sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION
Michael Kennedy, MFT – Division Director

# Case Discussion
# Starring Melissa Ladrech as Sara Bonjovi and Michael Kozart as Dr. Keigh

Directed by

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# Patient Interview Simulations

**This is a fictitious story based on made-up characters. Any resemblance to living people, current or historical, is entirely coincidental and unintended.**

# Simulated Case: Chapter 1

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# Chapter 1

## Discussion Overview

**Young adult woman presents with symptoms of depression:**

- Topics for Discussion
  - Primary vs. Secondary Depression
  - Medication vs. Counseling

# Primary vs. Secondary Depression

- **8 different Primary Depressive Disorders**
  - Major Depressive D/O
  - Disruptive Mood Dysregulation 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
- **Depression can also be a secondary characteristic of every diagnosis in the DSM.**

# Major Depression

- **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

# MDD with Specifiers

- **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).

# MDD Epidemiology

- **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.**

(Kaplan and Sadock, Synopsis of Psychiatry):

# System of Care

- **Do we feel at this stage that the case is appropriate to be managed by PCP, or should we seek out BH consultation?**

- **What about the role of medication vs. counseling?**
  - **Should the PCP be doing something different? Is the medication approach to depression the most inclusive framework?**

# Simulated Case: Chapter 2

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# Chapter 2

## Discussion Overview

**The focus of the case has now shifted to the management chronic pain and opiate dependency:**

- Topics for Discussion;
  - At what point do we cross the line from chronic pain diagnosis to a Substance Use disorder?
  - What do we mean by co-occurring disorder?
  - Maintenance/Harm Reduction vs. Tapering and Discontinuation

# Substance Use Disorders

- Definition of SUD:
  - Criteria A: Problematic substance use leading to clinically significant impairment or distress as manifested by at least two of following within a 12 month period.
    - Drugs taken in larger amounts for longer periods than indicated
    - Desire to cut down, but unable to do so
    - Trying to obtain drugs at the expense of other daily activities
    - Craving/urge to use
    - Social/occupational impairment
    - Use that results in physically hazardous situations
    - Persistent use despite knowledge of detriments
    - Tolerance
    - Withdrawal symptoms

# Dual Diagnosis Considerations

- 'Dual Diagnosis' does not exist in the DSM, but SAMSHA does refer to 'Co-Occurring Disorders.'
- The concept is challenging:
  - Are we talking about two or more independent or two mutually-dependent disorders. (Opiate Use Disorder, Depression, Pain). Conceptually, what are the benefits of addressing these disorders as discrete/different entities versus as one whole entity?

# Pain Disorder vs SUD

- Is the focus on Pain 'legitimate,' or should we be collapsing that into the focus on a substance use disorder, or should we be dealing with both simultaneously?
  - Has pain become a smoke-screen for the underlying depression and/or substance use disorder?

# Simulated Case: Chapter 3

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# Chapter 3

## Discussion Overview

**We now learn that there are deeper psychological themes that may be driving the depression and the substance use disorder.**

- Topics for discussion:
    - Personality Disorder vs. Personality Profile
    - How might we reformulate the case around ‘Obsessive-Compulsive’ traits?
    - A counseling approach

# Personality

- Prior to DSM 5, personality was coded on Axis II. In DSM 5, there is no distinction between Axis I and II.
- 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. Only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute personality disorders.
  - (DSM 5, p. 647).

# Personality cont.

- **Three Clusters of Personality**
  - Cluster A: Paranoid, Schizoid, Schizotypal
  - Cluster B: Antisocial, Borderline, Narcissistic
  - Cluster C: Avoidant, Dependent, Obsessive-Compulsive
- **Personality Disorder**
  - Qualitatively Distinct Syndrome. DSM 5 recognizes 9 different specific syndromes as outlined above.
  - "An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture."
- **Personality Profile**
  - An evaluation of personality that rests on a continuum between 'normal' and 'maladaptive.'
  - Traits are identified, measured, and clumped into a general profile, but they do not necessarily constitute a disorder.
  - DSM 5 recognizes 6 such profiles: Antisocial, Avoidant, Borderline, Narcissistic, Obsessive-Compulsive, and Schizotypal.

# Personality, continued

- **Obsessive-Compulsive Profile:**
  - Self-identity defined in relation to work or productivity
  - Difficulty completing tasks or realizing goals, associated with rigid and unreasonably high standards
  - So caught up in internal world, has difficulty identify with others. Perceived lack of empathy
  - Relationships sacrificed for work goals.
  - Inflexibility
  - Restricted emotional expression

- The line between Profile and Disorder is one of degree or intensity

# Addressing Depression and Substance Use

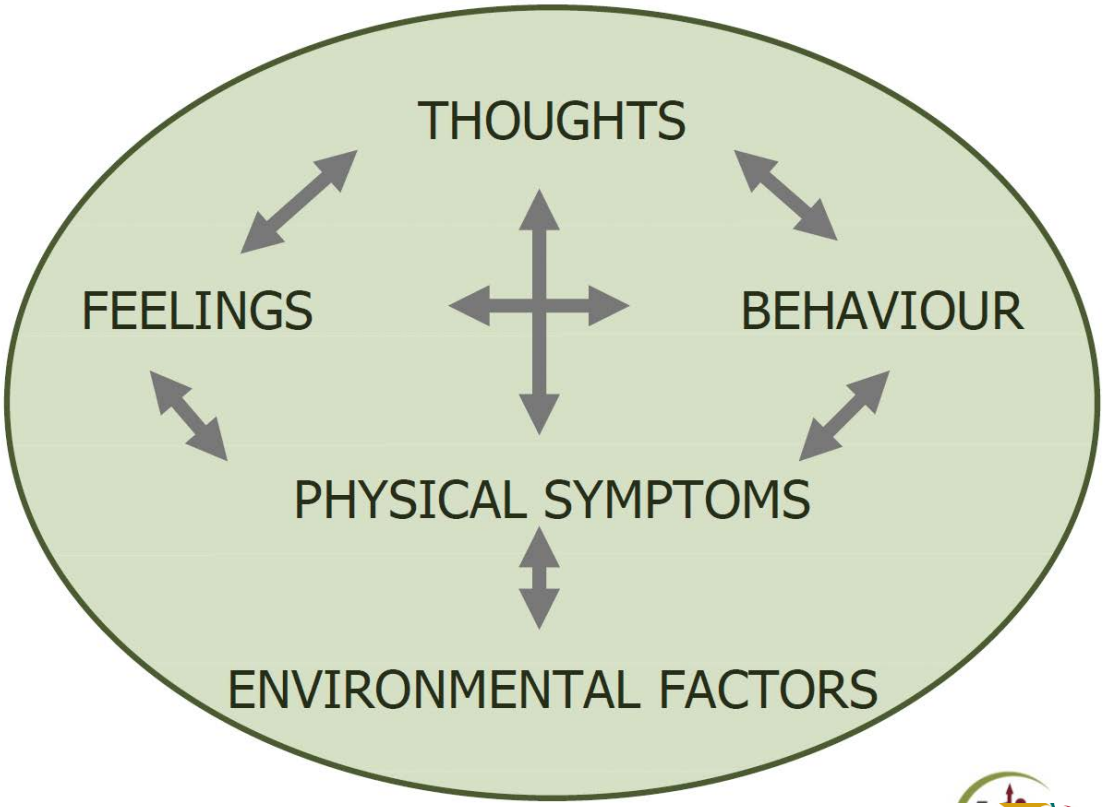
- Arguably, Sara's mental distress is driven by her marked Obsessive-Compulsive personality traits, suggesting that counseling rather than medication might be more valuable.

- Most substance use reflects a self-medicating process. Individuals treat uncomfortable emotions, thoughts, or impulsive behaviors with a numbing/calming/uplifting drug. There is no way to get at the core of the substance use disorder without identifying what they are trying to medicate. By this definition, Substance Use is a manifestation of an underlying 'other' disorder. In the case of Sara, the other disorder could well involve her O-C personality traits.
- Consider the Dynamic/Cognitive approach (as opposed to the static approach).

# The Dynamic/Cognitive Approach

- **One dynamic/cognitive approach is to identify a core vulnerability. In many Obsessive-Compulsive individuals, lack of trust in one's own judgement or ability lies at the heart of the problem.**
- **With our Cognitive Behavioral Model, we can try to key into a key thought that exerts a negative influence over other feelings, behaviors and physical symptoms.**

# The Five Areas of the Cognitive Behavioral Model (CBM)



# The Cognitive Dynamic Approach

- **Core Thought:**
  - "I do not know enough to make a rational decision about…
    …whether I've put in enough effort
    …whether my work job is complete
    …whether I've meet expectations for better or for worse
    …whether I can overlook certain imperfections or risks
    …whether I can say 'this is the best it's going to get'
    …whether I can turn my back on a potential threat and move on."
- **These core thoughts lead to corresponding reactions:**
  - Feelings: anxious, worried, overwhelmed,
  - Behavior: frozen, rigid, perfectionistic
  - Physical Symptoms: tired, tense
- **Reciprocal Effects:**
  - Feelings, Behaviors and Symptoms magnify the thought that one is truly lacking in some ability or skill to be the person you want to be. This further erodes trust in self, leading to more self-defeating thoughts.

# The Cognitive Dynamic Approach

- **Psychological Antidotes:**
  - Focus on correcting core thoughts through rational persuasion, insight. Offer alternative thinking systems. Explain how errant thoughts came to be.
  - Focus of relaxation to address anxiety, fear, worry
  - Behavioral exercises to test out new possibilities

# Concluding Thoughts

- **Valuable counseling breakthroughs can occur in a 15 minute, primary care visit, providing the case formulation is accurate, and efficient therapeutic skills are utilized.**

- **BH consultation can aid in this process: the warm-hand off can flow both ways!!!!**

"Become like water, my friend," Bruce Lee.