

THE HOSPITALIZED PATIENT EXPERIENCE - ANXIETY AND DEPRESSION IN THE MEDICALLY ILL

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Disclosures

- None

Learning Objectives

- Significance
- Epidemiology
- Bio-Psycho-Social Contributors
- Diagnosis
- Management
 - ▣ Non-pharmacologic Management
 - ▣ Psychopharmacology

Significance

- Prolonged hospital stay
- Increased health care utilization
- Worsens physical complaints/pain perception
- Drives maladaptive behaviors (compliance, avoidance, overutilization, substance use)

- Quality of life reductions
- Increased morbidity and mortality
- Increased disability

Epidemiology

- Medical illness and depressive/anxiety symptomatology highly comorbid
 - ▣ Depression annual prevalence 2-5% community vs. 5-10% primary care vs. 6-14% hospital inpatients
 - ▣ Anxiety annual prevalence 2-5% community, 11% in primary care, 10-14% cardiology inpatients

Bio-Psycho-Social Contributors

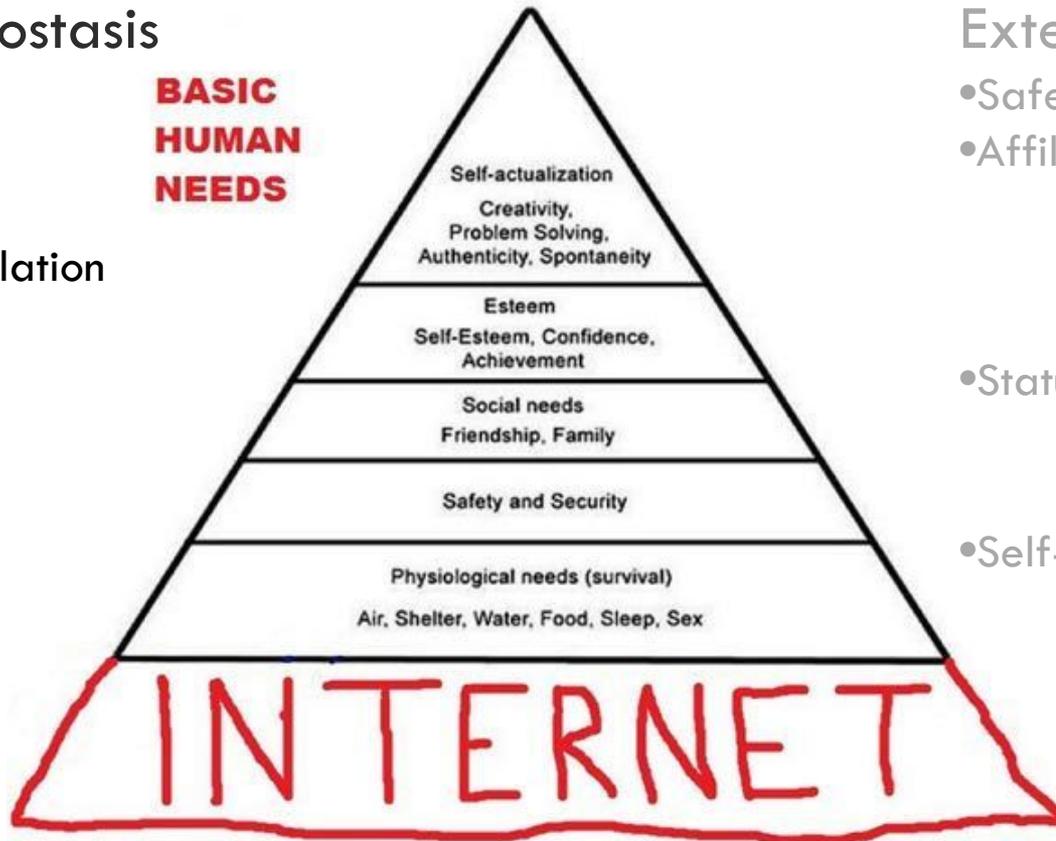
- Lifetime Prevalence
 - Depression 8-18%
 - Anxiety 14-33%
 - Schizophrenia <1%, Bipolar 1-3%, Autism ~1%, OCD ~2%
- “psyche and soma are intimately intertwined and the Cartesian duality that drives a wedge between objective signs and subjective symptoms does not reflect our patients’ reality. A biopsychosociospiritual formulation—and of course the tools relevant to each realm—is indispensable in creating a coherent explanation of a patient’s experience and formulating integrated treatment goals.”

Biological Contributors

Internal Homeostasis

- Oxygenation
- Hydration
- Nutrition
- Temperature regulation
- Sleep Regulation
- Physical Trauma
- Survival
- Reproduction

BASIC HUMAN NEEDS



External Homeostasis

- Safety
- Affiliative needs
 - Love/affection
 - Belonging
 - Support
- Status needs
 - Esteem of others
 - Self esteem
- Self-Actualization
 - Autonomy
 - Self Expression
 - Creativity

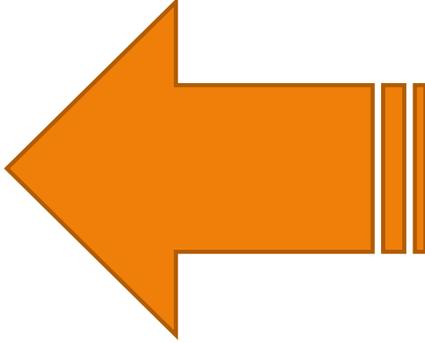
- “Forces from the outside world impinging on the individual. Stress is a normal part of life that can help us learn and grow. Conversely, stress can cause us significant problems.”

Biological Contributors

□ Highly Comorbid with Biological Illness

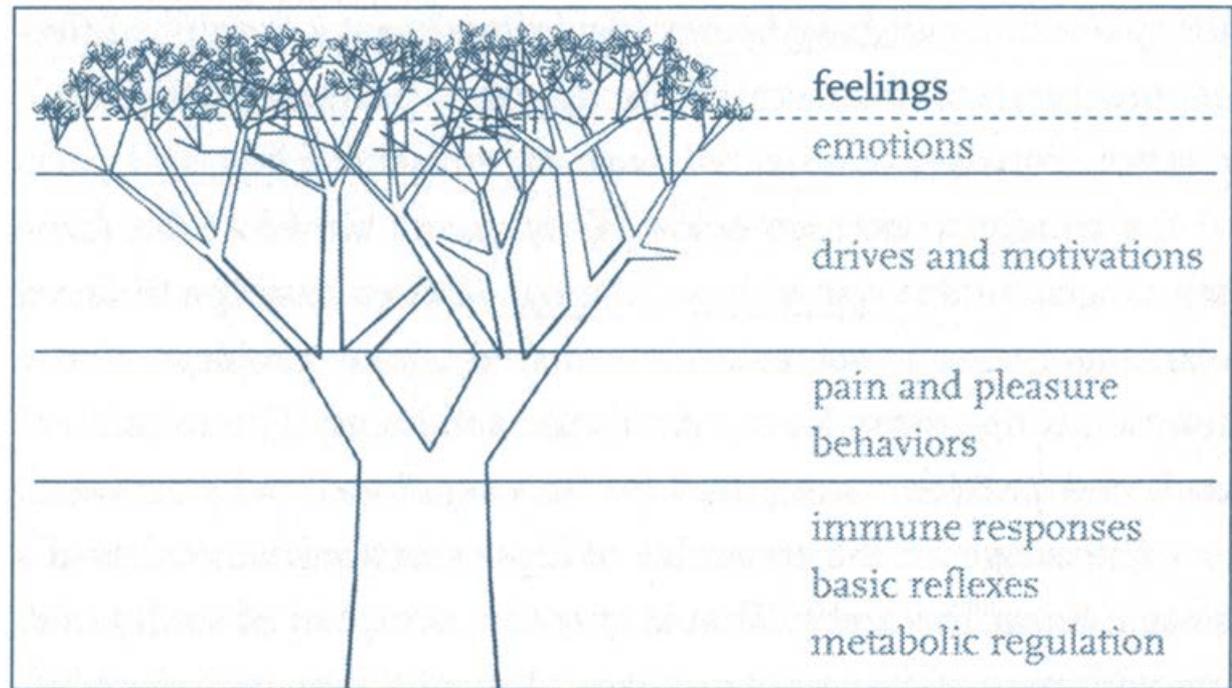
- Iatrogenic
- Respiratory
 - (Asthma, COPD)
- Cardiovascular & Circulatory
 - (Anemia, CHF, CAD/MI, Arrhythmia)
- Neurologic
 - (Neoplasia, CVA, Epilepsy, Migraine, Multiple Sclerosis, Huntington's, Parkinson's, Essential Tremor)
- GI
 - (Dysmotility, dyspepsia, discontinuity)
- Renal
 - (Hemodialysis)
- Endocrine
 - (Diabetes, Cushing's, Addison's, Carcinoid, Hyper/Hypo Parathyroid, Hyper/Hypo Thyroid, Estrogen/Testosterone deficiency)
- Metabolic
 - (Electrolyte abnormality, acidosis, hypo-vitaminosis, nutrition)
- Rheum
 - (RA, SLE)
- Infectious
 - (HIV, Treponema, TB, Hepatitis)
- Pain
- Intoxication/Withdrawal

What are Emotions Really?

- Fear
 - Surprise
 - Disgust
 - Anger
 - Sadness
 - Happiness
 - Other?
- 
- Reactive
 - Reflexive
 - Alterations in Behaviors
 - Alterations in Cognitions

Biological Contributors

- Link between mind body
 - ▣ Brain as a secondary organ sub-serving mobility and nutrition



- ▣ Emotion > motion > Feelings

Biological Contributors

- Illness behaviors as a natural response to internal/external milieu
 - ▣ Internal Milieu
 - Inflammatory response, GI upset, hunger
 - → Illness behaviors
 - Ability to discern visceral signals
 - → Misinterpretation, Catastrophization, Illness Anxiety Disorders

Emotions → Cognitions → Actions

- Psychological Reaction to the Experience of Illness
- Uncertainty Regarding Medical Diagnosis
- Uncertainty Regarding Medical Prognosis
- Anxiety about the loss of One's 'Wholeness'
- Anxiety about Identity/Livelihood
- Fear of Death
- Anxiety about Strangers/Strange Situations
- Anxiety about Judgment from Clinicians

Illness Anxiety Disorder

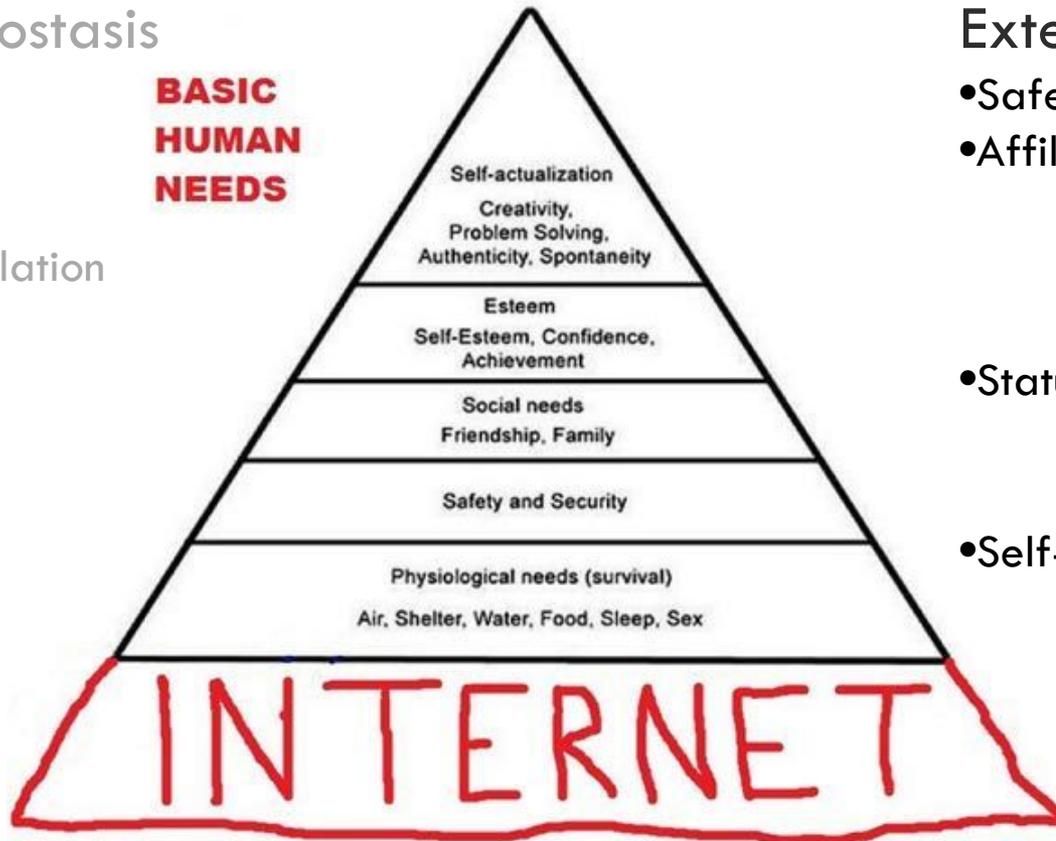
- Preoccupation with having or acquiring a serious illness
- Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (eg strong family history), the preoccupation is clearly excessive or disproportionate.
- There is a high level of anxiety about health, and the individual is easily alarmed about personal health status
- The individual performs excessive health-related behaviors (eg repeated checks for signs of illness) or exhibits maladaptive avoidance (eg doctor visits/hospitals)
- Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
- The illness-related preoccupation is not better explained by another medical disorder.

Psychosocial Contributors

Internal Homeostasis

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- Hydration
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- Sleep Regulation
- Physical Trauma
- Survival
- Reproduction

BASIC HUMAN NEEDS



External Homeostasis

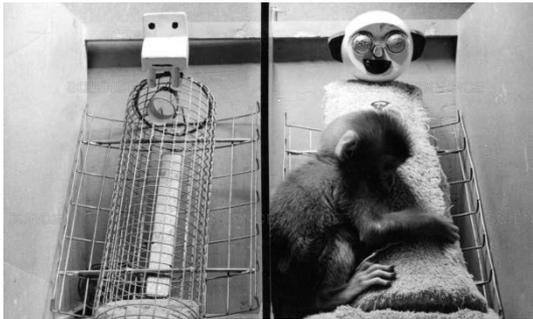
- Safety
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Psychosocial Contributors

Animal Models of Depression/Anxiety

Maternal Deprivation



Learned Helplessness

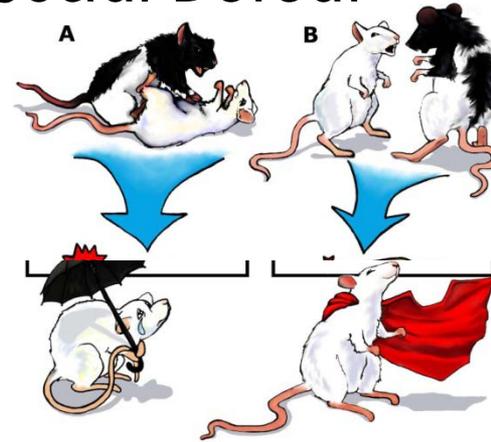


Forced Novelty



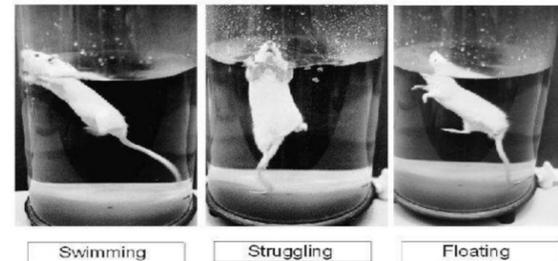
“Why Your Cat Loves Boxes, According to Science”

Social Defeat



Despair Based

Forced Swimming



Psychosocial Contributors

- Illness behaviors as a natural response to external/internal milieu
 - External Milieu
 - Environment of hospitalization
 - → Loss of safety, security, autonomy
 - Reduced mobility, quality of life
 - → Chronic stress, demoralization, depression
 - Somatization
 - Somatic Symptom Disorders, Functional Neurologic Symptom Disorders, Compensation Neurosis

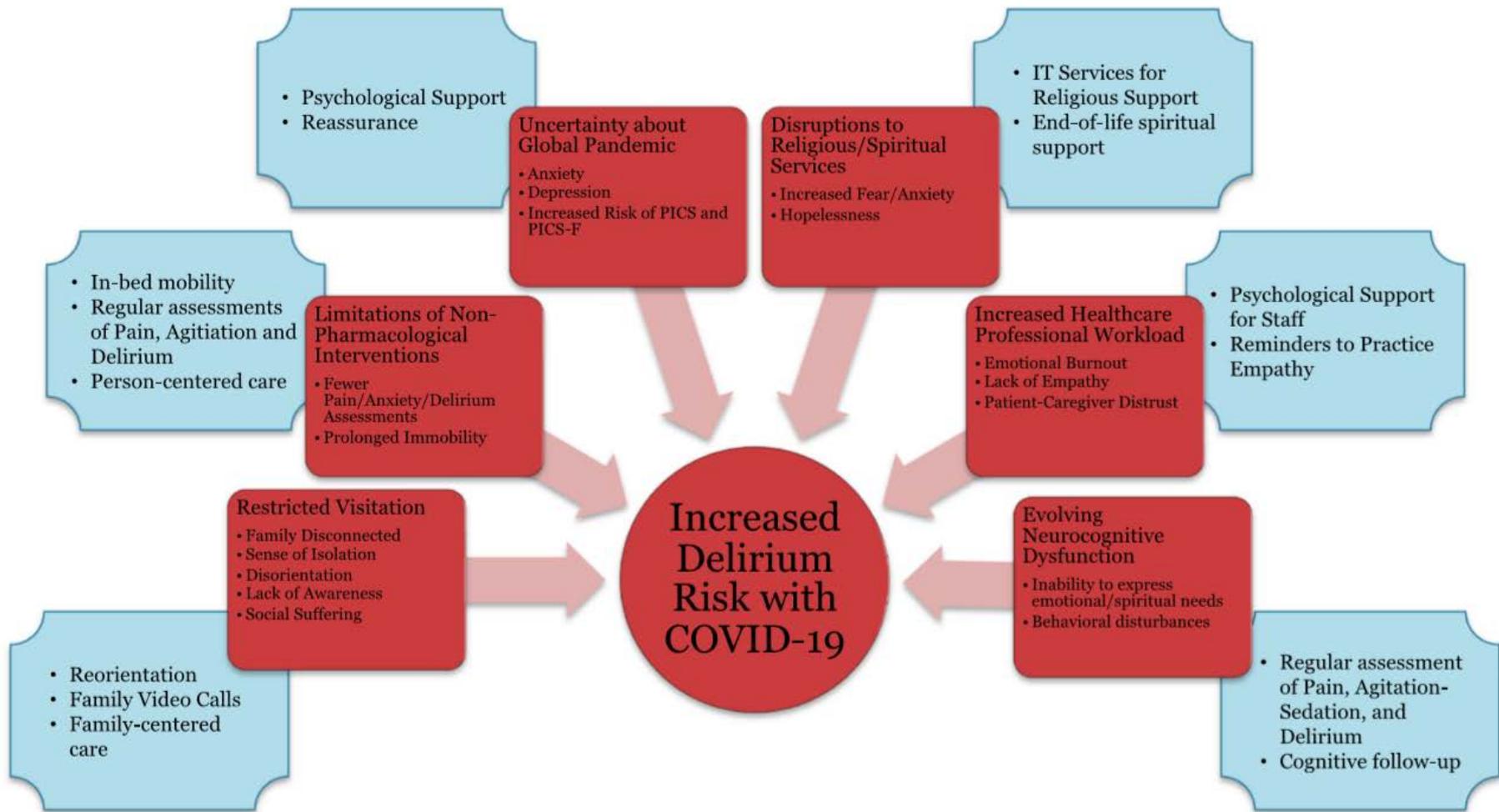


Fig. 1 Potential factors contributing to ICU delirium during the SARS-CoV-2 pandemic

Identification - Barriers

- Possible normalization of depression response during medical illness resulting in under diagnosis
- Illness behaviors and regression - patients somatize depressive symptoms and don't complain of depressive symptoms.
 - ▣ Only 48% of patients that present with somatic complaints are correctly diagnosed.
- Depressive symptoms often overlap with symptoms of physical illness
 - ▣ insomnia, reduced appetite, anergia/fatigue, social withdrawal
 - ▣ r/o delirium
 - ▣ r/o Amotivation/Abulia/Akinetic Syndromes, Catatonia

Diagnosis - Barriers

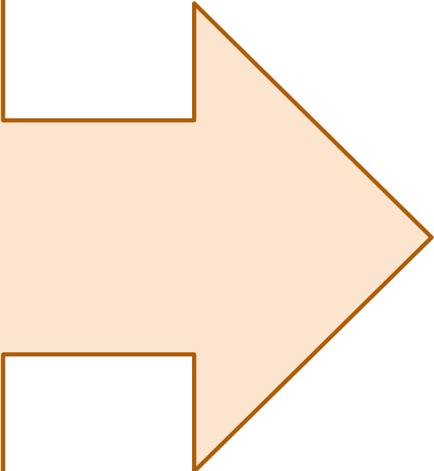
- Disease classification can range from demoralization, adjustment disorders with depressed mood and depressive disorders
 - ▣ intensity, duration, and burden of symptoms.

- Demoralization –
 - ▣ disempowerment (awareness at having failed to meet own expectations) and
 - ▣ sense of futility (inability to cope with pressing problems) resulting in hopelessness/helplessness

- Rule out other Emotions
 - ▣ Anger, Irritation, Disgust, Surprise

Significance Redux

- Anhedonia
- Amotivation
- Helplessness
- Hopelessness
- Suicidal Ideation
- Avoidance
- Psychomotor Retardation
- Appetite Changes/Nutrition
- Cognitive Impairment
- HPA axis Changes



**Morbidity
Mortality**

Identification – Overcoming Barriers



- Retain a High Degree of Suspicion
- Utilize Collateral
- Validated Clinical Scales

Management



- Non-Pharmacologic Management Strategies
- Psychopharmacology
- Neuromodulation

Non-Pharmacologic Strategies

- Family education to reduce stress, increase understanding, respite care
 - Monitor physician burnout/demoralization
 - Supportive services or groups
 - Pastoral services
 - Holistic options
- } A little bit of agency goes a long way
- Psychotherapy

Psychotherapy

- Supportive Psychotherapy is a given
- Consider your patient population - better for mild-moderate depressive disorders, less so for severe depressive disorders, the cognitively impaired, impairments in communication
- Interpersonal psychotherapy IPT - Discussions about changing life roles with emphasis on retained value rather than lost abilities
- Ditto Narrative/Existential therapies
- Good evidence for effectiveness of CBT with high effect size for depressive symptom reduction in patients with somatic disease - address thought distortions that accompany illness, behavioral activation
- Attempt to improve social isolation, challenge lack of self-efficacy, improve coping styles

Psychopharmacology

- Anti-depressants separate from placebo in Cochrane review of patients with medical illness with moderate effect size (NNT 6-7, NNH 19)
- Aggressive management to improve participation with support services may reduce subsequent debility/morbidity

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Social Determinants of Mental Health

- Certain population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, interrelated with gender. Disadvantage starts before birth and accumulates throughout life. A significant body of work now exists that emphasizes the need for a life course approach to understanding and tackling mental and physical health inequalities. This approach takes into account the differential experience and impact of social determinants throughout life. A life course approach proposes actions to improve the conditions in which people are born, grow, live, work, and age. Actions that prevent mental disorders and promote mental health are an essential part of efforts to improve the health of the world's population and to reduce health inequities. There is firm consensus on known protective and risk factors for mental disorders. In addition, a growing body of evidence exists, not only from high-income countries but growing in low- and middle-income countries, that shows effective actions can be successfully implemented in countries at all stages of development.