffee, tea, soda, or eat before going to sleep?
    - Take daytime naps?
    - Changes to your routine (e.g., shift work)
    - Hear disruptive noises at night?
  - 4) Problems sleeping at least 3 times a week
  - 5) Has anyone told you that you snore?
  - 6) Do you get sudden uncontrollable sleep attacks during the day?
  - 7) Do you have low mood or loss of interest/pleasure?
  - 8) Are you worried/anxious/tense?
  - 9) How much alcohol do you drink in a typical week?

- Positive for any of the screening questions plus positive for any of 1) through 3):
  - Consider management of the underlying problem

- Positive to 4) is indicative of clinical sleep problem
- Positive to 5) consider sleep apnea
- Positive to 6) consider narcolepsy (and/or severe sleep apnea)
- Positive to 7) consider depressive disorder
- Positive to 8) consider anxiety disorder
- Positive to 9) consider alcohol use disorder

Chronic Tiredness

- First Ask:
  - Do you get tired easily?
    - Tired all the time?
    - Easily tired out after performing every day tasks?
    - Difficult to recover from the tiredness despite rest?
- If Yes:
  - 1) Do you have any medical problems of physical pains?
  - 2) Are you taking any medication?
  - 3) Do you have low mood or loss of interest/pleasure?
  - 4) Are you worried/anxious/tense?
  - 5) How much alcohol do you drink in a typical week?
  - 6) Are you doing too much at home and/or work?
  - 7) Do you fail to set time aside for leisure activity?
  - 8) Have you been having problems with sleep?

- Positive to any screening question:Indicates a fatigue problem
- Positive to 1) or 2): Consider management of the underlying problem
- Positive to 3): consider depressive disorder
- Positive to 4): consider anxiety disorder
- Positive to 5): is weekly intake of > 21 drinks for men and 14 drinks for women: consider alcohol use disorder
- Positive to 6) or 7): consider lifestyle change
- Positive to 8): consider sleep problem

Unexplained Somatic Complaints

- Is there:
  - Continuing aches or pains or other physical complaints for which a cause has not been found?
    - Nausea
    - Vomiting
    - Diarrhea
    - Shortness of breath
    - Chest pain
    - Headache
    - Abdominal Pain

- If Yes:
  - 1)Have you seen more than one doctor for these problems?
  - 2) Have you seen any specialists about these problems?
  - 3) Have you experienced these problems for more than 6 months?
  - 4) Do you have low mood or loss of interest or pleasure?
  - 5) Are you worried, anxious, or tense in general?
  - 6) How much alcohol do you drink in a typical week?

- Positive screening question and at least one positive from 1) through 3)
- More likely if negative to 4) through 6):
- Consider a somatic symptom disorder if:
  - medical test results are either normal or do not explain the person's symptoms
  - history and physical examination do not indicate the presence of a known medical condition that could cause them
  - patient must also be excessively worried about their symptoms, and this worry must be judged to be out of proportion to the severity of the physical complaints themselves.
  - requires that the subject have recurring somatic complaints for at least six months, and may last years
- Usually, the symptoms begin appearing during adolescence, and patients are diagnosed before the age of 30 years.
- Somatic symptom disorders are not the result of conscious malingering (fabricating or exaggerating symptoms for secondary motives) or factitious disorders (deliberately producing, feigning, or exaggerating symptoms).

Somatic symptom disorder is difficult to diagnose and treat

Explanations:

- One of the oldest theories is that it is a result of the body's attempt to cope with emotional and psychological stress.
    - symptoms are experienced as physical
        - principally affecting the digestive, nervous, and reproductive systems
            - headaches are known to be associated with psychological factors
            - stress and the hormone cortisol are known to have a negative impact on immune functions
            - more likely in people with irritable bowel syndrome
    - patients with SSD are more likely to have a mood or anxiety disorder.
    - increased incidence of SSD in women with a history of physical, emotional or sexual abuse
    - people with the disorder have heightened sensitivity to internal physical sensations and pain

Somatic symptom disorder is difficult to diagnose and treat

- A biological sensitivity to somatic feelings could predispose a person to developing SSD
- A person's body might develop increased sensitivity of nerves associated with pain and those responsible for pain perception, as a result of chronic exposure to stressors.
- Cognitive theories explain somatization disorder as arising from negative, distorted, and catastrophic thoughts and reinforcement of these cognitions.
  - Catastrophic thinking could lead a person to believe that slight ailments, such as mild muscle pain or shortness of breath, are evidence of a serious illness such as cancer or a tumor.
  - These thoughts can then be reinforced by supportive social connections.
    - A spouse who responds more to his or her partner's pain cues makes it more likely that he or she will express greater pain.
    - Children of parents who are preoccupied or overly attentive to the somatic complaints of their children are more likely to develop somatic symptoms.
  - Severe cognitive distortions can make a person with SSD limit the behaviors he or she engages in, and cause increased disability and impaired functioning.

Somatic symptom disorder is difficult to diagnose and treat

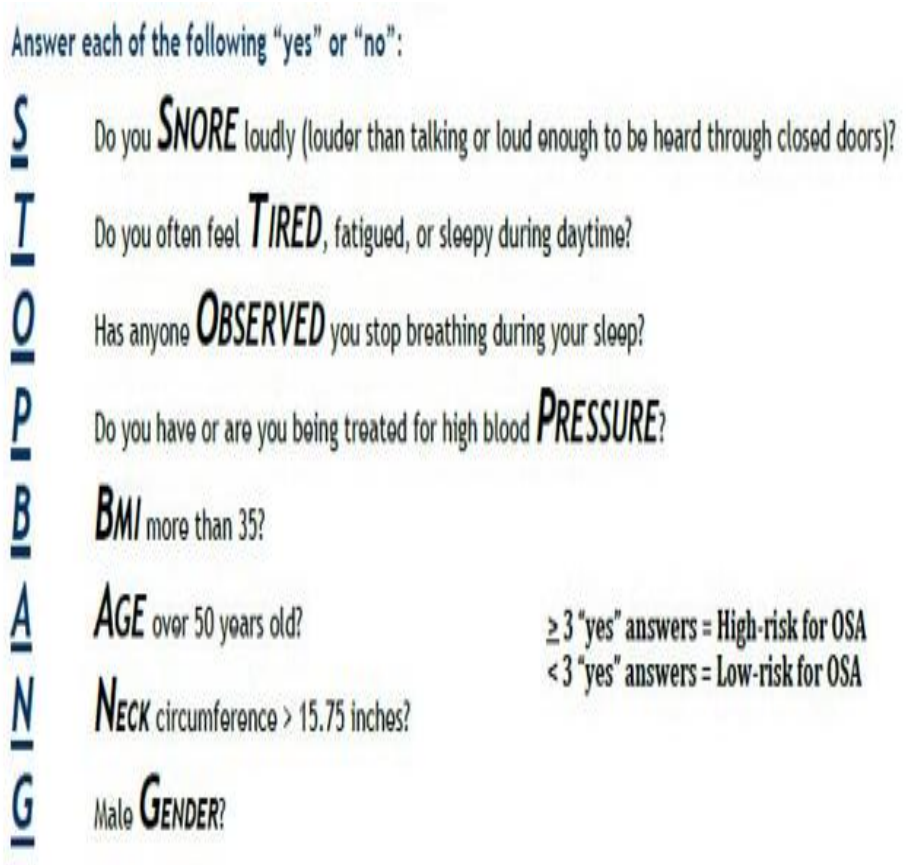
- To date, cognitive behavioral therapy (CBT) is the best established treatment for a variety of somatoform disorders
  - Aim is to help patients realize their ailments are not catastrophic
  - enables them to gradually return to activities they previously engaged in, without fear of "worsening their symptoms"
- Regular consultation and collaboration with the primary care physician also demonstrated some effectiveness
- The use of antidepressants does not yet show conclusive evidence
- Address a common difficulty in a patient’s reading of their own emotions
  - This may be a central feature of treatment

General Treatment Tips:

- Treat alcohol use disorder first if present
  - First evaluate willingness to change
  - Explore pattern of drinking to determine best approach
- Treatment for depression takes priority over anxiety or unexplained somatic complaints
- Treatment for anxiety takes priority over unexplained somatic complaints (which increase if both issues are present)
- If a patient is sleepy or fatigued and reports snoring, refer them to a sleep specialist to evaluate for sleep apnea
  - 86% of obese diabetic patients have undiagnosed sleep apnea

Obstructive sleep apnea can present as a mood or anxiety problem

- Poor sleep quality and sleep fragmentation has negative consequences on mood and memory
- Difficulty going to sleep and waking anxious during the night can be due to apneic breathing events and resultant oxygen desaturations
  - "Fight or flight response" during usual "rest and digest" time
- Waking too early in the morning is a sign of depression, of alcohol use disorder, and of obstructive sleep apnea



Untreated Sleep Apnea

1868 subjects followed 20 years

Incidence of multiple organ diseases higher in OSA Group:	32% with OSA	68% without OSA
• Hypertension:	79%	25%
• Coronary heart disease:	56%	24%
• Pulmonary heart disease:	6%	4%
• Stroke:	27%	7.5%
• Diabetes:	12%	5.4%

Referral to a psychiatrist should be considered in the following circumstances:

1. if the patient is expressing a suicidal intent or if there was a recent suicide attempt
2. if the patient is elderly, confused and presentation of the history is unclear
3. if the presenting symptoms of the disorder are severe, e.g., severe weight loss or weight gain , severe physical damage from drinking, severe withdrawal symptoms, several unsuccessful attempts to quit drinking.
4. if the diagnosis is not clear
5. if the treatment fails after the patient has received an appropriate medication trial
6. if the management requires hospitalization or intensive treatment e.g. extreme hostility, aggression or homicide
7. if there is of comorbidity with severe physical or other mental disorder

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