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Meeting the Increased Demand for Mental Health Treatment in the Age of COVID-19

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Michael R. Clark, MD, MPH, MBA

Professor of Psychiatry and Behavioral Sciences

George Washington School of Medicine and Health Sciences

Learning Objectives

- Discuss the psychological impacts of the COVID-19 pandemic and rise in mental disorders
- Outline strategies to address the increased demand for mental health treatment
- Identify and diagnose patients with depressive and anxiety disorders
- Review initial therapies for patients with depressive and anxiety disorders
- Describe how to implement patient-centered treatment plans by collaborating with patients

Salient Features of the COVID-19 Pandemic

- Novel and unknown
- Potentially deadly
- Lack of appropriate resources
- Ineffective system

Novelty

- The quality of being new, original, or unusual
- Unfamiliar ≠ unknown
- A growing body of science exists about the novel coronavirus
- That fund of knowledge will continue to expand
- The wisdom we gain is informing our ability to innovate
- Conclusion: we must engage with the virus to overcome it

Deadliness

- The degree to which something is likely to kill
- The fact that people are dying from COVID-19 does not necessarily define the deadliness of the virus
- Death results from a combination of factors, especially our ability to accurately diagnose and treat the illness
- Experience with the virus over time will determine its deadliness
- Our willingness to gain that experience and refine preparedness will decrease the number of deaths

- Conclusion: we must treat patients to learn how to save them

Resources

- Appropriate resources are defined by their suitability or compatibility for the circumstances
- We are resource-rich but lacking in how best to deploy specific resources to achieve success
- Stockpiles only allow for experimentation with new tactics
- The strategy for deployment will determine the success of our plan

- Conclusion: we must shift our focus from stockpiling to utilization

Effectiveness

- The degree to which something is successful in producing a desired result
- Systems are effective not because they are perfect but because they learn and adapt with experience
- The best experience comes from practice
- Extensive practice produces true expertise

- Conclusion: we must overcome fear and take action to improve

Demand for Mental Health Treatment

- Increased rates of depression and anxiety in the general population
- Increased rates of suicidality in healthcare workers
- Increased rates of alcohol and other substance consumption
- Increased rates of women leaving the workforce
- Increased rates of turnover in healthcare
- Increased rates of mental healthcare utilization including SUD treatment

Differential Diagnosis Demands a Framework

- The patient may be sick with a disease
- The patient may be in trouble from an inappropriate behavior
- The patient may be frustrated by his/her own vulnerabilities
- The patient may be demoralized by a particular stressor

Perspectives of Psychiatry Derivations from Sources

- Disease
  - What the patient *Has*
  - Derivation by Category
- Dimensions
  - What the patient *Is*
  - Derivation by Gradation and Quantification
- Behaviors
  - What the patient *Does*
  - Derivation by Goals and Choices
- Life Story
  - What the patient *Encounters*
  - Derivation by Narrative

McHugh & Slavney, 1998

Diseases

Case 1: Etiology → Pathology → Syndrome

Abnormality in structure or function

Broken parts require fixing

Diseases: What Patients Have

- A broken part in the body or brain is generating a pathologic condition and its subsequent symptoms and signs, which include the way the patient is acting
- The structure or function of a bodily part is transformed from normal to abnormal
- Causal relationships explain “how” physiology becomes pathophysiology
- Cures prevent or correct the abnormality

Diseases: What You Should Do

- Search for all possible broken parts causing pathology
- Fix as many broken parts as completely as possible to minimize pathology
- Select treatments that will minimize new damage and subsequent pathology
- Avoid labeling the patient as synonymous with the defect

Case 1: Major Depression & Brain Fog

- 33 y/o woman w/depression, fatigue, and difficulty concentrating
- Mood is “down,” anxious, frustrated, and cannot do anything
- Depression is unresponsive to positive life events with anhedonia
- Cognitive abilities “offline” with inability to multitask and shift focus
- Worried that she has COVID-19, ruminating that tests “don’t work”
- Reading about every organ being affected and unknown consequences
- Unable to work, life stresses increased, pessimistic about the future
- Not sure what treatments to try, more hopeless, thinking about dying

Case 1: Patient-Centered Treatment

- Diagnosis of major depression made
- Neurologic inflammation and/or autoimmune disorders considered
- Ineffective medications lacking specificity tapered and discontinued
- SNRI was started and titrated over several weeks
- Anticonvulsant added for augmentation and titrated w/serum levels
- Husband encouraged and more supportive seeing improvement
- Neurologic work-up/monitoring of inflammatory markers negative
- Discussions with employer about possible return to part-time work

Major Depressive Disorder Critical Elements

- Sustained change in mood, self-attitude, and vital sense disconnected from varying circumstances
- Suicidality is not normal
- Anhedonia
- Deterioration in self-image
- Cognitive dysfunction
- Vegetative signs
  - Diurnal mood variation
  - Early morning awakening

Case 1: Optimistic Outcome

- Depression remitted with positive emotions, optimism, and energy
- Cognitive SXs decreased in intensity w/mild fatigue “not interfering”
- Activity increased with gradual disappearance of brain fog
- Active exercise normalized energy, interest, and vitality
- Previous success in work used as a rationale to return to full-time
- Marital stress and financial problems improved with mutual effort
- Increased socialization with friends reinforced network of support
- No time for doctors’ appointments and Internet chat rooms

Dimensions

Case 2: Potential → Provocation → Response

Quantifiable and measurable traits

Inherent strengths and vulnerabilities

Dimensions: What Patients Are

- Personal features can be quantified along a continuous spectrum of measurement
- Inherent vulnerabilities are evoked by the demands of the setting
- The mismatch results in a physical or emotional reaction
- Guidance toward settings that utilize strengths will avoid having to rely on weaknesses

Dimensions: What You Should Do

- Obtain descriptions of who the patient was before their illness
- Recognize how much of each trait a patient possesses
- Remediation can “add” to a specific quantity
- Match the strengths of each trait with specific tasks to enhance capabilities instead of focusing on the vulnerabilities of deviance

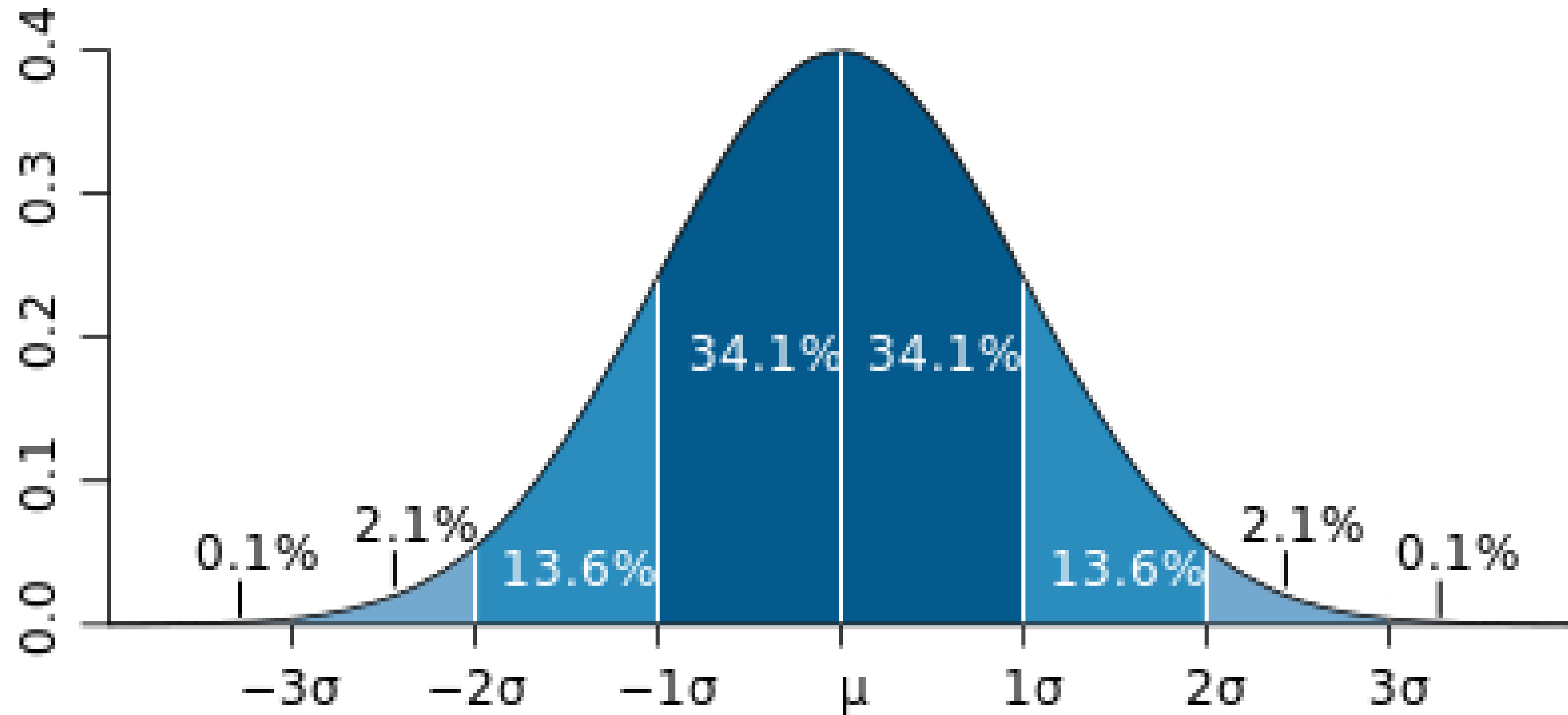
Case 2: Introversion & Somatosensory Focus

- 28 y/o man w/anxiety, upper back pain, and generalized “achiness”
- Pain in shoulders, R > L but hurts everywhere
- Mood is anxious, nervous, worried, and fearful of getting worse
- Pain is a dull ache w/tightness from neck down to shoulder blades
- Multiple somatic symptoms are noted in the Review of Systems
- Multiple HCPs w/lack of progress, works remotely due to COVID-19
- Medications cause side effects and “just mask the underlying cause”
- Spending excess time cataloguing symptoms, exercising to stay fit
- Requesting more consultations to find the broken part and fix it

Case 2: Patient-Centered Treatment

- Affective and anxiety disorders ruled out
- Pain work-up reviewed for completeness and lack of new signs
- Explained pre-morbid personality of an unstable “neurotic” introvert
- Added that usual strengths of organization and fixing problems are now vulnerabilities that are provoking anxiety about failing himself
- Extensive monitoring of body increasing somatosensory amplification
- Directed to stop collecting more information to improve S/N ratio
- Referred to a psychologist for biofeedback and relaxation training
- Increased frequency of follow-up to track condition and limit consults

Normal Distribution



Neurotic Introverts

- Tend to experience negative emotions
- High intensity emotions
- React poorly to stress
- Unpredictable reactions
- Easily threatened
- Sensitive to withdrawal of attention
- Dramatic catastrophizers

- Internally focused by nature
- Prone to somatic preoccupation
- Detail-oriented (trees > forest)
- Analytical and solution-based
- Suffer in ruminative silence
- What did you miss?
- What will go wrong?
- I don’t want to feel bad

Case 2: Optimistic Outcome

- Impressed by referral to an “expert” in biofeedback w/equipment
- Focused obsessionality on learning relaxation techniques “perfectly”
- Anxiety and somatic symptoms decreased with brief body scanning
- Rejected external information sources as not specific to his problems
- Reassured by more frequent appointments to update the doctor
- As pain and other symptoms receded, rib arthropathy diagnosed
- Prescribed specific regimen of rest, stretching, limited exercise
- Validated that there was something wrong but fixable
- Asked to decrease frequency of appointments to focus on work

Behaviors

Case 3: Drive → Choice → Learning

Actions motivated by design and purpose

Complex behaviors result from personal choice

Behaviors: What Patients Do

- Certain behaviors can be problematic and habitually reinforced
- Behavior is the cumulative result of components interacting with a design and purpose
- A behavior has to stop before its components can be altered or shaped to prevent its relapse

Behaviors: What You Should Do

- Point out problematic behaviors every time they occur to promote change to reach the patient's desired goals
- Insist the patient take responsibility for his choices to emphasize looking for options to stop undermining improvement
- Reinforce productive behaviors and their positive consequences whenever possible
- Look for all possible drivers of their actions not just placing blame

Case 3: Addiction & Avoidance

- 58 y/o man w/depression and disability
- Mood is sad, frustrated, angry with ineffectiveness at work and insomnia
- Feels overwhelmed with the responsibilities of work and family
- Working remotely without privacy or socialization with peers
- Wife feels he is less engaged with everything (work, family, hobbies)
- Spending increasing amounts of time alone “working”
- When confronted, he feels overwhelmed and unable to cope
- Alcohol and sedative/hypnotics to reduce anxiety, sleep, and escape
- Physician states that he needs to re-engage with his pre-COVID life

Case 3: Patient-Centered Treatment

- Expressed concern about the lack of a systematic approach
- Utilized motivational interviewing to initiate needed changes
- Developed a plan for stabilizing alcohol use and tapering to baseline
- Described the syndrome alcohol and sedative/hypnotic use disorder
- Discussed elements of avoidance and withdrawal relating to anxiety
- Added basic sleep hygiene techniques to improve insomnia
- Added visual imagery and self-hypnosis for anxiety reduction
- Employed motivational interviewing and mindfulness stress reduction
- Referred to addiction medicine specialist for group behavior therapy

Addiction: Disordered Function

- Preoccupation with something you want to do (craving)
- Being unable to resist the urge to do something (compulsive)
- Loss of the ability to stop something you do (control)
- Doing something despite adverse outcomes (consequences)

Guiding Principles of Motivational Interviewing

- Expressing empathy
  - Acceptance of what is
  - Understanding ambivalence is normal
  - Reflective listening to hear their own words
- Developing discrepancy
  - What is vs what is personally wanted
- Rolling with resistance
  - Solutions reside within the patient
  - Avoids criticism of where the patient is
- Supporting self-efficacy
  - Understand beliefs about ability to change are directly related to their capacity for change
  - Provider believes in the patient’s ability to decide when and how to make desired changes

Case 3: Optimistic Outcome

- Patient acknowledged wanting to change but lacking a plan or skills
- Standing schedules of benzodiazepines and tapering alcohol
- As adverse effects of medications subsided, engagement increased
- Sleep improved with nonmedication techniques
- Anxiety improved with mastery of relaxation techniques
- Increased energy and improved self-efficacy facilitated progress
- Group therapy reinforced new behaviors by confrontation from peers
- Patient able to articulate a variety of poor coping strategies
- Establishing clear value-based goals facilitated progress toward change

Life Stories

Case 4: Setting → Sequence → Outcome

Meaningful events and encounters

Interpretations of success and failure

Life Stories: What Patients Want

- Unintended consequences result from intentional actions
- Meaningful events accumulate to produce a narrative for understanding "why"
- Meaningful connections must be replaced with new interpretations to restore mastery

Life Stories: What You Should Do

- Expand the history to include every aspect of the patient's life
- Understand what it means to the patient to suffer from chronic pain
- Help the patient find an answer to the question, "What good does life hold for me?"
- Recognize there is not just one "true" story

Case 4: Grief & PTSD

- 45 y/o woman w/anxiety and depression
- Anxiety is constant with tension, worry, and feeling “on-guard”
- Depression is episodic with crying spells remembering pre-pandemic
- At her worst, anxiety is uncontrollable and situation feels hopeless
- She has alienated her support system with intrusive distress
- Her husband notes she always “flies off the handle for no reason”
- Her work was a source of pride and validation of her success in life
- She has nightmares of patients dying and tries to delegate patient care
- Now considering “retiring” or requesting a transfer

Case 4: Patient-Centered Treatment

- Explained the reactive state of demoralization and grieving process
- Normalized negative feelings as legitimate and needing validation
- Introduced the concepts of trauma, PTSD, and restoring resilience
- +TIC: Safety, Choice, Collaboration, Trustworthiness, Empowerment
- Discontinued PRNs (muscle relaxants, NSAIDs, sleep aids, tramadol)
- Referred for interpersonal psychotherapy to include her husband
- Found a support group for healthcare professionals affected by COVID
- Developed skills to acknowledge feelings but remain actively engaged
- Redefined work as a means to cope with rather than cause SXs

Grief Therapy as a Work in Progress

- Not a process of waiting out a series of predictable emotional transitions

- An individual period of action
  - Reconstructing a personal world of meaning that has been challenged and
  - Affirming a life that is forever transformed by loss and
  - Renewing oneself with the gains of hard work and achievements realized

- Task theory (Worden)
  - Accept the reality of the loss (reject denial)
  - Experience the pain of grief (avoid withdrawal)
  - Adjust to a changed world without what has been lost (engage challenges)
  - Withdraw emotional energy and reinvest (embrace others)

Case 4: Optimistic Outcome

- Grief improved with less frequent crying spells and losing control
- Identified clear tasks, appropriate boundaries, and skill development
- Stopped all medications citing more confidence in “doing it myself”
- Developed a “toolkit for pacing” to avoid depleting her “gas tank”
- Built a support network of healthcare workers sharing coping skills
- Marital therapy focused on themes of complimentary strengths
- Settled WC claim to eliminate distractions and negative stress
- Re-scripted life story with a focus on new potential for success

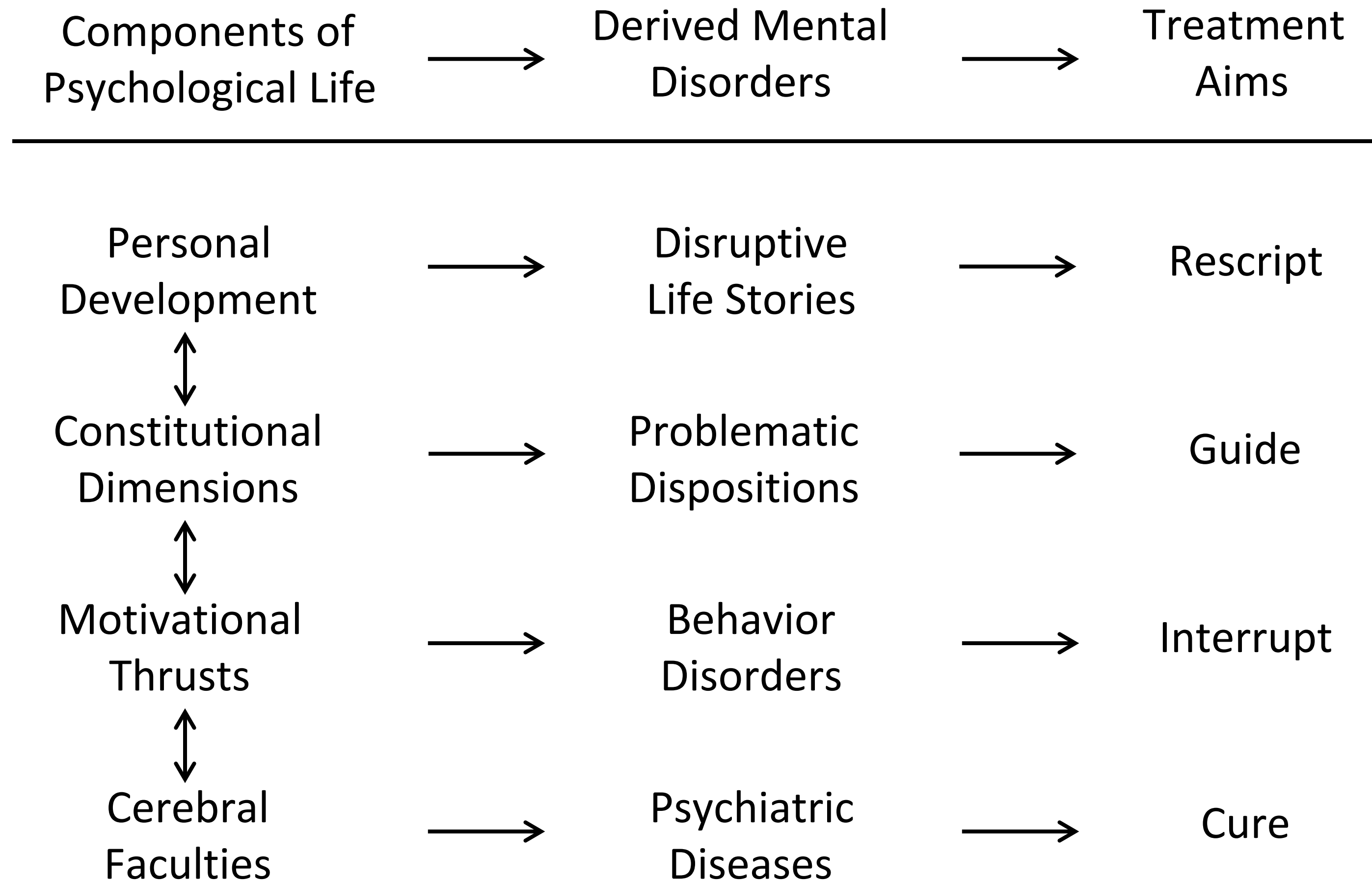
Conclusion

Formulation determines treatment

Personal Stories

- Each person has a sense of potential or hope for what he or she wants out of life
- A series of events may result in which hopes have not been realized or potential not fulfilled
- Demoralization occurs when the patient reaches a meaningful realization that some aspect of their personal life is a failure

Interactive Domains of Mental Life and the Nature of Disorders



References

References

Benzo RP, Kramer KM, Hoult JP, Anderson PM, Begue IM, Seifert SJ. Development and feasibility of a home pulmonary rehabilitation program with health coaching. Respir Care. 2018;63(2):131-140. Accessed March 30, 2021. doi: 10.4187/respcare.05690.

Chen J, Zhao H, Hao S, Xie J, Ouyang Y, Zhao S. Motivational interviewing to improve the self-care behaviors for patients with chronic heart failure: A randomized controlled trial. International Journal of Nursing Sciences. 2018;5(3):213-217. https://www.sciencedirect.com/science/article/pii/S2352013217301679. doi: https://doi.org/10.1016/j.ijnss.2018.04.012.

Dunn P, Conard S. Chronic care model in research and in practice. International Journal of Cardiology. 2018;258. Accessed Apr 2, 2021. doi: 10.1016/j.ijcard.2018.01.078.

Fu SS, Roth C, Battaglia CT, Nelson DB, Farmer MM, Do T, Goldstein MG, Widome R, Hagedorn H, Zillich AJ. Training primary care clinicians in motivational interviewing: A comparison of two models. Patient Educ Couns 2015, 98:61-68

Hashim MJ, MD. Patient-centered communication: Basic skills. American family physician. 2017;95(1):29-34. https://www.clinicalkey.es/playcontent/1-s2.0-S0002838X16304038.

Lown BA, Manning CF. The schwartz center rounds: Evaluation of an interdisciplinary approach to enhancing patient-centered communication, teamwork, and provider support. Academic Medicine. 2010;85(6):1073–1081. https://journals.lww.com/academicmedicine/Fulltext/2010/06000/The_Schwartz_Center_Rounds__Evaluation_of_an.37.aspx. Accessed Apr 2, 2021. doi: 10.1097/ACM.0b013e3181dbf741.

Naar S, MacDonell K, Chapman JE, et al. Testing a motivational interviewing implementation intervention in adolescent HIV clinics: Protocol for a type 3, hybrid implementation-effectiveness trial. JMIR Res Protoc. 2019;8(6):e11200. Accessed Apr 2, 2021. doi: 10.2196/11200.

References

Perlman AI, Abu Dabrh AM. Health and wellness coaching in serving the needs of today's patients: A primer for healthcare professionals. Glob Adv Health Med. 2020;9:2164956120959274. Accessed March 30, 2021. doi: 10.1177/2164956120959274.

Purcell N, Zamora K, Tighe J, Li Y, Douraghi M, Seal K. The integrated pain team: A mixed-methods evaluation of the impact of an embedded interdisciplinary pain care intervention on primary care team satisfaction, confidence, and perceptions of care effectiveness. Pain Med. 2018;19(9):1748-1763. Accessed Apr 5, 2021. doi: 10.1093/pm/pnx254.

Reger GM, Norr AM, Rizzo AS, et al. Virtual standardized patients vs academic training for learning motivational interviewing skills in the US department of veterans affairs and the US military: A randomized trial. JAMA Netw Open. 2020;3(10):e2017348. Accessed Apr 9, 2021. doi: 10.1001/jamanetworkopen.2020.17348.

Richards PS, Inglehart MR. An interdisciplinary approach to case-based teaching: Does it create patient-centered and culturally sensitive providers? Journal of Dental Education. 2006;70(3):284-291. https://onlinelibrary.wiley.com/doi/abs/10.1002/j.0022-0337.2006.70.3.tb04084.x. Accessed March 30, 2021. doi: https://doi.org/10.1002/j.0022-0337.2006.70.3.tb04084.x.

Shemtob L. Should motivational interviewing training be mandatory for medical students? Med Educ Online. 2016;21. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4772702/. Accessed Apr 2, 2021. doi: 10.3402/meo.v21.31272.

Seal K, Becker W, Tighe J, Li Y, Rife T. Managing chronic pain in primary care: It really does take a village. J Gen Intern Med. 2017;32(8):931-934. Accessed Apr 5, 2021. doi: 10.1007/s11606-017-4047-5.