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BEHAVIORAL HEALTH DIVISION
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Mental Health Review for Primary Care Providers: A Primer for Effective Integration

April 7, 2016

German Ascani, MD
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Outline of the Day

I. Introduction: *Michael Kozart, MD, PhD (5 min.)*

II. Global Perspectives on Mental Illness: *Michael Kozart, MD, PhD (25 min.)*

III. The Spectrum of Depression: *Michael Kozart, MD, PhD (40 min.)*

Break (5 min.)

IV. Assessment of Suicidality: *Melissa Ladrech, LMFT (40 min.)*

V. Mood Swings: *Megan Burns, MD (40 min.)*

VI. Somatization: *Michael Kozart, MD, PhD (handout only)*

Break (10 min.)

VII. Case Presentation in Three Parts with Breakout (60 min.)

Discussion: *German Ascani, MD, Michael Kozart, MD, PhD, Melissa Ladrech, LMFT*

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Introduction
Michael Kozart, MD, PhD

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Congratulations and Thanks!

- Mental Illness is an extremely important and yet complex area of Primary Care.
  - Approximately 25% of primary care pts. carry a psychiatric dx. (Katon, 2013)
  - Over 50% of U.S. patients receive MH care exclusively in the primary care setting. (Tesar 2010)
- There has been a tremendous commitment among our local primary care organizations to collaborate around mental health services. It truly puts Sonoma County on the map.
- Special Thanks to RCHC for sponsoring this training series and taking a leading role in helping to integrate mental health services in primary care programs throughout the North Bay.

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The Role of PCPs in Mental Health Care

- Primary care providers play a central role in mental health care:
  - Numerous studies show that PCPs provide the majority of psychiatric care in the U.S.
  - Even in health centers with robust, specialized mental health programs, PCPs are often responsible for:
    - The initial psychiatric diagnosis
    - Initiating and managing ongoing psychotropic prescriptions
    - The decision when/if to refer to a mental health specialist
    - Front line crisis management

The Role of PCPs in Mental Health Care

- Role Primary care providers (continued):
  - And even when patients are referred to BH specialists:
    - There tends to be low rates of follow-through for pts. referred by PCPs to BH specialists. One study gave a nationwide average of only 60% (Grembowski 2002).
    - Another nationwide study suggested the mean number of BH Specialist appointments for each case in which there is follow-through is only two (Katon, 2013).
    - We would imagine these rates to be much higher for BH specialists who operate in-house, in well integrated BH programs, but still…

The Role of PCPs in Mental Health Care

- Role Primary care providers (continued):
  - In short, for most mild to moderate mental health conditions, primary care providers represent the de factor psychiatrists across the United States, and primary care health centers, with their allied teams of BH specialists, represent the de-facto mental health system.

The Role of PCPs in Mental Health Care

This Conference focuses on the knowledge base and skills to help PCPs handle front-line mental health issues.

Specific MH Care challenges that PCPs face are:

- Many of their patients are new to the health center, and/or present with new MH complaints that require initial workup.
- PCPs operate with stringent time constraints.
- They deal with very large problem lists and increasing demands on their time to screen for preventable health conditions.

The Role of PCPs in Mental Health Care

Additional challenges:

- It is not always clear how best to use the **EHR to document mental health history**, which is often best recorded through narrative. Templates help, but require time to learn.

- PCPs may not have had extensive **specialized training in counseling psychology or psychiatry**, and yet they are being asked to tackle very complex mental health issues.

- It is not always feasible to **'curbside' a mental health specialist** in a busy primary care clinic.

The Role of PCPs in Mental Health Care

And yet more challenges:

- What are the **criteria for referral** to a **psychiatrist** or a **behavioral health specialist?**
- What are the criteria for **referral** to an **outside resource**, such as Sonoma County Behavioral Health or Beacon?
- What are the national, community, and local **standards for assessment and ongoing care** for various **mental health problems**?
- Should **PCPs** be handling MH **patients of all ages**?

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The Role of PCPs in Mental Health Care

- Our eight hours of training are just a beginning: we won't be able to answer all these questions—even if we *Really, Really, Really* try.
- Hopefully this training leads to future dialogue, centered in local health centers. Each health center is different, and we need to develop models of effective mental health integration that reflect the uniqueness of each site.

The Role of PCPs in Mental Health Care

Main cross-cutting themes for April 7 and May 17:

- Defining mental disorders in **Categorical** and **Dimensional** terms
- **Conservative Psychopharmacology**
- **Counseling Psychology** in the primary care visit; PCPs can be highly effective at therapeutic talk—we will be discussing specific CBT approaches.
- Thinking through simulated cases.

Although the two trainings are labeled 'Evaluation' and 'Management' respectively, in truth it is impossible to avoid integrating these concepts, as we will see…

Diagnostic Terminology

- DSM: first introduce in 1952. Recently updated from DSM IV to DSM 5 in 2013
- DSM contains the standard criteria and definitions of mental disorders approved by the American Psychiatric Association. It is linked to ICD codes (DM5 lists both ICD 9 and ICD 10).
- Crosswalks: DSM IV, DSM 5, ICD 10 are readily available on the internet

General Terminology

- Patients, Clients, Consumers
- Providers/Specialists
  - Psychiatric vs. Mental Health/Behavioral Health.
- Psychiatric Providers
  - Psychiatrist, PMHNP, Psychiatric PA
- Therapist, Counselor, BH Clinician
- Psychotropic, Psychiatric Medication
- Adjectives
  - psychiatric, mental health, behavioral health
- PES, CSU, Sonoma County Behavior Health Urgent Care Center at the Lakes

Global Perspectives on Mental Illness
Michael Kozart, MD, PhD

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Global Perspectives On Mental Illness: Basic and Dynamic Definitions

April 7, 2016

Michael Kozart, MD, PhD
Medical Director, Sonoma County Behavioral Health

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Intro to Intro

Potpourri of Interrelated Topics

- Defining Mental Illness in Basic Terms
  - Categorical vs. Dimensional Terms
- Defining Mental Illness in Dynamic Terms
  - Reactivity
- Techniques for managing MH in a Primary Care Setting
  - BATHE
  - 4 Habits

Two Approaches to Defining Mental Illness in Basic Terms: Categorical and Dimensional

The Categorical Approach

- **Categorical View**: Mental Illness can be objectively named, just like a sore throat, broken arm, or hypertension.
- The naming of mental illness involves **diagnostic categories** that include:
  - A symptom checklist.
  - Clear inclusion and exclusion criteria.
- According to this view:
  - Mental disorders are all or nothing phenomena: you have one or you don't.
  - Symptoms are relevant insofar as they contribute to the picture of a disorder.

- **Categorical View: Benefit**
  - Diagnosis is a relatively simple process of running down a **symptom checklist**.
    - This works well for disorders that are truly discrete and clearly offset from normal life experience—example: full mania or florid psychosis.
  - Categorical diagnosis makes it relatively easy to **code the visit**, which is important for billing and for reports.
    - The system of care in FQHCs is very much driven by diagnosis.

- **Categorical Approach: Disadvantages**
  - Limits history taking to just the diagnostic criteria of various named disorders.
  - As soon as the number of symptoms satisfy the criteria for a diagnosis, you're labeled. This makes for a **risk of over-diagnosis**.
    - Veritable explosion in # people diagnosed with Mental Illness after the categorical approach was introduced with DSM III in 1980.
    - DSM IV (1994) mitigated the risk by adding the criterion of "clinically significant distress and impairment" to all mental disorders. Still, there has been a proliferation of MH Dx. Under DSM. More people diagnosed does not necessarily mean that more people are sick (Whooly 2013).
  - **Risk of over-medication**: if you have a diagnosis, it should be treated, right?
  - Symptoms that fail to meet the criteria of a diagnosis get assigned the **NOS** (Not Otherwise Specified) category—which lacks descriptive/explanatory value.

The Dimensional Approach

- An alternative to the **Categorical Approach** is the **Dimensional Approach**.
- Instead of naming a disorder, you 'quantify' the symptoms. The dimension speaks to the way the symptom is measured.
  - These values lie on a **continuum with normal**, and also on a **continuum with each other**.
  - PHQ 9 is a well known example.
- Diagnosis becomes less about whether or not you have a certain disorder, and more about the **degree to which you suffer certain symptoms**.
- Equivalent to the medical '**Review of Symptoms**'

- **Dimensional Diagnosis: Benefits**
  - Many symptoms lie on a **continuum with normal** —especially true for mood, anxiety and personality states, and many of these symptoms are missed by categorical criteria.
  - **Sub-syndromal disorders** (syndromes below the threshold of categorical diagnosis) still contribute heavily to important health and social problems.
    - Identification of these symptoms may improve general health and well-being.
  - More humanistic: we are not disorders, but rather individuals with diverse, fluctuating feelings and thoughts.

- The APA framework for the Dimensional Approach is presented in the **DSM V, Section III: Assessment Measures**.
- The dimensional View can:
  - "Aid in a more comprehensive mental status assessment by drawing attention to symptoms that may not fit neatly into the diagnostic criteria suggested by the individual's present symptoms, but may nonetheless be important to the individual's care. "

- **Dimensional Approach: Disadvantages**

  - It doesn't fit with our current system of clinical documentation and diagnostic coding.
  - Lots of training and time required to properly quantify symptoms, especially as the rating scales become more elaborate.
  - No clear consensus on how to build reliable diagnoses from dimensional data.
  - Has not been comprehensively reconciled with the dominant Categorical Approach.

Categorical vs. Dimensional

- Where is Psychiatry Headed?
  - The categorical approach is still the reigning paradigm (DSM 5, Section II).
  - The dimensional approach is up and coming (DSM 5, Section III)—especially for mood, anxiety, and personality states.
  - Ratings scales like the **PHQ 9 potentially** combine both approaches (Kupfer 2013).
    - Equating number scale intervals to DSM Categories, e.g., PHQ score greater than 15 equals MDD.

Categorical vs. Dimensional

Before leaving this discussion of the categorical vs. the dimensional, lets consider one example of how these two approaches play out: let's consider personality.

Personality Defined: "Enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts." (DSM V, p. 645).

Varying Approaches to Personality

- In the **Categorical View**, Personality is defined in the context of disorders: All disorders are associated with intense subjective distress and impairment in functioning
  - E.g., Avoidant Personality Disorder (profound feelings of inadequacy); Borderline Personality Disorder (intense interpersonal instability, hypersensitivity to rejection); Obsessive-Compulsive Personality Disorder (preoccupation with orderliness and perfection).
- In the **Dimensional View**, Personality is defined around traits that lie on a continuum between normal and pathological. This leads to a **Personality Profile** rather than simply a **Personality Disorder**.

Personality Profiles

- **Personality Profiles**: Examples
  - **Avoidant**: The tendency to be overwhelmed by challenges, causing individuals to doubt their resiliency.
  - **Borderline**: The tendency to distrust, and as a result, to feel threatened, leading to dichotomous 'all or nothing' thinking.
  - **Obsessive-Compulsive**: The tendency to fixate on a problem, rather than move beyond it.

None of these profiles are pathological by definition. Everything comes down to the intensity of the tendency, and whether the individual can adapt to stressors and demands.

Summary So Far

We have introduced two approaches: the **Categorical** and the **Dimensional**

While quite different, both approaches are similar in the sense that they describe mental illness in static terms: i.e., a snapshot in time.

Yet mental illness really exists in the flux of experience. It is not a **'thing'** but rather a **'process'** whose significance is played out in terms of how we think, feel, and act each moment of the day.

What does it mean therefore to define mental illness **dynamically**, as a process?

What Is Mental Illness?
A Dynamic Approach

- Let us begin with the presence of a symptom. This can be any form of mental distress:
    - E.g., a depressed, anxious, panicky, psychotic, obsessive, existential-worried state of mind.
- Assuming that experience is uncomfortable, it will **always** cause a psychological reaction:
    - As humans, we are programmed to react to uncomfortable things. They are naturally salient aspects of experience. We usually don't ignore things that are painful.
    - Reactions can be in terms of thoughts, feelings or actions.

What Is Mental Illness?
A Dynamic Approach

- This reaction has profound impact on the significance of the symptom in terms of the future flow of experience.
- We can react to the symptom ‘constructively’ or ‘counter-productively.’

A Dynamic Approach to Mental Illness

- Constructive examples:
  - ‘It’s not the worse thing in the world.’
  - ‘Let me get to the root of the problem.’
  - ‘I’ve got other areas of my life that are relatively okay.’
  - ‘It’s bad, but I can get help.’
  - ‘I’ll be okay in the end.’
  - ‘I have to keep going.’

A Dynamic Approach to Mental Illness

- Counter-productive examples:
  - Worrying that because of the symptom, something bad will happen:
    - “I’ll be rejected.”
    - “I’ll be ridiculed.”
    - “I won’t be able to get a job.”
    - “I won’t be able to think straight.”
    - “I’ll lose my mind and go crazy.”
    - “I’ll never have the capacity for peace or contentment.”
    - “I’ll be lost in the universe.”
    - “I won’t be able to find my way back home.”

A Dynamic Approach to Mental Illness

- It becomes easy to see how a counter-productive response can lead to a vicious cycle:
  - Becoming depressed about being depressed,
  - Anxious about being anxious.
  - Even with psychosis, the sheer fact of being worried, anxious, or depressed can worsen the underlying thought disorder that contributes to the perceptual disturbance in the first place.
  - Mental illness is very much a syndrome of reactivity.

A Dynamic Approach to Mental Illness

In fact many psychiatric conditions operate as a vicious cycle, in which a reaction to a symptom makes the symptom worse.

If we want to understand more about these reactions, we need to return to the theme of Personality.

The way react to our own states of mind very much reflects our personalities.

(Other things can be involved too…such as the role of trauma…but that is another talk).

Reactivity and Mental Illness

The Avoidant

- The avoidant individual may confront his/her distress, becoming overwhelmed, fearful that he/she will never be able to overcome the problem.
  - "How will I make friends? How will I meet a partner? How will I be hired or promoted at work?"
- This quickly leads to a vicious cycle, whereby someone becomes more distressed because they are already distressed. (We will cover this in depth when we discuss depression).

Reactivity and Mental Illness?

The Borderline

- The borderline may fear that he/she will be subject to disdain, rejection, or ridicule by others.
- This can lead to secondary feelings of alienation, isolation and anger, which deepens the individuals' demoralization and angst, leading to another vicious cycle.

Reactivity and Mental Illness?

The Obsessive-Compulsive

- The obsessive-compulsive individual may become fixated on the problem, to a point that he/she cannot turn away from it.
  - "Everything I see or do is about my depression."
- The problem takes on greater prominence and importance in one's life, to a point that it encroaches on the very definition of self. The bigger the problem, the more it becomes the centerpiece of experience.

Toward a Dynamic Approach: Summary

In many respects, the experience of mental illness is not just the **'thing'** (e.g. the depression, the anxiety, or the psychosis), but rather the '**thing and our reaction to it**.'

This dynamic approach is not just descriptive, but directly therapeutic. It leads to a therapeutic angle on all mental illness:

To help individuals **accept** primary symptoms, rather than to react to them with sadness, fear, anxiety, or panic.

Acceptance of primary symptoms represents the first step towards wellness.

> "It is bad enough to be depressed, worse enough to be depressed about being depressed, so let's just be depressed…"

Reactivity and Wellness

Although the experience of mental illness is determined by many factors, including “genetic makeup, early history, previous life experience with illness, current life situation, and aspirations for the future,” (Stuart 2015), reactions to current state of mind are probably the most amenable to modification.

From Concept to Practice

Before concluding this introduction, let's consider some of the obvious practical challenges to treating mental illness—many of which we've already alluded to:

- The work of categorical and dimensional assessment is time consuming
- The dynamic description of mental illness involves a careful process of distinguishing primary symptoms from reactions, which is also potentially time consuming.
- Many patients have to work through resistance to dealing with mental health symptoms because of their potentially stigmatizing nature—this can apply to providers as well.
- Many PCPs are already dealing with 'too much' work to accomplish in a short, 15-20 minute visit.

Practical Mental Health Care Work

Two Models to Facilitate MH work in Primary Care Settings.

- Marian Stuart (2015): **BATHE** Technique
- Kaiser Permanente: **4 Habits**.

BATHE Technique

Domain	Recommended Question	Rationale
Background	"How do you fill your time?"	Open ended question designed to elicit psychosocial info.
Affect	"How do you feel about your day?"	Pt reports on feelings
Trouble	"What about your day troubles you?"	Focus on perceived difficulties.
Handling	"How do you handle that?"	Elicits pt's perspective on need for help or support
Empathy	"That must be difficult"	Normalizes the patient's reaction and demonstrates understanding

*Adapted from Tesar 2010.

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The 4 Habits

The 4 Habits is another technique to make the work of mental health diagnosis and assessment more acceptable or natural for the patient.

- Focuses on aligning expectations around shared agendas and eliciting the patient's perspective in a ways that validate the patient's own feelings and priorities.
- Highly useful for bracketing the qualitatively distinct work of mental health care: it may take a separate appointment(s) to adequately address MH themes.
- Patients may need to be coached and reassured that it is okay to bring of MH themes.

The Four Habits: Overview

Habit:	Skill Set:
1. **Invest in the Beginning**	Plan the visit with the client; explain the parameters of a mental health visit. Acknowledge time limitations; Establish buy-in. **Justify the agenda**, rather than simply impose it. "I noticed you appeared sad, and I just wanted to have some time for us to talk about that."
2. **Elicit the Client's Perspective**	**Elicit symptoms** rather than diagnoses; **Focus on experience** rather than pathology; understand the client's world
3. **Demonstrate Empathy**	Convey **genuine concern** and **sincerity** through verbal and non-verbal acts; **Be open to modifying the agenda**; Think on your feet rather than according to a script.
4. **Invest in the End**	**Summarize** what has been accomplished and what hasn't; Present ordering concepts that reflect the client's desire for answers and solutions; Justify next steps; **OFFER HOPE**; Complete the visit.

Concluding Remarks

- The **Categorical Approach** is an integral feature of our Medical Culture. It allows for efficient diagnosis. It can also lead to over-diagnosis because symptoms are not considered on a continuum with normal experience.
- The **Dimensional Approach** is a rising paradigm in Psychiatry. It regards symptoms as lying on a continuum with normal. What matters is the severity of the symptoms, not their presence or absence.
- **Personality Profile** is one example of a Dimensional Approach
- Both the Categorical and Dimensional approaches are essentially **static.**
- A **Dynamic Definition of** M**ental Illness** that has wide applicability involves the theme of reactivity—specifically, **how individuals react to their own state of mind**. This approach is also, potentially, directly therapeutic. We will talk much more of this in our discussion of depression.
- The **BATHE Technique** and **4 Habits** are two tools to incorporate MH care into primary care work.

The Spectrum of Depression
Michael Kozart, MD, PhD

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The Spectrum of Depression

April 7, 2016

8:30 AM

Michael Kozart, MD, PhD
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Setting the Stage: Why is Depression Important for PCPs?

- Depression is the **most prevalent** mental disorder in primary care. (Thompson 2001).
- **Lifetime prevalence** of a diagnosis: nearly 20% (Nieuswma 2012)
- It is estimated that nearly 80% of all patients with depression present initially with **physical symptoms such as pain or fatigue** (AAFP 2016)

Setting the Stage

- **Modality of Diagnosis by PCPs**
  - 1999 study * suggested that most PCPs suspect depression based on **recognized cues**, such as 'depressed appearance.' Few rely on **routine screens** like PHQ. Formal diagnosis does not generally follow DSM recommended guidelines, due in large part to time constraints. **Average length of visit is 13 minutes, average problem list is 6 problems, and average time it takes to apply formal dx criteria is 8 minutes.**
  - Same study: 73% of PCPS prescribed antidepressants; 38% engaged in counseling of more than 5 minutes duration; 38% referred pts to a BH specialist.
  - Vast majority of PCPs interviewed were **not confident in their ability to treat depression with counseling.**

*Williams, 1999.

Setting the Stage

- **Modality of Treatment by PCPs**
  - **Medication** is by far the most common primary care intervention for depression (Robinson 2005).
  - However, many PCPs utilize some form of **Therapeutic Talk** to help their depressed pts, even if that modality is not specifically named (AAFP 2016)
  - There are emerging models to structure **Therapeutic Talk** by PCPs around core **CBT** and **Cognitive Therapy** concepts.

General Definition of Depression

- Depression is a word that describes any sad, empty, irritable state, often associated with somatic and cognitive changes such as low energy, mired thinking
- Depression can be also a 'catch all term' or (as **Medical Anthropologists** would say), an '**idiom of distress**.
  - "For example, everyday talk about 'nerves' or 'depression' may refer to widely varying forms of suffering without mapping onto a discrete set of symptoms, syndrome, or disorder" (DSM 5, p. 758).

The Spectrum of Depression

The Dimensional View

The Spectrum of Depression

- **Dimensional view: rating scales**
  - The **PHQ-9** is perhaps the most widely used dimensional tool to illuminate depression
    - 9 point, **self-assessment** scale drawn from the first rank criteria **(Criteria A**) for Major Depressive Episode in DSM 5
    - We will be having another talk on the use of the PDQ and GAD 7 later on.
    - Scores of **10-15 or above** correlate closely with **Major Depression Dx**.
    - Lower scores may signal **sub-syndromal depression** that may impact other health conditions (Judd 1996).
    - Use of the PDQ has expanded with the advent of EHRs and Federal incentives for quality improvement. These screens can be easily incorporated into clinic flow at FQHCs.
  - Other Scales include the **PHQ-15, GAD-7**, **Hamilton Depression Rating Scale, Beck Depression Inventory, etc.**

The Spectrum of Depression

Interpreting PHQ-9 Scores

Diagnosis	Total Score	For Score	Action
Minimal depression	0-4	≤4	The score suggested the patient may not need depression treatment
Mild depression	5-9	5-14	Physician uses clinical judgement about treatment, base on patient's duration of symptoms and functional impairment
Moderate depression	10-14		
Moderately severe depression	15-19	>14	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment
Severe depression	20-27		

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The Spectrum of Depression

- **Talking about depression qualitatively**.
  - Characterizing the patient's subjective state:
    - Feeling blue, in the dumps, worthless, expendable
    - Sense of emotional pain
    - Absence of emotion: emptiness. Crying without tears
    - Withdrawal from normal life activities, friends, relatives
    - Reduced energy with difficulty completing tasks
    - Decreased motivation, especially with new projects
    - Trouble sleeping—or too much sleeping
    - Decreased appetite, weight loss—though increased appetite is possible too.
    - Associated anxiety. Aggravation of concurrent medical complaints because of inattentiveness
    - Diminished sexual interest
    - Concurrent anxiety
    - Substance abuse
    - Cognitive symptoms: diminished memory or concentration
    - In children: enhanced phobias—avoiding school, or poor academic performance
    - Suicidal thinking. Reckless, impulsive behavior
    - Concurrent somatization symptoms

The Spectrum of Depression

- Describing the depression objectively:
  - General appearance: psychomotor retardation—or agitation (hand wringing, hair pulling). Stooped posture, lacking spontaneous movements, downcast averted gaze.
  - Constricted range of emotion.
  - Decreased rate and volume of speech. Paucity of words.
  - Possibility of thought disorganization or hallucinations in the most severe states. If delusions are present, generally considered 'mood congruent.
  - Thought content is generally negative, nihilistic, lacking in passion. There may be thought blocking.
  - Cognitively, memory may be impaired. Concentration may be diminished, generally due to poor effort.

The Spectrum of Depression

Shifting Gears: Dimensional to Categorical

The Spectrum of Depression

- **Categorical Approach: Overview**
  - Important to remember that depression can be primary or secondary to some other psychiatric and/or medical disorder. Today we will be reviewing mainly the primary depressive disorders—but depression can be a feature of every single psychiatric disorder listed in the DSM.
  - It is a matter of interpretation whether to consider a state of depression primary or secondary.
  - Giant caveat: Not all depression is pathological.

The Spectrum of Depression

- **Categorical Approach: DSM 5 overview**
  - 8 different Primary Depressive Disorders
    - Disruptive Mood Dysregulation D/O
    - Major Depressive D/O
    - Persistent Depressive D/O (Dysthymia)
    - Premenstrual Dysphoric D/O
    - Substance/Mediation-Induced Depressive D/O
    - Depressive D/O due to a Another Medical Condition
    - Other Specified Depressive D/O
    - Unspecified Depressive D/O

The Spectrum of Depression

- **Categorical Approach:**
  - **Disruptive Mood Dysregulation D/O (F34.8)**
    - "New Inclusion"—can be applied 'first time' up to age 16
    - Embraces 'severe temper outbursts' plus persistent irritability
    - Must be carefully distinguished from the persistent irritability/anger of Bipolar, the conflictual demeanor of Oppositional Defiant Disorder, and the episodic nature of Intermittent Explosive Disorder

The Spectrum of Depression

- **Categorical Approach: Major Depressive Disorder (F32-F33)**
  - 5 or more of the following 9 (Criteria A) symptoms, each persisting for 2 wks. or more:
    - Depressed mood
    - Markedly diminished interest or pleasure in most activities
    - Significant weight loss or gain (up to 5% of baseline weight)
    - Sleep disturbance: insomnia or hypersomnia
    - Energy disturbance: psychomotor agitation or retardation
    - Fatigue
    - Feelings of worthlessness, guilt
    - Diminished ability to concentrate, make decisions
    - Recurrent thoughts of death, Suicidal Ideation
  - Distinguishing MDD from Grief
    - Grief is all about the pain of Loss/emptiness
    - MDD is about inability to anticipate happiness or pleasure

The Spectrum of Depression

- **Categorical Approach: Major Depressive Disorder, Continued.**
    - **Specific Qualifiers** in the DSM (p. 184-188)
        - **Melancholic**, Anxious, Mixed (hyponmanic/manic), **Atypical**, Psychotic, Seasonal
    - **Melancholic Features** ('pseudo-dementia' picture)
        - Somewhat equivalent to the antiquated 'endogenous' depression category from the DSM-II.
            - Extreme loss of pleasure and reactivity
            - Diurnal variation (worse in AM)
            - Marked psychomotor retardation or agitation
            - Significant weight change
            - Overwhelming sense of Guilt
            - Probably the most responsive to AD treatment (indeed the prototype condition for all early AD efficacy studies).

The Spectrum of Depression

- **Categorical Approach: Major Depressive Disorder, Continued.**
  - **Atypical Features:**
    - Prominent mood reactivity—mood brightens in response to positive events
    - Two or more of the following
      - Weight gain or increased appetite
      - Hypersomnia
      - Leaden paralysis
      - Long standing pattern of heightened sensitivity to rejection
      - Often correlated with increased risk for development of Bipolar Disorder

The Spectrum of Depression

- **Categorical Approach: Major Depressive Disorder, Continued.**
  - **Epidemiology (Kaplan and Sadock, Synopsis of Psychiatry):**
    - **15% lifetime prevalence**
    - **10% incidence in primary care populations**
    - **Women are twice as likely as men to develop MDD**
    - **Mean age of onset is between ages 40-50—but can arise at all age ranges.**
    - **Lifetime risk of suicide for all pts. with MDD is 2.2-15%**
    - **<25% of all MDD pts. meet the criteria for MDD with melancholic features.**
    - **Untreated, typical Major Depressive episode last 6-13 mo**
    - **5-10% of everyone who develops MDD later go on to develop BPAD.**

The Spectrum of Depression

- **Categorical Approach: Persistent Depressive Disorder (Dysthymia) (F34.1)**
    - Persistently depressed mood for at least two years
    - 2 or more of the following symptoms which have each persisted for 2 years (no more than 2 months without symptoms):
        - Poor appetite or overeating
        - Insomnia or hypersomnia
        - Low energy/fatigue
        - Low self esteem
        - Poor concentration
        - Feelings of hopelessness

The Spectrum of Depression

- **Categorical Approach: Premenstrual Dysphoric Disorder (N94.3)**
    - 5 or more symptoms that start in week before onset of menses, start to improve within a few days after onset, and become minimal or absent in the week post-menses.
        - One or more of:
            - Mood swings, e.g. sad/tearful, hypersensitivity to rejection
            - Market irritability or anger
            - Marked depressed mood, hopelessness, self-deprecating thoughts
            - Marked anxiety
        - One or more of:
            - Decreased interest in usual activities
            - Difficulty in concentration
            - Lethargy
            - Marked change in appetite
            - Hypersomnia or insomnia
            - Feeling overwhelmed
            - Physical symptoms: breast tenderness, joint pain

The Spectrum of Depression

- **Categorical Approach: Substance-Induced Depressive Disorder (Varying codes F10..-F19..)**
    - A prominent and persistent depressed mood or markedly diminished interest or pleasure in all, or almost all, activities that predominates in the clinical picture . This diagnosis is applicable only when mood symptoms predominate.
    - Mood Symptoms occur during or soon after substance intoxication and/or withdrawal, and the substance is known to have mood altering properties

The Spectrum of Depression

- **Categorical Approach: Depressive Disorder due to Another Medical Condition (F06..)**
    - A prominent and persistent depressed mood or markedly diminished interest or pleasure in all, or almost all, activities that predominates in the clinical picture . This diagnosis is applicable only when mood symptoms predominate.
    - There is evidence that the disturbance is the direct pathophysiological consequence of another medication condition.

The Spectrum of Depression

- **Categorical Approach: Other Depressive Disorder (F32.8)**
  - A prominent and persistent depressed mood that does not meet the full criteria for any of the disorders in the other primary categories.
  - Examples
    - **Recurrent brief depression**: a least four basic symptoms lasting 2-13 days, at least once a month.
    - **Short-duration episode** (4-13 days): Depressed affect+ 4 sxs.
    - **Depressive episode with insufficient symptoms**: Depressed affect + at least one other symptoms x 2 weeks or more.
- **Categorical Approach: Unspecified Depressive Disorder (F32.9).**
  - Generally applies to a state of primary depression for which there is insufficient information to further specify

The Spectrum of Depression

Shifting Gears: Work-Up for Depression:

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Work-Up for Depression: General Themes

- Mental Health History should be problem-oriented.
  - Paradox:
    - In order to embark on the history you need to know the presenting problem
    - But in order to know the presenting problem, you really need to know the history
    - This is because what patients say and what they feel often evolves the deeper you get into the history, and the more comfortable the patient is about talking about mental illness, the more direct and descriptive they are about describing the presenting problem.
- Much of the history is built from an understanding of the history of relationships (friends, family and lovers), education, career, and housing status. Specific questions about Trauma are also important.

The Spectrum of Depression

Work-Up

Presenting Problem:

- Ask about emotions in a open-ended way: how do you feel about life?
- Ask whether the problem has always been about the same, or is it getting worse
- Ask if the depression gets in the way of important life goals: we are as (if not more) interested in how the depression relates to activity and functionality.
- Don’t hesitate to ask about suicidality (more to come).
- Be prepared to modify the presenting problem: remember, ‘depression’ can be a general idiom of distress, and it can be primary or secondary.

The Spectrum of Depression

Work-Up

- HPI: try to relate as much as the history as you can to the presenting complaint, even though it is important to stray beyond the complaint itself.
  - 'How do you fill your time?' establishes a framework to understand how patients function in their usual environment.
  - Stressors: life changes, setbacks, losses
  - "How do you relieve stress?"
  - What do you like to do? Is there anything you are passionate about?
  - Elicit information about substances.
  - Cross-sectional review of other psychiatric disorders
    - Screen for thought disorders, developmental disorders, cognitive disorders, and bipolar disorders
  - Pertinent medical issues (see PMH below)

The Spectrum of Depression

Work-Up

Past Psychiatric History:

- Knowledge about prior hospitalizations, holds, medication trials or course of outpatient treatment.
- Attempt to compose a personality profile—this may take many meetings.
- Always ask about substance use history
- Suicide attempts are always salient—as are non-suicidal acts of self-harm.

Family History:

- Often difficult to know what's nature vs. nurture
- Family history of suicides or treatment for depression
- History of BPAD: up to 10% more likely in first degree relatives
- History of MDD: up to 2.5% more likely in first degree relatives

The Spectrum of Depression

Work-Up

- Past Medical History
  - Medical issues that may drive primary depression
    - Pregnancy status
    - Thyroid issues; CVAs; Cognitive impairment
    - Medical problems that may lead to secondary depression
      - End of life concerns
      - Medical issues that affect life expectancy, or daily life functionality
  - Inventory of meds to see if any could be implicated in depression
    - This is an area of controversy: many meds are conceivably linked to depression, though whether they are directly causative is extremely difficult to ascertain.
      - Antivirals—Interferon and Sustiva
      - Statins
      - Accutane
      - Oral Contraceptive Pills
      - Certain Anti-hypertensives (reserpine)

The Spectrum of Depression

Work-Up

- Social History: (overlaps with HPI)
  - Housing
  - Relationship status
  - Primary support network
  - Occupation/Employment
  - Education History
  - Legal History
  - Personal tastes
    - Music, film, literature, food,

The Spectrum of Depression

Work-Up

- Mental Status Exam:
  - General appearance: glum, sad, restless, agitated, angry?
  - Motor: psychomotor retarded?
  - Speech: lacking in volume or prosody?
  - Mood: “patient’s subjective state in the moment of the interview.”
  - Affect: the objective presentation of mood: sad, angry, constricted, congruent or non-congruent with mood?
  - TP: logical? Spontaneous? Mired?
  - TC: Any notable delusions, Suicidal ideation, Homicidal ideation, AH/VH?
  - Cog: level of alertness and orientation.

The Spectrum of Depression

Work-Up

- Tests:
  - Labs: TSH, pregnancy status, and general COMP/CBC panel (generally useful for establishing medication safety and ruling out any concurrent medical conditions)
  - EKG: usually important if starting meds in patient over 40, and always important if there's a medical history that could make the use of meds more risks
  - Head imaging: generally not indicated for first-line workup. There are no clinically validated applications for structural or functional brain imaging. Imaging may be indicated if depression is particularly severe or atypical.
  - Psychological testing: seldom required or available in primary care clinics for the workup of depression.

The Spectrum of Depression

Shifting Gears: Treatment Considerations

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The Spectrum of Depression
Treatment Modalities

- **Brief Review of Pharmacology**
- **Review of Psychotherapy Techniques in the Primary Care Context**

The Spectrum of Depression
Treatment Modalities: Meds

- **Pharmacology Overview**
  - So far, we've seen that Depression is a very heterogeneous condition.
    - It can be defined multiple ways
    - It can be primary or secondary
    - It lies on a continuum with normal experience
    - Evaluation of the efficacy of treatments has been hindered by the lack of clear consensus on diagnosis, scarcity of head-to-head comparisons and placebo-controlled studies, and unity around the benchmarks for improvement: e.g. remission versus reduction; felt-experience versus functionality.

The Spectrum of Depression

Treatment Modalities: Meds

- **The Pharmacology**
  - **Antidepressants**
  - **Atypical Antipsychotics**
  - **Other augmentation techniques**
  - **Concurrent symptom management**
    - **Anxiety**
    - **Insomnia**

The Spectrum of Depression
Treatment Modalities: Meds

- **Antidepressants**
  - History
    - Mono-amine deficiency hypothesis in the early 1960s led to rational design of drugs to replete monoamines, like dopamine and serotonin.
    - Development of the 'new' generation AD's began with Prozac in 1980. Phenomenal increase in use of class: national spending on anti-depressants increased 600% during 1990s. Currently, AD's are the second most commonly prescribed class of meds (cholesterol lowering drugs are the first).
  - Types:
    - MAOI's
    - TCAs
    - SSRIs
    - SSNIs
    - Heterogenious Agents

The Spectrum of Depression

Treatment Modalities: Meds

- **Antidepressants**
  - MAOI's—phenelzine (Nardil)
  - TCAs—nortriptyline (Pamelor), amitriptyline (Elavil), desipramine (Norpramin), imipramine (Tofranil)
  - SSRIs—citalopram (Celexa), estalopram (Lexapro), sertraline (Zoloft), paroxetine (Paxil), fluoxetine (Prozac)
  - SSNIs—venlafazine (Effexor), desvenlafxine (Pristiq), duloxetine (Cymbalta),
  - Atypical Agents—mirtazapine (Remeron), vilazodone (Vibryd), nefazodone (Serzone), desyrel (Trazodone), buproprion (Wellbutrin).
  - Pearls: Celexa/Lexapro—very well tolerated. Wellbutrin—slightly stimulating. Cymbalta has a specific indicator for pain. Wellbutrin has a specific indicator for smoking cessation.

The Spectrum of Depression

Treatment Modalities: Meds

- **Antidepressants: Are they safe?**
  - Clear risks with the 'older' classes: MAOIs and TCAs.
    - Risk of lethality in overdose clearly documented
    - Anticholinergic, orthostatic, and EKG side-effects
    - Serious drug-drug interactions with MAOIs
    - Poorly tolerated by the elderly.
    - MAOIs always to avoid in pregnancy
  - New generation (beginning with SSRIs):
    - Very safe by comparison.
    - Risk of lethality with OD is relatively low
    - Generally 'safe' in pregnancy—with notable exception of Paxil, though all this is evolving.
    - Drug-drug interactions need to be considered, though not nearly as risk as with MAOIs.

The Spectrum of Depression
Treatment Modalities: Meds

- **Antidepressants**
  - **Do they work? Believe it or not, we're not entirely sure.**
    - 2008 Kirsch study: for mild-moderate, treatment no different from placebo; better efficacy rates for more severe depression.
    - 2010 Fournier article in JAMA: "the magnitude of benefit of AD medication compared with placebo may be minimal or nonexistent in patients with mild or moderate symptoms."
    - 2011 Khin study: compiled efficacy data on all randomized double-blind phase 3 clinical trials 1983-2008: only 53% showed efficacy over Placebo.
    - Concerns over (+) reporting bias: most 'real world' major depressed patients would not qualify for phase 3 clinical trials due to exclusion criteria. AD failure rates among this non-qualifying patient group are much higher (Wisniewski 2009).

The Spectrum of Depression
Treatment Modalities: Meds

- **Antidepressants**
  - **What about the 'real world'? STAR * D**
    - STAR*D NIMH study: 2001-2006—largest, most expensive study ever on the pharmacotherapy for depression:
      - Began with 4041 'real world' pts with major depression; up to 78% of the study group would not have qualified for a phase 3 clinical trial
      - Studied these patients through 4 stages of treatment that involved switches and add-on augmentation techniques. Each subsequent stage was for non-responders to previous stage(s).
      - Each stage involved up to three months of treatment. All remitters (regardless of stage) were followed for up to 1 yr.
      - Trial meds: Citalopram, Sertraline, Bupropion, Venlafaxine, Buspirone, Mirtazapine, Triiodothyronine, Nortriptyline, Tranylcypromine, Lithium

The Spectrum of Depression
Treatment Modalities: Meds

- **Antidepressants**
  - **STAR * D: Findings:**
    - The **official initial remission** rate for stage 1 (Celexa only) was 36.8 %. The **official cumulative remission** rate through all four stages was **67%**. However, these numbers rely upon an evaluation tool (**QID-SR**) that was different and more lenient than the one originally proposed by investigators (**HRSD**)
    - Utilizing the original HRSD tool and counting all patients who entered study, **initial remission rate was 25%** and **cumulative remission rate was 38%.** These numbers are considered valid by the study researchers.
    - **7.1% remission** rate for those who stayed in study up to 12 months. This is an undisputed number.
    - There were no clear advantages to using any one drug regimen over another.

The Spectrum of Depression

Treatment Modalities: Meds

- **Antidepressants**
  - **Do they work? STAR * D: Take Home Points**
    - **In short, less than a third of all patients on ADs achieve initial remission of Major Depression. Less than 40% achieve remission after multiple treatment trials.**
    - **Very few (as few as 7%) stay on antidepressants and report that they are in remission at one year.**
    - **All antidepressants appear to be more or less of equal efficacy, varying mainly in terms of side effect profiles and tolerability.**

The Spectrum of Depression
Treatment Modalities: Meds

- **Atypical Antipsychotics and Depression**
  - Augmentation: meds added-on to an AD regimen.
    - Abilify, Seroquel and Zyprexa/Prozac have been FDA approved adjuncts for MDD. Seroquel and Latuda are FDA approved for Bipolar depression.
    - Very marginal efficacy of these meds is offset by adverse effects (akathisia, sedation, weight gain and metabolic changes (Spielman 2013).
  - Monotherapy: only Seroquel has demonstrated efficacy.
    - Utility limited by sedation effects.
    - Very limited data comparing to AD's.

The Spectrum of Depression

Treatment Modalities: Meds

- **General Augmentation:**
  - Meds that are added to antidepressants to achieve greater treatment effect
    - Lithium, Buspar, Thyroid Hormone, second antidepressants (Wellbutrin and Remeron), Topamax, Lamictal, stimulants, Pindolol, sex hormones, supplements (SAMe, creatinine, omega e fatty acids
    - Very limited head-to-head and placebo controlled research.
      - STAR*D established essentially no advantage of Lithuim vs. Wellbutrin vs. Remeron vs. Buspar. And as a whole, augmentation did not offer much advantage compared to monotherapy for AD.
      - Stimulants, lamictal, sex hormones, Pindolol—largely negative studies.
      - Some positive reports with Topamax
      - Supplements may be helpful , but limited placebo studies.

The Spectrum of Depression
Treatment Modalities: Meds

- **Concurrent Symptom Management**
  - Anxiety
    - Adjunctive use of benzos, low dose range Seroquel (25-100 mg on PRN basis), hydroxyzine.
  - Insomnia
    - Trazodone and Remeron are time honored technques
      - Trazodone: 1:7000 risk of priapism
      - Remeron: weight gain issues!

The Spectrum of Depression

Treatment Modalities: Meds

- **What to do with the medication resistant patient:**
  - It is important to clarify the preferences of the patient. A high medication-motivation vs. low medication-motivation.
    - There is no rule that says 'you can't respond' eventually.
    - Whether the eventual response is placebo or related to natural remission may be ultimately hard to know
  - Avoidance of polypharmacy, though it is generally accepted practice to utilize two antidepressants at once, preferably from different classes.
    - This does not include use of Trazodone or Remeron for sleep
    - QTc monitoring as number and doses of antidepressants increase.
  - As noted, exercise great caution/reservation around use of adjunctive agents like antipsychotics, lithium, thyroid hormone.
  - Consider role of other primary symptoms in the etiology of depression—e.g. mood cycling—for which other medication classes may be appropriate.

The Spectrum of Depression

Pharmacotherapy: take home points

Do antidepressants work? Yes—and so do sugar pills. Specific efficacy appears very low for mild to moderate depression. Highest success rate for Melancholic type major depressive disorder. For most patients, the efficacy of placebo and antidepressant is about equal.

When to use antidepressants? Considering that they are so safe, they can be used frequently, especially when the patient requests them. Remember—AD's are part of our medical culture, whether we like them or not.

Which antidepressants work best? They are all about the same. Specific choices should be driven by the side-effect profiles, safety considerations, and other medical factors (e.g. pregnancy status).

What about use of Antipsychotics and other Augmenting Agents? Very limited efficacy data. Be very careful about exposing pt. to unnecessary risk from drugs with adverse effects.

The Spectrum of Depression

Switching Gears: Counseling Psychology in Primary Care

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Treatment Modalities: Psychotherapy

Overview

- It has long been asserted that the **combination of counseling and pharmacology** is often better than the use of either modality alone (Thase 1997).
- Considering the high rate of placebo effect with antidepressants, we know that psychological factors play a key role in treatment outcomes, even in 'pharmacotherapy-only' cases.
- There are **many different types of psychotherapy**. Very few studies have shown convincing efficacy for any one school over another for the treatment of depression. The most robust factor associated with the success of any therapy is the strength of the **patient-provider bond, i.e., the therapeutic alliance**.
- The **BATHE Technique and the 4 Habits** are two methods for strengthening the therapeutic alliance.
- **Cognitive and Cognitive Behavioral Therapy** are the best known and most researched psychotherapies in the primary care context. They can be applied in short sessions, and individually tailored to the needs of the patient (Orlowska 2016; Studart 2008).

The Spectrum of Depression
Treatment Modalities: Psychotherapy

- **CT/CBT Overview**
  - CT is based around revising **inaccurate beliefs** or **errors in reasoning** that contribute to mental distress.
  - CBT is the combination of CT with behavioral techniques that encourage individuals to **modify actions in specific environments**, and to learn from those experiences.
  - CBT aims to reassert the individual's control over feeling and action.
  - Most studies suggest **equivalent efficacy of CT/CBT vs. Pharmacotherapy** for depression at varying levels of severity. However, the effects of psychotherapy vary according to the experience of the clinician. (DeRubeis 2005).

The Spectrum of Depression

Treatment Modalities: Psychotherapy

- **Models for the CT/CBT:**
  - Orlowska (2016): “10 Minute CBT in primary care”
    - The five-point cognitive behavioral model.
  - Stuart (2008): “The 15 Minute Hour.” (See citation).
  - Case example: Reactivity re-visited

The Spectrum of Depression

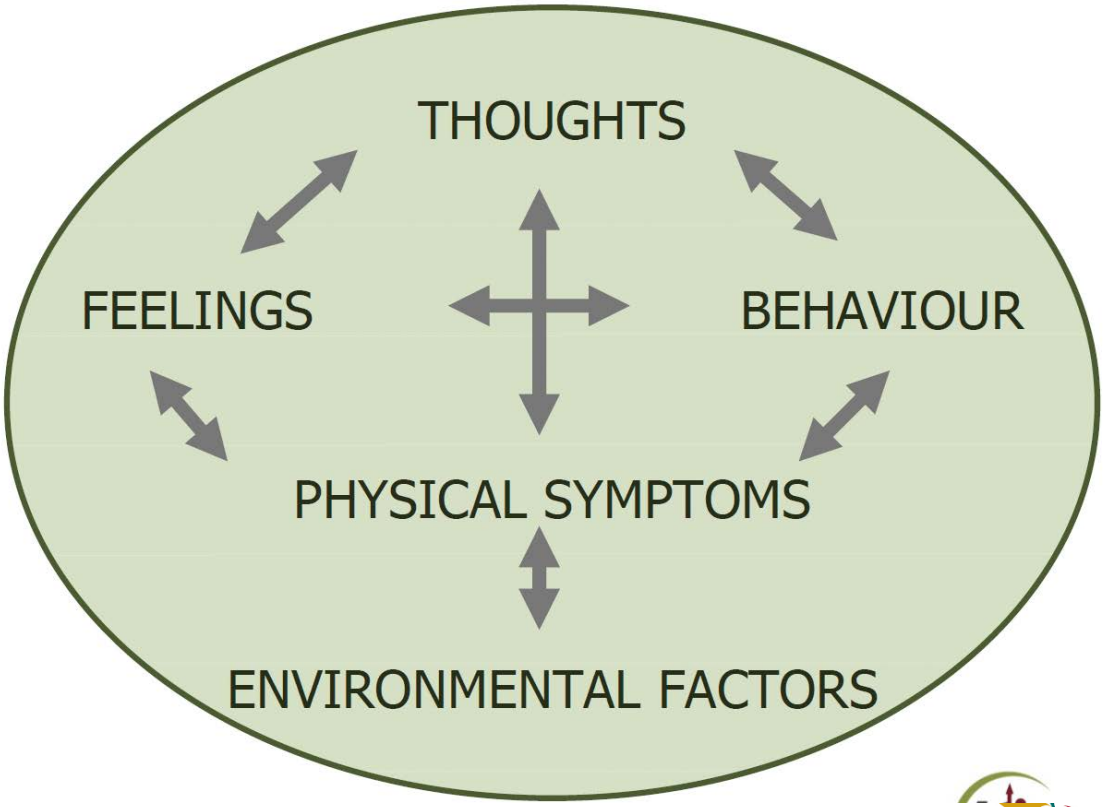
Treatment Modalities: Psychotherapy

- **Models for the CT/CBT:**
  - Orlowska: “10 Minute CBT in primary care”
    - Thoughts reciprocally influence feelings, actions, and physical symptoms, and all this has an effect on how we relate to our environment.
    - Everything really begins with thoughts, examining how certain thoughts lead to reactions in terms of “How I feel,” “What I do,” and “And how my body reacts,” with the ultimate goal of understanding how all this relates to real-life situations and contexts.
      - It may be useful to offer handouts for the patient to fill-in.
    - The business of isolating thoughts is really what we call ‘being mindful.’ It is non-judgmental and objective.

The Spectrum of Depression

Treatment Modalities: Psychotherapy

- **CBT continued: The Five Areas of the Cognitive Behavioral Model (CBM)**



The Spectrum of Depression

Treatment Modalities: Psychotherapy

- **Utilizing the 5-Point CBM**
  - One of the greatest challenges of therapy is in getting patients to communicate their **thoughts in isolation**.
  - Sometimes these thoughts are so tied to certain emotional or behavioral reactions, that it they are difficult to isolate from the reactions themselves.
    - Anger, anxiety, guilt, restlessness, running away, never returning.
  - There is a role, therefore, for **deep breathing, relaxation, reassurance** to untangle thoughts from reactions.
  - There is also a role for helping patients realize that we approach problems **one step at a time**. We do not need to grasp the whole or the big picture—just the immediate thought. Mindfulness is the first step to therapeutic change.

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Treatment Modalities: Psychotherapy

- **Utilizing the 5-Point CBM (continued):**
  - We are not trying to correct thoughts because the patient is ‘wrong,’ ‘bad,’ or ‘inferior’ in any which way.
    - I often use the metaphor of enhancing one’s view of the world through diverse perspectives: this is the only way we can learn new things. We can only learn and become wiser through the incorporation of perspectives that differ from our own **natural or original** way of thinking.
    - We each possess a natural/original system of thinking; our goal in life is to expand beyond that system.
      - Natural/original thinking is very tied to personality
      - It can be also tied to events, such as trauma: this is what we mean by **“Trauma Informed Care.”**

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Treatment Modalities: Psychotherapy

The 5-Point CBM in action: Self-Reactivity Reprise

The cycle of depression often begins with self-awareness over the fact of being depressed.

The Case of the Avoidant: Untangling the Thought-Feeling complex

Thought: "If I am this sad, hopeless, gloomy, lethargic, unmotivated, uninterested, unrested, then I will never:

- Be accepted/successful.
- Establish a relationship
- Enjoy my life

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Feeling: Because of these catastrophizing thoughts, I feel:

- Ever more sad, hopeless, overwhelmed, fatigued
- These feelings intensify my thinking that I am utterly doomed because of my depression, which further intensify my feelings, etc.

A Cognitive Solution: "Wait a minute, who said that being so depressed means you will never be successful in life?"

- There is no shame in being depressed
- There is no rule that says we must be happy
- There are countless examples of absolutely amazing depressed people in the world.
- If I can accept my depression, I won't feel so depressed about being depressed, therefore I will be less depressed, even though I'm still depressed.

The Spectrum of Depression

- **An Affective Solution**: “I actually feel less depressed now, because I’m not depressed about being depressed.”
- **In this way, we can begin to work to solutions at all points in the Cognitive Behavioral Model.**

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- We have considered the specific case of using **CBT** to treat depression in the context of an **avoidant personality profile**, and we have keyed into the interrelationship between thought and feeling around a critical system of thought:
  - The thoughts pertaining to our very state of mind.
- We can generalize the model by invoking other interrelationships over the 5-point CBM.
- We can also consider the entire system in the context of other personality profiles, such as the borderline or the OCD.

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Shifting Gears: The Collaborative Care Model

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- So far, we have discussed the use of medication and psychotherapy to treat depression.
- Nothing is clearly formulaic or algorithmic
- In terms of pharmacotherapy, there are huge, unsolved questions about what to do when the meds fail to work, which is quite common.
- In terms of psychotherapy, we have seen that there are powerful models that can enable PCPs to utilize talk therapy in their practice, but these models are still quite complex, involving concepts like 5-Point CBM, Personality Profile, Mindfulness and Acceptance.

The Spectrum of Depression

- It is therefore understandable, and altogether desirable, to have BH specialists (therapists and psychiatric providers) available in community health centers to help design primary care interventions, especially for complex cases.
- While there are many models for the integration of BH specialists in primary care, we are going to close with just one model: The Collaborative Care Model

The Spectrum of Depression

The Collaborative Care Model (Unutzer 2013).

- Evidence based model for integrating physical and BH services in primary care settings.
- Central elements:
  - Care management with BH specialists
    - Nurses, social workers, psychologists trained in brief-structured psychotherapy
  - Psychiatric consultant
  - PCP

The Spectrum of Depression

The Collaborative Care Model (Unutzer 2013).

- Each patient's progress is tracked using validated clinical scales like PHQ-9.
- Treatment is adjusted and stepped up for patients who are not responding.
- Philosophy is not simply to refer complex cases who meet a pre-defined threshold of severity or chronicity, but to empower PCPs with greater understanding and versatility in the treatment of challenging cases.

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Closing Question for Consideration

Given the profound role of counseling psychology in the treatment of depression, is it not reasonable to consider opening up anti-depressant prescribing to highly trained counseling psychologists—that is to say, PhD level Clinical Psychologists, assuming they acquire advanced medical training in the use and monitoring of medication and providing they are closely supervised by PCPs?

Assessment of Suicidality
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Suicide is a challenging topic to discuss for many reasons.

What is it about suicide that creates challenges for open discussion with clients and colleagues?

Challenges to Talking with Clients about suicide:

Historical Stigma
Fear of making client worse or litigation
Hopelessness/Helplessness
Irritation/Anger/Feeling manipulated

Why focus on suicide prevention in the primary care setting?

- Primary care, especially in rural areas, is where people come for most of their health needs (both physical and mental).

- 70% to 80% of antidepressants are prescribed in primary care settings.

- Approximately 45% of people who died by suicide were seen by their primary care provider within a month before their death.

California

Fatal & Non-Fatal Self-Inflicted Injuries 2013

Overall fatal & non-fatal injury data	Number	Rate
Population (2013)	38,118,385	--
Suicide deaths (2013)	3,990	10.5
Non-fatal self-inflicted injury leading to hospitalization (2013)	15,115	39.7
Non-fatal self-inflicted injury leading to ER treatment (2013)	31,269	82.0

By age	10-14	15-19	20-24	25-44	45-64	65-84	85+
Population	2,509,890	2,755,827	2,873,605	10,584,509	9,631,112	4,060,745	649,913
Suicide deaths	29	149	301	1,159	1,544	639	169
Suicide rate	1.2	5.4	10.5	10.9	16.0	15.7	26.0

By gender	Females	Males
Population	19,142,254	18,976,130
Suicide deaths	936	3,054
Suicide rate	4.9	16.1

By race/ethnicity	AI/AN	Asian/PI	Black/AA	Hispanic	White/Other/Unknown
Population	165,507	5,086,013	2,209,668	14,739,554	14,925,449
Suicide deaths	25	338	166	661	2,800
Suicide rate	15.1	6.6	7.5	4.5	18.8

California and Sonoma County EpiCenter data from the California Department of Public Health

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Fatal & Non-Fatal Self-Inflicted Injuries 2013

Overall fatal & non-fatal injury data	Number	Rate
Population (2013)	491,582	--
Suicide deaths (2013)	52	10.6
Non-fatal self-inflicted injury leading to hospitalization (2013)	184	37.4
Non-fatal self-inflicted injury leading to ER treatment (2013)	581	118.2

By age	10-14	15-19	20-24	25-44	45-64	65-84	85+
Population	29,664	32,378	34,508	121,575	140,467	65,119	11,275
Suicide deaths	1	1	2	8	23	15	2
Suicide rate	*	*	*	*	16.4	*	*

By gender	Females	Males
Population	249,278	242,303
Suicide deaths	8	44
Suicide rate	*	18.2

By race/ethnicity	White/Other/Unknown	Latino/Hispanic	Asian/PI
Population	320,831	126,706	19,554
Suicide deaths	48	1	3
Suicide rate	15.0	*	*

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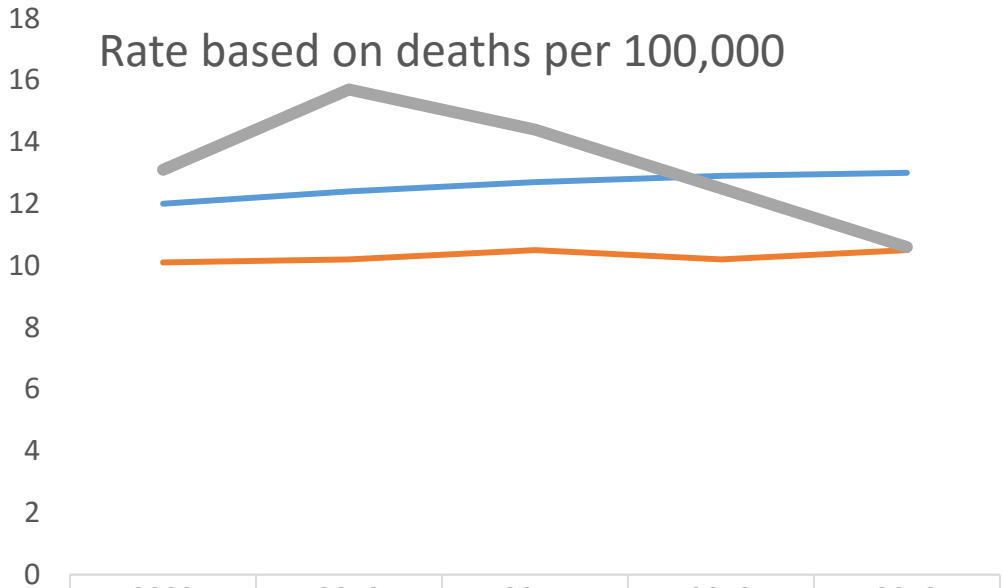
California and Sonoma County EpiCenter data from the California Department of Public Health

Suicide Rate Comparison of USA, California and Sonoma County



	2009	2010	2011	2012	2013
USA	12	12.4	12.7	12.9	13
California	10.1	10.2	10.5	10.2	10.5
Sonoma	13.1	15.7	14.4	12.5	10.6

California and Sonoma County EpiCenter data from the California Department of Public Health, USA data from AAS

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Individual Risk Factors

Previous suicide attempt	Mental disorders, especially major depression
Family history of suicide	Substance abuse disorders or significant changes in substance use
Major physical illnesses, especially with chronic pain	Impulsive and/or aggressive tendencies
Central nervous system disorders, including traumatic brain injury (TBI)	Chaotic family history (divorce, change in living situation, incarceration)
History of trauma or abuse	Lack of social support and increasing isolation
Older White Males	LGBT+

Assessment of Suicidality

- Developing a Collaborative, Non-adversarial Stance with client
- When to ask a client about suicidal thinking
- How to ask a client about suicidal thinking
- What information do we need to ask a client about suicidal thinking to develop a comprehensive risk assessment
- Safety planning

Developing a Collaborative Approach

- **Understand that suicidal thinking makes sense to the patient** when viewed in the context of pt.'s Hx

  "Given what you have been through, I can see why you are having thoughts of suicide."

- **Validate** the depth of patient's **pain**
- **Articulate** that **you want to help patient get out of the pain**, and you can see other options besides suicide

  "We know from research about depression that when you've been in so much pain and hurt, you can get 'tunnel vision' and you may begin to think there is only one solution to the pain...ending your life. I'm not in that state, so I can see lots of options for you, but I understand that might sound impossible to you right now."

- Convey **hope**

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When to Ask Patients About Suicide

Symptoms of Depression Present	• PHQ 9/HAM • Anhedonia, sleep disruption, change in appetite • Irritability, anger, risky behavior, difficulty concentrating • Hopelessness, helplessness, desperation, low self esteem • **Thoughts that life is not worth living/what's the point**
New or Intensified Stressors	• Stressors involving loss and/or shame • **Loss** of housing, job, relationship, **death loved one**, sobriety, health, freedom • Stressor that triggered past suicide attempt
Changes in Clinical Presentation/Transition	• **Increased substance abuse** • Decreased hope for recovery • Agitation/withdrawal/insomnia • Change in psychotropic Rx or change in provider • Unexplained improvement in affect

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How to Ask Patients about Suicide Ideation and Behavior

- **Severity/intensity of past and present ideation**
- **Frequency Duration**
- **Onset**

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Severity of Ideation	Sample Question
Wish to be dead	Have you ever wished you were dead or wished you could go to sleep and not wake up?
Non-specific active suicidal thought	Have you actually had any thoughts of killing yourself?
Active suicide ideation with methods (not plan) without intent to act	Have you been thinking about how you might do this?
Active suicide ideation with some intent to act	Have you had these thought and had some intention of acting on them?
Active suicide ideation with specific plan and intent	Have you started to work out the details of how to kill yourself?
Intensity of Ideation	**Sample Question**
Frequency	How often have you had these thoughts?
Duration	When you have the thoughts how long do they last?
Controllability	Could/can you stop thinking about killing yourself or wanting to die if you want to?
Deterrents	Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?
Reasons	What sort of reasons did you have for thinking about wanting to die or killing yourself? For example, did you want end the pain or stop the way you were feeling, to get someone's attention, get revenge? More than one reason?

Validity Techniques for Eliciting Suicide Ideation, Intent, Plans and Behavior

- **Normalization:** Gentling leading in to the topic by letting the client know that other people with similar feelings think about killing themselves.

- **Shame Attenuation:** Phrase questions so that a positive response does not feel self-incriminating.

- **Behavioral Incident:** Ask for specific facts, details or trains of thought, followed by questions about what happened next.

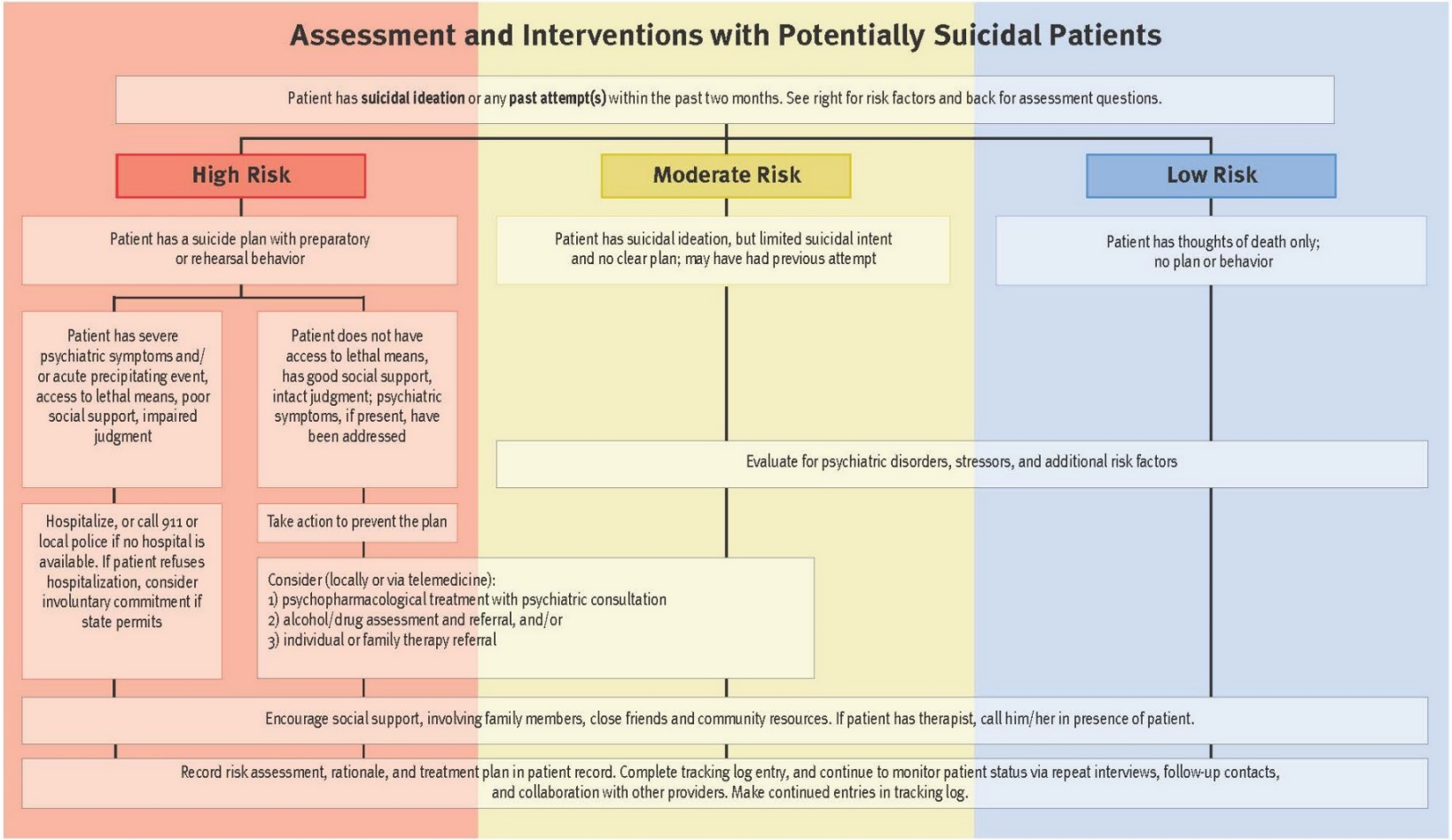
Validity Techniques for Eliciting Suicide Ideation, Intent, Plans and Behavior Part 2

- **Gentle Assumption:** Ask as if assuming that a given behavior has occurred, as opposed to asking whether or not it occurred.

- **Symptom Amplification:** Avoid distortion by setting high upper limits:

On the days when you are thinking about suicide, how much of the time do you spend thinking about suicide, 80% or 90% of the day?

Clinical Judgment



Medical/Legal Criteria

- Reasonable chance that person has a plan and a means to carry out plan.
  - Call law enforcement for 5150 evaluation or certain CMH Providers and certain LPS designated facility workers are authorized in by SC-BHD to write a 5150 hold
- False positives are better than death by suicide
- A 5150 hold has no criminal implications
  - Some clients may experience shame, try to help them see that this is a way to keep them safe for now so that they can get the help they need
- It is not your responsibility to hold a patient against their will.

Safety Planning

http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):
Step 3: People and social settings that provide distraction:
Step 4: People whom I can ask for help:
Step 5: Professionals or agencies I can contact during a crisis:
Step 6: Making the environment safe:
Step 7: Deterrent, what is the person, thing that is worth living for

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Additional Training Opportunities

- Suicide Prevention for Primary Care Settings
  - Developed by
  - 1-2 hours
  - Customizable for your staff
  - No cost
- Assessing and Managing Suicide Risk
  - 7 Hour training for MDs, RNs, Behavioral Health Clinicians
  - CEUs provided (even CMEs)

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