Brief Mental Health Interventions

Michele Larzelere, PhD
Why discuss this?

- A high number of patient encounters will include psychological/psychosocial complaints
- AND- physical and mental health are rarely separate
- AND- it is often hard to get patients to access mental health resources
- So, practical primary care strategies are needed
BUT…..

- Time pressures are a big barrier to social and mental health services in primary care
- Reimbursement for psychosocial counseling/treatment is often problematic
If you take up the challenge to address psychosocial issues:

- Patients more likely to feel understood
- Greater patient satisfaction
  - Fewer lawsuits?
- Less physician frustration
- Greater patient adherence
If you address psychosocial needs you may also experience:

- Improved patient biomedical outcomes
  - Symptom reduction
  - Improved physiological status (e.g., DM)
  - More efficient data gathering & treatment - Less follow-up on vague psychosomatic complaints
    - Fewer procedures and tests required
  - More likely to follow preventive advice
General Strategies

- Assessment: (Stress, Sleep, Substances, Social life)
  - Have there been any major stressors or changes in your life during the past year?
    - How are you coping?
    - How has your mood been?
  - How are you sleeping?
    - Have you been nervous lately? Have you been depressed or down lately?
General Strategies

Assessment:

- When was your last drink of beer/alcohol?
  - How much did you drink at that time?
- Are you participating in your normal activities?
General Treatment Tips

- Never give an anti-depressant without giving an immediate “assignment” at the same time.
- *Rarely* give an anxiolytic or sleep medication for more than 2 weeks.
- If the problem has gone on more than 6 months without the person seeking help, consider a referral.
Prescriptive Assignments

- Helpful even if pharmacotherapy not accepted by patient
- Way to hasten improvement and/or “bridge the gap” until medications kick in
  - STAR-D study
- Gets patients actively involved in the treatment of their condition- enhances self responsibility for mood/situation
  - “Frame” for medications
Prescriptive assignments should be:

- 1) Given with rationale
- 2) Targeted toward most disruptive symptom
- 3) Specific
- 4) Written down
Prescriptive assignments must be:

- 5) Small, easily accomplished
- 6) Made with patient’s input
- 7) Checked on during next appointment
- 8) Highly reinforced
General Treatment Tips

- If they are literate give them the name of a **good** self-help book
  - First line before referral
  - “Bring the experts to you”
  - Especially if you are in an area where there are no good referrals
- Or if they are resistant to therapy
- Or if they don’t have the funds/insurance for therapy
- On-line ordering- no more embarrassment
Mrs. Wilson, 45 y.o. A-AF

- “Crying all the time”
- Depressed mood “since the end of summer”
- Low energy
- Sleep onset and maintenance insomnia
- Increased appetite- 15 lb. weight gain
- Agitated
- Poor concentration
- Feels worthless, helpless, hopeless
- No SI/No HI
Depression-Depressed mood assignments

- Increase your frequency of moderate exercise (e.g., walking) by 10 minutes per day. Mead GE, Morley W, Campbell P et al. Exercise for depression. Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD004366.DOI:10.1002/14651858.CD004366.pub3.


- Increase your number of social contacts each week.

- Volunteer work
Depression: Anhedonia

- Do one positive thing for a stranger
- Spend 1 hour volunteering somewhere, even if you don’t feel like it.
- Increase the number of (previously) pleasurable activities you engage in.
  - “Pleasure predicting” assignment
Bibliotherapy

- Depression - Feeling Good - David Burns (NOT Feeling Good Handbook) OR Mind Over Mood - Greenberger & Padesky

OR Thoughts and Feelings: taking control of your moods and your life – McKay, Davis, Fanning
Risk Factors for Suicide

- Major affective disorders
- Substance abuse or family history of substance abuse
- Psychosis
- Feelings of hopelessness
- Recent loss (e.g., death, separation, divorce, job loss)
- Marital discord
- Family history of suicide attempts
Risk Factors for Suicide II

- Previous suicide attempts
- General medical illness
- Male gender
- Caucasian race
- Living alone or poor general social support
- Advanced age
- History of interpersonal violence
Assessment of Suicidality I

- Brief mental status evaluation
- Assessment of suicidal ideation
- Assessment of suicide plan
- Assessment of suicide preparations
- Assessment for previous experiences with suicide
- Assessment of means
Assessment of Suicidality II

- Assessment of intent and goals of the behavior
- Assessment of current stressors and expected stressors
- Assessment of for imminent “anniversary dates”
- Assessment of social support
- Assessment of reasons to live
Interventions for Suicidality

- Remove the means
- Non-lethal doses of medication
- Contact family/friends with patient present
- Future linkage
- Referral for therapy
- 24 hour company
- Hospitalization if cannot contract for safety
- What about “No suicide” contract?
“No Suicide Contract”

- “I _____ promise that I will not hurt or kill myself, accidentally or on purpose, before my next appointment with Dr. _____ which is on _______. If I feel like I cannot keep this contract I will do the following things:
  1. Call LSU Family Practice for immediate appointment (or talk to on-call doctor)
  2. Call (social supports)__________, ________, or __________
  3. Go to the (nearest) emergency room
  4. Call 911
Mrs. Wilson returns

- 6 mo later
- Depression symptoms significantly reduced except insomnia
- Ave 1 hr 30 minute sleep onset insomnia; 2-3 45+ minute awakenings each night
- Total sleep 7 hours (including 1 hour mid-day nap)
- Daytime sleepiness moderate
Primary Insomnia

- Sleep hygiene (handout)
- Sleep restriction (handout)
- Writing about ruminations (“can’t shut my brain off”)
- Avoid meds, if at all possible (Meds two weeks or less, if you feel you have to prescribe)-
  Remember to ask about OTCs
Bibliotherapy

- **Insomnia** - *No More Sleepless Nights* - Hauri & Linde
Mr. Martin, 35 y.o. WM

- Presents to the ED
- 2 recent episodes of chest pain and SOB
- Cardiac causes ruled out by ED
- Panic attacks with agoraphobic avoidance of bridges, Wal Mart, grocery stores
Anxiety

- Break avoidance cycle - exposure to feared thing
  - Catch panic disorder early
- Exercise
- Detailed fear diary
- Relaxation exercises
- OCD & PTSD - refer, if possible
Bibliotherapy

- **Anxiety Disorders** (especially GAD)- The Anxiety and Phobia Workbook- Edmund Bourne
- **GAD**- Mastery of Your Anxiety and Worry- Craske, Barlow & O’Leary
- **Panic Disorder**- Mastery of Your Anxiety and Panic- Barlow & Craske
Bibliotherapy

- **OCD** - *OCD Handbook* - Hyman & Pedrick
- **PTSD** - *I Can’t Get Over It* - Matsakis
- **Social Phobia** - *The Shyness and Social Anxiety Workbook* - Swinson
Somatoform Disorders
(Barksy and Ahern)

- ONE doctor
- Find acceptable “label” (e.g., chronic pain, chronic nausea, etc.)
- Pleasant events scheduling
- Exercise
- Volunteer work or regular work if they are not working now
- Relaxation exercises
- Set time contingent appointments- not symptom contingent
Bibliotherapy

- Somatoform & Chronic Pain -
The Chronic Pain Control Workbook - Catalano & Hardin
Nonadherence

- Assess understanding & willingness
- Assess barriers - Ds (Depression, Drugs, Dollars, Denial)
- Simple reminders/associations, if problem is forgetfulness
- Stages of change (key ingredients - small steps, one behavior at a time, self-monitoring, frequent reinforcers)
Bibliotherapy

- Diabetic nonadherence-
  Diabetes Burnout - Polonsky
  (also works for HTN or other chronic disease noncompliance as long as you explain rationale to patient)
Habit Problems (e.g., smoking cessation, weight loss)

- Stages of change
- Ask about behavior at every visit
- Self-monitoring
- Small goals
- Reinforcement for ANY change
Smoking Cessation

- When they are ready to quit:
  - Scheduled smoking
  - Delay first cigarette
  - Brand fading
  - Rate reduction

- Set **written** quit date

- Modify environment prior to quit date: no smoking indoors, get rid of reminders, throw away cigs, tell friends and family about quit date.
Bibliotherapy

- Weight Loss- The LEARN Program of Weight Management- Brownell
- Smoking Cessation- Quit Smoking For Good- Baer
Eating Disorders

- Refer for outpatient therapy
- Hospitalize if weight is 30% below ideal weight
- If significant others are involved in medical visit-
  - Discourage battles over food
  - Make increased freedoms/positive activities contingent on weight gain
  - For athletes- participation contingent on weight gain/maintenance of normal weight
Bibliotherapy

- Eating Disorders- The Body Image Workbook- Cash
Sexual Problems

- Rule out depression and relationship problems first
- Check medication list
- If problem is long-standing, refer for outpatient therapy
- Encourage to work with Sensate Focus exercises (LoPiccolo)
- Ask them to refrain from sex- until in therapy or until working on sensate focus (restraining directives)
Bibliotherapy

- Sexual Dysfunction: **Becoming Orgasmic**- Heiman & LoPiccolo (guide to sensate focus exercises)
- **Premature Ejaculation**- How to Overcome Premature Ejaculation- Helen Singer Kaplan
Marital Problems

- Say something nice to partner on a daily basis
- Do something nice for partner 1-2X week
- Schedule pleasurable outings
- Referral if
  - not a recent problem
  - Abuse
  - one partner won’t play along
Bibliotherapy

- **General**- Seven Principles to Making Marriage Work- Gottman & Silver
- **Infidelity**- After the Affair- Janice Abrahms Spring (helpful for both partners)
Children

- **Behavior Problems** - 1-2-3 Magic (videos may be preferable to book- most libraries have them)

- **Sleep, Toilet Training, Habit issues** (thumb sucking, nose picking, nail biting), **Eating issues** - Often respond well to parent support and education
Most Important

- ALWAYS ASK ABOUT INTERVENTION AT THE TIME OF NEXT APPOINTMENT!!!!