Lecture: Arm Yourself with Knowledge: Skills & Strategies for Dealing with Mental Health Issues

Robert Piccinini, DO
Stephanie B. Milstein, Ph.D

The Cosmopolitan of Las Vegas
March 12-15, 2015 | Las Vegas, Nevada
39.5 Category 1-A CME credits anticipated - Includes 15 pre-con credits beginning on March 11
ACOFP FULL DISCLOSURE FOR CME ACTIVITIES

Please check where applicable and sign below. Provide additional pages as necessary.

Name of CME Activity: ACOFP 52nd Annual Convention and Scientific Seminars

Dates and Location of CME Activity: March 12-15, 2015, The Cosmopolitan Las Vegas, Nevada
Lecture: Neuropharmacology of the Brain with Cannabis
Friday, March 13, 2015 3:30-5:30 pm
Lecture: Arm Yourself with Knowledge: Skills & Strategies for Dealing with Mental Health Issues
Friday, March 13, 2015 8:00-10:00 am

Name of Faculty/Moderator: Robert Piccinini, DO

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Robert Piccinini, DO

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Deadline: Monday, January 12, 2015
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Stephanie B. Milstein, Ph.D

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Deadline: Monday, January 12, 2015
Surviving The Medication Maze

Robert G.G. Piccinini, D.O., dFACN

Psychosis and Schizophrenia

- Conventional Antipsychotics
- Second Generation Antipsychotics
  - Olanzapine, Quetiapine, Asenapine
  - Risperidone, Paliperidone, Ziprasidone, Iloperidone, Lurasidone
  - Aripiprazole
- The Art of Switching Antipsychotics
Mood Disorders

- Mood Episodes
  - Bipolar
  - Major Depression
  - Dysthymia (Chronic Depressive Disorder)
  - Double Depression

- Can Unipolar Depression be distinguished from Bipolar Depression

Mood Disorders

- Matching depressive symptoms to circuits
  - Positive and Negative Affect

- Matching manic symptoms to circuits
Antidepressants

- Over the life Cycle
  - Female Patients
- SSRI
- SNRI
- NDRI
- NRI
- Mirtazepine

Antidepressants

- Serotonin toxicity
- TCA
- MAOI
- Vortioxetine
- Augmenting Antidepressants
- How to chose an Antidepressants
Mood Stabilizers

- Lithium
- Anticonvulsants
- Second Generation Neuroleptics
- How to Choose a Mood Stabilizer

Anxiety Disorders

- Neurotransmitters in Anxiety
- Generalized Anxiety Disorder
- Panic Disorder
- Social Anxiety
- Post Traumatic Stress Disorder
References

- Stahl’s Essential Psychopharmacology Fourth Edition
  2013
Arm Yourself with Knowledge:

skills and strategies for dealing with mental health issues in the clinical practice

Stephanie B. Milstein, Ph.D.
Robert G.G. Piccinini, D.O., dFACN

Objectives

By the end of this presentation, attendees will:

• Be able to determine proper patient secondary referral:
  ○ when to refer patients to psychiatrist vs. psychologist, or when both are necessary

• Be familiar with the need for and the benefits of utilizing an interdisciplinary treatment team.
  ○ Suggestions will be provided for facilitation of team formation, collaboration, and communication

• Have increased knowledge and understanding of specific tools and strategies to apply when working with patients dealing with mental health issues.

• Be provided with resources for professional use as a physician as well as information and resources to share with patients and various mental health topics
What If People Treated a Physical Illness Like Mental illness? Helpful Advice?!

I get that you have food poisoning and all, but you have to at least make an effort.

You just need to change your frame of mind. Then you'll feel better.

It's like you're not even trying.

Have you tried...you know... not having the flu?

Well, lying in bed obviously isn't helping you. You need to try something else.

I don't think it's healthy that you have to take medication every day just to feel normal. Don't you worry that it's changing you from who you really are?

Adapted from www.robot-hugs.com

Symptoms are Complicated and are not always Clear!!

Misinterpretation(s) can lead to:

• Stigma
• Fear and Mistrust
• Incorrect diagnosis
• Failure to seek treatment
• Vicious cycle of shame and guilt
It Takes a Team

• Family practice physicians traditionally focus on treating the whole patient and recognize the mind body and spirit connection → thereby, promoting overall mental health

• The family physician is frequently the first to detect symptoms due to having contact with the entire family and knowing patients for prolonged period of time.

• On account of having rapport with your patient and their family, you are best situated to have open communication about symptoms, concerns, and overall mental health issues.

• It’s important to openly talk about mental health!!
  • Ignoring, minimizing or avoiding discussion of symptoms perpetuates stigma, leads to fear, mistrust, incorrect diagnosis, and a vicious cycle of shame & guilt

Open communication leads to early intervention, comprehensive care, and the best treatment outcome → a healthy, well functioning patient!

Multi-Disciplinary/Comprehensive Treatment is the Gold Standard: It Takes A Team!
Psychologist vs Psychiatrist: determining proper referral to one or both

**Psychologist**

- Pt/family seeking mental health intervention and presenting concern doesn't seem to require immediate pharmacological intervention
- Pt/family not receptive towards medication, but willing to see therapist. Refer to therapist to establish rapport and further assess
- Pt/family already on medication & need psychoeducation, psychotherapy, patient/parent/family support or skill building
- Psychological testing, evaluation, and intervention

**Psychiatrist**

- Pt/family seeking pharmacological intervention/medication & unwilling to engage in therapy. Refer to establish rapport, assess & then make referrals
- Moderate-Severe symptoms with significant impairments in functioning
- Severity of symptoms interferes w/ability to engage in therapy: ie severe ADHD, active mania, immobilizing OCD
- Pt medication seeking: refer to psychiatrist who can reinforce need for comprehensive treatment

Treatment that includes psychotherapy/behavioral interventions combined with psychiatric medication management and continuity of care **is the evidence-based care standard for all conditions**

**Psychotherapy/Treatment Interventions**

- Evidence-based treatment entails a combination of psychotherapy and psychiatric medication management
- **Skills Oriented Treatments/Interventions**: Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT), Mindfulness-Based Treatments
- **Family Focused Therapy**: involves family members by enhancing family coping strategies.
  - associated with: recognizing new episodes early, preventing relapse, improved communication amongst family members, improved problem-solving skills, enhanced functioning
- **Psychoeducation**: teaches patients and their support people about the illness, treatment interventions, and connects them with sources of support.
  - Informed/educated consumers are more effectively able to advocate on their behalf, intervene earlier to offset a slip, more likely to fully adhere to their treatment plan.
  - Medication Options/Side Effects: Don’t assume anything with respect to what patients may/may not know about medication administration, side effects, what to expect, etc.

- **Psychosocial Interventions**: The primary goals of psychotherapeutic treatments are to reduce stress and improve the patient's functioning between episodes and decrease the likelihood and severity of future episodes
- Monitoring and accountability
- Overall balanced self-care
Referral Process and Team Communication
Goal: Continuity of Care and Patient Satisfaction

Establish Referral Protocol

- Develop a comprehensive list of community resources/referrals by area of specialization
- Establish a protocol for referrals and ongoing patient collaboration
- Use of a standardized form & process optimizes flow of info and prevents delays
  - Reason for referral
  - Signed release of info form
  - Goals/Objectives to Address
- Relevant Religious/Cultural, family info
- Means of communication
- Tracking system: Follow Up!!
- Effective & Timely Communication b/w Providers
- Reinforce recommendations
- Provides accountability, enhances support, increases follow through, decreases chances of miscommunication
- Increases patient confidence

What You Can Expect From “Me”

- Signed “Release of Information” with psychological assessment, including individualized treatment recommendations
- Proposed plan for communication/patient collaboration
- List of recommended resources provided to patient and/or family
- Timely feedback regarding outcome of your referral of patient (to me)
- Ongoing feedback/communication on patient progress
- Patient progress, notes, updates. Treatment recommendations.
- Reinforcement of your recommendations

Example/Template: Patient Referral Form

Date of Referral: _________   Confirmed Appointment for (date): _________

Referring Providers Name/Credentials
Type of Provider/Specialization
Office Address
Phone /Fax Number

Patient’s Name: _______________________________________________________

Gender: M/F   DOB/Age: _________________________________

Patient is being referred to see the following provider:

Name/Credentials
Type of Provider/Specialization
Office Address
Phone /Fax Number

Main reason for referral/Overview of the presenting problem/concern:

_____________________________________________________________________
_____________________________________________________________________

Additional Factors/Medical issues/concerns:

_____________________________________________________________________
_____________________________________________________________________

When patient’s presenting concern is related to weight/eating issues please provide the following additional information in advance of their initial appointment:

- Growth Records/Charts for children/adolescents
- Weight & Vital Logs (Blood Pressure/Pulse/Weight/Height) for adult patients as well as children & adolescents in addition to growth charts
- Most recent history & physical exam summary including: EKG/Lab Results
- Summary of any medical issues/medications pertaining to presenting condition
- History of highest/lowest & recommended weight range

**template provided in resource handout packet**
Self Injury

Psychotherapy?  
Pharmacotherapy?  
Both???

Self-Injury….What is it?

**Self-Injury (SI)** – the deliberate, repetitive, impulsive, non-lethal harming of one’s own body, often done in a secretive manner.

- It usually leaves marks or causes tissue damage.

- These behaviors, which pose serious risks, may be symptoms of another clinical condition and can be treated.

- High co-morbidity with:
  - Eating Disorders (BN), Mood Disorders & Substance Abuse Disorders
  - Avg age of onset: 12 YO (F>M)

- **Synonyms**: Self-Harm, Self-Mutilation, Para-Suicide, Self Abuse
WARNING SIGNS THAT SOMEONE IS ENGAGING IN SELF-HARMING/RISK FACTORS

• Repetitive observation of cuts, scratches, or scars on extremities; evasive answers to inquiries about injuries.

• Wears multiple layers of clothing (especially long sleeves, pants) even when weather is warm/hot
  ○ Resists disrobing for exam

• Increase in secretive behavior, social isolation, increased need for privacy & extreme anger when privacy invaded.
  ○ Risk of infection, losing too much blood, accidental injury

• Loss of control over frequency and intensity.
  ○ Short-term relief followed by long term pain & consequences

• Scars and long-term marks/damage from wounds

Factors that Contribute to Increased Prevalence of Self-Harming Related Behaviors

• 1% of U.S. population (avg); Increased prevalence 80’s-2000’s
• Elevated stress
• Increased competition
• Younger age, sex
• Increased emotional intensity
• Media influence: quick fix
• Lack of perceived consequences
• Role of alcohol and other drugs
• Lack of coping skills
Self-Injury Assessment

• **Mandatory assessment:** the **adaptive function of the behavior**, determine co-occurring conditions and safety-risk.

• Try to engage Pt in communication w/o judgement:
  • collect data about onset, frequency, tools used, areas of body, intended results, after effects/payoff, rituals

• Assess wounds, Rule Out infection.
  • Treat wounds, and **don’t** keep it a secret!
  • Assess for co-morbid or co-occurring conditions (e.g. depression, anxiety, eating disorders, PTSD)

• Educate about wound care and safety

**Remember:**
Self-harm is **NOT** limited to a particular age, gender or age

What is the adaptive function of their behavior?

- **Relief from Feelings**
- **Self-Nurture**
- **Euphoric Feelings**
- **Temporary Relief & Sense of Control**
- **Physically Express Pain**
- **Self-Punish**
- **A Method of Coping**
  - Communicate
- **Control Dissociation**
  - Re-Enact Abuse

**Why?! **
**Why Self Harm?**
Urge Management/Emotional Regulation

** Universal Coping and Management Skills **
useful and applicable for multiple conditions (to be discussed)

- Use of substitutes for self-harm and maintain safety
- Delay acting on urges
  - Develop a “crash card” to aid in coping w/urges
  - Acknowledge that you expect they will experience urges and may engage in symptoms; it's about progress, NOT perfection.
- Therapy combined with skill building and support
  - Development of effective coping strategies
  - Identify sources of support
  - Relapse Prevention Planning
- Treatment of co-occurring conditions
- Assess for appropriateness of psychotropic medications
- Clinical collaboration and family involvement

**DBT: Distress Tolerance Coping Skills**

- **Crash Card**: Tool to aid in managing urges
- **Identify**: high-risk situations, alternative behaviors, support people including contact information
- **Delay, interrupt, and/or refrain**: replace behavior w/ effective coping skills, support
- **Stop and Think before taking action**: engage in distraction for 15 min, make list of 5 distractions
- **Express emotions/Communicate**: journal, talk to safe person, call hotline, yell, cry
- **Alternative sensations**: ice, silly putty, balloons, shower, exercise, self-soothing, deep mindful breathing, yoga
### Crash Card

**Psychologist vs Psychiatrist:**

**#1 Priority: Patient Safety**

**Psychologist**

- Superficial wounds, Non-Suicidal Intent w/o lethal means, has motivation towards treatment and w/o psychotic symptoms or active suicidal plan/intent/imminent risk
- Willingness to identify/utilize support, use distractions to delay acting on urges and tend to wound
- **Skill Development and Utilization:**
  - Urge Management, Emotion Regulation, Distress Tolerance, Interpersonal Effectiveness
- Further assess for co-occurring conditions, trauma, and enhance use of support

**Psychiatrist**

- Patient presents with:
  - significant suicidal risks, minimum social support, unable to imagine not harming and maintaining safety, co-occurring conditions, sense of hopelessness or helplessness and/or severe depression, prior suicide attempts or psychiatric hospitalizations, psychosis or thought disorders, major recent loss, and/or chemical dependency issues
- **Assess: need for immediate care vs outpatient referral:**
  - ER/Inpatient Psychiatric Triage, outpatient psychiatrist
- Prior psychiatric treatment: Self Harming may be utilized to self-mEDIATE untreated symptoms therefore increase risks with abstinence

---

**Treatment that includes psychotherapy/behavioral interventions combined with psychiatric medication management and continuity of care is the evidence-based care standard for all conditions**
Why can’t they “JUST EAT”?

EATING DISORDERS: The Basics

• Eating disorders are serious disorders with life-threatening physical and psychological complications

• **highest mortality rate of all psychiatric conditions**

• ED’s are the result of interactions between a person’s underlying biology and environmental influences
  
  • Genetics plays a **HUGE** role in determining who is at risk (50-80%)

• 90-95% of known EDs are females; typical onset is around puberty; more then 98% Caucasian.… *however, ED’s ALSO affect:*
  
  • boys/men, children, adolescents, and adults
  
  • people from all ethnicities and socioeconomic backgrounds
  
  • people with a variety of body shapes, weights and sizes

• Early intervention *combined with* comprehensive assessment, treatment, and continuity of care are associated with the best prognosis
The Etiology of Eating Disorders is Unknown:
Causation is Multi-Factorial and Varies
Risk of Developing an ED is 50-80% Genetic-linked

Solution: Patients-Family AND Providers jointly working together as a TEAM to combat the ED and blow it away!

Prevalence of Eating Disorders

Female Prevalence

<table>
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<tr>
<th>Disorder</th>
<th>Prevalence</th>
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<tr>
<td>Anorexia Nervosa</td>
<td>0.5-1%</td>
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<tr>
<td>Bulimia Nervosa</td>
<td>1-3%</td>
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<tr>
<td>Binge Eating Disorder</td>
<td>0.7-4%</td>
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**10% endorse ED symptoms

** Males suffer from ED too...
~ 10% of patients seeking treatment for ED are male
Unique Influences for Today’s Adolescents

Increased access to information with privacy from parents
- websites, online advertisements, smart phones, digital advertisements, applications, social media

Challenges integrating online and media messages

School Influences: “health” class and inaccurate nutrition information, integration of rules relating to good/bad foods, BMI screening, increased competitive drive towards team sports at younger ages

Societal Influences: "The Obesity Epidemic"
- elevated uncertainty about the future resulting in increased pressure at younger ages and performance anxiety

Social Influences: Increased exposure to outside influences
- variation in eating patterns, desire for social affiliation, increased time away from home around eating times & decrease in family meals
- Subgroup have biogenetic vulnerabilities for ED that are provoked by the experimental dieting and exercise behaviors.

Question:
Increase in prevalence of ED vs Improved detection/diagnosis

Earlier intervention ➔ Improved prognosis

Comprehensive Assessment vs ED Screening

SCREENING

• To assess for possibility of an eating disorder in addition to primary clinical area of focus

• To assess the role that ED symptoms play in overall presentation of pathology to aid in determining if/what medication is appropriate

• Increase awareness of other medical/medication issues to take under advisement when determining plan for patient care

• To aid in determining if appropriate for outpatient treatment or to determine the appropriate level of care as well as to referral to specialized providers
ED Screening Questions

1. Is your weight significantly different than it was a year ago? Yes or No
   - If yes, is it higher or lower? And by how much?

2. How do you feel about your current weight?

3. Have you tried any weight loss methods in the past year that you feel embarrassed or ashamed about? Yes or No
   - If yes, what were they?

4. Do you have any history of binge eating (e.g., eating a large amount of food in a short period of time and not being able to stop even if you wanted to?) Yes or No

5. For females: Have you had your first menses? Yes or No
   - If yes, when did you have your first menses? (age and date)

6. Have you ever stopped having your period? Yes or No
   - If yes, when? For how long?

7. What is your current height? Weight? For females, what is the date of your last menstrual cycle?
   - If the patient’s weight is significantly different than a year ago and/or they are currently engaging in active compensatory behaviors/symptoms → refer for a more detailed eating disorder/dietary assessment

**** Other Validated Screening Assessments: Eating Attitudes Test (EAT), Bulimia Test – Revised (BULIT-R), SCOFF

CLINICAL INTAKE INTERVIEW:
Symptom Assessment: Most Relevant to Treatment You’re Providing

1. Binge Eating
   • Objective vs. Subjective episodes; Loss of control? Frequency?

2. Purging/Compensatory Behavior
   • Self-induced vomiting (method to facilitate: hand, toothbrush, ipecac*)
   • Laxative abuse, enema or colonic misuse; diuretic misuse
   • Diet pills (kind/amount/frequency); Smoking or Caffeine Use for Weight Control (frequency/amount)
   • Chewing and spitting

3. Eating patterns and dietary restriction
   • Frequency of and timing between meals/snacks
   • Food avoidance, Preoccupation and rituals pertaining to food consumption & restriction

4. Weight history
   • Current height, weight, BMI
   • Lowest and highest weight (at corresponding age)
   • Pattern of weight fluctuation; Desired weight

5. Body Image
   • Body dissatisfaction (overall + specific body parts); fear of weight gain
   • Preoccupations, rituals, checking, and avoidance behaviors related to weight and shape
How Medical Providers Can Help:  
“First, Do No Harm”

• Collaboration-Communication: Team Approach to decision making

• Thorough medical assessment and ongoing continuum of care

• Avoiding judgment especially relating to weight/diet/food issues  
  - refrain from discussions about dieting or referring to food as good or bad

• Involve family members and loved ones in treatment

• Reinforcement of critical recommendations (e.g. importance of overall balance  
  (sleep, nutrition, self care, adherence to treatment recommendations) as well as  
  comprehensive and consistent treatment with full team

• Forearm with accurate info relating to medications to counteract EDs  
  emotional reactions (i.e. weight/appetite)

• Be aware of unintentional minimization of symptoms and other providers’  
  concerns

• Avoid making comments pertaining to weight, shape, and appearance

How Medical Providers Can Help, Cont’d:  
“First, Do No Harm”

• Focus on markers of health i.e. progress, growth/dev. instead of weight

• Children/Adolescents: get growth charts.

The number one mistake…… is assuming that when a child loses weight (or fails to  
  gain) but they are still within "normal range" on growth chart (%), that there isn't a  
  problem.  **WRONG!**

Weight loss in childhood is not normal.  
**The real questions are:** has the child lost weight? Have they failed to gain weight  
  since the last time they saw the doctor? Is it another medical problem?  
  **Assess behaviors.**

• Develop process that begins with early detection, comprehensive  
  assessment, family involvement, and referrals to ED specialists.

• Create a list of ED specialists and referrals
2-20 Years: Girls

Stature-for-age and Weight-for-Age percentiles

To Calculate BMI:

\[
\text{Weight (kg)} \div \text{Stature (cm)} \div \text{Stature (cm)} \times 10,000
\]

Or

\[
\text{Weight (lb)} \div \text{Stature (in)} \div \text{Stature (in)} \times 703
\]

http://www.cdc.gov/growthcharts

Prevention Priority: Prevent alteration of neurochemistry that results from dieting, bingeing, purging, and excessive exercise.

Primary Importance....

Treatment: The Earlier, the Better

⭐⭐ The earlier the intervention, the shorter the treatment period

Place the individual in the correct level of care by referring them to an eating disorder specialist. The sooner that the individual is placed at the appropriate level of care the better the prognosis.

Treatment Priority: Restore and maintain normal neurochemistry through nutritional rehabilitation and management of other ED-related behaviors.
AN/BN: Early Intervention Strategies

- Comprehensive Physical Assessment
- Review growth charts to see typical pattern (% height/weight) to determine appropriate individual weight range, refrain from discussing goals in # terms
- Blind weights taken after voiding- and in single gown and height
- Supine and standing heart rate and blood pressure, respiratory rate and temperature (to detect for hypothermia <96 F/35.6 C)
- Labs: CBC, sed rate, CMP, pre-albumin, thyroid studies, serum zinc & amylase, US and EKG
- Refer to therapist that specializes in eating disorders as well as eating disorder specialized RD and/or assess for the appropriate level of care
- Schedule follow-up for check in, provide challenge/goal: increase intake/decrease purging as initial baseline (e.g. add ensure plus 2x/day to current intake)

Pharmacotherapy

- Few drugs have been shown helpful, although SSRI's and atypicals are widely prescribed
  - Prozac is the only officially studied SSRI for EDs with BN
- Small scale studies suggest some atypicals (Olanzapine & Aripiprazole) may reduce anxiety, decrease obsessive symptoms, and lead to earlier attainment of goal weight in AN (UCSD, Kaye).
  - BUT patients with AN tend to resist taking medications
- Indicated with co-morbid conditions, if they predate the onset of ED
- Similar to other psychiatric illnesses:
  ** the most effective results are associated with comprehensive care, integration of full nutrition (Food really is Medicine), pharmacological interventions, psychotherapy and psychoeducation, family involvement, and behavioral changes
Chemical Dependency/ Addiction

Psychotherapy?
Pharmacotherapy?
Both???

Chemical Dependency (CD) and Addiction

**Disease Characteristics:**

- Signs and Symptoms
  - Primary
  - Progressive
  - Chronic
  - Familial
  - Treatable
  - Bio-Psycho-Social-Spiritual

**The 3 C’s of Addiction** (patient):
- Loss of **CONTROL**
- **Compulsion** to use
- **Continued Use**, despite negative **Consequences**

**The 3 C’s of Addiction**
(Co-Dependents, Family members, Support)
- **Compulsion** to help, (i.e. Fix by taking care of negative consequences)
- Efforts to **CONTROL**
- **Continued** efforts to control, despite negative **Consequences**
ADDICTION IS A FAMILY DISEASE

Addiction impacts the entire system; therefore, it’s important for everyone affected to seek and utilize treatment and support.

Family members develop unhealthy ways of communicating with each other and coping with the addiction.

“Rules” in addicted families:
- DON’T TALK
- DON’T TRUST
- DON’T FEEL

BREAK THE SILENCE
- Connect with Safe People
- Identify Healthy Sources of Support
- AA/NA/Al-Anon, Sponsorship
- Professional Treatment Providers

Assessment Tools

- **CAGE Questionnaire**: 4 question self-test used to identify usage patterns that may reflect problems with alcohol
  - Have you ever felt you should Cut down on your drinking? Y/N
  - Have people Annoyed you by criticizing your drinking? Y/N
  - Have you ever felt bad or Guilty about your drinking? Y/N
  - Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)? Y/N

  **Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.**

- **Michigan Alcohol Screening Test (MAST)**: 22 questions

- **Drug Abuse Screen Test (DAST)**: 28 Questions
American Society of Addiction Medicine ASAM Criteria: The 6 Dimensions of Multidimensional Assessment

1. Acute Intoxication and/or Withdrawal Potential
   - Individuals past & current experiences of substance use/withdrawal

2. Biomedical Conditions and Complications
   - Individuals health history & current physical condition

3. Emotional, Behavioral, or Cognitive Conditions and Complications
   - Individuals thoughts, emotions, and mental health issues

4. Readiness and Interest to Change

5. Relapse, Continued Use, or Continued Problem Potential

6. Recovery/Living Environment

Educate about Post Acute Withdrawal Syndrome (PAWS)

**PAWS:** Psychological symptoms that accompany early recovery and have the potential to interfere w/daily functioning

- Symptoms result from a substance-induced chemical imbalance in the brain
- Symptoms are temporary
- They can impact all aspects of functioning: Bio-Psycho-Social-Spiritual

*** therefore, treatment needs to be comprehensive

**Knowledge ➔ Understanding ➔ Empowerment, Planning & Support**

6 Categories of PAWS Symptoms:

- Inability to think clearly
- Memory Problems
- Emotional Overreactions or Numbness
- Sleep Disturbances
- Physical Coordination Problems
- Stress Sensitivity

What is Health & Well-Being?
Strategies for Combating CDs Denial...
Empower Patients/Family Members in Recovery

• Use a direct approach to express concern
  • Stick to the facts

• Identify concrete examples of consequences experienced that have impacted Bio-Psycho-Social-Spiritual Functioning i.e. lab results, legal

• Avoid judging, moralizing or condemning

• Listen, offer emotional support & validation without seeking to “fix”

• Provide resources for treatment and support

• Assist patient in establishing short term goals to promote change

• Schedule follow up appointment for continued screening
  • Assess for cross-addiction, co-occurring psychiatric conditions, physical consequences
  • Warn about risks of abrupt cessation

Recovery Resources & Tools

• **Crash Card**: Tool to aid in managing urges

• **12 Step Programs & Collective Recovery**
  AA/NA/Al-Anon, Ala-teen, Sponsorship, Spiritual Consultants

• **Professional Treatment Providers/Programs**: ASAM Criteria for Level of Care, Types of Treatment, etc.

• **24 Hr Support/Psycho-educational Materials**: Hot lines, Online Support, Collective Recovery, Disease Concept Materials

• **H.O.W. Communication**: Honest, Open, Willing

• **Develop & Utilize Sober Support Network**: Meetings, Sponsor, Safe People

• **Family Involvement in Treatment**

• **Relapse Prevention Planning**

• **Comprehensive Treatment**: including overall self care
Psychologist vs Psychiatrist: #1 Priority: Patient Safety

**Psychologist**

- Once sobriety/abstinence has been attained, work on developing and utilizing skills to cope with daily life while maintaining sobriety
- Supportive interventions in conjunction with collective recovery to proactively address consequences of CD
- Urge Management Skills, Developing coping strategies for living life sober, family based treatment interventions to work on family healing
- Further assess for co-occurring conditions and monitor for symptom substitution and/or cross addiction

**Psychiatrist**

- Assess for co-occurring conditions
- Treatment of co-occurring conditions
- Determine if appropriate candidate for: Antabuse, Naltrexone, Suboxone, Vivitrol, etc.
- Monitor & continue to assess for elevated symptoms of hopelessness or helplessness and/or severe depression due to chemical changes in the brain associated with detoxification, early recovery and removal of primary coping strategy

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**Assess for need for need for immediate care vs outpatient referral:**
ER/Triage for CD specific treatment OR 12 Step Meetings/Collective Recovery combined with Professional Individualized Treatment is the evidence-based care standard

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**ADD/ADHD**

*Psychotherapy? Pharmacotherapy? Both???*
The ADHD child is **NOT** dumb, lazy, weird or out of control!! They are **smart, creative, talented** kids who need our **help to learn strategies to be successful**!

- Not about low IQ, but rather instability of control processes that govern everyday applications to the environment (executive functioning)

- **EXTERNALIZING** the illness is a way of reinforcing “You are more than your diagnosis and symptoms” to patients.

- It is important to openly talk about mental health to counteract myths, misunderstandings & stigma

Open communication leads to early intervention, comprehensive care, and the best treatment outcome ---> a healthy, well functioning patient!

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**Externalize the Illness:** You are **more** than a diagnosis

**Goal:** Develop skills & use support to get into a **WISE** mind-set, Attain Balance

**Key:** transition from **Emotional** mind-set to a **WISE** state of mind.

Patients, parents, family are **ALL** impacted under the influence of Illness
ADHD symptom presentation may differ between patients

** Symptoms can easily be misinterpreted!**
This reinforces the importance of **completing a comprehensive assessment**, including diagnostic testing.

### Diagnostic Testing/Assessment

#### Function of Testing:
- **Testing must be completed** to make an accurate diagnosis of ADD/ADHD, assess for co-occurring conditions, and to identify the appropriate individualized treatment plan and/or interventions**
- Private Psychological Testing vs School-based testing
- **School involvement and communication is essential!!**
- Use of Parent/Teacher Report forms to re-assess treatment response

#### Comprehensive Assessment Includes:
- IQ and Achievement Testing
- Full Clinical Interview with Patient and Family Members
  - Assess ADHD symptoms and co-morbid conditions based on DSM-5
- Rating Scales across at least 2 settings
- School/Academic Performance History
- Adults: Adult ADHD Self Report Scale (ASRS)
- Most Commonly Used Rating Scales for Parents and Teachers to complete:
  - Connors Parent & Teacher Rating Scales
  - Teach Report Form (TRF)
  - Parent Completed Child Behavior Checklist
  - ADHD Rating Scale or the Behavior Rating Form
  - Barkley Home/School Situation Questionnaires (HSQ/SSQ)
School-Based Treatment and Interventions

- **Educational Accommodations**
  - Individuals w/ Disabilities Education Act (IDEA) provides early intervention, special education and related services to eligible students pre-K-12, up to 21 YO
  - Testing Accommodations: extra time on tests, separate room free from distractions, modified assignments, tutoring services, in-school behavioral interventions, ancillary services, monitored medication administrating during school

- **Classroom Interventions**
  - Logs: Parent/Teachers maintain logs that cite observations of behaviors, specific details, frequency of occurrence as well as interventions applied & outcome; Homework logs/planners
  - Distraction Management: Closer seating to the teacher, sit in rows instead of tables, break tasks into smaller steps, frequent breaks, pair w/peer mentor, one on one work instead of group projects
  - Concrete & Visual Learning Strategies

- **Behavioral Interventions/Psycho-Social Skills Training: Patients, Parents & Families**
  - Skills Groups/Training: Self-Esteem, Managing Feelings/Anger Management, Making & Keeping Friends, Time Management & Study Skills, Coping Skills
  - Positive Reinforcement, Use of incentive systems, behavioral re-direction with prompts, Plan in advance for changes and transitions
  - Use of Role Play with Feedback

***STOP, THINK…then ACT***
Treatment and Interventions, con’t.

Strategies to Address Executive Functioning Deficits

• Skills geared towards organizing & management time, developing & implementing action plans, dealing with changes/transitions (set shifting), self-monitoring
• Use step-by-step approaches, visual organizational aids, technology as tool
• Plan for change & transitions in advance
• Establish Routines: School Day Routines, Wind Down Routine, Weekend Routine
• Use of Checklists: “To Do” Lists
• Set Time Limits
• Choice amongst lack of alternatives: give limited options to aid w/decision making

Parent/Family Skills Training & Support Groups

• Focused on managing child’s symptoms (moods/behaviors) & impact on the family system
• Aids parents in externalizing symptoms & provides support reinforcing “you are not alone” while building skills (they are willful/you are skillful)

Assess & Treat Co-Occurring Conditions

• Cognitive-Behavioral Therapy (CBT)
• Family-Focused Therapy
• Medication Management

Factors to Consider when Prescribing Commonly Used Medications

• Stimulants are most frequently used, (very effective with proper use)
  • Disadvantages:
    • high rates of abuse/misuse Be alert to potential drug seeking behaviors from adolescents as well as adults
    • Undesirable side effects that interfere with medication compliance, impact on personality/mood, impact on growth/appetite, On/Off effect

• Non-Stimulants:
  • Unpleasant side effects: impact on sleep and appetite, gastrointestinal symptoms, headaches

General Guidelines:

• Establish protocol for administration, monitoring:
• Don’t make assumptions
• Use Parent/Teacher Report Forms to assess ongoing treatment response

The Most effective treatment is the combination of medication management with behavioral-based therapy to aid patient/families learn how to manage & modify problematic behaviors in all settings. Stimulant Medication is the most effective Stand Alone Treatment.
ADHD and Comorbidities

ADHD SELDOM RIDES ALONE!

Psychologist vs Psychiatrist:
determining proper referral to one or both

**Psychologist**
- No psychological/academic testing has been completed. Refer to clinician that specializes in assessment and ADHD.
- Pt/family seeking to begin with behavioral interventions or diagnostic testing prior to medication
- Testing has been completed, patient already on medications, and Pt/family would benefit from behavioral/emotionally/family support based interventions
- To assess & treat co-occurring conditions once ADHD symptoms are managed.

**Psychiatrist**
- Pt/family seeking pharmacological intervention/medication and unwilling to engage in therapy until behaviors are under management- Establish rapport, assess, and then make referrals
- After a couple of medication trials w/o success, Refer to further assess for co-occurring conditions.
- Past history of substance use/abuse
- To treat co-occurring conditions once ADHD symptoms are under management

The Most effective treatment is the combination of medication management with behavioral-based therapy to aid patient/families learn how to manage & modify problematic behaviors in all settings. **Stimulant Medication is the most effective Stand Alone Treatment.**
**Five Senses: Mindfulness**

**Mindfulness** is to be aware. To be aware when you are breathing in, and to be aware when you are breathing out. It is the capacity to be aware of what is here. Anything can be the object of mindfulness. Your breath. The sky. It is to be in touch with our felt experience in each moment. - Thich Nhat Hanh

**Mindful Eating**

Mindfulness decreases stress, which in turn, reduces emotional eating.

Utilized for treatment of Bulimia and Binge Eating Disorder:
- Am I Physically Hungry? What do I feel like eating?
- Portion out foods, sit down and eat in a mindful manner
- Promotes self-control and ENJOYMENT of food, & removal of judgment of self and food as good/bad
Mood Disorders

Psychotherapy?  Pharmacotherapy?  Both???

***Accurate diagnosis is key for the best prognosis, and it is essential for treatment plan development!***

Emotion Regulation: Anxiety Management

**Breathing Exercises:**
- 3 Deep Breaths
- Mindful Breathing

**Mindfulness:**
- Mindful Breathing
- Being mindful in the moment

**Relaxation:**
- Gradual Muscle Relaxation
- Wind-Down Routine
- Self Soothing Activities

**Emotional Release/Outlets:** Unexpressed anxiety intensifies
- Journal: thoughts, worries, fears, identify triggers and plan of action
- Worry List or Worry Jar
- Set aside worry time
- Talk back to worry thoughts: replace worry thoughts with empowering statements

**Overall Balance:**
- Balanced Nutrition: e.g. hydration, limit alcohol & caffeine
- Balance physical activity/exercise
- Good sleep hygiene & balanced sleep

**Comprehensive Treatment:**
- Overall self-care
- Treatment of emotional and physical ailments
“The greatest medicine of all is to teach people how not to need it”  - SUSHRUTA 600 BC

Bipolar Disorder

Overall Balanced Living is the Key to Recovery and Relapse Prevention

- Balanced and Consistent Eating Patterns
- Regular engagement in Physical Activity
- Abstinence/Moderation: Alcohol, Nicotine, Caffeine
- Good Sleep Hygiene: regulated sleep is associated with reduced risk of relapse and decreased hospitalizations

Recovery Entails Making Lifestyle Changes

- Use of patient/physician relationship for support and connection to additional resources
- Developing healthy relationships/sources of support
- Use of effective coping skills and positive support to manage stress, promote relaxation
- Structure and Routine: Planning in advance
- Consistent Self-Care
- Taking prescribed medications as directed: abstaining from non prescribed drugs

Helpful Hints for Good Sleep Hygiene

- Have a fixed time for going to sleep and awakening: *we are creatures of habit!*
- Develop a “wind down” bedtime routine
- Avoid napping, but if you do nap, *limit to 30 minutes or less*
- Limit caffeine and alcohol. Avoid both 4-6 hours before bed
- Exercise regularly, but not immediately before bed
- Refrain from going online, checking email/social media in bed
  - *Keep electronics out of bed/bedroom!!*
- Don’t take your worries to bed: use a worry list/jar
- Bed should be used for sleep and……..
- Sleep Diary: aid for further evaluating sleep disturbances (e.g. sleep apnea, insomnia, hypersomnia, Restless Leg Syndrome, Narcolepsy, REM sleep disorder)
Relapse Prevention Planning & Urge Management

Be on guard for:

• symptom substitution
• “I want to be normal” → discontinuing treatment/medication → Relapse

• Assess for co-occurring conditions & monitor for comprehensive treatment

• Reinforce the need for:
  ○ Multi-Disciplinary Treatment Team
  ○ Continuum of Care
  ○ Utilization of Positive Peer/Family Support: Family Involvement in Treatment
  ○ Good sleep hygiene: impaired sleep is prevalent side effect of medication, with negative impacts on all aspects of functioning; Relapse Trigger

• Encourage patient to identify and share relapse signs/indicators/triggers to aid with early recognition and intervention
  ○ RED, Yellow, GREEN Traffic Light Plan: Indicators, Symptoms & Interventions

• Educate about Medications: Openly discuss Pros & Cons

Traffic Light Relapse Prevention Planning

Red Light: Signs & Indicators of Full Blown Relapse

Yellow Light: Things are getting rough, heading towards Relapse

Green Light: Signs of Ongoing Recovery
### Psychologist vs Psychiatrist: bipolar disorder, major depression

<table>
<thead>
<tr>
<th>Psychologist</th>
<th>Psychiatrist</th>
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<tbody>
<tr>
<td>• Pt is already stabilized on medication and continuing to work with comprehensive team for medication management and now able to effectively engage in therapy.</td>
<td>• Almost always refer to psychiatrist for comprehensive assessment especially when following are present: psychotic/catatonic/atypical symptoms, history of suicide attempts, family history of bipolar disorder and/or extensive mental health and CD issues, co-occurring CD.</td>
</tr>
<tr>
<td>• Pt was in therapy previously, gradually tapered due to improved functioning now going through major life transitions and would benefit from added support.</td>
<td>• Assess for appropriate level of care.</td>
</tr>
<tr>
<td>• Pt/family already on medication &amp; need psychoeducation, psychotherapy, patient/parent/family support or skill building.</td>
<td>• Moderate-Severe symptoms with significant impairments in functioning.</td>
</tr>
<tr>
<td>• To work on quality of life, development of effective coping strategies &amp; relapse prevention.</td>
<td>• Pts often need to stabilize on meds prior to being able to effectively engage in therapy.</td>
</tr>
</tbody>
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"In almost every case a psychotherapist is a valuable treatment component to anyone suffering from clinical depression" (American Psychological Association, Monitor)

### The Elephant Parable

Incomplete perceptions each form a different angle of view of a more complex reality, or whole picture.

Effective interdisciplinary treatment allows us ALL of US to look at all angles of the individual that we are treating...and to provide the most competent, complete care possible.
Take-Home Tools

• Handouts Include: list of recommended reading, resources, online links by subject heading

• Discussed Screening & Assessment Tools

• Treatment Referral Form Example

• Crash Card Example

Take Home Suggestions/Applications:

“Stigma Busters”, Communication Enhancers

• Consider ordering free brochures on Mental Health Issues to display in your lobby, exam rooms

• Develop resource list, including local treatment providers

• Implement referral and collaboration protocol