TOOLS FOR ADDRESSING MENTAL HEALTH DISORDERS IN PRIMARY CARE

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WE WILL EXAMINE THE FOLLOWING DISORDERS:

- Major Depressive Disorder
- Generalized Anxiety and Panic Disorder
- Bipolar Affective Disorder
- PTSD

OBJECTIVES

- 1. Identify psychiatric disorders that may require intervention at primary care.
- 2. Analyze the biological and psychosocial factors that can trigger, exacerbate or ameliorate symptoms of MDD, Anxiety & PTSD.
- 3. Explore the pathophysiology of MDD, Anxiety & PTSD.. Examine the common pharmacologic treatments and implications for primary care providers of these clients.

PRIMARY CARE AND MENTAL HEALTH

- Nearly 60% or patients receiving antidepressant therapy are receiving it in the primary care setting. (Barkeil-Otei, 2013)
- In 2016, the United States Preventive Services Task Force updated its recommendations for screening for depression in adults.

DIAGNOSING

- DSM 5 (2013)
  - Reorganized from Lifespan= Neurodevelopmental to Neurocognitive 20 Categories
- Anxiety disorders changed
  - OCD, PTSD separated and new stand alone categories

MOOD DISORDERS

- Major Depression
  - Change in DSM-5 now allows for bereavement
- Bipolar Disorder I & II

MAJOR DEPRESSIVE DISORDER

- http://www.youtube.com/watch?v=mlNCavst2EU

ASSESSMENT OF MOOD DISORDERS

- Changes in mood-previous level (happy to sad or very sad)
- Tearfulness
- Energy level
- Sleep Pattern /Appetite
- Speech and thought process
- Concentration
- Social & Occupational Functioning

BEREAVEMENT

Grief-process we go through with a loss (loved one, relationship, job, home etc)

Bereavement is the period of time one goes through grief following a death.

Prior to the DSM 5 a person would not meet the criteria for MDD if there had been loss due to a death in their life within 6-12 months. Now if the person is grieving but not processing through and meets MDD criteria one can diagnose depression.

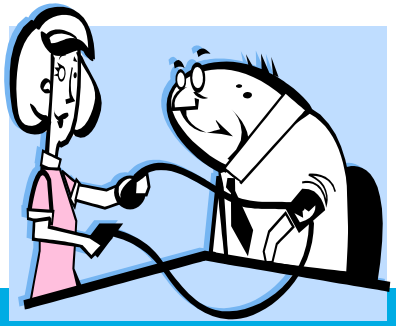
SCREENING TOOLS

- PHQ-9- http://www.phqscreeners.com
- Depression and Dysthymia-Children's Depression Inventory, Beck's Depression Scale, Hamilton Depression Rating Scale
- Bipolar Disorder- Mood Disorder Questionnaire, Young Mania Rating Scale
- www.integration.samhsa.gov/clinical-practice/screening-tools

CASE STUDY

- Maria, is a 42 yo H/F, who comes to the office with chief c/o difficulty concentrating, feeling edgy and irritable, not enjoying work, family or friends and poor quality sleep. She notes that these symptoms are causing a decline in work performance. What else do you need to assess?

OTHER DATA



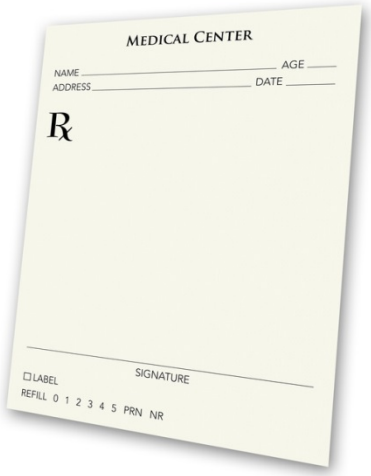
- PMH
- Social HX
- Family HX
- Mental Status Exam
- ROS-What should we rule out?

DIAGNOSIS & TREATMENT

- What is your diagnosis?

- How can we treat Maria?

TREATMENT MODALITIES



- Pharmacotherapy
- Psychotherapy
- Exercise
- Education

COUNSELING FOR DEPRESSION

- Psychotherapy
  - Cognitive-behavioral (CBT) and interpersonal (IPT) therapies used
- Group therapy
  - Helps decrease feelings of isolation, hopelessness, helplessness and alienation

PHARMACOTHERAPY

- SSRI's-Fluoxetine, Sertraline, Paroxetine, Fluvoxamine, Citalopram, Escitalopram, Vilazadone, Vortioxetine
- SNRI's-Venlafaxine, Desvenlafaxine, Milnacipran, levomilnacipran. NDRI-Buproprion
- NSSA-Mirtazipine
- TCA's-Imipramine, Amitryptyline, Desipramine

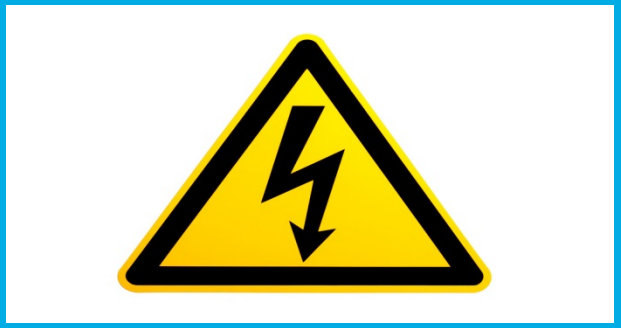
RISK/BENEFIT ANALYSIS

- Of the SSRI's only Fluoxetine and Sertraline have any FDA approved indications for children or adolescents.

- Current concerns: The FDA has recommended that all classes of antidepressants now include a warning that persons on antidepressants may need monitoring to assess for increased self-harm behaviors or suicide risk.

TREATMENT FOR DEPRESSION: ANTIDEPRESSANT MEDICATIONS

- Advantage
  - Can help alter withdrawan behavior, vegetative symptoms, activity level; improve self-concept
- Drawback
  - Can take 3-4+ weeks to note improvement



- **Safety considerations**
  - Concerns about relationship between use of antidepressant drugs and suicide; however, no conclusive evidence to support this

TREATMENT FOR DEPRESSION: SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)

- Action: selectively block neuronal uptake of serotonin
- Common adverse reactions
  - Agitation, anxiety, sleep disturbance, tremor, sexual dysfunction, headache, weight changes, nausea, diarrhea, dry mouth
- Potential toxic effect
  - Serotonin syndrome (SS): potentially fatal reaction when more than one antidepressant used

TREATMENT FOR DEPRESSION: TRICYCLIC ANTIDEPRESSANTS (TCAS)

- Action: inhibit reuptake of norepinephrine and serotonin by presynaptic neurons
- Dose: start low and gradually increase

- Common adverse reactions
  - Dry mouth, blurred vision, constipation, and urinary retention
  - Sedation
  - Potential dysrhythmias, hypotension, myocardial infarction

SYMPTOMS AND TREATMENT OF SEROTONIN SYNDROME (SS)

- Symptoms
  - Hyperactivity, severe muscle spasms, tachycardia leading to cardiovascular shock, hyperpyrexia, hypertension, delirium, seizures, coma, death
- Treatment
  - Stop offending agents
  - Provide respiratory, circulatory support in intensive care environment
  - Use medications to reverse excess serotonin: cyproheptadine, methysergide, propranolol

TREATMENT FOR DEPRESSION: NEWER ATYPICAL AGENTS

- Action: affect variety of NTs including those affecting serotonin and norepinephrine
- Advantage
  - Can target unique populations of depressed individuals
  - Can be used to treat other conditions

TREATMENT FOR DEPRESSION: MONOAMINE OXIDASE INHIBITORS (MAOIS)

- Action: enhance NTs at synapse by preventing the enzyme monoamine oxidase from breaking them down
- Common adverse reactions
  - Hypotension, sedation, insomnia, changes in cardiac rhythm, muscle cramps, sexual impotence, anticholinergic effects, weight gain
- Potential toxic reaction
  - Hypertensive crisis-Food triggers

HYPERTENSIVE CRISIS AND MAOIS

- Can occur when monoamine oxidase inhibition prevents the breakdown of tyramine, which is used by the body to make norepinephrine
- Preventing hypertensive crisis involves maintaining a special diet (low tyramine) and avoiding medications that contain ephedrine/other psychoactive substances

TREATMENT FOR DEPRESSION: SOMATIC TREATMENTS

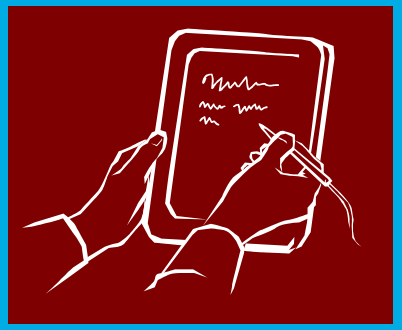
- Electroconvulsive therapy (ECT)
  - Course of treatment: 2 or 3 treatments/week for total of 6 to 12 treatments
  - For patients not responding to antidepressants or for depression with psychosis
  - Potential adverse reactions
    - Initial confusion and disorientation on awakening from treatment
    - Memory deficits
- Vagal Nerve Stimulation
- Transcranial Magnetic Stimulation (rTMS)

TREATMENT FOR DEPRESSION: INTEGRATIVE THERAPIES

- St. John's wort
  - Plant with antidepressant properties
  - Not regulated by FDA
  - Research suggests effective in mild depression
- Sam-E-herbal supplement, some evidence mild improvement.
- Exercise

TREATMENT PLAN

- Medication
- Psychotherapy
- Lifestyle modifications.



WHAT HELPS

- http://www.youtube.com/watch?v=DlV_QRHVSkg

TOOLKIT

- Please refer to http://www.guideline.gov/content.aspx?id=24158 for evidence based guidelines

BIPOLAR DISORDERS

BIPOLAR DISORDERS: PREVALENCE AND COMORBIDITY

- Prevalence
  - Lifetime prevalence in U.S. estimated at 3.9%
  - First episode typically between ages 18 and 30
- Comorbidity
  - Substance use disorders, personality disorders, anxiety disorders, attention deficit hyperactivity disorder
  - Medical conditions: cardiovascular, cerebrovascular, metabolic disorders

TYPES OF BIPOLAR DISORDERS

- Bipolar I
  - At least one episode of mania alternating with major depression
  - Psychosis may accompany manic episode
- Bipolar II
  - Hypomanic episode(s) alternating with major depression
  - Not accompanied by psychosis

BIPOLAR DISORDER (TYPE I)

- Severe changes in mood- irritable and angry to silly, elated
- Grandiosity, over inflated self-esteem
- Increased energy or motor activity
- Decreased need for sleep
- Hyperverbal; disorganized content
- Distractibility
- Reckless, dangerous behavior

BIPOLAR DISORDER

- Mania
  - Episode associated with marked impairment in function
  - Hospitalization necessary

BIPOLAR DISORDER: COMMON SYMPTOMS

- Cognitive symptoms (thought processes)
  - Poor concentration, problems with verbal memory, sustained attention and executive functioning (may persist even in remission)
  - Flight of ideas: continuous flow of accelerated speech with abrupt changes from topic to topic usually based on understandable associations

BIPOLAR DISORDER II

- Similar to I but with highs never reaching mania, at least one hypomanic episode

- More complaints of depressive episodes. Is frequently misdiagnosed MDD or dysthymia.

CASE STUDY

- Jennie is a 20 yo Asian American female, who is a sophomore at a local university. She is coming in with a chief c/o "I haven't slept in 4-5 days. I am a wreck, my friends are so mean to me and my boyfriend broke up with me two days ago. He says I am too mean and jealous for him. I have missed some classes and my grades are horrible."
- What are your initial thoughts?
- What other data will help confirm your diagnosis?

OTHER FINDINGS

- PMH
- Family Hx
- Social Hx
- Mental Status Assessment
- ROS

TREATMENT OPTIONS

- What are your thoughts?

TREATMENTS

- Pharmacotherapy
- Psychotherapy
- Behavioral Strategies

PHARMACOTHERAPY: BIPOLAR DISORDER

Mood Stabilizing Agents

Lithium

Depakote

Tegretol

Second Generation Atypicals

Abilify

Latuda

Risperdal

Seroquel

Zyprexa

Geodon

TREATMENT FOR BIPOLAR DISORDERS: MOOD STABILIZERS

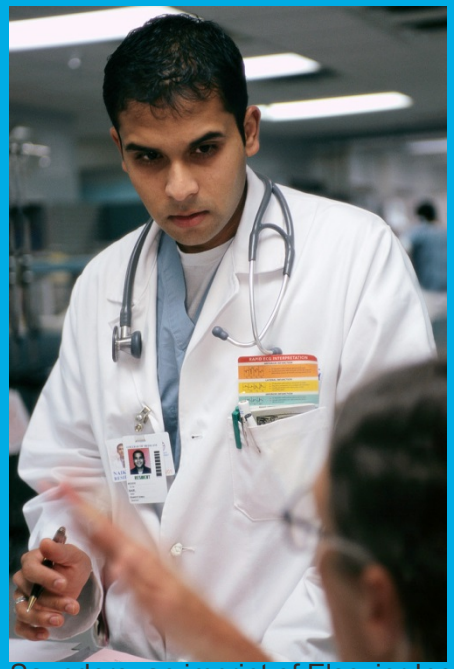
- Used for lifetime maintenance therapy
- Lithium carbonate: first-line treatment for mania
  - Therapeutic blood level must be reached for drug to be effective (usually takes 7-14 days)
    - Maintenance/therapeutic blood levels between 0.4 and 1.3 mEq/L
  - Used in combination with antipsychotics or antianxiety medications in initial acute mania

TREATMENT FOR BIPOLAR DISORDERS: LITHIUM CARBONATE

- Adverse reactions
  - Related to lithium toxicity—fine line between therapeutic and toxic levels
  - Lithium toxicity ranges from mild to moderate and severe symptoms depending on blood level
    - Severe symptoms include ataxia, ECG changes, clonic movements, seizures, coma, and death

TREATMENT FOR BIPOLAR DISORDERS: LITHIUM CARBONATE

- Major long-term risks include hypothyroidism and kidney impairment
  - Necessity for periodic thyroid and renal function tests



TREATMENT FOR BIPOLAR DISORDERS: LITHIUM CARBONATE

- Patient and family teaching important
  - Continue drug therapy to prevent relapse
  - Maintenance of normal diet with normal salt and fluid intake (1500-3000 mL/day)
    - Lithium decreases sodium absorption and low sodium levels/dehydration cause lithium toxicity
  - Stop taking lithium and call physician if symptoms of dehydration develop from sweating and/or nausea, vomiting, diarrhea

TREATMENT FOR BIPOLAR DISORDERS: ANTIEPILEPTIC MEDICATIONS

- Adjunct to lithium or for patients not responsive to lithium
- Most commonly used-
  - Carbamazepine (Tegretol), divalproex (Depakote), lamotrigine (Lamictal)
- Adverse effects of individual antiepileptic drugs vary but include such problems as sedation, agranulocytosis, hepatitis, life-threatening rash

TREATMENT FOR BIPOLAR-SGAS

- BPAD 1-Mania /Mixed
- Aripiprazole
- Ziprazidone
- Quietiapine
- Olanzapine
- Asenapine (LAI)
- Iloperidone (LAI)
- Paliperidone (LAI)

TREATMENT FOR BIPOLAR DISORDERS: ELECTROCONVULSIVE (ECT) THERAPY

- Can be used to subdue severe manic behavior in patients who are treatment resistant to usual medications
- May also be used in patients who are suicidal

TREATMENT FOR BIPOLAR DISORDERS: PSYCHOTHERAPY

- Cognitive-behavioral therapy
  - Cognitive restructuring effective in decreasing affective symptoms, increasing social functioning, and reducing relapse
- Interpersonal and social rhythm therapy (IPSRT)
  - Focuses on resolution of interpersonal problems and prevention of further disputes

TREATMENT FOR BIPOLAR DISORDERS: PSYCHOTHERAPY

- Family-focused therapy
  - Treatment approach focusing on communication within family, communication skills, and education to prevent relapse

TREATMENT

What are your recommendations?

BEHAVIORAL STRATEGIES

- Develop a solid routine
- Develop a list of triggers (and factors that ameliorate)
- Sleep hygiene and plan for intervention if not sleeping
- Stress management
- Lifestyle modifications
- Knowing your signs and symptoms and seeking intervention early

STRESS RELATED DISORDERS


PTSD
RESTLESS PARALYZED FLASHBACKS IRRITABLE ANGRY INSOMNIA FEAR PANIC HELPLESS POWERLESS NUMB DEPRESSED STRESSED LOSS OF MEMORY SOCIAL ANXIETY LACK OF CONCENTRATION SADNESS TIRED LONELINESS DISAPPOINTED

POST TRAUMATIC STRESS DISORDER

- Prevalence-
  - 3-6% of US general population

- Veterans- 8% male, 20% female

POST TRAUMATIC STRESS DISORDER

1. Exposure to traumatic stressor
2. A. Intrusive thoughts

   B. Avoidance

   C. Negative alterations in cognition and mood.

   D. Alterations in arousal and reactivity

SCREENING

- Primary Care PTSD Screening- http://www.ptsd.va.gov/professional/pages/assessments/pc-ptsd.asp

TREATMENT

- Medications
- Psychotherapy
- Individualize to patient and symptoms

PHARMACOTHERAPY

- SSRIs-Zoloft and Paxil have FDA indication, other agents may be used
- Atypical antipsychotics in severe PTSD
- Mood stabilizing agents
- Address sleep disturbance-Prazocin
  - avoid benzodiazepines and hypnotics

PSYCHOTHERAPY

- Cognitive Behavioral
- Cognitive Processing
- Prolonged Exposure
- EMDR

TREATMENTS

- Therapy and Meds

- Go to ptsd.va.gov for guidelines and resources

CONNECTIONS
RESOURCES FOR HELPING THOSE WITH PTSD

- http://www.ptsd.va.gov/professional/pages/fslist_ptsd_overview.asp

- http://maketheconnection.net/conditions/ptsd?gclid=CIvQvNrHlrgCFZBj7Aod4TkAOw