Understanding and management of mental health crisis

Acute stress Reaction, Depression, PTSD

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Trauma and Stressor-Related Disorders

- Acute Stress Disorder(ASD)
- Adjustment Disorders
- Posttraumatic Stress Disorder(PTSD)

Post-traumatic Stress Disorder

- **Exposure** to actual or threatened death, serious or sexual violence in one or more of the following ways:
  - Direct experiencing of traumatic event(s)
  - Witnessed in person the events as it occurred to others
  - Learning that the traumatic events occurred to person close to them
  - Experiencing repeated or extreme exposure to aversive details of trauma
  - Others: exclude electronic media, TV , movies or pictures, unless it is work related

PTSD continued

- Presence of 1 or more intrusive symptoms after the event:
- Recurrent, involuntary and intrusive memories of event
- Recurrent trauma-related nightmares
- Dissociative reactions
- Intense physiologic distress at cue exposure
- Marked physiological reactivity at cue exposure

PTSD continued

- Persistent avoidance by 1 or both:
- Avoidance of distressing memories, thoughts or feelings of the event(s)
- Avoidance of external reminders of that arouse memories of event(s) e.g. people, places, activities

Negative alterations in cognitions and mood associated with the traumatic event(s) as evidenced by 2 or more of the following:

- Inability to remember an important aspect of the traumatic event(s)
- Persistent distorted cognitions about cause or consequence of event that lead to blame of self or others
- Persistent negative emotional state
- Marked diminished interest
- Feeling detached from others
- Persistent inability to experience positive emotions

Marked alterations in arousal and reactivity with 2 or more of:

- Irritable behavior and angry outbursts
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance

- Duration of disturbance is more than one month AND causes significant impairment in function
- Specifiers:
- With dissociative symptoms (derealization or depersonalization)
- With delayed expression (don't meet criteria until >6 months after event)

PTSD Epidemiology

- 7-9% of general population
- 60-80% of trauma victims
- 30% of combat veterans
- 50-80% of sexual assault victims
- Increased risk in women, younger people
- Risk increases with “dose” of trauma, lack of social support, pre-existing psychiatric disorder

Comorbidities

- Depression
- Other anxiety disorders
- Substance use disorders
- Somatization
- Dissociative disorders

Post Traumatic Stress Disorder Etiology

- Conditioned fear
- Genetic/familial vulnerability
- Stress-induced release
  - Norepinephrine, CRF, Cortisol
- Autonomic arousal immediately after trauma predicts PTSD

PTSD Treatment

- Debriefing immediately following trauma is NOT necessarily effective
- Cognitive-behavioral therapy, exposure
- Group therapy
- Medications – antidepressants, mood stabilizers, beta-blockers, clonidine, prazosin, gabapentin

Pharmacotherapy for post traumatic stress disorder.
Cochrane Database Sys Rev 2006 Jan 25(1):CD002795

Acute Stress Disorder

- Similar exposure as in PTSD
- Presence of ≥9 of 5 categories of intrusion, negative mood, dissociation, avoidance, and arousal related to the trauma.
- Duration of disturbance is 3 days to 1 month after trauma
- Causes significant impairment

General treatment approaches

- Pharmacotherapy
  - Antidepressants
  - Anxiolytics
  - Antipsychotics
  - Mood stabilizers
  - Others
- Psychotherapy- Cognitive Behavior Therapy, trauma-focused
- EMDR

Cautions

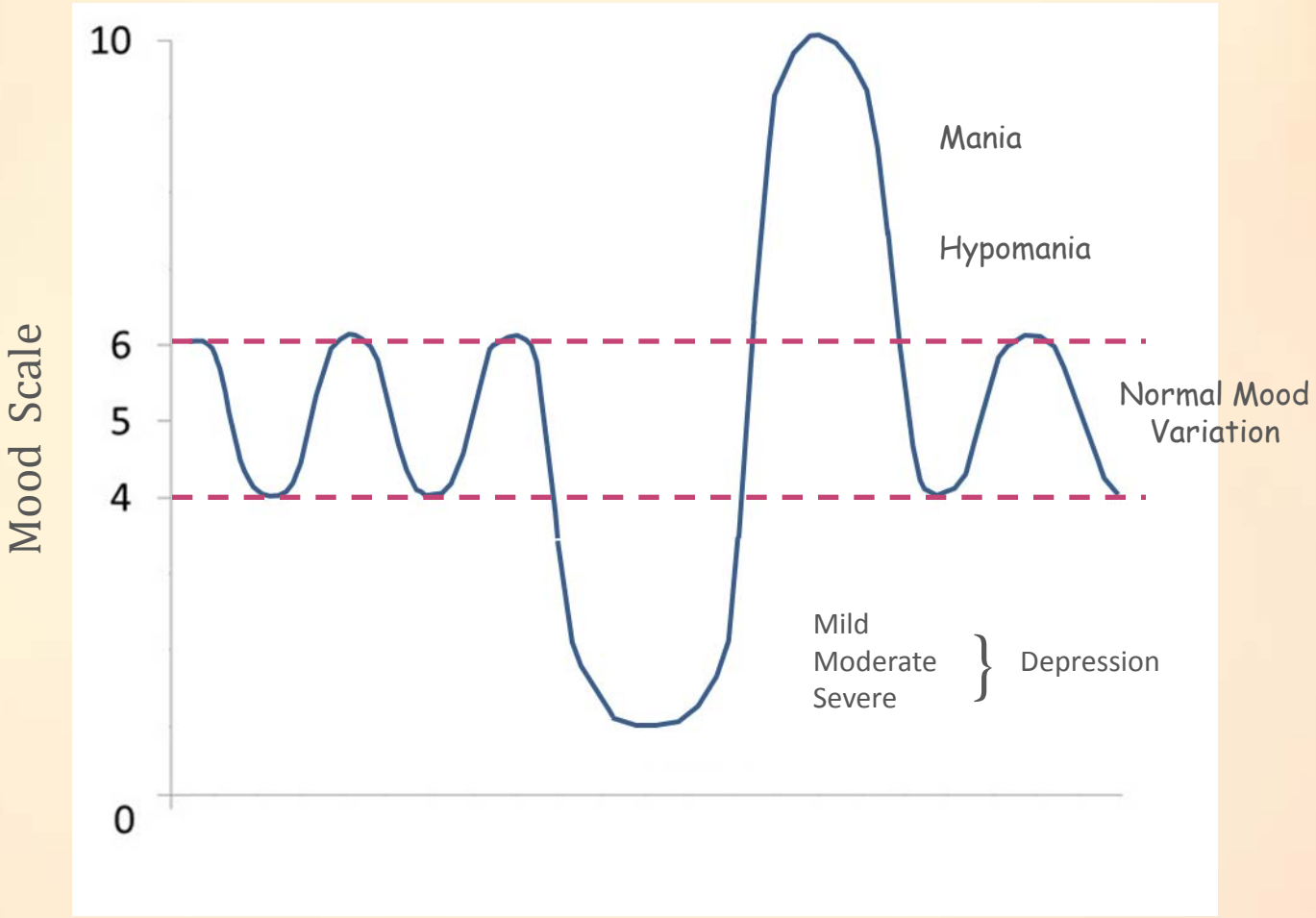
- Benzodiazepines are very effective in reducing anxiety symptoms however due to the risk of dependence must use with caution
- Depending on the patient may either use on a prn basis or scheduled
- For patients with a history of addiction or active drug/ alcohol abuse or dependence benzodiazepines are not an option

Depression

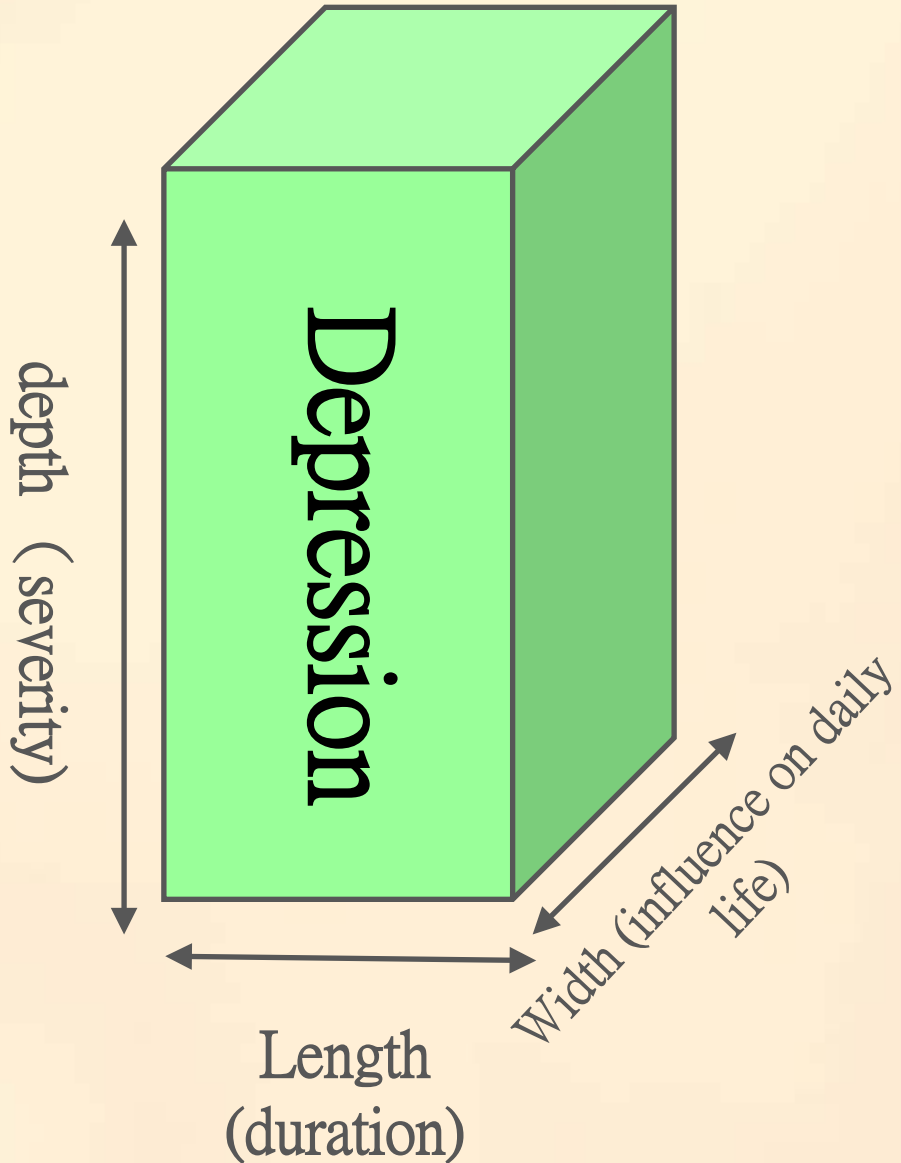
Epidemiology

- Prevalence: 0.9% - 3.4% (using the DSM-IV standard for community surveys of children and adolescents in different countries)
- The proportion of depression among boys and girls is similar during childhood, but the prevalence of depression among adolescent girls is twice that of boys
- Children's clinical manifestations may differ from adolescents. Children may show irritability, separation anxiety and hyperactivity / poor concentration more frequently
- Compared to children, depressed teenagers are more likely to show despair and helplessness, lack of motivation or fatigue, lack of sleep, weight loss, substance abuse, delusions, suicidal ideation and suicidal attempts
- Similar to adults, Major Depressive Disorder (MDD) in adolescents has a chance of recurrence with an average depressive episode of 7 to 9 months
- 60-80% of Mood disorder patients can recover with appropriate treatment

Depressed symptoms: a continuum



Difference between normal mood fluctuation and depression



Depressed s/s: a continuum

- Normal mood variation
- Adjustment disorder
- Dysthymia
- Depressive episode: mild, moderate, severe severity
- Bipolar affective disorder

Diagnostic criteria

- WHO
  - International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)

  《疾病和有關健康問題的國際統計分類

  (第10次修訂本) 》
- APA
  - The Diagnostic and Statistical Manual of Mental Disorders 5th version (DSM-5)

  《精神疾病診斷與統計手冊 (第5次修訂本)》

Symptoms of Depression	
Emotion	➢ Persistent low mood or feeling of emptiness ➢ Loss of interest in previous enjoyable activities ➢ Restlessness and irritability
Biological	➢ Weight loss/ gain, increase/ decrease in appetite ➢ Insomnia/ hypersomnia ➢ Fatigue, low energy level
Cognitions	➢ Sense of hopelessness and guilty feeling ➢ Poor concentration and indecisiveness ➢ Sense of uselessness, worthlessness, meaningless ➢ Suicidal idea and attempt
Psychotic symptoms	➢ Hallucinations and delusions

Normal mood fluctuation vs. depression

Severity	Normal mood fluctuation	Depression
Durations	Shorter (several hours to few days)	Longer (at least persistent for over two weeks, can lengthen to months or years)
Symptoms	Less severe symptoms	More severe
	Mood: depressive, grief, sad	Mood: chronic low mood, or irritability
	Cognitions: may not be too negative	Cognitions: low self-esteem, hopelessness, unreasonable guilt, suicidal idea, may have psychotic symptoms such as delusion and hallucination
	Physical: normal	Physical: increase or decrease in appetite and body weight, insomnia/ hypersomnia, anxiety, poor concentration, psychomotor retardation
	Behaviours: less influence in daily life	Behaviours: repeated rumination about being failure, loss of interest in previous enjoyable activities

Severity	Normal mood fluctuation	Depression
Daily life	Only affected some aspects	*Generally affected (e.g. peer relationship, work/ academic performance, self-care, etc.)*
Self-image	Temporary changes of confidence, still with hope about future	*Poor self-esteem, being a failure/ burden to others*
Aetiologies	Environmental/ personality	Biological/ hereditary Environmental/ personality
Treatment	Psychiatrist consultation may not be necessary Some counselling services such as self-help group, social support etc.	Drug treatment/ Counselling Psychotherapy Social support

Depression symptoms in children and adolescents

	Children	Adolescents
Physical	▪ physical discomfort (e.g. epigastric pain, headache)	▪ physical discomfort ▪ fatigue ▪ weight gain or loss
Emotion	▪ irritability	▪ irritability, depressive mood, hopelessness
Thoughts	▪ negative cognitions	▪ low self-esteem, poor confidence ▪ negative cognitions
Behaviours	▪ oppositional, disruptive behaviors, fights	▪ Social withdrawal, deterioration in academic performance, school refusal ▪ *Deliberate self-harm behaviours/ suicidal attempts*

Friedberg, Robert D., McClure Jessica M. (2002). **Clinical Practice of Cognitive Therapy with Children and Adolescents**. *Chapter 11 Working with Depressed Children and Adolescents*. P.181-217

Assessment

- Clinical assessment

  - Interviews : current symptoms, comorbidities

- Personal history : Developmental, School, Social and Drug Abuse History, Past medical history, Personality
- Family history: family circumstances and patterns of discipline and interaction
- Mental state examination during interview
- Observation and information on other channels (e.g. family members, school, social workers, etc.)
- Assess the impact of symptoms on daily life - such as school performance, work, relationships, etc.
- Physical examination and other tests
- Questionnaires :
  - Beck Depression Inventory (BDI) ,
  - Hamilton Anxiety Rating Scale (HAM-A) ,
  - Positive and Negative Syndrome Scale (PANSS)

Differential diagnosis

Adjustment disorder

- Caused by stress of a particular incident
- Usually lasts not longer than three months
- Can clearly identify the reasons
- High risk group: poor stress coping skills, poor social support
- Symptoms resolved when stress decreased
- Counselling and occasionally drug medication can cure the disorder
- If there is delay in diagnosis and treatment, the condition may deteriorate, and even evolve into anxiety or depression

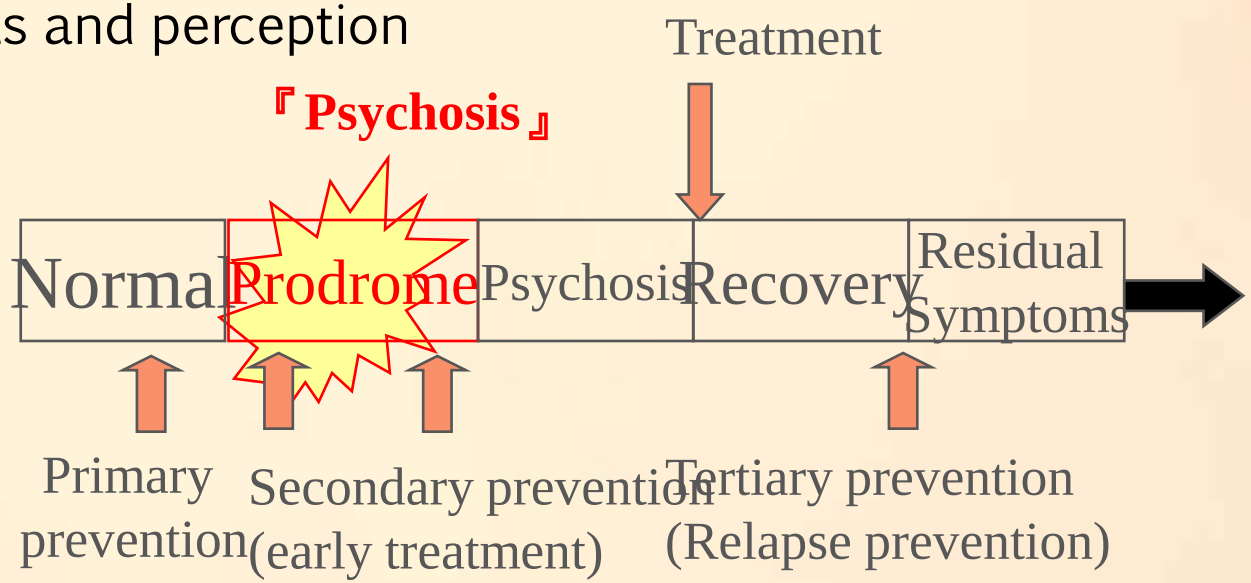
Bipolar affective disorder

- The so-called "mania" refers to the emotional out of control, elated mood, in short, is the opposite of depression.
- About one out of every hundred people have manic depression. Most of the onset of age in adolescence to adulthood. Fewer patients have onset after the age of 40. The proportion of men and women is about one to one.
- Aetiologies:
  - Imbalance of neuro-transmitters, such as serotonin
  - Hereditary : 70-80%
  - Sometimes, patients are first diagnosed with depression. When they take antidepressants, and they themselves inherit the gene for manic depression, they may turn from depression to mania.

Symptoms of Bipolar Affective Disorder	
Patients may experience signs of depression or mania. Usually patients have only one symptom at one time, but with some exceptions.	
Depressive episode	Persistent low mood, inability to cope with daily life
Manic swing	Hypomania and mania, depending on the severity and duration
Emotions	Patients are elated or easily irritable
Cognitions	Flight of ideas, felt being superior to others, poor judgment, some severe cases may have grandiose delusion
Biological	High energy level, decrease need to sleep, increase libido
Behaviours	Overtalkativeness, difficult to be interrupted, overspending, overfriendly, promiscuity

Psychosis

- Disturbance of neurotransmitters such as dopamine, causing disorders of thoughts and perception



- About 1% of the total population suffers from this disease. Every ten thousand people, there are 5 newly emerged cases each year, more often in adolescence and early adulthood.

Symptoms of psychosis	
Positive symptom (陽性病徵)	Delusion, hallucination, thought disorder
Delusion	False belief, based on incorrect interference about external reality, inconsistent with facts, violate logic and can not be explained by the social cultures (e.g. religions and customs) in which they live. Most patients become suspicious, believing they are being monitored, tracked, and persecuted
Hallucination	Sensory abnormality when one hears, sees, smelt, or physically feels something that does not exist. For example, where there is no one is around, patients heard someone talking to them.
Derailment of thoughts/ speech	The content of the conversation is often out of tune, incoherent or poverty in content
Negative symptom (陰性病徵)	Affective flattening or blunting, poverty of speech or speech content, poor self-care, lack of motivation, anhedonia, social withdrawal.
In addition to positive and negative symptoms, patients have impaired cognitive, such as concentration, judgment, and memory loss. These symptoms make the patient's social and work ability decline significantly.	

Treatment of Depression

Drug treatment

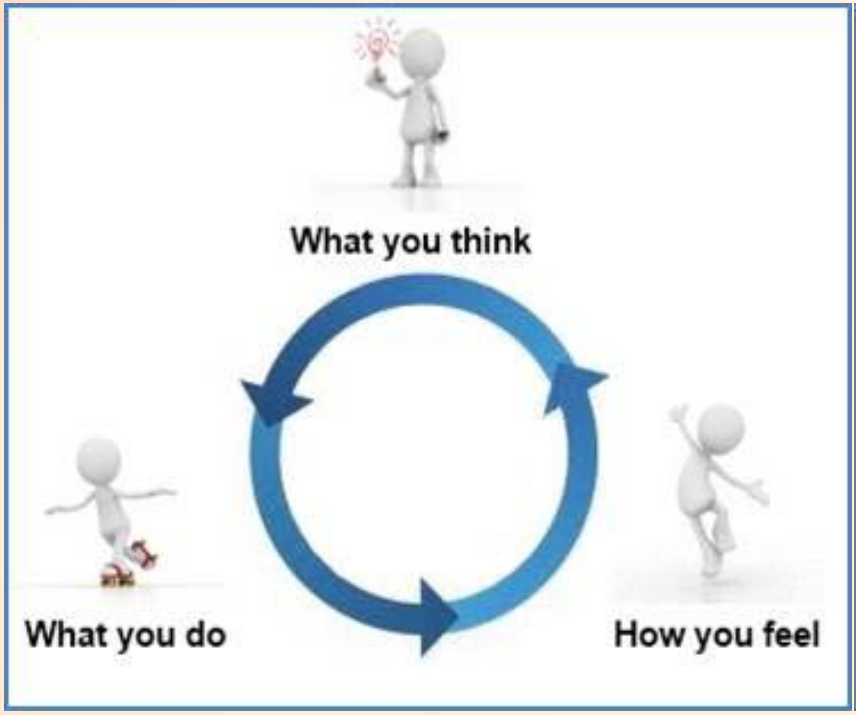
- Selective Serotonin Reuptake Inhibitor (SSRI), e.g. Fluoxetine (to monitor suicidal risk)
- Other antidepressant: Mirtazapine, Venlafaxine, Desvenlafaxine
- TCA/ MAOI are not used in adolescence
- Patients usually have significant improvement in the first two weeks after taking the medication, but usually take 6 to 8 weeks to take effect
- More common side effects include: anxiety, indigestion, diarrhoea or constipation, loss of appetite and weight loss, sleep problems (insomnia or drowsiness), dizziness, headache, etc. These side effects usually improve over time
- When patients respond to one or more medications, medications should be taken for 6 to 12 months or longer to avoid recurrence

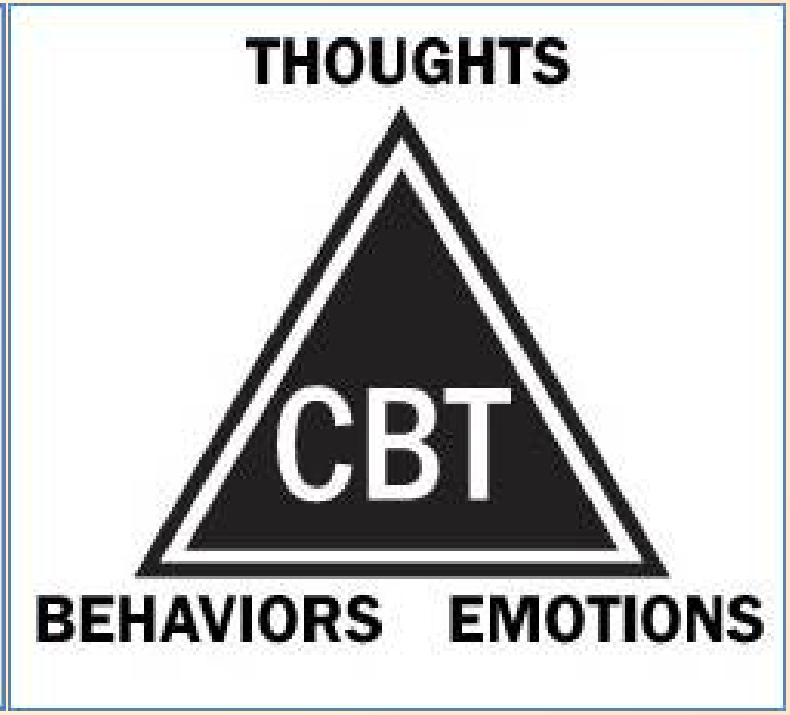
Psychotherapy

- Problem Solving : to handle stress-coping, emotional or peer relationship problems
- Cognitive Behavioral Therapy (CBT) : change inappropriate cognitions and behavioural patterns
- Interpersonal Therapy (IPT-A) : Suitable for suicide adolescents with interpersonal problems, short course of treatment (12-14 weeks)
- Dialectical Behavior Therapy (DBT) : improve resistance
- Family Therapy : Suitable for adolescents with family problems, strengthening problem solving and conflict resolution capabilities within the family and reducing family members' reproof and adversarial pressure on young people

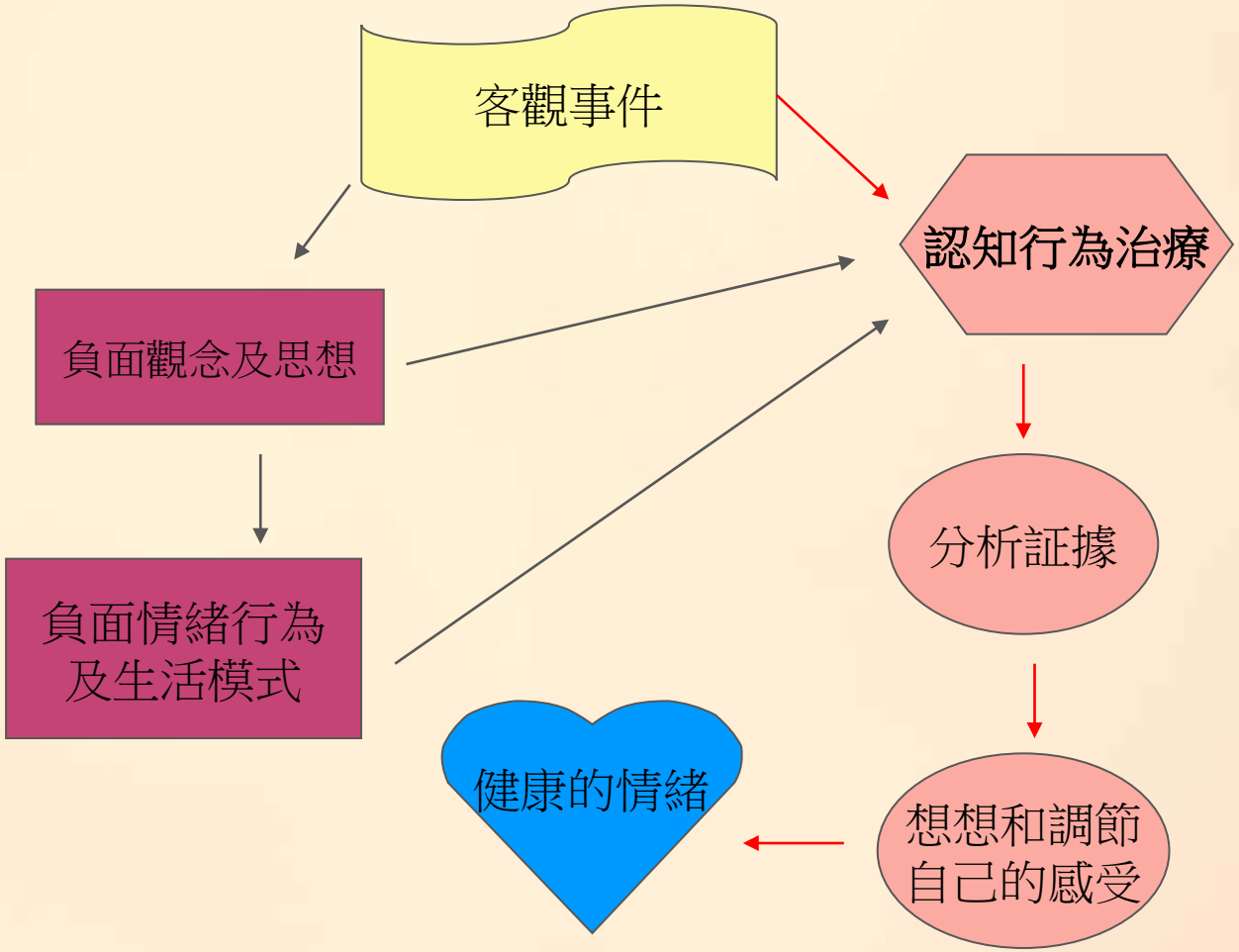
Cognitive behavioral therapy

The core principle of CBT is that identifying and changing maladaptive thinking leads to change in affect and in behavior

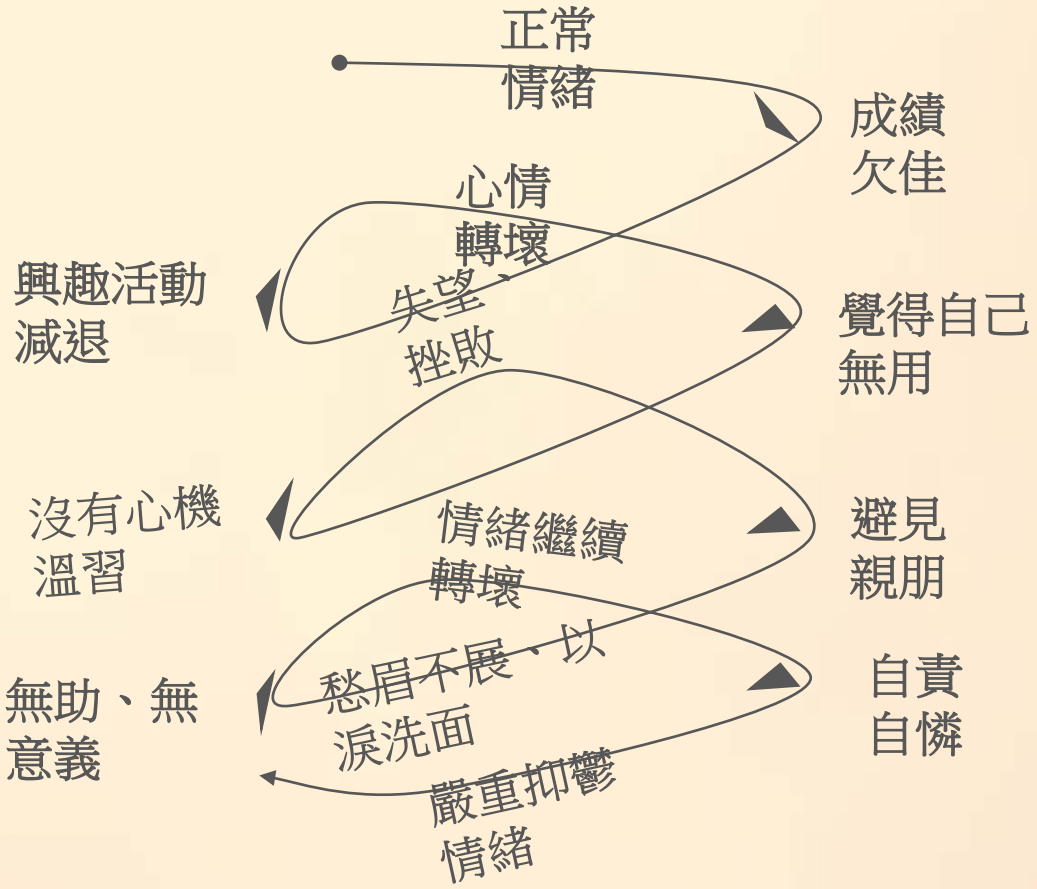




CBT Cognitive behavioral therapy (認知行為治療)



抑鬱情緒持續出現與行為的關係



Take Home Message

Depression is a well defined biological illness

Depression is common

Depression is underdiagnosed

Depression is highly treatable with medications

Newer drugs have fewer side effects and high tolerability

Early detection and treatment of depression is vital due to high suicide risk

Depression causes lots of suffering to patient and family, costs a lot to society (the worst disease) !

Obstacles to treatment: ignorance and stigmatization

How health professionals help students with depression?

- Listening: Learn more about patients, encourage patients to express feelings and difficulties, and give appropriate support
- Encourage patients to arrange a regular life (Activity Scheduling, Behaviorial activation)
- Encourage patients to have some degree of social contact
- Let patients know more about their condition, encourage patients to receive treatment and cooperate with health care workers
- Advise patients to stop drinking or drug abuse (if applicable)
- Pay attention to the changes of the patients' condition.
- If there is a tendency of self-harm behavior, seek help from the relevant parties/AED as soon as possible

The Hong Kong College of Psychiatrists
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- Thank You!
- Q & A ?