ECHO Idaho: Behavioral Health in Primary Care

Chronic Medical Conditions and Mental Illness

November 6, 2019
Tara Whitaker, MD

The speaker has no significant financial conflicts of interest to disclose.
Learning Objectives

• Identify connections between mental illness and chronic disease
• Encourage communication among the medical and mental health teams
• Discuss specific strategies that can help promote physical and mental health when they coexist
Chronic Diseases and Mental Health

• Chronic diseases: generally non-communicable, prolonged in duration, do not resolve spontaneously and are rarely cured completely

• Include illnesses such as diabetes, cancer, COPD, arthritis and heart disease
Chronic disease is common

Six in ten adults in the US have a chronic disease and four in ten adults have two or more.

- Heart Disease
- Cancer
- Chronic Lung Disease
- Stroke
- Alzheimer's Disease
- Diabetes
- Chronic Kidney Disease
Depression and chronic disease

• Commonly coexist
• Unclear if depression causes chronic disease or chronic disease causes depression
• Multiple associations
  – Risk of tobacco use is about 2 times as high for those with mental illness
  – Injuries, both intentional and unintentional, are 2-6 times higher for persons with a history of mental illness than those without the history
Prevalence of major depression in chronic medical illness

- Alzheimer's disease: 11%
- HIV: 12%
- CAD: 17%
- Stroke: 23%
- MI: 25%
- Diabetes: 27%
- Cancer: 42%
- Parkinson's disease: 51%

Anxiety and depression in COPD

- GAD is 3 times more prevalent in COPD than the general population, up to 55%
- MDD affects approximately 40% of COPD patients
- COPD patients report heightened edginess, anxiousness, tiredness, distractibility and irritability—Likely all at least partially related to breathlessness
Anxiety and depression in COPD, Cont

• 2 way street:
  – COPD increases the risk of major depression
  – Major depression is associated with
    • tobacco consumption
    • poor adherence to medications
    • decreased physical activity
  – Volume reductions in anterior cingulate cortex correlate with persistent fear of performing physical activity
Treat mental illness early in COPD

• Don’t overlook somatic symptoms of anxiety (or attribute symptoms only to anxiety)
• Harder to differentiate processes in younger patients (less than 60)
• Treat early in disease course!
Treatment options

• OK to treat with pharmacotherapy, but try to avoid benzodiazepines (opt for buspirone, TCAs, SNRIs, SSRIs)—all have been shown to reduce MDD, GAD, and shortness of breath

• Motivational interviewing to promote engagement in care and promotion of self-management of symptoms
  – Progressive muscle relaxation
  – Pulmonary rehab
  – Physiotherapy
  – CBT
Depression after Acute Coronary Syndrome (heart attacks)

• AAFP guideline 2019:
  – Patients should be routinely screened for depression after heart attack (Beck, PHQ, Geriatric Depression Scale)
  – Combination of antidepressants and CBT seem to be effective
  – Women have higher rates of depression after acute coronary syndrome than men
Prescription medication contribution to depression

- Prevalence of use of medications with depression as an adverse effect: 37.2%
- Prevalence of depression was 15% for those who reported use of 3 or more medications with depression as an adverse effect vs 4.7% for those not using such medications
- Patients may not have insight into cumulative, long-term effect
Medications and depression, cont.

• Look at the med list!
  – Narcotic pain meds
  – Beta-blockers (metoprolol, atenolol)
  – Hormone therapy (estradiol)
  – Ibuprofen
  – Anxiolytics, hypnotics (benzos, zolpidem)
  – Antacids (PPIs and H2 blockers)
  – Antihistamines (cetirizine, etc.)
  – Anticonvulsants (gabapentin, benzos)
  – Corticosteroids (prednisone, etc.)
  – Antidepressants (look to depression as a side effect as well!)
Resource Plug

• RESOURCE PLUG: deprescribing.org—evidence based guidelines for deprescribing appropriately
Grief or depression?

- Differentiation in seriously ill patients is important.
- Seriously ill patients commonly struggle with grief, but can have comorbid depression.
- Approximately 1 in 5 patients who are seriously ill are depressed.
- Early detection and treatment with medications and therapeutic strategies is essential.
- RELIEVER mnemonic for facilitating grief in seriously ill patients.
<table>
<thead>
<tr>
<th>Task</th>
<th>How to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reflect</td>
<td>Reflect on or mirror the patient’s feelings by naming and summarizing the underlying emotion. Example: If the patient asks, “Why did I get this horrible disease?” respond with, “I can see that you are angry.”</td>
</tr>
<tr>
<td>Empathize</td>
<td>Example: “It must be really hard for an independent person like you to accept help. I really admire how gracious you are being about this.”</td>
</tr>
<tr>
<td>Lead</td>
<td>Guided questions can help facilitate the grief process. Examples: A. “As you are planning for the time ahead, what are you looking for?” B. “Thinking about the time ahead, what worries you the most?”</td>
</tr>
<tr>
<td>Improvise</td>
<td>A grieving patient’s mood often fluctuates over time. Patients may suddenly change coping strategies, which requires flexibility on the part of the physician to be able to respond appropriately. It is important to first gauge the patient’s current mood and offer support congruent to the patient’s current emotional state. Some patients may want to process their grief by recounting past or recent experiences. Others may want a quiet and supportive presence, and prefer to remain in companionable silence.</td>
</tr>
<tr>
<td>Educate</td>
<td>Explain to the patient that grief ebbs and flows. Ensure that the patient and the patient’s family understand that persons grieve in different ways, and that feelings of anger, yearning, and sadness are all common manifestations of grief. Similarly, family members may manifest their anticipatory grief as anxiety or anger towards the patient. Identifying, validating, and channeling constructive outlets for anger help decrease conflicts between patients and their families.</td>
</tr>
<tr>
<td>Validate the experience</td>
<td>Validate the normalcy of the “emotional rollercoaster” experience and support your patient through the process. Example: “It seems to me that you are responding normally to a very difficult situation,” or “These mood swings are very common when coping with a serious illness.”</td>
</tr>
<tr>
<td>Recall</td>
<td>Many patients who are seriously ill often do a life review and reflect on their accomplishments and disappointments. Ask about personal accomplishments, special stories, or legacies that patients may wish to hand down to future generations.</td>
</tr>
</tbody>
</table>

*Information from reference 5.*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Normal grief</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature of response</td>
<td>Adaptive</td>
<td>Maladaptive</td>
</tr>
<tr>
<td>Focus of distress</td>
<td>Distress is in response to a particular loss and does not affect all aspects of life</td>
<td>Distress is pervasive and affects all aspects of life</td>
</tr>
<tr>
<td>Symptom fluctuations</td>
<td>Comes in waves but generally improves with time</td>
<td>Constant</td>
</tr>
<tr>
<td>Mood</td>
<td>Sadness and dysphoria</td>
<td>Protracted and constant depression or flat affect</td>
</tr>
<tr>
<td>Interests/capacity for pleasure</td>
<td>Interests and capacity for pleasure intact, although engagement in activities may be diminished because of functional decline</td>
<td>Anhedonia with markedly diminished interest or pleasure in all activities</td>
</tr>
<tr>
<td>Hope</td>
<td>Episodic and focal loss of hope; hopes may change over time, giving persons positive orientation toward the future</td>
<td>Hopelessness is persistent and pervasive</td>
</tr>
<tr>
<td>Self-worth</td>
<td>Maintained self-worth, although feelings of helplessness are common</td>
<td>Worthlessness with feeling that one’s life has no value</td>
</tr>
<tr>
<td>Guilt</td>
<td>Regrets and guilt over specific events</td>
<td>Excessive feelings of guilt</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td>Passive and fleeting desire for hastened death</td>
<td>Preoccupation with a desire to die</td>
</tr>
</tbody>
</table>

Information from references 17 and 28.
Key Points

• Chronic medical diseases and mental illness often coexist and exacerbate each other

• All members of the healthcare team have a role in helping identify and treat comorbid conditions

• Deprescribe when possible

• Identify and work to support patients in grief associated with serious medical illness
References

- Mental Health and Chronic Disease. Issue Brief No. 2, October 2012. CDC.gov

- Additional resources upon request