Mood Disturbances

Part 2

How to understand the abnormal?

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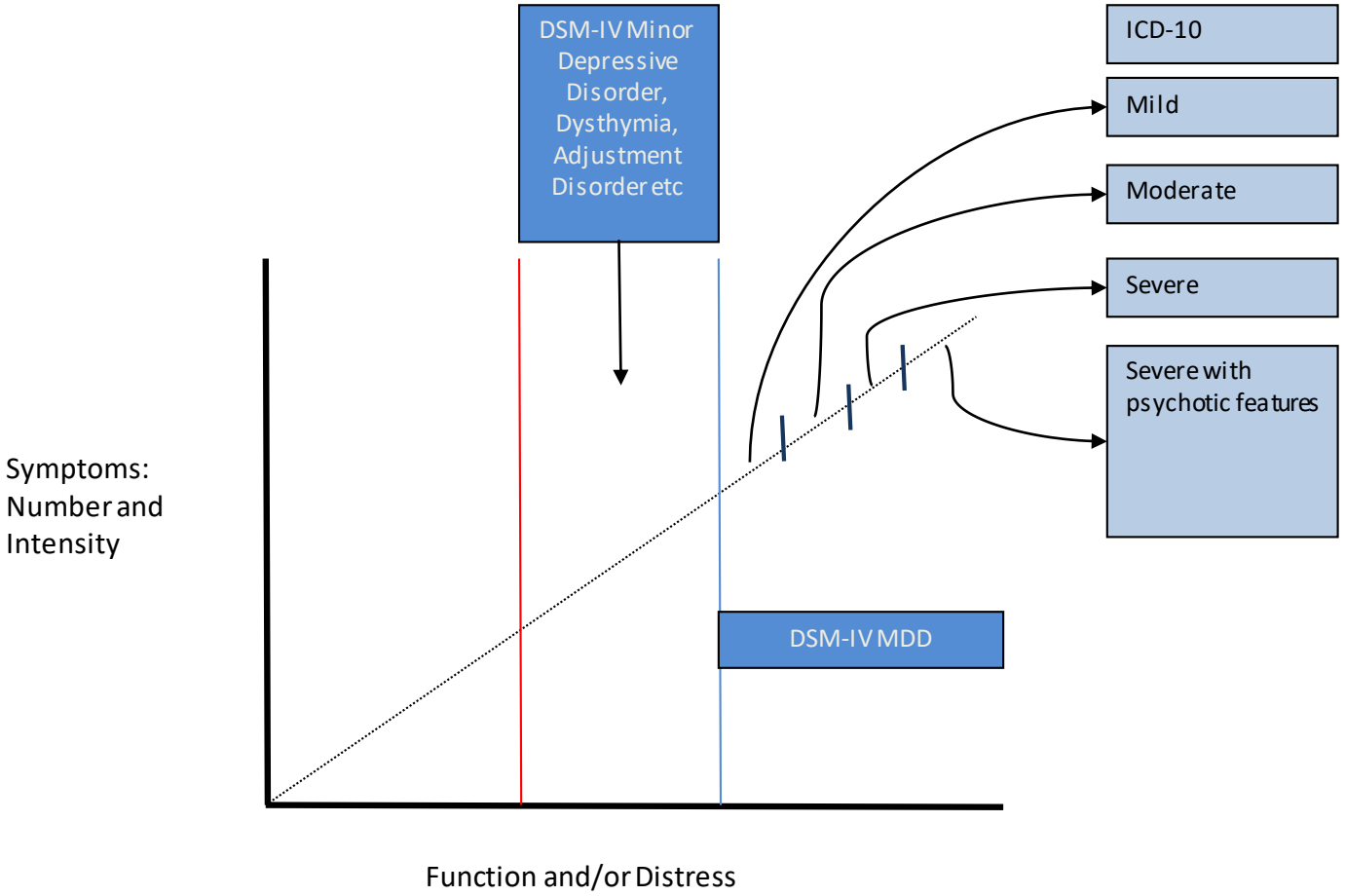
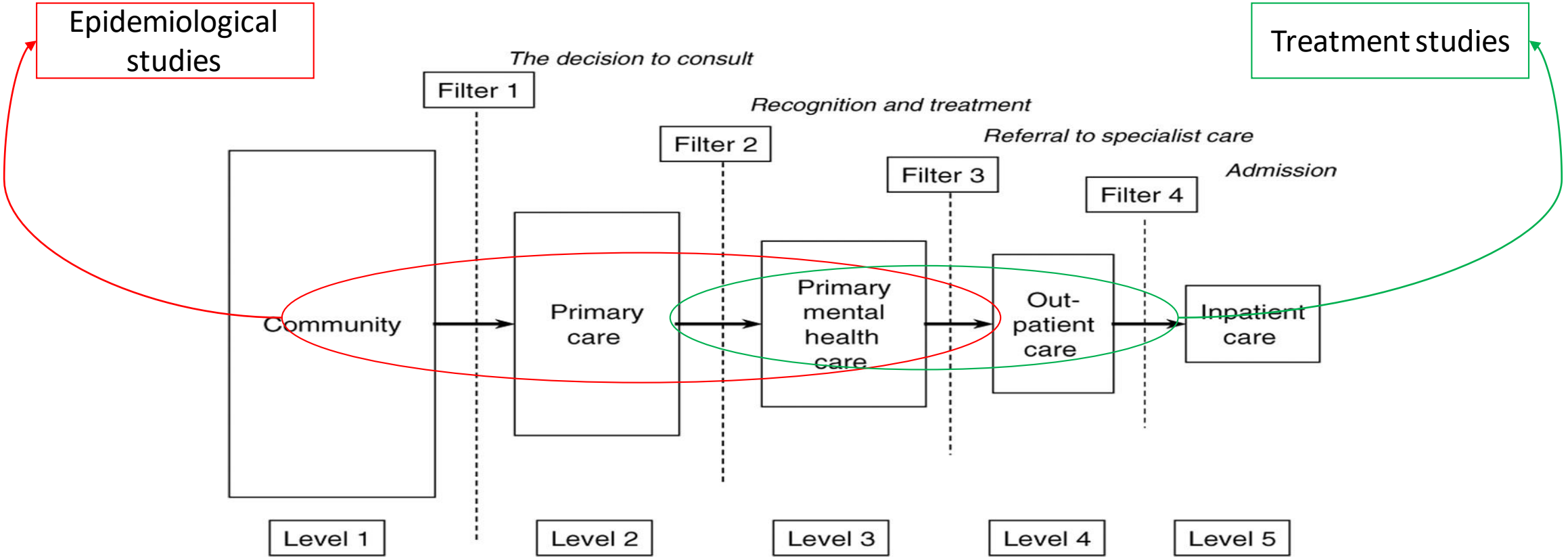
Recap 1

- Numbers matter – how many symptoms from the syndrome of depression (DSM/ICD)?
- Intensity and quality matter – how intense were the symptoms? What was the quality of mood?
- Context matters – how does it make sense to the person?
  - financial resources,
  - social supports,
  - coping strategies, and
  - number and demandingness of roles.
- Together, all these matter

Recap 2


DSM-IV Minor Depressive Disorder, Dysthymia, Adjustment Disorder etc
ICD-10
Mild
Moderate
Severe
Severe with psychotic features
DSM-IV MDD
Symptoms: Number and Intensity
Function and/or Distress

Recap 3



Adapted from: Issakidis C, Andrews G. Who treats whom? An application of the Pathways to Care model in Australia. Aust N Z J Psychiatry. 2006 Jan;40(1):74-86. doi: 10.1080/j.1440-1614.2006.01746.x. PMID: 16403043.
Jacob KS. The diagnosis and management of depression and anxiety in primary care: the need for a different framework. Postgrad Med J. 2006 Dec;82(974):836-9. doi: 10.1136/pgmj.2006.051185. PMID: 17148710; PMCID: PMC2653935.

Diagnosing with screening instruments

- PHQ-9 (see: https://www.phqscreeners.com/ - pharmaceutical industry sponsored)
- Its nine items align with the DSM criteria for major depression.
- Standard cutoff is ≥10 for screening to detect major depression
- Pooled PHQ-9 ≥10 prevalence (25%) was double-pooled SCID major depression prevalence (12%); pooled difference from each study was 12% (mean ratio: 2.5 times).

Levis B et al. Patient Health Questionnaire-9 scores do not accurately estimate depression prevalence: individual participant data meta-analysis. J Clin Epidemiol. 2020 Jun;122:115-128.e1. doi: 10.1016/j.jclinepi.2020.02.002. Epub 2020 Feb 24. PMID: 32105798.

Incidentally, how good is SCID?

- Consecutive admitted patients being able to tolerate a lengthy interview. Sample size n = 100
  - SCID by a Clinical Psychologist. Average time 1.5 hours
  - Semi-structured conversational interview (SSCI) by a psychiatrist who "*explored the items in a sequence that was felt appropriate and adequate to the subject's own concerns and responses*." Average time 3.5 hours!
- Overall diagnostic concordance between these two approaches was 0.18.
  - Values ≤ 0 as indicating no agreement and 0.01–0.20 as none to slight, 0.21–0.40 as fair, 0.41– 0.60 as moderate, 0.61–0.80 as substantial, and 0.81–1.00 as almost perfect agreement.

Nordgaard J, Revsbech R, Sæbye D, Parnas J. Assessing the diagnostic validity of a structured psychiatric interview in a first-admission hospital sample. World Psychiatry. 2012 Oct;11(3):181-5. doi: 10.1002/j.2051-5545.2012.tb00128.x. PMID: 23024678; PMCID: PMC3449355.

What about all the other stuff?

- 75% of depressed patients had comorbid anxiety, somatization or both
- 57% of the patients with anxiety had comorbid depression, somatization or both
- 54% of the patients with somatization had comorbid depression, anxiety or both.

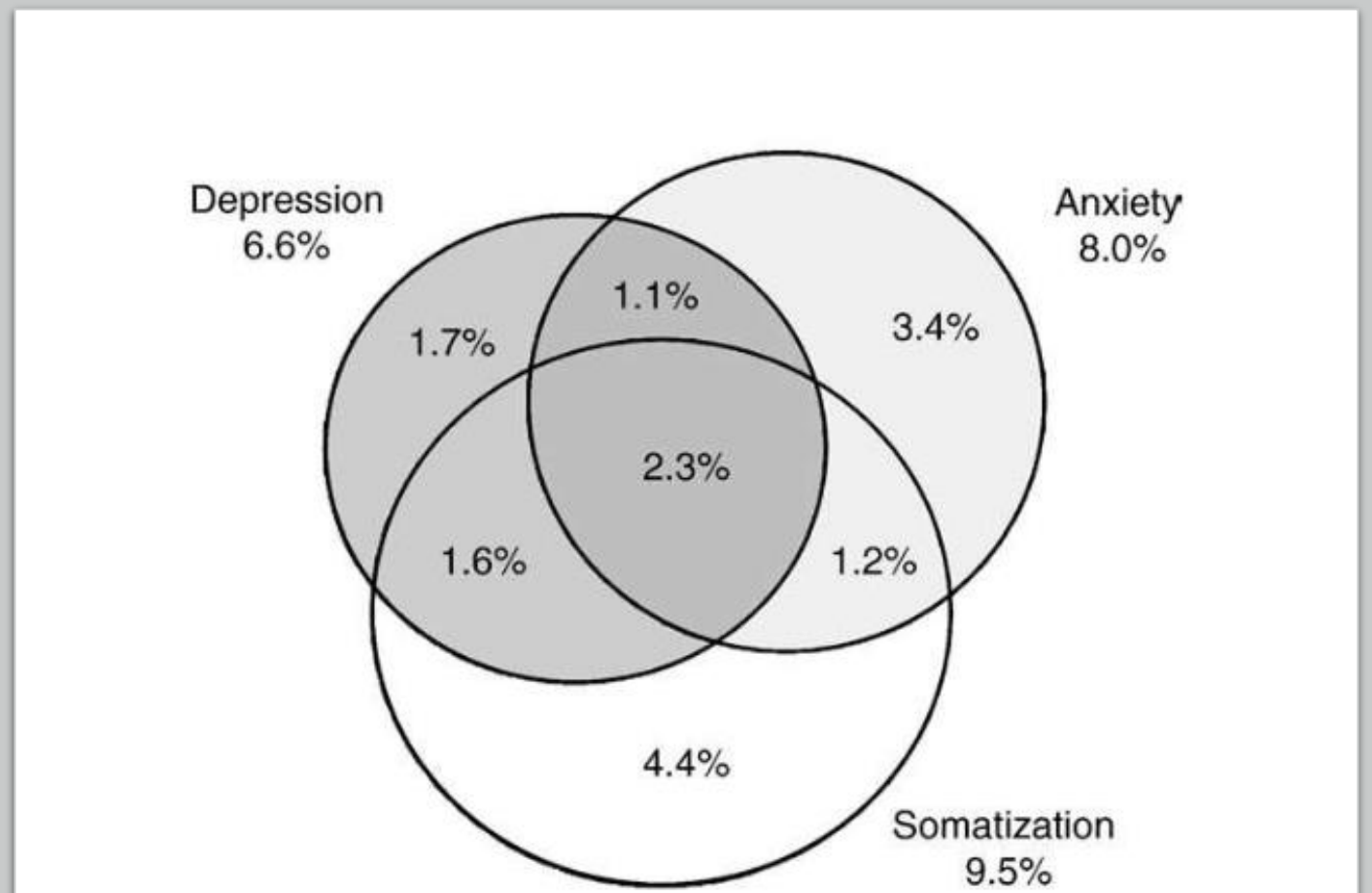


Fig. 1. Overlap of severe depression, severe anxiety and severe somatization as a percentage of the total sample (N=2091).

Löwe B, Spitzer RL, Williams JB, Mussell M, Schellberg D, Kroenke K. Depression, anxiety and somatization in primary care: syndrome overlap and functional impairment. Gen Hosp Psychiatry. 2008 May-Jun;30(3):191-9. doi: 10.1016/j.genhosppsych.2008.01.001. PMID: 18433651.

Bio-Psycho-Social

Engel GL. The need for a new medical model: a challenge for biomedicine. Science. 1977 Apr 8;196(4286):129-36. doi: 10.1126/science.847460. PMID: 847460.
https://www.vectorstock.com/royalty-free-vector/funny-cartoon-girl-making-cake-vector-11673713

Vulnerability-Stress-Adaptation

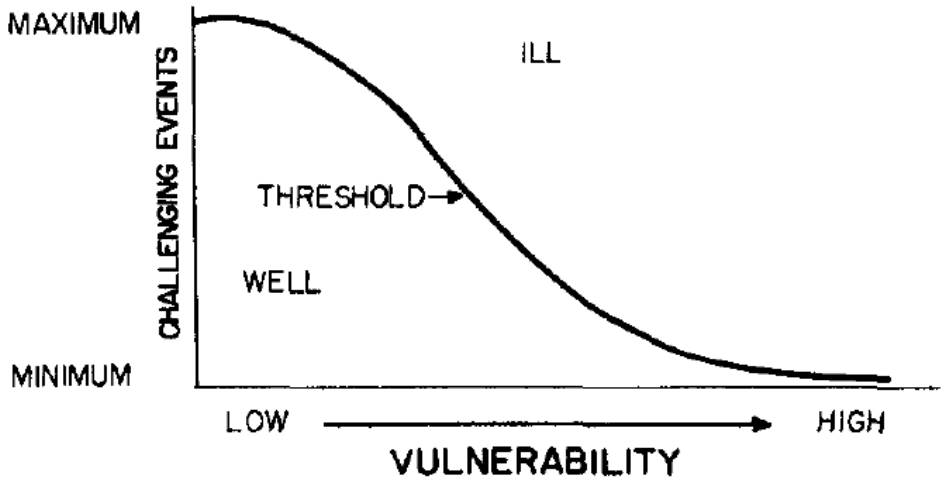


Figure 2. Relation between vulnerability and challenging events.

Helps to have a recipe!

Zubin J, Spring B. Vulnerability--a new view of schizophrenia. J Abnorm Psychol. 1977 Apr;86(2):103-26. doi: 10.1037//0021-843x.86.2.103. PMID: 858828.
https://www.shutterstock.com/image-vector/cartoon-little-girl-holding-batter-cake-282507674

Vulnerability-Stress-Adaptation

Table 1
Patterns of Response to Stressors in Relation to Components of Adaptation and Its Outcome

	Components of adaptation			
Pattern	Coping effort	Felt discrepancy	Competence	Outcome
1	+	+	+	joy
2	+	+	−	frustration–anxiety
3	+	−	+	obsessive behavior
4	+	−	−	obsessive rumination
5	−	+	+	inhibition
6	−	+	−	ineffectual complaints
7	−	−	+	unstressed
8	−	−	−	passivity (?)

Note. Table adapted with modifications from French and Steward (1976, p. 469, Table 1).
Plus = presence of component; minus = absence.

Zubin J, Spring B. Vulnerability--a new view of schizophrenia. J Abnorm Psychol. 1977 Apr;86(2):103-26. doi: 10.1037//0021-843x.86.2.103. PMID: 858828.

Enactive Psychiatry – Cake Making!

As any baker – or any regular watcher of baking shows – knows, the ingredients affect each other. The amount of sugar for instance not only contributes to the sweetness of the cake, but also affects the dough's gluten, thereby affecting the structure of the sponge. It is not only the precise amounts of flour, eggs, baking powder, milk, and butter that influence the cake's eventual taste; it also matters how long you knead the dough, and at which temperature and how long you bake it. Now, the amount of sugar (or any other ingredient) obviously affects the overall taste of the cake. The sugar, however, does not cause the cake's taste in a billiard-ball fashion. Rather it co-determines the cake's taste by being part of it. A change in the amount of any of the ingredients is a change of the cake as a whole. There are thresholds: not all changes at a local level will be noticeable at the global level.

de Haan S. Bio-psycho-social interaction: an enactive perspective. Int Rev Psychiatry. 2021 Aug;33(5):471-477. doi: 10.1080/09540261.2020.1830753. Epub 2020 Nov 25. PMID: 33236671.

The case of John

‘John’ a kind, clever man, 63 years old, who had just come to accept that he would not be holding a paid job anymore. He wanted to understand how these depressions that had, and still have, so much impact on his life had come about. He felt the strong need to make sense of his depressions – also in order to do as much a possible to prevent them from happening again. Was it down to genetics?, he wondered. Looking back, he concluded that his mother must have had depressive episodes herself, even though she was never diagnosed. Or was it his upbringing in an emotionally unsafe environment, with a largely absent father and an emotionally frail mother? As the eldest son he was expected to be tough, not show any feelings, and help out with his younger brothers and sisters. It was also clear that his depressive episodes typically coincided with feeling overburdened at work, by too much responsibility and too many tasks. Some of his personality traits probably did not help either, he thought, like his perfectionism, his tendency to feel responsible, and to prioritize helping others instead of recognizing his own needs. But then again, where did these personality traits come from? And what did it mean that some medication worked quite well for him?

de Haan S. Bio-psycho-social interaction: an enactive perspective. Int Rev Psychiatry. 2021 Aug;33(5):471-477. doi: 10.1080/09540261.2020.1830753. Epub 2020 Nov 25. PMID: 33236671.

The case of John

The BPS model would tell him that his recurrent depressions were probably due to a combination of biological (genetic), psychological (personality traits) and social factors (upbringing, current stressors). It could accordingly list the concrete correlations that have been found in these respective areas of depression research. Based on more concrete details of John's situation, an estimation could be made of the likely relevance of these general findings.

de Haan S. Bio-psycho-social interaction: an enactive perspective. Int Rev Psychiatry. 2021 Aug;33(5):471-477. doi: 10.1080/09540261.2020.1830753. Epub 2020 Nov 25. PMID: 33236671.

The case of John

John's *upbringing*, and more generally the environment he grew up in, have shaped his inclinations in his way of reacting to the world. Later on, his work as a nurse also fitted his self-effacing tendency to be directed at caring for others. His *personality traits* at least partly reflect this deeply engrained pattern of behaviour. Anything we do, and especially what we do repeatedly, changes our *brains*. Here too, paths are laid down by walking: functional connectivity between brain regions strengthens due to repeated behaviours. This also explains the efficacy of *medication* and other brain-targeted interventions. Their efficacy does not imply that the brain is at the root of everything, as neuroreductionists would say, but rather reflects that the brain is what we could call a 'mediating organ.'

de Haan S. Bio-psycho-social interaction: an enactive perspective. Int Rev Psychiatry. 2021 Aug;33(5):471-477. doi: 10.1080/09540261.2020.1830753. Epub 2020 Nov 25. PMID: 33236671.

The case of John

An enactive perspective starts from John in relation to his world as forming one system, already offering an outlook on the interrelation of the physiological, psychological, and environmental processes involved.

It supports the holistic practice of cooperation in interdisciplinary teams of social workers, psychologists, psychiatrists, nurses, and other professionals, and as such supports optimal care.

de Haan S. Bio-psycho-social interaction: an enactive perspective. Int Rev Psychiatry. 2021 Aug;33(5):471-477. doi: 10.1080/09540261.2020.1830753. Epub 2020 Nov 25. PMID: 33236671.

What to do?

- Manage of common mental disorders without formal diagnosis
- The use of a single general protocol for management

Jacob KS. The diagnosis and management of depression and anxiety in primary care: the need for a different framework. Postgrad Med J. 2006 Dec;82(974):836-9. doi: 10.1136/pgmj.2006.051185. PMID: 17148710; PMCID: PMC2653935.

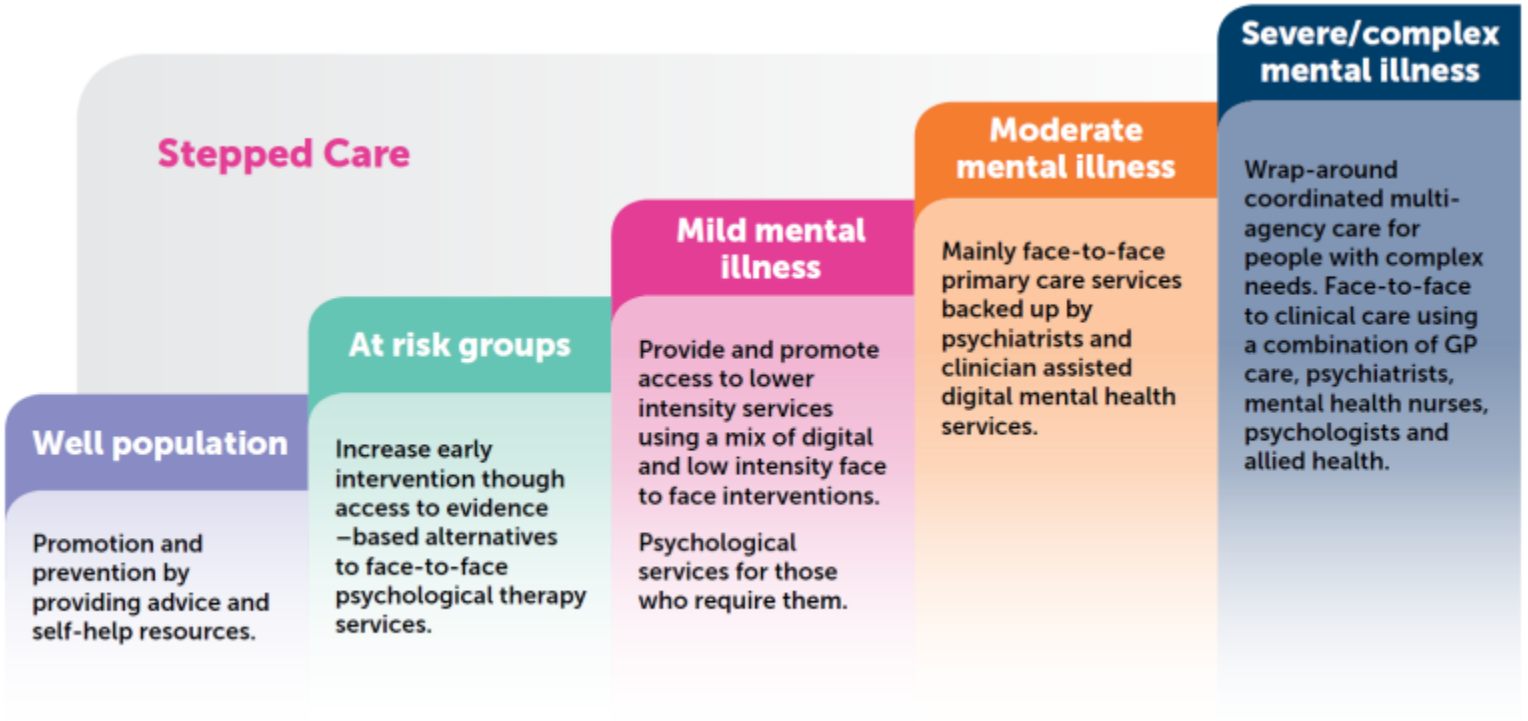
Table 2 Practical Strategies for Smaller Primary Care Practices

No.	Strategy
1	Use *self-administered measures* not only for screening but also to monitor and adjust therapy
2	Assess *suicidality* efficiently (e.g., P4 screener) to stratify referral urgency and develop practice protocols for the assessment, triage, and follow-up of patients at risk for suicide
3	Track *key treatment metrics* (symptom response, adherence, side effects) in home-based fashion (e.g., secure website, telephonically, HIPPA-compliant texting or e-mails, etc.)
4	Acquire skills in *brief therapy techniques* (e.g., behavioral activation; motivational interviewing; problem-solving treatment) and train other practice members as appropriate (e.g., social workers or nurses) in such skills
5	Direct patients to *self-management resources* (including web-based) to complement therapy
6	Educate patients with milder symptoms or in remission how to *detect worsening and seek care; establish relapse prevention plans for patients in remission*
7	Train *least costly office staff* for simple tasks (screening, education, monitoring depressive symptom response and treatment adherence, referral)
8	Establish a *list/registry* of patients who have initiated treatment for common mental disorders and a protocol for reviewing this list on a regular basis to identify patients who need changes in treatment, consultation, or a higher level of care (e.g., specialty referral)

PHQ-9 is useful for measuring change
A 3- to 5-point change on the PHQ-9 is clinically significant; a ≥50% decrease and a score <10 typically signify a treatment response and a score <5 a remission.

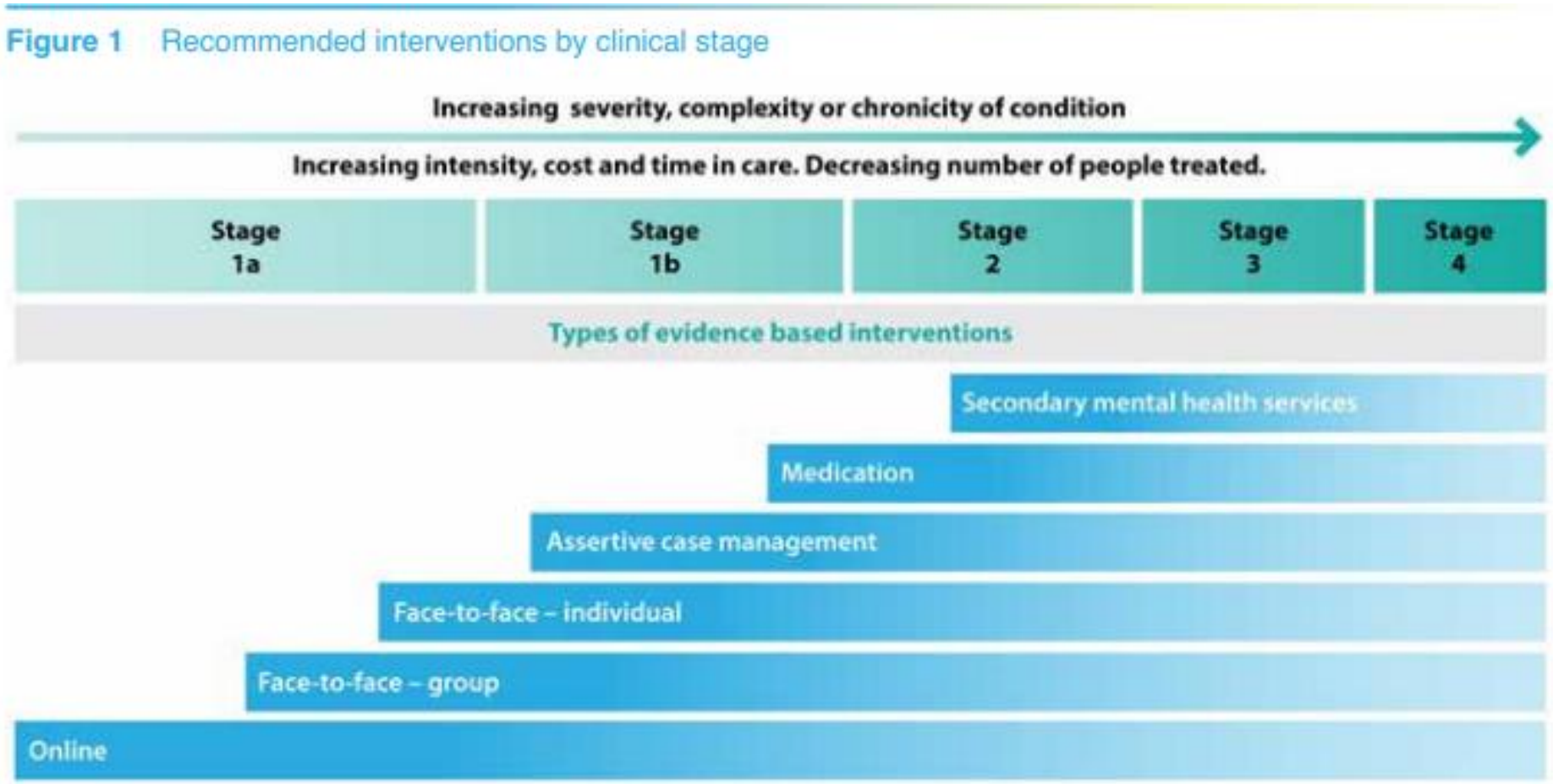
Kroenke K, Unutzer J. Closing the False Divide: Sustainable Approaches to Integrating Mental Health Services into Primary Care. J Gen Intern Med. 2017 Apr;32(4):404-410. doi: 10.1007/s11606-016-3967-9. Epub 2017 Feb 27. PMID: 28243873; PMCID: PMC5377893.

Stepped Care – Illness Model



https://www.murrayphn.org.au/information-and-resources-for-health-professionals/mentalhealth/steppedcare/

Stepped Care – Transdiagnostic Model



Listening – Local Solutions

- Friendship Bench intervention has been developed over a 20-year period from community research.
- This intervention is problem-solving therapy, in which the patient identifies a problem (e.g., unemployment) rather than a diagnosis or symptom.
- Participants were taught a structured approach to identifying problems and finding workable solutions
- The first session includes 3 components called Opening the Mind (kuvhura pfungwa), Uplifting (kusimudzira), and Strengthening (kusimbisa), with subsequent sessions building on the first.
- Opening the Mind refers to the therapeutic process by which, through asking questions, clients were encouraged to open their minds to identify their problems, choose one to work on, identify a feasible solution, and agree on an action plan through an iterative process guided by the LHWs.

Chibanda D, Weiss HA, Verhey R, Simms V, Munjoma R, Rusakaniko S, Chingono A, Munetsi E, Bere T, Manda E, Abas M, Araya R. Effect of a Primary Care-Based Psychological Intervention on Symptoms of Common Mental Disorders in Zimbabwe: A Randomized Clinical Trial. JAMA. 2016 Dec 27;316(24):2618-2626. doi: 10.1001/jama.2016.19102. PMID: 28027368.

https://www.ted.com/talks/dixon_chibanda_why_i_train_grandmothers_to_treat_depression?language=en