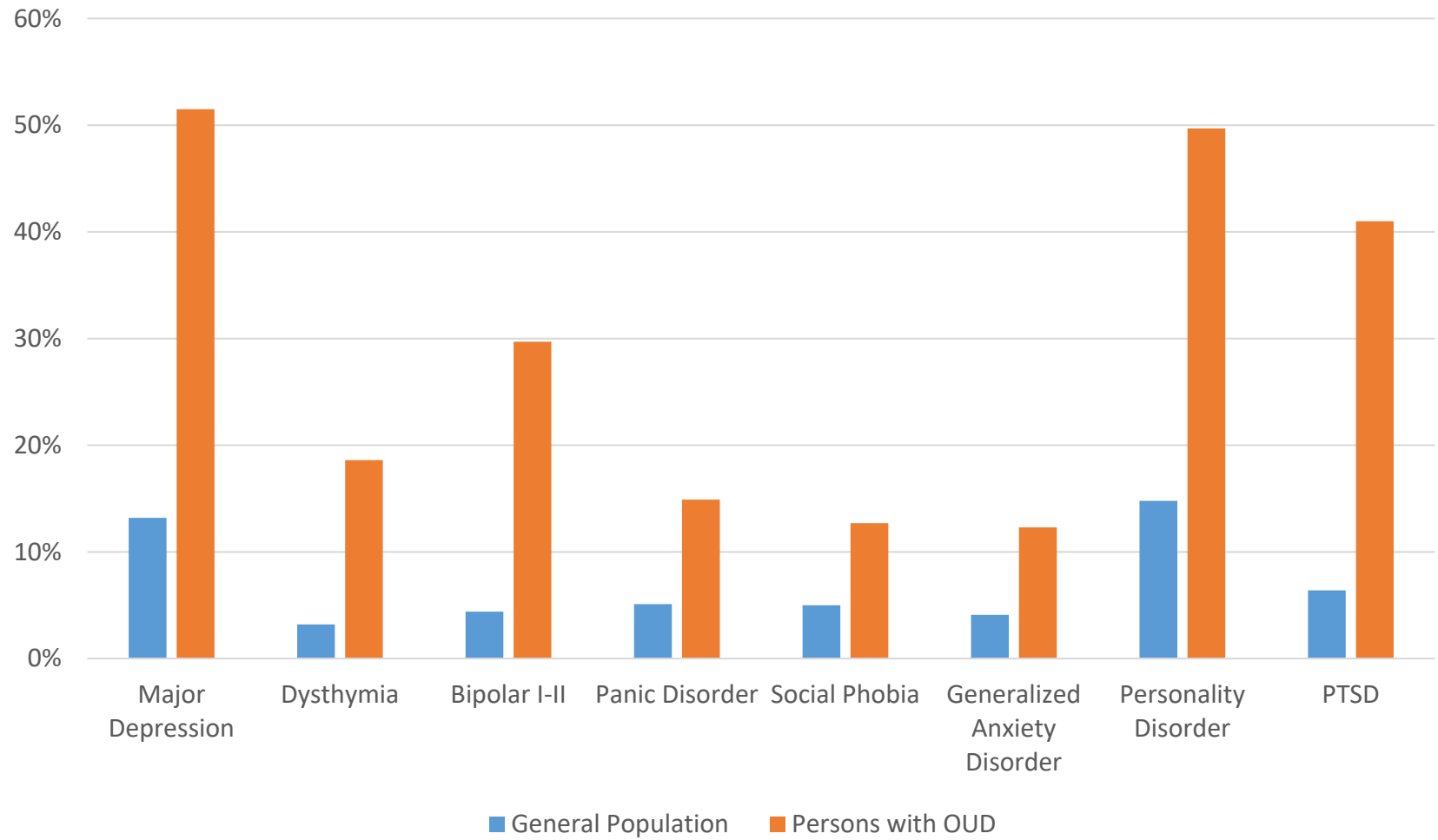
Lifetime Prevalence of Psychiatric Disorders: General Population vs OUD



Grant et al 2004, Grella et al 2009, Hasin et al 2015, Mills et al 2004

Bipolar schizoaffective post traumatic ADHD

Translation I’ve had adverse childhood experiences continued stressors and now I’m suffering from substance use disorders and anxiety disorders…

B.Z. Toons by Brian Zaikowski

www.bztoons.com

Sir, I think there is a mistake.
I ordered "Crab-Rangoon."

Generalized Anxiety Disorder

Diagnostic Criteria **300.02 (F41.1)**

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Panic Disorder

Diagnostic Criteria

300.01 (F41.0)

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy").

2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

Since individuals with anxiety disorders typically overestimate the danger in situations they fear or avoid, the primary determination of whether the fear or anxiety is excessive or out of proportion is made by the clinician, taking cultural contextual factors into account

The term *unexpected* refers to a panic attack for which there is no obvious cue or trigger at the time of occurrence—that is, the attack appears to occur from out of the blue, such as when the individual is relaxing or emerging from sleep (nocturnal panic attack). In contrast, *expected* panic attacks are attacks for which there is an obvious cue or trigger, such as a situation in which panic attacks typically occur.

The determination of whether panic attacks are expected or unexpected is made by the clinician, who makes this judgment based on a combination of careful questioning as to the sequence of events preceding or leading up to the attack and the individual's own judgment of whether or not the attack seemed to occur for no apparent reason.

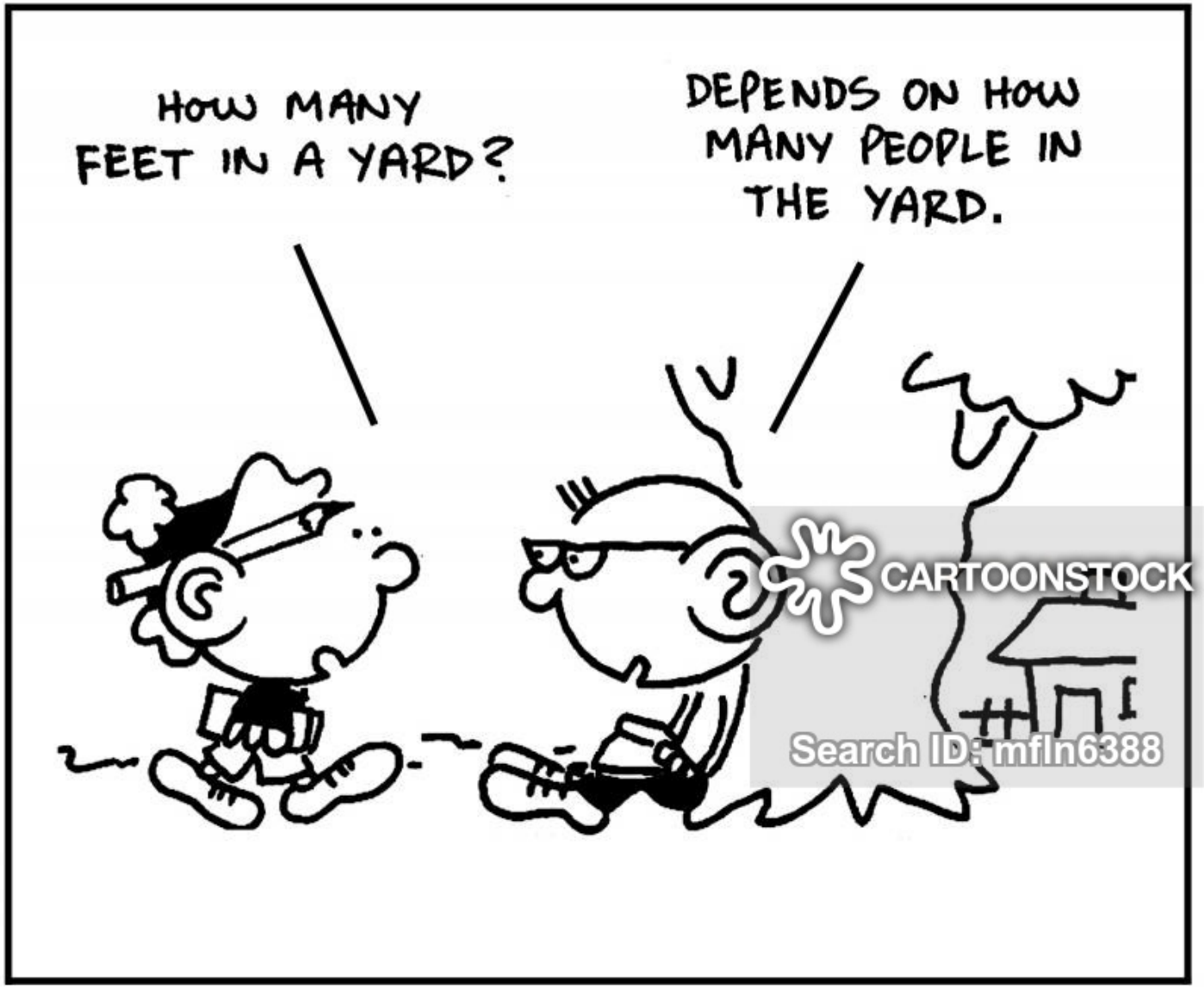
Panic attacks function as a marker and prognostic factor for severity of diagnosis, course, and comorbidity across an array of disorders, including, but not limited to, the anxiety disorders (e.g., substance use, depressive and psychotic disorders). Panic attack may therefore be used as a descriptive specifier for any anxiety disorder as well as other mental disorders.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt fearful.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt anxious.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt worried.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I found it hard to focus on anything other than my anxiety.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt nervous.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt uneasy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt tense.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	


HOW MANY FEET IN A YARD?
DEPENDS ON HOW MANY PEOPLE IN THE YARD.
CARTOONSTOCK
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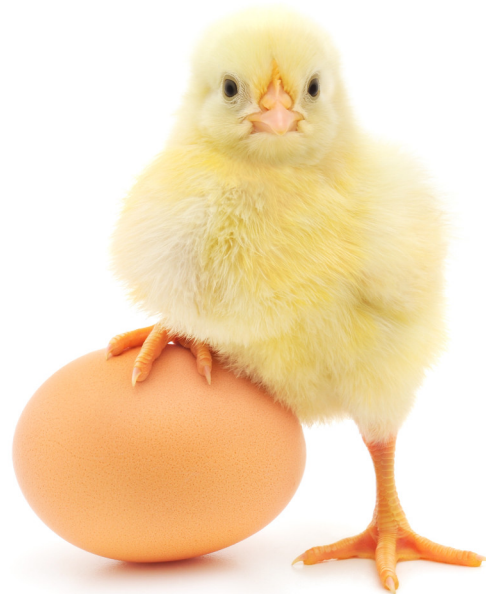
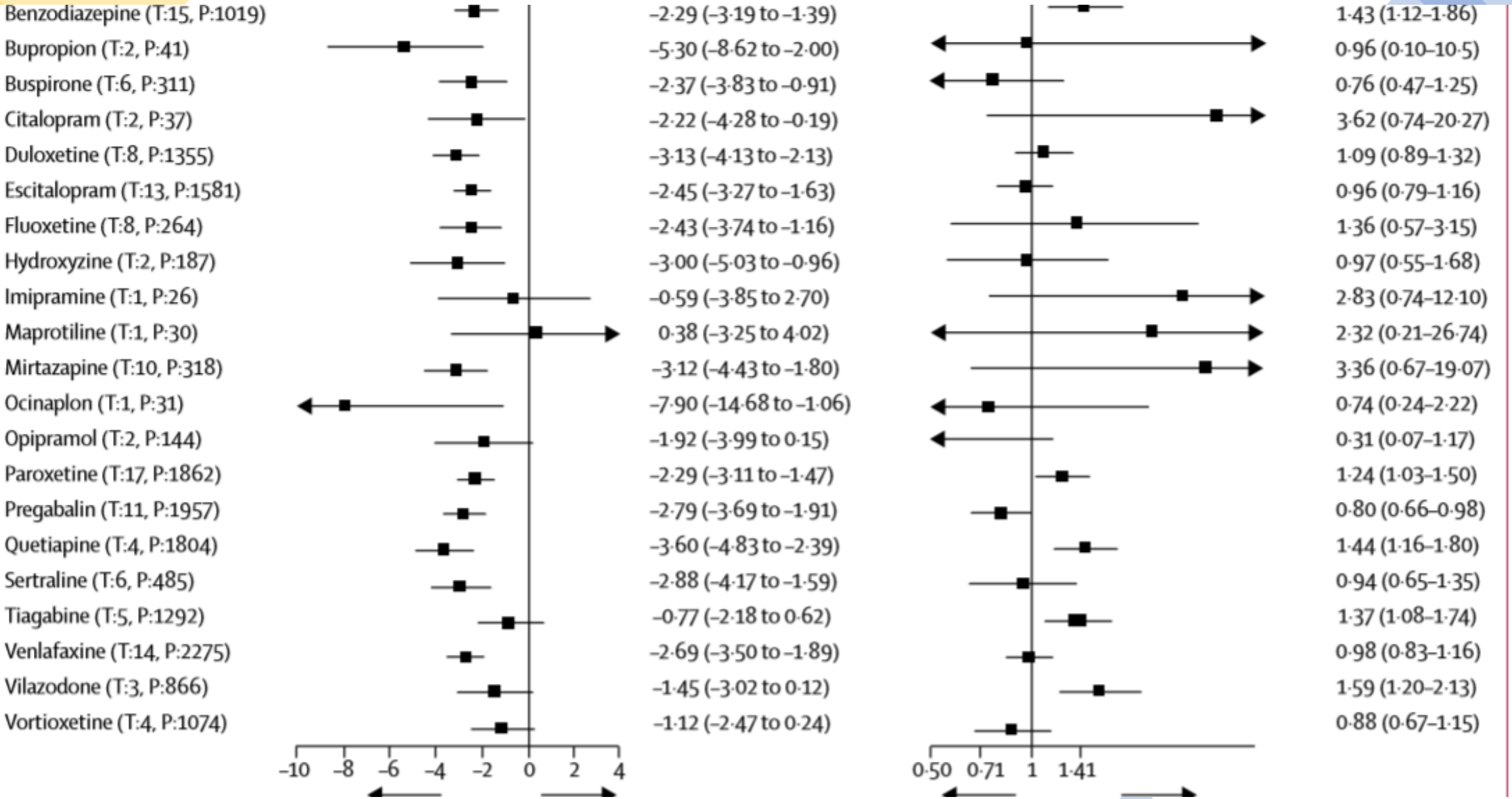
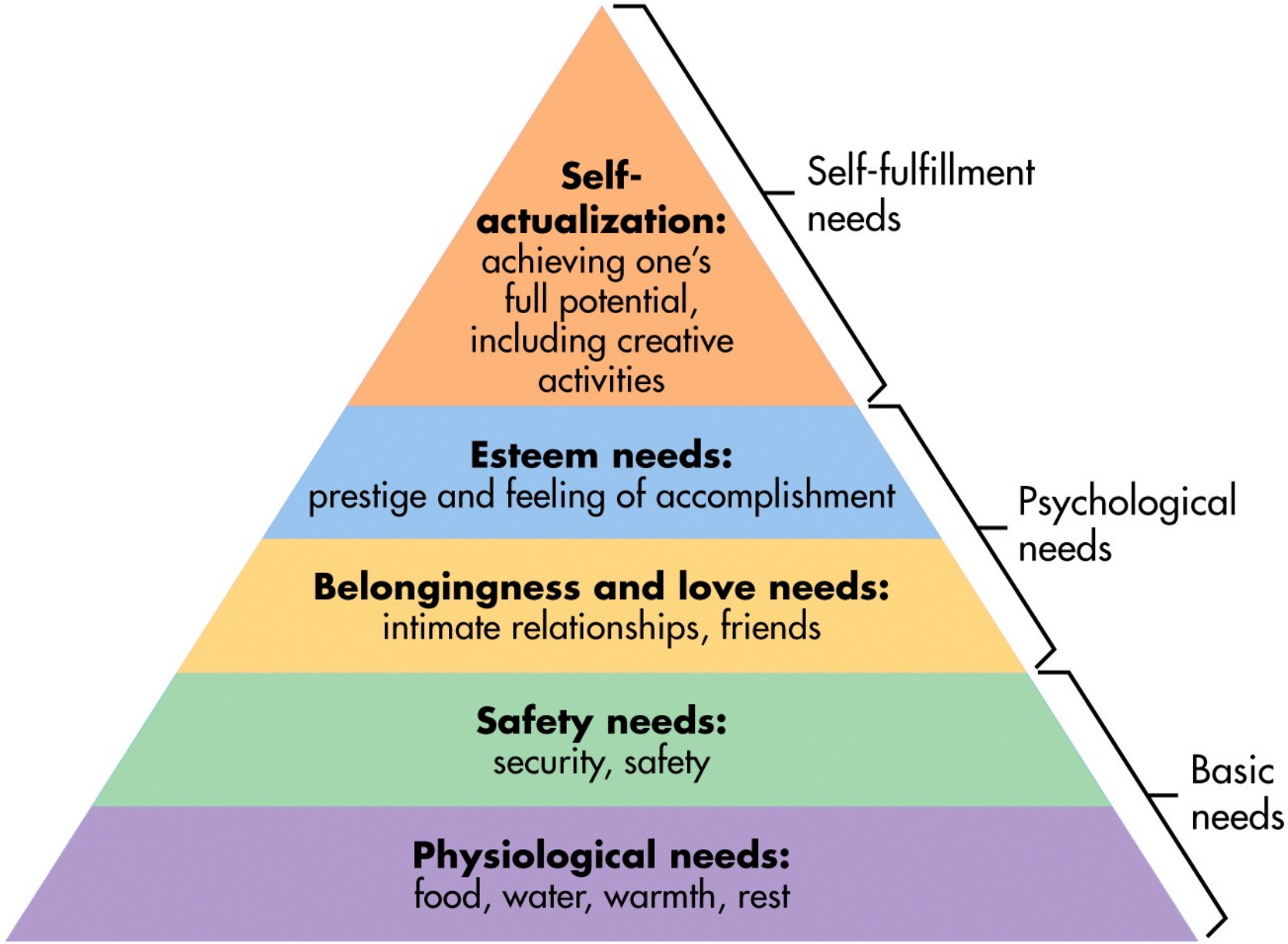



Benzodiazepine (T:15, P:1019) −2·29 (−3·19 to −1·39) 1·43 (1·12–1·86)
Bupropion (T:2, P:41) −5·30 (−8·62 to −2·00) 0·96 (0·10–10·5)
Buspirone (T:6, P:311) −2·37 (−3·83 to −0·91) 0·76 (0·47–1·25)
Citalopram (T:2, P:37) −2·22 (−4·28 to −0·19) 3·62 (0·74–20·27)
Duloxetine (T:8, P:1355) −3·13 (−4·13 to −2·13) 1·09 (0·89–1·32)
Escitalopram (T:13, P:1581) −2·45 (−3·27 to −1·63) 0·96 (0·79–1·16)
Fluoxetine (T:8, P:264) −2·43 (−3·74 to −1·16) 1·36 (0·57–3·15)
Hydroxyzine (T:2, P:187) −3·00 (−5·03 to −0·96) 0·97 (0·55–1·68)
Imipramine (T:1, P:26) −0·59 (−3·85 to 2·70) 2·83 (0·74–12·10)
Maprotiline (T:1, P:30) 0·38 (−3·25 to 4·02) 2·32 (0·21–26·74)
Mirtazapine (T:10, P:318) −3·12 (−4·43 to −1·80) 3·36 (0·67–19·07)
Ocinaplon (T:1, P:31) −7·90 (−14·68 to −1·06) 0·74 (0·24–2·22)
Opipramol (T:2, P:144) −1·92 (−3·99 to 0·15) 0·31 (0·07–1·17)
Paroxetine (T:17, P:1862) −2·29 (−3·11 to −1·47) 1·24 (1·03–1·50)
Pregabalin (T:11, P:1957) −2·79 (−3·69 to −1·91) 0·80 (0·66–0·98)
Quetiapine (T:4, P:1804) −3·60 (−4·83 to −2·39) 1·44 (1·16–1·80)
Sertraline (T:6, P:485) −2·88 (−4·17 to −1·59) 0·94 (0·65–1·35)
Tiagabine (T:5, P:1292) −0·77 (−2·18 to 0·62) 1·37 (1·08–1·74)
Venlafaxine (T:14, P:2275) −2·69 (−3·50 to −1·89) 0·98 (0·83–1·16)
Vilazodone (T:3, P:866) −1·45 (−3·02 to 0·12) 1·59 (1·20–2·13)
Vortioxetine (T:4, P:1074) −1·12 (−2·47 to 0·24) 0·88 (0·67–1·15)
−10 −8 −6 −4 −2 0 2 4
0·50 0·71 1 1·41


Self-actualization: achieving one's full potential, including creative activities
Esteem needs: prestige and feeling of accomplishment
Belongingness and love needs: intimate relationships, friends
Safety needs: security, safety
Physiological needs: food, water, warmth, rest
Self-fulfillment needs
Psychological needs
Basic needs

Reasonable treatment progression to avoid beating a dead horse.

- Have a three to four step road map in place
- Start sertraline or comparable ssri
- Optimize dose

  Does not necessarily mean keep increasing dose every 6 weeks to max dose
- Augment with buspirone then buproprion

  Better to try buproprion then a 4th ssri
- Taper prior trial and start venlafaxine
- Augment with mirtazpine
- Trial of other agents

Propranolol in performance anxiety

Common options

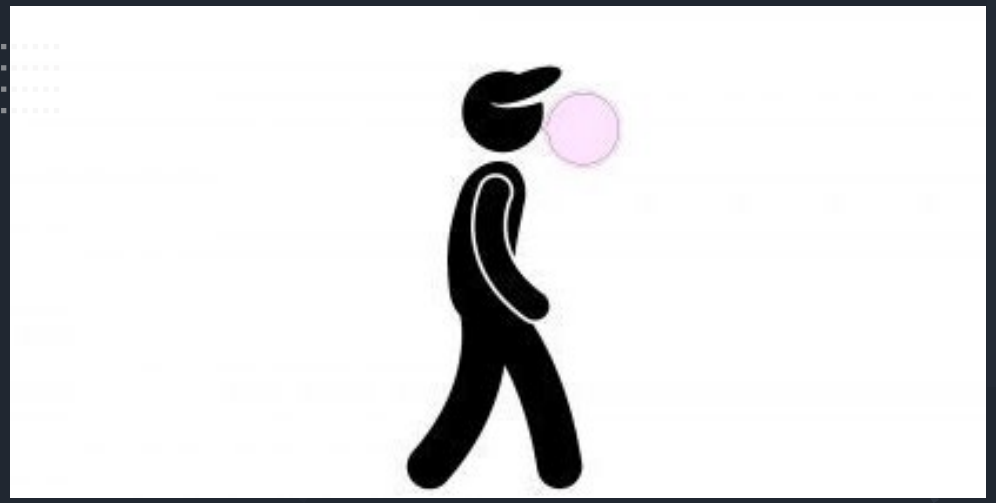
- Hydroxyzine 50-100 mg
- Propranolol 10-20 mg
- Prazosin starting low and titrating
- Low dose Antipsychotics including typical agents
- Anticonvulsants
- Trazodone 25-50 mg BID and 20o mg qhs

Benzodiazepines

- Scheduled
- Time limited
- Specific reason

A consistent finding in this literature is that treating one disorder does not typically confer improvements in the other and that when only a single disorder is treated, significant distress and disability may remain. Nonetheless, whether co-occurring disorders are associated with worse outcome for the treated disorder (i.e., whether an anxiety disorder is associated with worse SUD outcomes) remains unclear.

Treat both or be left behind.



Autobiography in Five Short Chapters

Chapter One
I walk down the street.
There is a deep hole in the sidewalk.
I fall in.
I am lost .... I am helpless.
It isn't my fault.
It takes forever to find a way out.

Chapter Two
I walk down the street.
There is a deep hole in the sidewalk.
I pretend that I don't see it.
I fall in again.
I can't believe I am in this same place.
But, it isn't my fault.
It still takes a long time to get out.

Chapter Three
I walk down the same street.
There is a deep hole in the sidewalk.
I see it is there.
I still fall in ... it's a habit ... but, my eyes are open.
I know where I am.
It is my fault.
I get out immediately.

Chapter Four
I walk down the same street.
There is a deep hole in the sidewalk.
I walk around it.

Chapter Five
I walk down another street.

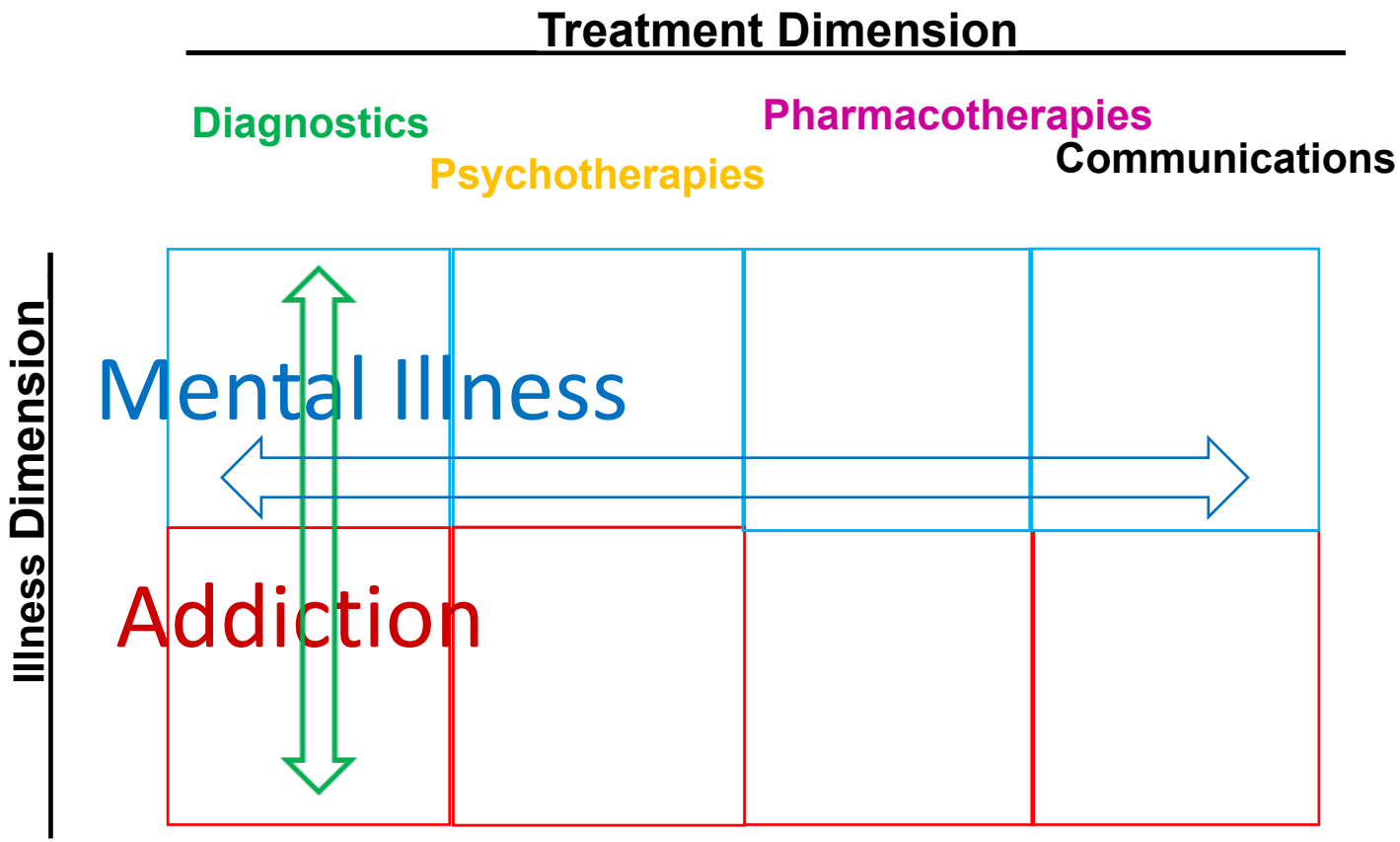
Autobiography in Five Short Chapters, by Portia Nelson

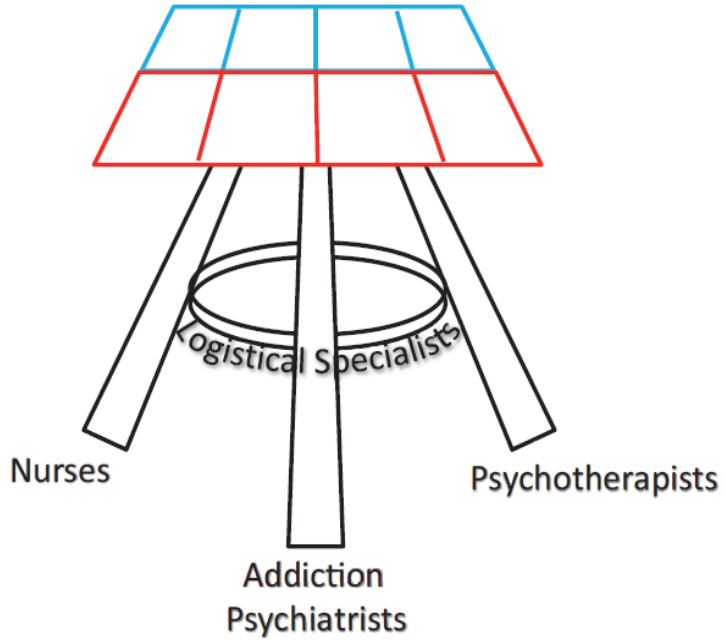
Seeking Safety

What are the key principles?

Seeking Safety is based on five central ideas: *(1) Safety as the priority of treatment. (2) Integrated treatment.(3) A focus on ideals. (4) Four content areas: cognitive, behavioral, interpersonal, and case management.* (5) *Attention to clinician processes*.

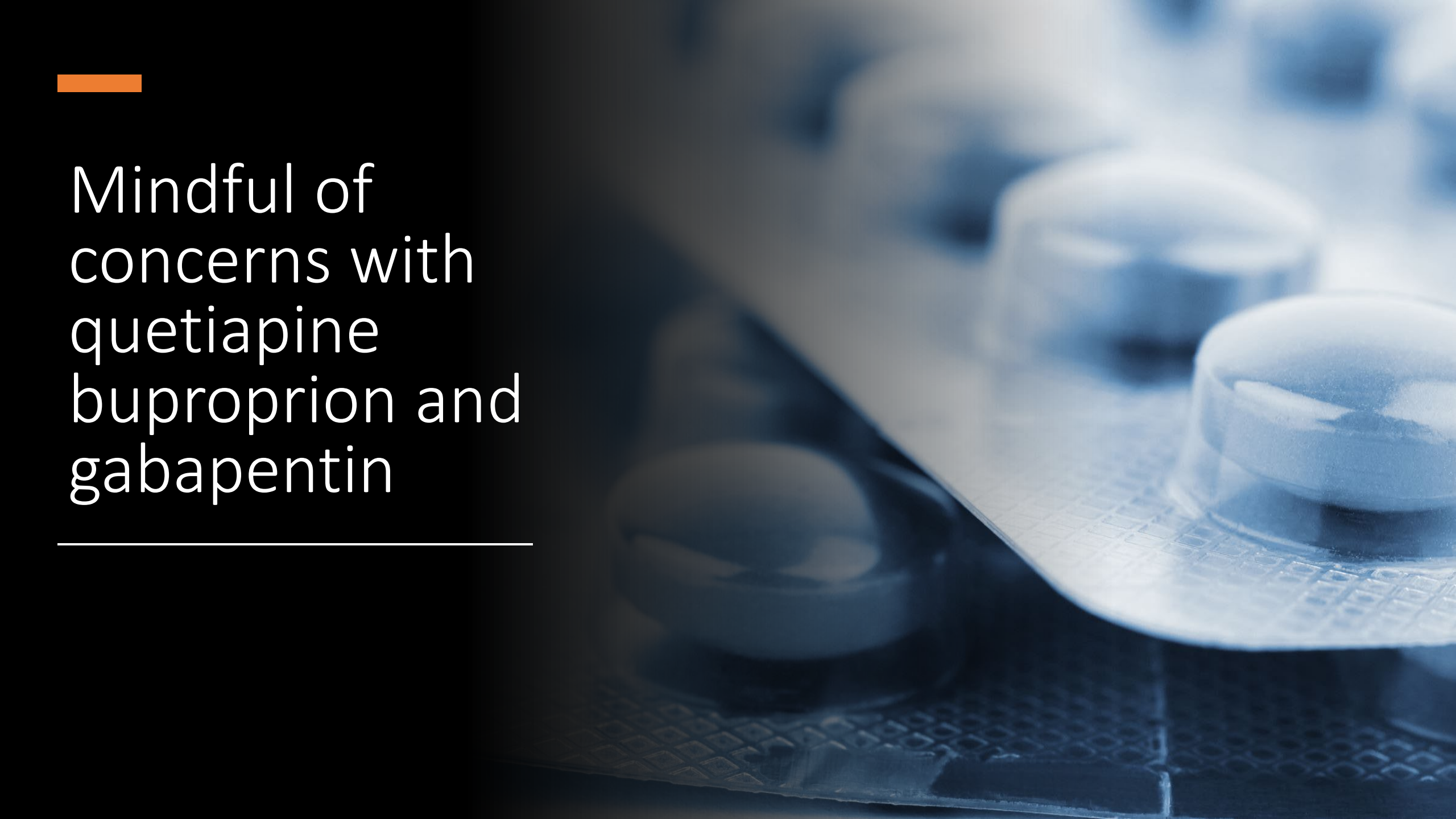
The 2 x 4 Model: A Neuroscience-based Blueprint for the Modern Integrated Addiction and Mental Health Treatment System



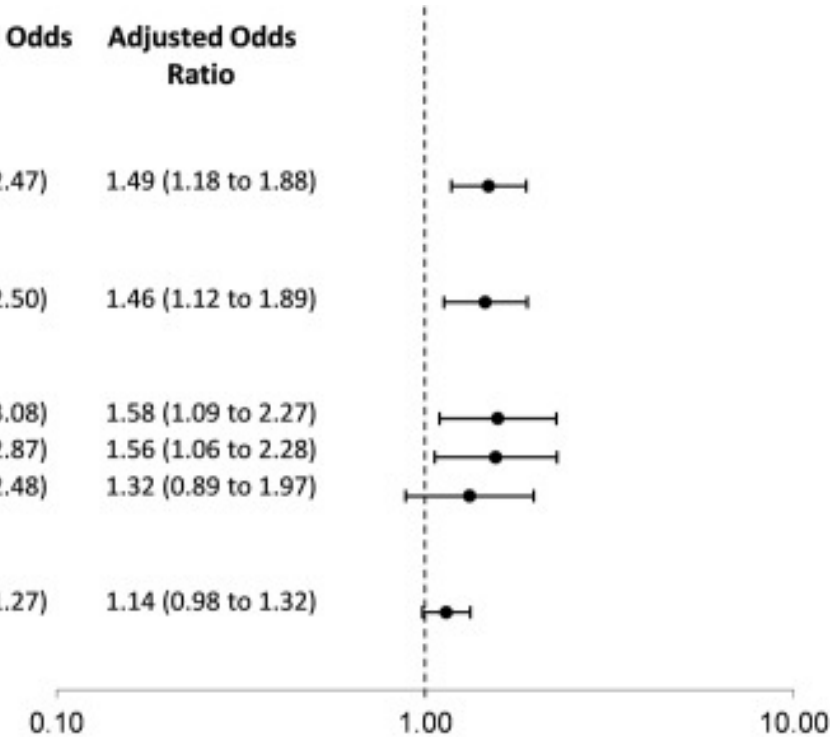


Adapted From: Chambers “The 2 x 4 Model”, Routledge/CRC press, New York, 2018

Mindful of concerns with quetiapine buproprion and gabapentin



	No. Exposed Cases	No. Exposed Controls	Unadjusted Odds Ratio	Adjusted Odds Ratio
Primary Analysis*:				
Recent Gabapentin Use	155 (12.3%)	313 (6.8%)	1.99 (1.61 to 2.47)	1.49 (1.18 to 1.88)
Sensitivity Analysis: Overlapping Gabapentin Use*				
Gabapentin Overlapping Index	121 (9.6%)	240 (5.2%)	1.98 (1.56 to 2.50)	1.46 (1.12 to 1.89)
Secondary Analysis: Gabapentin Dose**				
High Dose	57 (4.5%)	101(2.2%)	2.20 (1.58 to 3.08)	1.58 (1.09 to 2.27)
Moderate Dose	57 (4.5%)	111 (2.4%)	2.05 (1.46 to 2.87)	1.56 (1.06 to 2.28)
Low Dose	41 (3.3%)	101 (2.2%)	1.70 (1.17 to 2.48)	1.32 (0.89 to 1.97)
Neutral Exposure†:				
Recent NSAID Use	480 (38.2%)	1647 (35.7%)	1.11 (0.98 to 1.27)	1.14 (0.98 to 1.32)



*1,256 cases and 4,619 controls; Reference Group: no gabapentin use

** Low dose: <900mg/day; moderate dose: 900-1799mg/day; high dose: ≥1800mg/day; Reference Group: no gabapentin use

† Reference Group: no NSAID use

Conversion Disorder (Functional Neurological Symptom Disorder)

Diagnostic Criteria

A. One or more symptoms of altered voluntary motor or sensory function.

B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.

C. The symptom or deficit is not better explained by another medical or mental disorder.

D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Table 3. Recommendations for Tactfully Delivering a Diagnosis of Conversion Disorder and for Managing the Condition[a]

Diagnosis Delivery Recommendations

- Acknowledge the patient's symptoms.
- Reassure the patient that the symptoms are very real despite the lack of a definitive organic diagnosis.
- Provide examples of how the subconscious influences behavior (eg, nail biting, pacing, foot tapping).
- Provide reassurance that no evidence of an underlying neurological disorder is present based on the tests that were performed and that the prognosis for recovery is very good.
- Provide positive reinforcement that the symptoms can improve spontaneously.
- Inform the patient that the symptoms are not volitional, and no one believes that he/she is faking.
- Provide a noninvasive way for the patient to improve, such as by allowing the symptom(s) to get better over time, just as symptoms from an organic disease might improve.

Pharmacological treatments for generalized anxiety disorder: a systematic review and network meta-analysis AprilSleeMSaIrwinNazarethMDaPaulinaBondaronekMSaYifengLiuMSaZhihangChengMBBScProfNickFreemantlePhDb

McHugh RK. Treatment of co-occurring anxiety disorders and substance use disorders. *Harv Rev Psychiatry*. 2015;23(2):99-111. doi:10.1097/HRP.0000000000000058

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