

# Mental health





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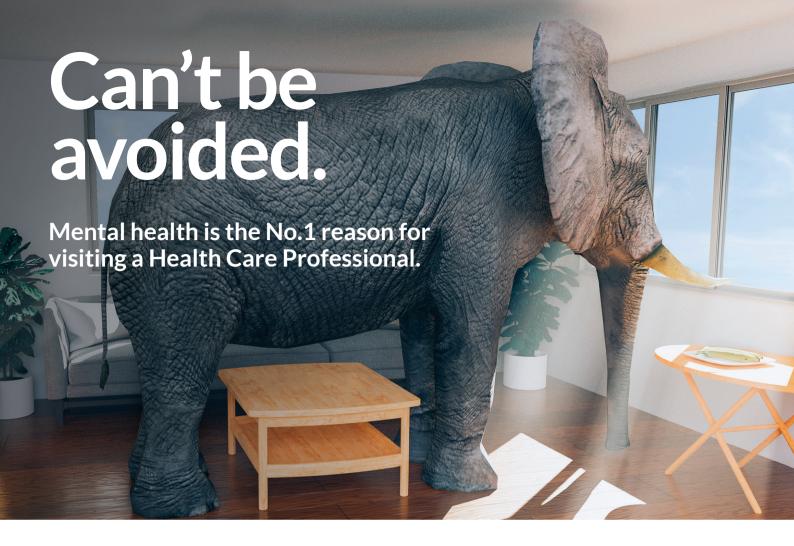
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# Mental health

# Unit 571 May 2020

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### The five domains of general practice

Communication skills and the patient-doctor relationship

Applied professional knowledge and skills

Population health and the context of general practice

Professional and ethical role

Organisational and legal dimensions



### **About this activity**

Mental health is the most common issue managed by general practitioners (GPs).<sup>1</sup> The percentage of GPs who listed mental health as one of the three most common presenting ailments increased from 61% in 2017 to 65% in 2019.<sup>1</sup>

In Australia, bipolar disorder affects approximately 1% of the population.<sup>2</sup> Treatment of bipolar disorder is crucial because patients with this disorder have an eight times greater risk of suicide than the general population.<sup>3</sup>

Between one and four per cent of Australians are affected by borderline personality disorder (BPD) throughout their lives.<sup>4</sup> BPD is more common in women and often appears in late adolescence or early adulthood.<sup>4</sup>

Approximately 3% of Australians experience generalised anxiety disorder within a 12-month period, with a mean age of onset of 33 years.<sup>5</sup>

In the perinatal period, 15% of mothers and 10% of fathers experience clinically diagnosed depression; 6 mild anxiety and mood disturbances are likely to be even more prevalent.

It is estimated that only half of Australians who have a mental health disorder receive the treatment they need. For patients experiencing barriers to face-to-face care, eHealth tools are increasingly becoming available to provide portals to care, websites for psycho-education and support, and online therapy.

This edition of *check* considers the investigation and management of mental health in general practice.

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### **Learning outcomes**

At the end of this activity, participants will be able to:

- identify situations that require the use of mental health assessment tools such as the Kessler Psychological Distress Scale and the Depression Anxiety Stress Scale
- discuss the appropriate management of borderline personality disorder
- outline how eHealth can be used in the treatment of depression
- discuss the process of diagnosing generalised anxiety disorder and bipolar disorder
- describe the approach to assessing and managing mental health in the perinatal period.

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### **Abbreviations**

ATAR Australian Tertiary

Admission Rank

BMI body mass index

BPD borderline personality disorder

**CBT** cognitive behavioural therapy

DASS Depression Anxiety Stress Scale

**DSM-V** Diagnostic and statistical

manual of mental disorders,

fifth edition

**EPDS** Edinburgh Postnatal

Depression Scale

FBE full blood examination

GAD generalised anxiety disorder

**GP** general practitioner

IT

HAM-AHamilton Anxiety Rating Scale

ICD-11 International Classification

of Diseases, 11th Revision information technology

K10 Kessler Psychological

Distress Scale

OCD obsessive compulsive disorder

PTSD post-traumatic stress disorder

rTMS repetitive transcranial magnetic

stimulation

SCID-5 Structured Clinical

Interview for DSM-V

SMA supplementary motor area

**SR** slow release

**SSRI** selective serotonin

re-uptake inhibitor

**TFT** thyroid function tests

TMHC Transcultural Mental Health

Centre

**TSH** thyroid stimulating hormone

### CASE

# 1

### Krish isn't feeling like himself

Krish, aged 33 years, is an information technology (IT) worker who has been brought in by his wife, Devika, to see you. Krish and Devika are first-generation Indian immigrants of Tamil heritage. They are fluent in English. Devika says that Krish is 'depressed' and has not been feeling like himself. He has not been going to work for the past week and his mood has been very low. His appetite and sleep are poor. He is upset and cries over minor issues. Krish has been irritable and has snapped at Devika. Krish is silent while Devika is talking.

Question 1 $\bigcirc$		
What would be your initial approach to this consultation?		

### **Further information**

Krish says that he has been feeling down as a result of stresses at work during the past four weeks. He admits that over the past two years, he has been feeling increasingly low. This has affected his performance in his current job as a programmer, which he commenced one year ago. The work is hectic, and Krish has a much higher workload and greater responsibility than he had previously been accustomed to. Consequently, his work performance has been affected and he has failed to meet the expectations of his role. Approximately four weeks ago, he had a meeting with his supervisors and it was decided that he should be placed on performance management. You identify this as a factor contributing to his current symptoms.

Krish admits to being depressed on and off since he was aged in his mid-20s. He has been reserved and shy all his life. He migrated to Australia in 2006 when he was 20, to study a Master of Information Technology. He secured a good job in IT and says that he has been 'lucky' and has always held a job.

Devika corroborates Krish's history. Krish married Devika in a traditional arranged marriage seven years ago. She reports that Krish has always been reserved, moody and sensitive.

Throughout their marriage, Devika noticed Krish occasionally feeling low for a few days several times; however, he soon bounced back. She did not think much about it at the time. Devika considers their marriage to be happy and stable. She says that they are a religious Hindu family and that Krish is happiest when he visits temples or participates in religious activities. Devika works at the community library and they have a daughter aged five years who attends the local primary school

Krish is medically well. There is no family history of mental illnesses. Krish is a non-smoker and does not report medication or alcohol dependencies.

What are your next steps?				

### **Further information**

Question 2

Krish scores 39 on the Kessler Psychological Distress Scale (K10). Although this score is not diagnostic, it is considered high, and therefore it is more likely that Krish has a mental health disorder.

You do a risk assessment and identify Krish has anhedonia. He reports occasional suicidal ideation but has no intent, plan or access to means. His family is a protective factor. You diagnose Krish with major depression. Your risk assessment identifies him as low risk for self-harm and harm to others. You prescribe fluoxetine 20 mg and make arrangements to review him in two weeks, or earlier if needed. You give Krish and Devika details of helplines and other resources for depression. You also give Krish a medical certificate for two weeks.

Krish returns for review in two weeks with Devika. She reports that Krish's mood has improved since he commenced the medication; however, there has been a major change in his behaviour. Krish has become very active and alert since taking the medication. He does not seem to be sleeping well and stays up late working. He seems to be unusually happy. He has also been spending a lot of time in the local temple, singing hymns constantly and engaging in prolonged religious rituals at home. Krish also made a \$5000 donation to the temple development fund, which Devika says has put them in financial stress.

You confirm these facts with Krish and he replies that he has never been better. He adds that he is planning an extension of the function hall of the temple and has been spending most of his time drawing up the plans and planning the finances. He is confident that he can raise the funds required. He is more vocal and animated than he was in the first consultation.  Krish denies any visual and auditory hallucinations. He shows poor insight into his current condition, and his judgment	Question 4
seems to be impaired.  You attempt to repeat the K10 assessment, but Krish is not able to concentrate. As a result, you do not proceed with it. You complete a mental state examination and determine that Krish displays no acute suicidality or homicidality.	
Question 3 😃	
What is your clinical impression?	Question 5
Further information	
Krish says his symptoms started when he first moved to Australia. He attributes them to the stress of living as a 'poor' international student in an expensive city. He reports that over the years he has experienced changes in his mood. He would become depressed at the slightest triggers but would recover in a few days. He has also had extended periods when he was well. Religion has always played an important part in his life, and Krish says there were also times when he became very religious and he was extremely happy during those times. He says it felt like God was with him during those times. During his student days, Krish was fortunate to have good friends and housemates who always supported him. He discloses that his friends did consider him sensitive and moody. He further adds that, because he was busy with study and work, he managed to hold himself together during those times. He considers himself resilient, like most immigrants.	Further information  On the basis of Krish's history and reported symptoms, and referring to the guidelines and the <i>Diagnostic and statistical manual of mental disorders</i> , fifth edition (DSM-V), you diagnose him as having bipolar II disorder. You tell Krish that from the history he has given you, his mother may also have a similar diagnosis.  Question 6    What would be your choice of treatment for Krish?
You elicit a family history from Krish. He hails from an affluent family in India. He reports having a normal childhood. He states again that there is no family history of mental illnesses. However, he says that his mother (who lives in India) is extremely religious and spends days performing intense religious activities. His mother was greatly respected because of her religiosity, but is also a moody and sensitive woman. He	

says that he got his religious outlook from his mother. Krish finds that prayer and religious rituals give him great happiness. He identifies religion as a huge guiding force in his life.

### **Further information**

Krish and Devika are a little confused by the diagnosis and concerned about the stigma of mental illness in Indian culture. You empathise with their concerns and offer them resources about bipolar disorder.

### Ouestion 7

/hat resources can you give Krish and Devika to assist them understand and accept Krish's diagnosis?	

### **Further information**

Krish commences treatment and you make arrangements to see him in one week. You tell him to present earlier if he has any concerns. You give him the relevant resources and helpline details

### Ouestion 8



What would be your next step when Krish comes for his follow-up appointment?

### CASE 1 Answers

### Answer 1

The clinical interview is an important part of mental health assessment. It is important to establish rapport and ensure the patient is comfortable. If the patient is able to provide details, it is importance to elicit a history from the patient. The clinician is able to assess many aspects of the patient's mental state during the initial clinical interview such as appearance, degree of cooperation, appropriateness of responses and attention.

Many patients may lack insight into their condition. People close to the patient such as family members and friends (especially those who live with them) are able to provide objective information (corroborative history) that will help in the assessment of the patient. However, it is important to ensure that they do not guide the consultation and speak for the patient.

Information elicited in the initial clinical interview helps determine the subsequent management steps and areas of focus.

### **Answer 2**

The next steps would be further assessment, developing a working diagnosis and formulating a management plan.

Any mental health assessment should take a biopsychosocial approach. This helps exclude non-psychiatric causes for the patient's condition.

Assessment tools such as the K10<sup>1</sup> or the Depression Anxiety Stress Scale (DASS)<sup>2</sup> can work as adjuncts in assessment. The K10 (www.beyondblue.org.au/the-facts/anxiety-anddepression-checklist-k10) is widely used as a clinical outcome measure in general practice as it can integrate with most clinical software. High K10 scores (>20) indicate a greater likelihood of a mental health diagnosis. Patients with scores of 20-24 are likely to have a mild mental health disorder, those with scores of 25-29 are likely to have a moderate mental health disorder, and those with scores of >30 are likely to have a severe mental health disorder.<sup>3</sup> Reductions in K10 scores post-treatment will represent real change in mental health status. However, diagnosis should not be based solely on the K10 score.3 Risk assessment is advised as part of a comprehensive mental health assessment.4

It is recommended to base any diagnosis on the criteria in the American Psychiatric Association's DSM-V<sup>5</sup> or the International Classification of Diseases, 11th Revision (ICD-11).6

Once the assessment is completed and a working diagnosis is reached, a management plan can be formulated. The treatment plan and the choice of pharmacotherapy (if required) is best made in consultation with the patient. It is important to clearly explain to the patient the need for a therapeutic trial period of at least 4-6 weeks before making any changes, and to emphasise the need for regular reviews.<sup>7</sup>

### Answer 3

The DSM-V defines bipolar disorder as 'a mood disorder that is characterised by periods of pathologic mood elevation (mania or hypomania)'.5

Bipolar disorder is often underdiagnosed as depression in patients who present with symptoms of depression. Treatment with antidepressants for patients with bipolar disorder during a depressive episode can trigger an episode of mania or hypomania. The aetiology of this remains unknown.8

Consequently, it is important to ask about mania and hypomania as a part of the initial history.<sup>5</sup> Patients with mania and hypomania present with similar symptoms of persistently and abnormally elevated or irritable mood and increased energy in conjunction with features such as grandiosity, lowered sleep requirements, racing thoughts, distractibility, talkativeness and engagement in potentially risky activities. However, these symptoms are less severe for patients with hypomania, and are present for a shorter period of time (at least four consecutive days, compared with at least one week for mania).<sup>2</sup>

At the same time, one should be cautious of not overdiagnosing bipolar disorder. Taking a thorough history will help avoid this common pitfall.

Krish fits the criteria for hypomania. He displays grandiosity (ability to raise money), he is more talkative, there is a reduced need for sleep and he displays goal-directed activity (increased religiosity and involvement in temple activities). His increased involvement with the temple and the donation of a large sum of money have resulted in adverse consequences (financial distress for his family). Krish does not show any marked impairment of social and occupational functions. He does not display any psychotic symptoms and is not unwell enough to necessitate hospitalisation. Hence he is unlikely to be suffering from mania. If he exhibited psychotic features, then he would be diagnosed as manic.

On the basis of these symptoms, it is reasonable to diagnose Krish as experiencing an episode of hypomania, which most likely has been triggered by the antidepressant medication.<sup>9</sup>

### **Answer 4**

Screening tools can be an aid to diagnosis. There are several self-reported and clinician-administered screening tools. Clinician tools include the Structured Clinical Interview for DSM-V (SCID-5).<sup>10</sup> This tool is recommended as it ensures that the major DSM-V diagnoses are systematically evaluated. However, the use of SCID-5 may involve a license fee depending on the intended use, and this could be a barrier to its use in the general practice setting.<sup>10</sup>

There are several self-reported screening tools in the public domain. The Black Dog Institute's bipolar disorder self-test is the most commonly accessed and used self-reported tool in Australia.<sup>11</sup>

While screening tools are a useful aid, using them routinely in clinical practice should be undertaken with caution, as they have not been shown to improve patient outcomes.<sup>12,13</sup>

### **Answer 5**

Krish can be diagnosed as having bipolar II disorder. His initial presentation can now be diagnosed as a depressive episode of bipolar disorder.

As described in the DSM-V, bipolar disorder can present as major depression, mania, hypomania or mixed symptoms (mood episodes that are accompanied by symptoms of the opposite polarity).<sup>5</sup>

Major depression is the most common presentation (54%) of the first episode of bipolar disorder, followed by mixed concurrent symptoms of depression and mania (24%) and mania (22%).<sup>14</sup> Symptoms of bipolar depression are similar to those of unipolar depression and hence there is a strong chance of misdiagnosis of bipolar disorder.

Once a diagnosis of bipolar disorder is made, the next step is to identify the subtype of bipolar disorder. The DSM-V outlines several subtypes including bipolar I disorder, bipolar II disorder, cyclothymic disorder, substance/medication-induced bipolar disorder and bipolar disorder due to another medical condition.<sup>5</sup>

Bipolar I disorder is diagnosed in patients with one or more manic episodes. Bipolar II disorder is diagnosed in patients with:

- a history of at least one episode of hypomania
- at least one episode of major depression
- no history of mania.5

In addition, bipolar disorder has a genetic component.<sup>15</sup>

A clear diagnosis helps with the formulation of a treatment plan. Bipolar depression is frequently misdiagnosed as unipolar depression in general practice. This misdiagnosis sometimes occurs because of the time limitations of consultation in general practice. Hence it is important to consider mania and hypomania in an initial assessment of depression.

While it may be unreasonable to expect general practitioners (GPs) to make a diagnosis of the subtype of bipolar disorder within the constraints of daily practice, awareness of bipolar disorder including subtypes I and II would be invaluable in preventing misdiagnosis and associated complications.

### **Answer 6**

Krish should commence treatment for bipolar II disorder. As a result of barriers to accessing specialist services, it is important not to delay initiation of treatment once a diagnosis has been made.

Therapeutic Guidelines Australia are a good resource to explore treatment options. If additional support is needed, The Royal Australian and New Zealand College of Psychiatrists provides a directory of psychiatrists (www.yourhealthinmind. org/find-a-psychiatrist) as well as guidelines for GPs (www. ranzcp.org/practice-education/guidelines-and-resources-forpractice/gps-and-psychiatrists). Specialist input can be obtained in NSW by accessing the GP Psychiatry Support Line, which is a free service (1800 16 17 18) and has a 24-hour response time. It is not a referral or triage service and is not intended for use in psychiatric emergencies. 16 The Northern Territory also has a psychiatry support line for GPs in the Darwin area (www.ntphn.org.au/psychiatric-advice-for-gps-1). For states or territories without such services, it is recommended to contact the local on-call psychiatrist at the nearest public hospital. Telehealth options are also available for patients outside major cities and regions, which can be accessed by GPs (www.ranzcp.org/practice-education/ telehealth-in-psychiatry).

Bipolar I and II disorders are treated with the same medications despite the clinical differences between the disorders. When treating bipolar depression, it is also recommended to consider maintenance therapy in addition to antidepressant therapy.

In Krish's case, fluoxetine 20 mg has triggered an episode of hypomania, so it would be prudent to stop this medication. Selective serotonin re-uptake inhibitors such as fluoxetine tend to be ineffective in treating bipolar depression, in addition to inducing hypomania/mania.<sup>17</sup> For this reason, Krish would be an ideal candidate to be treated with second generation antipsychotic monotherapy.

Krish could commence monotherapy with a titrating dose of quetiapine. There is good evidence to support quetiapine monotherapy for the treatment of bipolar depression.<sup>18</sup>

Therapeutic guidelines recommend 50 mg slow release (SR) orally, twice daily on day one; then 100 mg SR twice daily on day two; then increasing to 150–300 mg SR, twice daily.<sup>19</sup>

Once treatment is initiated, it is important that the patient is monitored closely. Clear instructions about dose titration should be given to the patient and close family members. This encourages compliance. The patient needs to be regularly and frequently reviewed while being trialled on pharmacotherapy.

### **Answer 7**

Despite recent advances, a mental health diagnosis can still be stigmatising in many cultures including South Asian cultures. GPs should be empathetic and provide appropriate assistance such as culturally specific resources and support groups. Interpreter services should be offered and organised as needed.

### **Answer 8**

In the review appointment, the GP should consider the following:

• Monitoring - The GP should explore compliance and progress on therapy. The most common cause for relapse in a stable patient with bipolar disorder is non-compliance with treatment, which includes prescribed medications. Medication non-adherence is prevalent in approximately one-third to half of all patients with bipolar disorder.<sup>20</sup> Substance use, stressful life events and suboptimal treatment can cause relapses, but medication noncompliance is the most common and widespread reason for relapses. Stable patients with bipolar disorder are at risk of non-compliance with treatment as they feel well and consequently self-cease their medications.<sup>21</sup> It is important to emphasise with the patient and their carers/family members the need for continuing treatment with mood stabilisers and support from clinicians for their continued stability. Adverse reactions, if any, should be identified. If there is a satisfactory therapeutic response, the patient should be informed about the therapeutic trial period, which is usually 6-8 weeks for bipolar I and II disorders. Risks should be assessed. Mood diaries and mood disorder questionnaires can help in monitoring the patient's mood and assessing efficacy in treatment.<sup>22</sup>

- Psychotherapy Adjunctive psychotherapy has been proven to prevent relapses and improve adherence to treatment. This should be offered when a patient has been stabilised and is essentially euthymic as they are better able to participate in psychotherapy than when acutely ill.<sup>23</sup>
- Specialist review It is good practice to refer the patient to a psychiatrist at this stage. This should be done for confirmation of diagnosis and optimisation of treatment.
- Continued education This is a confusing diagnosis, and Krish and his partner will need continued education about the condition to help them to cope with the diagnosis and ongoing care.
- Physical care Antipsychotics can lead to weight gain, and this is a problem that may be ongoing.

### **Resources for doctors**

- Royal Australian and New Zealand College of Psychiatrists
   Clinical practice guidelines for mood disorders 2015, www.ranzcp.org/files/resources/college\_statements/ clinician/cpg/mood-disorders-cpg.aspx
- Black Dog Institute Clinical resources, www. blackdoginstitute.org.au/clinical-resources
- GP Psychiatry Support Line, www.gpsupport.org.au
- Mood Disorder Questionnaire, www.integration.samhsa. gov/images/res/MDQ.pdf

### **Resources for patients**

- · Black Dog Institute, www.blackdoginstitute.org.au
- Centre for Clinical Interventions Looking after yourself/ Bipolar, www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Bipolar
- Sane Australia, www.sane.org/information-stories/factsand-quides/bipolar-disorder
- Head to Health, https://headtohealth.gov.au/mentalhealth-difficulties/what-should-you-know-about-mentalhealth-conditions-and-disorders

### **Support services**

- Transcultural Mental Health Centre (TMHC) NSW Health state-wide service hosted within the Western Sydney Local Health District. Individuals can access TMHC through the mental health line on 1800 011 511, www.dhi.health.nsw.gov. au/transcultural-mental-health-centre
- Embrace Multicultural Mental Health The Embrace Project is run by Mental Health Australia and provides a national focus on mental health and suicide prevention for people from culturally and linguistically diverse backgrounds, https://embracementalhealth.org.au
- Beyond Blue Bipolar Life online support forum, www. beyondblue.org.au/get-support/online-forums/staying-well/this-bipolar-life

 Bipolar India (taking into account the cultural background of the case study patient) – The first and only online support forum based in India that can provide culture-specific support to the patient, www.bipolarindia.com

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### CASE

## Is Craig depressed again?

Craig, aged 34 years, is a primary school teacher who lives with his wife, Angie, and their baby boy, aged three months, on an acreage just outside town. He and Angie are both delighted with their healthy baby, and Angie is managing well physically and emotionally.

Craig has come to ask if you think he might be becoming depressed again. He says that for the past couple of weeks he has been unable to get back to sleep when disturbed and finds himself lying awake worrying about the future. He has not been experiencing low mood or negative thinking to the same extent that he did when he was depressed in the past, but he has been very tired and is not interested in pleasurable activities. He remembers experiencing these symptoms early in previous episodes. He is especially concerned about recent bursts of irritability at work.

Craig has no family history of bipolar disorder and no personal history of mania or hypomania. Despite their severity, his depressive episodes have not had melancholic features.

### **Question 1**

Sec.	-
_	

depressed again?				

How can you help Craig decide whether or not he is becoming

### **Further information**

According to your clinical assessment, though Craig is clearly tired and somewhat anxious, he does not currently meet criteria for a diagnosis of major depression.

### Question 2

What assessment instruments would be helpful and practic to use in assessing Craig's psychological state?			

### **Further information**

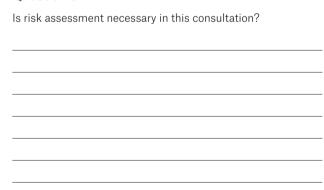
Craig's Kessler Psychological Distress Scale (K10) score is 24, indicating mild psychological distress warranting further assessment. Craig's scores on the Depression Anxiety Stress Scale (DASS) 21 are:

• depression: 4 (normal) • anxiety: 11 (moderate)

• stress: 20 (moderate).

His score on the online bipolar self-test does not suggest a possible a bipolar disorder diagnosis.

### Question 3



### **Further information**

Craig says he is not suicidal, stating that he has never been 'back there' since his teens, but that he has always been inclined to worry. He experienced a serious episode of depression and suicidality in his final year of high school. He spent a week in hospital and missed enough school to cause him to withdraw from his studies. Craig saw a psychologist and was prescribed a selective serotonin re-uptake inhibitor (SSRI) for six months. He also received cognitive behavioural therapy (CBT). After working as an apprentice carpenter for two years, he completed his high school education, then spent several years living in the city while qualifying to be a teacher.

Craig experienced another episode of depression when aged 25 years after a relationship break-up and was again treated During that time, he was offered a job in the town in which he

successfully with an SSRI that he continued for 12 months. grew up, and he was very pleased and relieved to come 'home'.

Question 4 😀	manage his symptoms and prevent depres
What diagnoses, other than recurrent unipolar depression, need to be considered for Craig?	
	Question 7 🥯
Question 5 👄	What can you do to help Craig engage wi resources?
What strategies can you encourage Craig to adopt to help reduce his risk of depression recurrence?	
	-
	_

### **Further information**

Craig accepts your conclusion that he is experiencing anxiety rather than depression, in addition to normal adjustment issues related to new parenthood. He is aware that he is at risk of becoming depressed again. He agrees that he needs to take steps to manage his anxiety.

Craig is not willing to see the local psychologist as she is a good friend of Angie's. The nearest alternative psychologist is 90 minutes' drive away. He does not want to restart medications. He says he would prefer to see you for support and wonders if there are any online programs you can recommend.

While his rural location means Craig is eligible for telepsychology consultations under the Medicare Benefits Schedule, he says he is not interested in talking to anyone about his current issues at the moment, even at a distance.

### Question 6

What online resources could you recommend to Craig to help manage his symptoms and prevent depression recurrence?
Question 7 🕶
What can you do to help Craig engage with these online resources?

### CASE 2 Answers

### **Answer 1**

Approximately 10% of new fathers experience depression, compared with 4.8% of the general male population. Craig has experienced depression several times in the past, and this increases the likelihood of his becoming depressed again. His concern warrants a full mental health assessment, including clinical interview and administration of a psychological assessment instrument.

It is important to determine whether Craig meets the criteria for a diagnosis of major depression. <sup>2</sup> To meet these criteria, Craig needs to have experienced low mood and/or loss of interest or pleasure in daily activities for two weeks or more along with at least five of the following:<sup>2</sup>

- · weight and appetite change
- change in level of physical activity (slowing or agitation)
- · difficulty with concentration, focus and decision making
- fatigue
- · sleep disturbance
- · feelings of worthlessness and/or guilt
- thoughts of self-harm or suicide.

### **Answer 2**

Psychological assessment instruments can be very useful for supporting clinical impressions and providing reliable information about clinical progress. Conflict between the results of instruments and clinical impression should trigger further clinical review; however, because self-report instruments have at best 80% reliability, the result of a comprehensive clinical assessment always takes precedence.<sup>3</sup>

The commonly used instruments in general practice are:

- K10,<sup>4</sup> which measures non-specific psychological distress. It consists of 10 general wellbeing questions in relation to the previous 30 days. Scores on the K10 indicate whether further assessment is appropriate.
- DASS,<sup>5</sup> which is a 21-item (or 42-item) self-report instrument that provides insight into the nature of psychological distress. It has separate scales for depression, anxiety and stress and considers only the previous seven days. The DASS21 has been shown to be as reliable as the original DASS42.<sup>6</sup>

Other less commonly used instruments include the Beck Depression Inventory<sup>7</sup> and the Hamilton Depression Rating Scale.<sup>8</sup>

Asking patients to access the Black Dog Institute Online Clinic (https://onlineclinic.blackdoginstitute.org.au) is a time-efficient way to administer instruments in general practice. This site provides a validated screening instrument for depression and a selection of instruments that users can opt to complete. These include screening instruments for alcohol use, bipolar disorder and psychotic symptoms. Results are calculated online, and the reports generated can be downloaded. Service users remain anonymous.

### **Answer 3**

Risk assessment is required in this consultation. A proportion of people who take their own lives are not depressed but may be experiencing other kinds of psychological distress including anxiety and adjustment difficulties. Anxiety disorders are independently associated with suicide.<sup>9</sup>

Key items in diagnostic instruments may provide clues to the presence of suicide risk (eg DASS question 10 – 'I felt I had nothing to look forward to'; question 21 – 'I felt that life was meaningless'), but clinical risk assessment remains necessary.

### **Answer 4**

Three additional diagnoses should be considered for Craig's presentation: adjustment disorder, anxiety disorder and bipolar depression.

The fifth edition of the *Diagnostic and statistical manual* of mental disorders (DSM-V) describes adjustment disorder as 'emotional and behavioural symptoms in response to identifiable stressors occurring within three months of the onset of the stressor(s)'.<sup>10</sup> These symptoms can be either out of proportion to the nature of the stressor or causing significant impairment of functioning. They can involve symptoms of depression or anxiety, or both.<sup>11</sup> The arrival of the baby is an identifiable stressor for Craig.

A moderate score for anxiety on the DASS supports a diagnosis of current problematic anxiety. At this stage there is not enough longitudinal evidence to diagnose an anxiety disorder; however, this remains a possibility. Craig's worrying may also be a reflection of his personality style.

Craig's scores on the bipolar screening tool do not indicate a high risk of bipolar disorder. While a history of recurrent depression should always raise some suspicion of the possibility of a bipolar diagnosis and prompt appropriate assessment, it seems unlikely in Craig's case.

### **Answer 5**

Several strategies can be used to reduce the risk of depression recurrence, including:

- · mindfulness practice
- · relaxation techniques
- · physical activity
- · good nutrition
- · sleep hygiene
- spending time in nature
- reducing time spent using electronic devices
- social interaction and community connection
- · reducing alcohol consumption and caffeinated drinks
- learning specific cognitive behavioural-based skills such as structured problem solving and SMART (specific, measurable, achievable, realistic, timely) goal setting.

Regular mindfulness practice has been shown to reduce the risk of recurrence of depression.<sup>12</sup> Craig may be willing to use the Smiling Mind app to help him develop a regular mindfulness practice. He may also benefit from learning

breath-based relaxation techniques (possibly with the aid of the ReachOut Breathe app) or progressive muscle relaxation techniques. Information about teaching these techniques to patients is available on many websites, including the Black Dog Institute's Psychological Toolkit (www.blackdoginstitute.org.au/education-training/health-professionals/psychological-toolkit).

Activity levels and diet quality have both been shown to be important in the prevention of depression and anxiety. 13,14 Physical activity should be encouraged. Nutritional recommendations for good mental health are readily available. 15 Craig may benefit from Deakin University's Food and Mood Clinic course (www.futurelearn.com/courses/food-and-mood).

A review of general sleep hygiene is appropriate, and practical interventions to ensure sleep requirements are met need to be discussed. Examples include taking turns with overnight care of the baby and providing the opportunity for each parent to take a break during the daytime.

Craig needs to be encouraged to persist with his usual activities and maintain social contacts. It is also recommended to remind him that alcohol is a depressant that interferes with mood and sleep quality.

### **Answer 6**

Australian evidence-based online resources have been shown to be very effective in the prevention and treatment of mild-to-moderate depression, anxiety and stress.<sup>13</sup> Some examples include:

- Head to Health (https://headtohealth.gov.au)
- THIS WAY UP (https://thiswayup.org.au)
- myCompass (www.mycompass.org.au)
- MindSpot Virtual Clinic (https://mindspot.org.au)
- MumSpace (www.mumspace.com.au)
- What Were We Thinking? (www.whatwerewethinking. org.au).

Information about these resources can be found in the Resource Guide on the e-Mental Health in Practice (eMHPrac) website (www.emhprac.org.au/) and on the Head to Health website (https://headtohealth.gov.au).

Head to Health is an online portal for evidence-based Australian mental health resources and treatment programs. Craig is likely to find a number of these resources contain useful reminders of the CBT strategies he learnt in past therapy. Options include the myCompass program, THIS WAY UP courses and the MindSpot Virtual Clinic's wellbeing program.

MumSpace is an online portal developed to help new parents find online support. The MumSpace listings include 'What Were We Thinking?', a website and 26-week support program designed for all new parents exploring both issues with the baby and adjustment within the relationship.

### **Answer 7**

Talk to Craig about the evidence supporting the use of online resources and show him some of the relevant websites. Make a specific program recommendation and help him register for that program. It is recommended that a follow-up appointment is made to check Craig's progress and his satisfaction with the online program.

Engagement and adherence remain the biggest barriers to patients gaining benefit from online programs and resources. <sup>16</sup> The Royal Australian College of General Practitioners has published a guide to help general practitioners (GPs) use these resources in ways that most benefit their patients (www.racgp.org.au/clinical-resources/clinical-guidelines/guidelines-by-topic/mental-health-1/e-mental-health-a-guide-for-gps).

### **Summary**

GPs are in an ideal position to identify psychological vulnerability.

Patients with a history of anxiety or recurrent depression are at risk of further recurrence – especially at times of stress. Early intervention may help reduce the risk of recurrence.

Face-to-face therapy is often unavailable, and many patients are unwilling to use these services even when they are available. Evidence-based Australian online mental health resources can be a useful adjunct to GP care.

### **Resources for doctors**

- e-Mental Health in Practice A Guide to Digital Mental Health Resources, www.emhprac.org.au/wp-content/ uploads/2019/12/eMHPrac-Resource-Guide-Mar2019-1.pdf
- The Royal Australian College of General Practitioners e-Mental Health: A guide for GPs, www.racgp.org.au/ getattachment/a5a2daae-77ca-4d0a-8dfd-81b04105409e/ e-Mental-health-A-quide-for-GPs.aspx
- Black Dog Institute Online Clinic, https://onlineclinic. blackdoginstitute.org
- Black Dog Institute Psychological Toolkit, www. blackdoginstitute.org.au/education-training/healthprofessionals/psychological-toolkit

### **Resources for patients**

- · Smiling Mind, from the App Store or Google Play
- ReachOut Breathe, from the App Store
- · Head to Health, www.headtohealth.gov.au
- MyCompass, www.mycompass.org.au
- THIS WAY UP Managing insomnia, https://thiswayup.org.au/how-we-can-help/courses/managing-insomnia
- THIS WAY UP, www.thiswayup.org.au
- MindSpot Clinic, www.mindspot.org.au

- · What Were We Thinking?, www.whatwerewethinking.org.au
- Deakin University Food and Mood: Improving Mental Health through Diet and Nutrition, www.futurelearn.com/ courses/food-and-mood
- e-Mental Health in Practice Online Program evidence library, www.emhprac.org.au/evidence

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### CASE

# Lilly has no energy

Lilly, aged 34 years, comes to see you to request blood tests as she thinks she may be 'lacking in something'. For the past few weeks she has been low in energy and is increasingly having trouble coping when looking after her daughter Romi, aged three months, who is exclusively breastfed.

Question 1 🖵	
What further history would you seek from Lilly?	
	Question 3 😃
	What investigations would you perform?
Further information	
Lilly reveals she had a postpartum haemorrhage following	
Romi's birth and was quite light-headed for 2–3 weeks	

afterwards, but she feels this has largely resolved. She has had two bouts of mastitis since Romi's birth that required antibiotic treatment.

Lilly's sleep has been disrupted by Romi's frequent waking, and she finds it takes some time to fall asleep once awakened. Her appetite has been erratic, and she often turns to sugary snacks but has little interest in her regular meals.

Lilly has found the transition to motherhood challenging and often feels she is letting Romi down as a mother. She is struggling to feel any positive emotion and her days often start with a sense of dread or foreboding. Lilly's mother has tried to support her, but Lilly experiences her as 'critical and controlling' and often feels worse after her visits. Lilly's partner, Patrick, injured his back while she was pregnant and has been unable to work his job as a carpenter for the past few months. According to Lilly he is 'not in a good place' and there is increasing financial pressure for Lilly to return to work sooner than they had originally planned.

### **Further information**

Question 2

What else would you include in your assessment of Lilly?

Lilly's blood tests are unremarkable other than a low ferritin level (10 µg/L). The reference range for a premenopausal adult female is  $20-220 \mu g/L$ .

There is no evidence of ongoing mastitis.

Lilly's Edinburgh Postnatal Depression Scale (EPDS) score is 18. She scored highly on the anxiety-related items on the scale and selected 'sometimes' regarding thoughts of selfharm. However, she feels strongly that she has no suicidal intent at present.

Her interactions with Romi suggest an insecure attachment style, varying between times of being seemingly preoccupied and disconnected from Romi's cues and times of anxiety or frustration elicited by Romi's crying.

Question 4 😃	Question 7 👄
What is your diagnosis for Lilly?	Would you involve Patrick in Lilly's care?
Question 5 😃	Question 8 😃
What would be the key elements of your management plan?	How would you address emerging insecure attachment between Lilly and Romi?
Question 6 C  Can Lilly continue to breastfeed if she starts treatment with	Question 9 👄
antidepressant medication?	What concerns would you have regarding future pregnancies?

### CASE 3 Answers

### **Answer 1**

Many factors may affect Lilly's energy level. Further history-taking would include enquiring regarding her:

- · general health
- obstetric history
- lifestyle factors (eg sleep, diet, physical activity, substance use)
- mental health (including personal and family history of symptoms of depression and anxiety)
- current supports, particularly with regard to her partner and family of origin.

### **Answer 2**

The EPDS¹ is primarily intended as a screening instrument rather than a diagnostic tool, but it can be useful for establishing a baseline score for future reference, with questions 3, 4 and 5 reflective of the presence of anxiety and question 10 asking about thoughts of self-harm. The EPDS can be downloaded from the Black Dog Institute website with the clinical scoring guide (www. blackdoginstitute.org.au/docs/default-source/psychological-toolkit/edinburgh-postnatal-depression-scale.pdf?sfvrsn=8).

Suicide is one of the leading causes of maternal death in the perinatal period; therefore, it is important to directly enquire regarding suicidal ideation, intent, plans and means as well as any previous suicide attempts and protective factors.<sup>2</sup>

Observing Lilly's interactions with Romi can be helpful to assess the emerging mother-infant attachment style, as forming a secure attachment plays a key role in Romi's future development. The Centre for Perinatal Excellence has developed a fact sheet for health professionals to assist with assessing mother-infant interaction (www.cope.org.au/wp-content/uploads/2018/07/Assessing-Mother-infant-Interaction.pdf).

Other useful areas of enquiry may include:

- expectations of childbirth and motherhood and Lilly's actual experience in relation to these
- Lilly's perception of Romi's delivery and any evidence of ongoing post-traumatic stress
- the quality of her current supports, given the difficulty in the relationship with her mother and her partner's own health concerns
- use of alcohol, analgesics or other substances.

### **Answer 3**

A full physical examination, in particular assessing for any ongoing mastitis or uterine tenderness or bleeding, may inform the need for any additional investigations.

Given the history of a postpartum haemorrhage and the presentation of low energy, it would be reasonable to request the following investigations:

- · full blood examination
- ferritin
- thyroid stimulating hormone.

### **Answer 4**

Although the arrival of a new baby is often considered a time of joy and celebration, for many new parents the transition into parenthood is also accompanied by a range of negative emotions. Lack of sleep, disconnection from work and friends, and inexperience in meeting the needs of an infant can lead to times of feeling sad, frustrated, overwhelmed and lonely. It is important to distinguish these normal transient emotions from perinatal depression which, similarly to depression at other life stages, is typified by persistent low mood and loss of interest and diminished pleasure in everyday activities.

Lilly meets the criteria for a major depressive disorder as she is experiencing low mood with loss of pleasure, disrupted sleep and appetite, low energy, feelings of guilt and worthlessness, and thoughts of self-harm.<sup>3</sup>

Depression is common in the postnatal period and affects one in seven women in the first year after birth.<sup>4</sup> Anxiety disorders are also common postnatally<sup>5</sup> and are often comorbid with depression. Similarly, perinatal depression can present with anxious features that are inherent to the experience of the depression and tend to resolve with the mood symptoms.

Lilly has been facing a range of stressors including health challenges, financial pressures and relationship issues that commonly occur in the perinatal period and can be both predisposing and precipitating factors for a depressive episode.

### **Answer 5**

Perinatal depression is generally caused by multiple factors and arises at a time of flux, both physically and emotionally. Management planning will therefore need to be multimodal, reflecting the broad biopsychosocial formulation of Lilly's presentation.

Establishing Lilly's priorities in terms of the areas of need she identifies as most pressing is important to create a management plan that is personally meaningful and relevant. Caring for a young baby may also limit Lilly's capacity to engage in the entire range of possible interventions, so it is vital to ensure the plan is realistic and achievable. Starting with smaller, more practical steps in the early phases may be helpful.

The management plan would include:

- · biological factors
  - improving sleep and diet
  - supplementing iron
  - considering the use of antidepressant medication

- · psychological factors
  - building skills to manage the symptoms of depression and anxiety; both cognitive behavioural therapy or interpersonal psychotherapy have strong evidence in this regard<sup>6</sup>
  - addressing adjustment distress inherent to the transition to parenthood
  - addressing relationship issues with Patrick
  - enhancing secure attachment with Romi
- · social factors
  - strengthening Lilly's support networks by linking her to local programs such as parenting support services and perinatal support groups
  - financial counselling.

General practitioners (GPs) can provide information, psychoeducation, support, pharmacological treatment, advocacy and monitoring; some also have additional training in psychological skills. If additional assistance is needed with psychological treatment, GPs can refer patients to a psychologist.

### **Answer 6**

Selective serotonin re-uptake inhibitors (SSRI) are a first-line treatment for moderate-to-severe depression in postnatal women. The exposure of the infant to antidepressant medication through lactation is significantly less than during pregnancy, given the generally poor penetration of this medication into breast milk. However, special care is required for premature infants or those with other health concerns. The negative effects of untreated persistent perinatal depression are well established. At Romi's age, the benefits of both continuing to breastfeed and improving Lilly's mood outweigh the risks of Lilly taking antidepressant medication while breastfeeding.

### **Answer 7**

Fathers can also experience perinatal depression, with approximately one in 10 men affected, 10 which also has documented effects on the development of children. 11 Encouraging Patrick to attend a visit with Lilly will allow you to provide them both with psycho-education regarding depression and early parenting, including the impact of depression on the couple's relationship and how that is best managed. It will also provide an opportunity to assess Patrick's emotional wellbeing.

### **Answer 8**

Many new parents find they do not have an immediate emotional connection with their newborn, at times taking months to develop a deeper bond with their infant. Conversely, not all parents with depression will express difficulty in their emotional connection with their infant, so this does not preclude a diagnosis of depression.

The quality of the mother-infant attachment refers specifically to the experience of the infant at times of distress with regard

to the response of their caregiver.

Alleviating Lilly's current depression may, in turn, enhance the security of the attachment between Lilly and Romi. However, this will require ongoing monitoring, particularly as Lilly has alluded to a difficult relationship with her own mother that may suggest an intergenerational pattern of insecure attachment. For some mothers and infants, therapies that focus specifically on attachment may be beneficial. Programs such as 'Circle of Security' or 'Watch, Wait and Wonder' can be helpful to promote secure attachment.<sup>12</sup>

### **Answer 9**

Previous perinatal depression is a strong risk factor for future perinatal depression.

It is important to check with Lilly whether she has any intent to become pregnant in the near future or whether she is using any form of contraception.

Concerns regarding exposure of the developing fetus to antidepressant medication lead many women to stop antidepressant medication early in pregnancy, further increasing their risk of relapse. <sup>13</sup> If Lilly is planning another pregnancy, it would be useful to discuss this with her prior to conception so that she is fully informed regarding the positives and negatives of continuing to take an SSRI while pregnant. This is always an individualised, case-by-case decision and often involves consultation with the obstetric team or a perinatal psychiatrist where available. Services such as MotherSafe in NSW or the Victorian Royal Women's Medicines Information Service can also be helpful.

Many of the psychosocial risk factors that predispose to perinatal depression are recurring; therefore, it is useful to continue addressing these issues as well as consolidating and practising psychological skills prior to conception or throughout the early months of pregnancy.

Nevertheless, relapses may still occur. An awareness of early warning signs combined with regular monitoring can assist with early recognition, triggering the implementation of a predetermined management plan.

### **Summary**

Depression is common in the perinatal period, coinciding with many biological and psychological stressors. GPs are well placed to routinely enquire regarding the emotional wellbeing of new parents and to actively screen for symptoms of depression. Management is invariably multifaceted and includes psychological strategies, enhanced social support and, when appropriate, antidepressant medication. Ultimately, timely recognition and treatment of perinatal depression benefits not only the identified patient but also their young child or children, positively affecting their current and future emotional health.

### **Resources for doctors**

 Centre of Perinatal Excellence, www.cope.org.au/ health-professionals

- Gidget Foundation Australia National Telehealth Program for Families Experiencing Perinatal Depression and Anxiety, https://gidgetfoundation.org.au/getsupport/start-talking-telehealth
- The Royal Women's Hospital Pregnancy and Breastfeeding Medicine Guide, https://thewomenspbmg.org.au

### **Resources for patients**

- Perinatal Anxiety & Depression Australia (PANDA), www. panda.org.au or national helpline 1300 726 306
- Perinatal Anxiety & Depression Australia (PANDA) How is dad going, www.howisdadgoing.org.au
- Gidget Foundation Australia, https://gidgetfoundation. org.au
- MumMoodBooster, https://mummoodbooster.com/public
- The University of Newcastle SMS4dads, www.sms4dads.com
- Smiling Mind Mind the Bump, mindthebump.org.au

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### CASE

## Scarlett wants to see a psychologist

Scarlett, aged 19 years, is a new patient to you and the practice. She is a well-dressed Chinese international student who speaks minimal English. She comes to see you one week before Christmas for a referral to see a psychologist. She feels depressed and teary, and says she has insomnia.

### Question 1 Q



What key features would help you to assess the situation when taking a history from Scarlett and performing an examination?			

### **Further information**

Scarlett tells you that she has been battling with a feeling of emptiness/abandonment throughout her life, even though she enjoys going out with friends and trying new restaurants and bars.

Scarlett is a single child from Shanghai, China. Her parents sent her to Australia in a homestay arrangement with the help of an immigration agent, and her family later migrated to Australia with the aid of a business visa. Despite being envied for her material possessions, Scarlett always felt neglected by her parents. They became critical of her when she could not obtain a high Australian Tertiary Admission Rank (ATAR) score at high school, which she felt she could never have achieved. She felt she struggled to adapt to the English environment and culture. Scarlett is currently studying business at university. She feels her parents do not understand why she cries and is depressed, and further accuse her of being lazy. She knows of no family history of mental health disorders, but does not believe her parents would tell her if there were. She feels they would not bear the embarrassment of her seeking professional help for her mental state.

Over the past week, she has been searching online for the least painful way to die. She tried to self-harm by taking a packet of paracetamol but says 'nothing happened'. She could not bear the pain and scars if she does not successfully die after cutting herself.

Scarlett has never tried smoking or recreational drugs. She is open to receiving medical help. She denies any hallucinations or periods of mania.

Scarlett lives with her boyfriend. She likes him because he is caring and 'cleans up the place' after she breaks plates when she gets angry at times. However, she is worried that he is only putting up with her in the hope that she will sponsor him for the Australian permanent residency spouse visa application. She feels that she is popular with others because she seems generous, smart and attractive but no one really knows or cares about her. Scarlett and her boyfriend are planning to go out with friends for dinner after this appointment. She reminds you that she is on a tight schedule to get changed and refresh her makeup before the dinner.

Scarlett was diagnosed with Grave's disease years ago but did not take the carbimazole prescribed because of her fear of weight gain. She says she is otherwise well and has been taking drospirenone/ethinyl estradiol 3 mg/0.02 mg long term for her skin. She is fearful of acne and scarring.

Scarlett's body mass index (BMI) is 19 kg/m<sup>2</sup>. Her heart rate is 93 beats per minute (regular). Her blood pressure is 129/88 mmHq.

She scores 40 on the Kessler Psychological Distress Scale (K10), which indicates that Scarlett is likely to have a severe mental health disorder. On the Depression Anxiety Stress Scale (DASS) 21 she scores:

What conditions would you include in your differential

- depression: 40 (extremely severe)
- anxiety: 24 (extremely severe)
- stress: 40 (extremely severe).

### Ouestion 2



diagnosis, and what features in the information Scarlett has provided prompt you to consider each differential diagnosis?

Question 3	You are contacted by the mental health care nurse, who informs you that they received a call from Scarlett's boyfriend who is concerned about Scarlett's plan to suicide on the weekend. The nurse also explains that Scarlett was not home at the agreed time and hung up when she received a telephone call from the mental health care team. The nurse is concerned about Scarlett's risk of suicide. You inform the nurse of Scarlett's hyperthyroid status identified on her blood examination results.			
	Scarlett misses her appointment and does not answer her phone when you try to call her. Her boyfriend's number also remains unanswered. You call the mental health care nurse to inform them, and they explain that they will arrange another home visit in the next 24 hours.			
	The next day you receive a message from your clinic nurse that Scarlett left a message for you to call her back and 'save her' urgently as the hospital team 'locked her up' in hospital against her will.			
Question 4 😃 How would you manage Scarlett at this initial appointment?	Question 5 😂 😍 How would you next respond?			

### **Further information**

You call the Mental Health Access Line with Scarlett present. During the teleconference, Scarlett says she feels calmer and is no longer suicidal after coming to see you, as she feels she has found someone who cares and understands her. After you have confirmed the correct contact details, the mental health nurse organises with Scarlett for a home review within 24 hours. You also arrange a follow-up review with Scarlett in two days.

You advise Scarlett of 24/7 crisis management plans and give her a mental health care plan, which summarises her situation and the crisis plan with contact details.

Two days later, you receive Scarlett's test results, noting the hyperthyroid status. All other results are unremarkable.

### **Further information**

The psychiatry registrar working in the mental health unit informs you that their assessment of Scarlett also suggests BPD. They have prescribed carbimazole 10 mg twice daily for her hyperthyroidism. Scarlett is no longer suicidal. After your discussion with the registrar, you call Scarlett, who is soon to be discharged from the hospital. You ask openly how she is feeling. She says she hated the hospital and being locked up, describing the poor care and abandonment of the staff. She says they did not give her any treatment except giving her thyroid medication. However, she says she does not want to end her life now, but sometimes develops intense mental states and, in this instance, was trying to seek help.

Scarlett says that she has good rapport with you and would prefer to see you long term. You arrange for a consultation the following day.

# Answer 1

CASE 4

**Answers** 

If the medical practitioner and patient cannot communicate in the same language fluently, it is advised to use credentialled interpreters. This is especially important when managing complex issues or crises, assessing patient competence and seeking informed consent. Using an interpreter helps to ensure information accuracy, reduce confusion, save time and protect the health practitioner from professional risks. General practitioners (GPs) can call the Medical Practitioner Priority Line on 1300 131 450 for 24/7 free telephone translating and interpreting services for Medicare Benefits Schedule-rebateable services for anyone in Australia who has a Medicare card. GPs can also prebook their telephone or onsite interpreting service.<sup>1</sup>

It is recommended to seek the following information when assessing patients who feel depressed:

- the 'Five P's'
  - presenting problem, such as the patient's concerns, symptoms, how their life has been affected
  - predisposing factors, such as biological/organic conditions, family history of mental health issues, environmental/ developmental/cultural/social influences and core beliefs

- precipitants, such as significant stressors preceding the onset of the presenting problems
- perpetuating factors that maintain the current difficulties
- protective factors, such as support systems, skills, interests and religion if applicable.<sup>2</sup>
- collateral history from previous health practitioners, family and close friends if available
- risk of self-harm/suicide and risk of harm to others
- · usual coping mechanism
- previous manic/hypomanic episodes for bipolar disorder
- · comorbid anxiety
- · medications (include recent changes)
- substance use, including alcohol, smoking and recreational drugs.<sup>3</sup>

The following examinations are recommended:

- · mental state examination
- DASS214 and/or K10.5

### **Answer 2**

Conditions to include in the differential diagnosis would include:

- BPD Scarlett displays pervasive patterns across different contexts, frantic efforts to avoid real or imagined abandonment, unstable and intense interpersonal relationships with her boyfriend and family, unstable self-image reflected by her concerns of her boyfriend and friends, marked reactivity of mood and intense anger (breaking plates when angry), chronic feelings of emptiness and suicidal thoughts.
- Major depressive disorder Scarlett presents feeling depressed and teary, with insomnia and suicidal tendency. However, there is no anhedonia.
- Adjustment disorder Scarlett describes worsening symptoms when she moved to Australia. However, the symptoms had presented beforehand. The *Diagnostic and* statistical manual of mental disorders, fifth edition (DSM-V) defines adjustment disorder as 'the presence of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s)'.6
- Generalised anxiety disorder Scarlett's history reflects excess worry about her boyfriend and friends not truly liking her and sleep disturbances. However, these are all people-centred anxieties, rather than being across multiple domains.
- Hyperthyroid Scarlett has a history of thyroid problems and medication non-compliance.
- Eating disorders Scarlett has a low BMI and fear of weight gain, but she has no history of restrictive eating or purging.

### **Answer 3**

BPD can be diagnosed using the DSM-V criteria.6

A diagnosis requires five or more criteria indicating 'a pervasive pattern of instability of interpersonal relationships, self-image and affects' to be met. Scarlett meets seven criteria:<sup>6</sup>

- · desperate attempts to avoid abandonment
- intense interpersonal relationships that are unstable
- insecurity
- recurrent suicidal thoughts/plans/attempts
- · emotional lability
- · persistent feelings of emptiness
- inability to control emotions, and extreme anger.

BPD often presents as symptoms of other psychiatric comorbidities, and people can have BPD in addition to other mental health conditions.

### **Answer 4**

You should explain to Scarlett that it is your duty to ensure her safety and follow-up. Explain that it can be difficult to arrange an appointment to see a psychologist immediately, especially before Christmas, but it is important to ensure her safety and stability.

Scarlett's initial presentation poses a high suicide risk, characterised by her research of plans for suicide and the unstable tendency in BPD. It would be recommended to contact the local mental health crisis team in the patient's presence (refer to Resources), explain the situation and work with the crisis team and patient to formulate a management plan.

Scarlett should also be advised of 24/7 crisis management plans, including calling the Nationwide Lifeline (13 11 14) or the Mental Health Access Line, or to present to hospital emergency for voluntary admission if she finds herself in crisis or becomes suicidal.<sup>7</sup> A mental health care plan should also be organised. It is important to obtain consent from the patient to collect collateral history from others.

Several other tests may be initiated to investigate for organic causes including a full blood examination, thyroid function test, ferritin, C-reactive protein, vitamin B12 and folate, vitamin D, electrolytes and liver function tests.

### **Answer 5**

It is recommended to first call the mental health unit to obtain an update of Scarlett's progress and plan before speaking with Scarlett.

### **Answer 6**

Scheduling a long consultation allows sufficient time to discuss Scarlett's admission experience, and to clarify her understanding of the situation, her diagnosis and agreement of the management plan.

With Scarlett's consent, it is beneficial to invite her boyfriend, family and close support people to the consultation and when making the management plan.

At the consultation, it is important to ensure that Scarlett has booked her psychologist appointment and update the mental health care plan with the current diagnosis.

Scarlett should also be assessed for hyperthyroid symptoms and carbimazole compliance. A repeat thyroid function test should be conducted in 6–8 weeks, and you could consider referring Scarlett to an endocrinologist if you have any concerns.

### **Answer 7**

GPs can help by providing a mental health care plan and referral to an experienced psychologist or psychiatrist. As the professional who sees the patient with BPD over many years (with maintained contact even after other professionals have finished their treatments), the GP also has a further role in monitoring physical and mental health, containment, providing support and advocacy.

When explaining BPD to the patient, it is important to understand that having BPD is not the patient's fault. Although the pathogenesis of BPD is still under investigation, current research indicates BPD is a result of biological factors and experiences in early life.<sup>8</sup>

Evidence-based treatment for BPD includes structured targeted psychological therapies to form short- and long-term goals, with the aim of remission and prevention of relapse. The health practitioner should be active, responsive and validating, while encouraging the patient to recognise their reactions to real-life events and practise self-control. 9

A range of structured therapies has been found to be effective and may be accessed through the acute mental health team. They include cognitive behavioural therapy, dialectical behaviour therapy, dynamic deconstructive psychotherapy, emotion regulation training, interpersonal psychotherapy, general psychiatric management, mentalisation-based therapy, motive-oriented therapeutic relationship, psychoanalysis, psychoeducation, schema-focused therapy, systems training for emotional predictability and problem-solving and psychodynamic psychotherapy. Dialectical behaviour therapy is a variation of cognitive behavioural therapy. It was initially created for BPD, but can be applied in the management of suicide prevention, self-harm, substance use, depression and eating disorders. It encourages patients to accept the way they are, and change in order to move forward to reach personal goals.<sup>10</sup> The type and frequency of therapy should be personalised to individual needs through shared decision making. The structured psychological therapies can be delivered individually or as group therapy. Long-term psychological therapies and follow-ups are often required, ranging from 13 weeks to years in clinical randomised controlled trials.8

Medications are ineffective as the primary therapy for isolated BPD.8 However, most patients with BPD have other psychiatric comorbidities. Clinicians should be cautious regarding the risk of overdose and suicide when prescribing

medications for BPD. Medications can be prescribed in acute settings, with a consensus among health professionals and the patient about the rationale, dosage and side effects. The lowest effective dose should be used.<sup>8</sup>

Admission to hospital is reserved for crisis situations when the patient with BPD is at risk of serious harm to themselves or others.<sup>8</sup>

When treating patients with BPD, GPs should facilitate open discussion among family members and develop a family crisis plan for when the patient becomes unwell.<sup>11</sup>

Although the underlying personality traits in BPD are hard to change, early diagnosis and intervention facilitates a healthier trajectory in functionality.<sup>12</sup>

Practitioners may find patients with BPD especially difficult, and it is easy for practitioners to feel inadequate when they cannot 'save' these patients and when they push boundaries. Common issues include missing appointments and demanding to be seen without booking or at inconvenient times. In order to set boundaries and sustain a long-term therapeutic relationship, a clear, consistent written plan of how the patient can access care, agreed by the patient, should be communicated with the multidisciplinary team of healthcare providers as well as administrative teams.<sup>8,10</sup>

Mental health support for GPs includes:

- The GP Support Program, which includes three free face-toface or telephone counselling sessions for members of The Royal Australian College of General Practitioners and can be accessed at 1300 361 008 or www.racgp.org.au/racgpmembership/member-offers/the-gp-support-program
- Doctors' Health Advisory Service
- · their own GPs.

### Conclusion

Scarlett starts seeing a clinical psychologist a few weeks after her hospital admission. She feels much better in terms of her insomnia. She has been compliant with the thyroid medications, and her follow-up full blood examination shows normal thyroid function. She has an appointment scheduled with an endocrinologist.

### **Resources for doctors**

- Mental health crisis assessment and treatment team for Australian states and territories:
  - ACT- Mental Health Triage Service, 1800 629 354
  - NSW Mental Health Line, 1800 011 511
  - NT Northern Territory Mental Health Line, 1800 682 288
  - Qld 24-hour specialist mental healthcare, 1300 MH CALL (1300 642 255)
  - SA Mental Health Triage Service, 13 14 65
  - Tas Mental Health Service Helpline, 1800 332 388

- Vic Victoria's Mental Health Services (www.health.vic. gov.au/mentalhealthservices/approved.htm for phone numbers and contact details of Victoria's approved area mental health services)
- WA Mental Health Emergency Response Line, 1800 676 822.
- Australian BPD Foundation Ltd for GPs, https:// bpdfoundation.org.au/for-gps.php
- Project Air Strategy for Personality Disorders, www. projectairstrategy.org/mpafactsheets/index.html
- Australian Government Caring for people with borderline personality disorder: A reference guide for health professionals, https://bpdfoundation.org.au/images/ mh25b bpd reference guide 130530.pdf
- Australian Government Free Interpreting Service for private medical practitioners, www.tisnational.gov.au/ Agencies/Charges-and-free-services/About-the-Free-Interpreting-Service/Free-Interpreting-Service-for-privatemedical-practitioners.aspx

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### CASE



## Wenling is anxious

Wenling is an otherwise well woman, aged 18 years, who recently commenced university. She lives at home with her married parents and a younger sibling. She presents with possible thyroid dysfunction found on previous testing, and worsening anxiety.

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How would you focus your initial history-taking in the consultation, given the complaints presented?
Question 2 👄
What systems questions would you ask to establish your hierarchy of further history-taking?

### **Further information**

You take a detailed history regarding thyroid symptoms, but this elicits only non-specific findings of generalised fatigue during the day, some reduced hours of sleep, no neck swelling or dysphagia, and no skin, eye, respiratory or cardiac symptoms. Wenling states that she had 'a blood test last year with a [thyroid] antibody of 1000' but she did not go back for further investigation because she 'didn't like the doctor'.

Further endocrine review is unremarkable, and includes normal menstrual cycles and normal growth and development trajectories.

You undertake a thorough physical examination. Central and peripheral nervous system examination, including cranial nerves, are typical. The thyroid examination is unremarkable, with typical palpation and no peripheral stigmata of thyroid disease. Cardiac, respiratory and gastrointestinal examinations are all within normal ranges, with blood pressure 114/74 mmHg, heart rate 73 beats per minute (regular) and temperature 37.0 degrees Celsius.

During the course of the examination you turn your attention to Wenling's complaint of worsening anxiety.

### Question 3

What specifi	features of the anxiety history are important to	)
establish an	ntegrated approach to understand this symptor	m?

•		

### **Further information**

Wenling states that she has had anxiety since she was a child. She has seen school counsellors and a psychologist in the past but she says 'they never helped'. A doctor once prescribed fluoxetine 20 mg but she was unsure for what symptoms and stopped taking the medication for reasons she cannot recall. She can usually manage her symptoms, but since starting part-time work and study at university, her symptoms have worsened. She reports disabling anxiety that has occurred in a range of settings and stopped her from socialising, caused her to have days off work and left her unable to finish university coursework. Finally, she remarks that she was drinking 1L of cola most days and says, 'I realise that is not good'. Wenling states that she feels she cannot stop drinking cola because her anxiety gets worse when she tries to stop.

Wenling does not use recreational drugs and abstains from alcohol. She does not recall any family members with anxiety or depression.

Though she finds her symptoms distressing at times, her mood is not depressed and she still enjoys pleasurable activities such as watching TV and spending time with her best friend.

Question 4 👄	Question 5 👄
What is your working diagnosis, taking into account the anxiety symptoms described? What focused psychological review questions should be emphasised if a person presents with generalised anxiety symptoms?	What is your hierarchical differential diagnosis for Wenling's presentation?
man generalised animoty symptome.	
Further information	Question 6 👄
Wenling reports that she has had hand-washing rituals since the age of approximately 15 years that have waxed and waned. Often, at worst, the rituals were prompted by fears of getting sick. She might wash her hands 20 times per day to the point of skin cracking and stinging. Resisting hand washing made her increasingly distressed, whereas undertaking hand	What physical investigations will assist in understanding your differential diagnosis?
washing often provided an immediate release of tension.	
She notes that, particularly at night, she has thoughts that 'pop	
into [her] head' and quickly escalate into the worst-case scenario. Examples include fears she has developed a brain	
tumour or that she might become a murderer after watching a violent movie. Wenling finds herself spending hours searching	
the internet because she is worried about physical symptoms that might represent sinister pathology. Her searches do not	
allay her worries, and she is preoccupied for days by the worry	
only for it to suddenly stop 'for no reason'. The cascade of increasing worry and rumination almost feels as if the thoughts	

### **Further information**

Repeat thyroid function tests (TFTs) and antibody testing indicate resolving inflammation, with negative thyroid peroxidase antibody, antithyroglobulin antibody of 374 (down from >1000 six months earlier) and serially normal thyroid stimulating hormone (TSH). Screening investigations including full blood examination (FBE), liver and renal function tests, vitamin B12, folate, vitamin D, fasting glucose, calcium, magnesium and phosphate are all within normal ranges.

Wenling completes the Hamilton Anxiety Rating Scale (HAM-A) and scores 36, which is consistent with severe anxiety symptoms.

and worries are not her own and are out of her control.

Sometimes she develops chest tightness and feels tense through her shoulders and neck. At work she is fearful that

of forgetting to do what her manager has asked her.

Sometimes Wenling also feels she is 'going crazy'.

she will make a mistake and becomes distracted to the point

Wenling finds novel situations stress provoking. She noticed

at university that trying to complete study tasks was causing

her to worry to the point of distraction, and she could not even

anxiety when interacting with strangers, even in larger groups.

get started with a new assignment because of overwhelming

concerns that she will 'get it all wrong'. She does not report

any fear of being out in public, and she is not provoked to

Question 7 🗢	
How do these investigation results management decisions?	s inform your
Question 8	
What aspects of Wenling's presen consideration of early medical ma	
Question 9 👄	
How would you manage Wenling	at this point?

### Further information

You refer Wenling to a psychologist and prescribe fluoxetine 10 mg dispersible tablet, ½ tablet daily, on a titration regimen, and a short course of diazepam 5 mg twice daily for a maximum for four weeks.

The mental health risk assessment is completed and there are no self-harm or suicidal ideation concerns. Wenling agrees that if this changes she will consent to the general practitioner (GP) contacting her parents. She also agrees that she will contact the GP or state/territory mental health helpline if needed. Wenling is also familiar with Headspace services and agrees to a referral for this service if required.

At the one-week review, Wenling reports no side effects from fluoxetine, and her dose is increased to 10 mg daily. She is still waiting for a psychologist appointment. She has not used any diazepam but reports that having it available has allowed her to use psychological strategies to effectively manage her anxiety symptoms.

At the two-week review, Wenling has developed nausea and vomiting, and she suspects that the fluoxetine dose of 10 mg may have contributed. The nausea follows her morning dose of fluoxetine approximately an hour later. She has vomited once each day for four days following the dose increase. A trial of ondansetron for nausea is started. Wenling has used diazepam three times in the preceding week with good effect. She has been able to attend university lectures and has had fewer ruminations at night, helping her to sleep.

By week three, the nausea has not resolved and fluoxetine is ceased. Wenling remains keen to trial medication for obsessive compulsive disorder (OCD) and agrees to a trial of clomipramine as an alternative to selective serotonin re-uptake inhibitor (SSRI) treatment, starting at a low dose and increasing weekly as tolerated.

A month later, Wenling presents for review. The nausea has completely resolved after stopping fluoxetine. She has noticed significantly improved OCD symptoms when taking a dose of 75 mg clomipramine twice daily, which has been titrated weekly over a month. On occasion she has used diazepam with good effect to reduce physical symptoms of acute anxiety provoked at university. She has significant constipation and dry mouth from clomipramine but is happy to continue treatment. Wenling has stopped drinking cola and is now drinking water. Serial TFTs remain within normal ranges.

At her review three months later, Wenling is joined by her mother, Carol. In the preceding month, after an initial improvement, Wenling has had worsening OCD symptoms almost exclusively with compulsions involving hand washing. She has started cognitive behavioural therapy (CBT) with a psychologist and is getting relief briefly each day by focusing her attention on organising her room. Her university attendance has dropped again and she is struggling to socialise with friends because of her anxiety about urges to wash her hands. She denies any significant psychosocial stressors and her mother is concerned that 'the medication is making her worse'.

### Question 10 😃

What are the possible causes of Wenling's deterioration?
What strategies could be explored to try to address her
worsening symptoms?

### CASE 5 Answers

### **Answer 1**

One principle of the initial consultation is to prioritise the presenting complaints to facilitate a quick and timely triage of symptoms and hypothesis for diagnosis, accepting the uncertainty that may be present diagnostically in the course of the review. The primary complaints – anxiety and thyroid issues – may represent a coherent singular diagnostic line of inquiry.

### **Answer 2**

Given symptoms of anxiety may be precipitated by thyroid dysfunction, taking an endocrine history is a reasonable next step.

### **Answer 3**

Anxiety is a complex phenomenon for which pathological characterisation is highly contingent on context. It is important to establish:

- the natural history have the symptoms been present for years or are they reactive to an adverse life event? Do the symptoms occur only in one domain of life or can they be provoked in many different situations?
- whether the symptoms interfere with the patient's ability to perform activities of daily living and/or whether they interfere with normal interpersonal relationships
- any predisposing factors that may increase the risk of anxiety symptoms (eg family history, early childhood trauma)
- any acute or chronic medical conditions that may exacerbate or precipitate anxiety symptoms
- whether symptoms include agoraphobia, panic, mood disturbance or pronounced physical symptoms.

### **Answer 4**

Distinguishing between generalised anxiety and other anxiety and mood disorders can be a difficult task because of significant overlap in patient symptoms.<sup>2</sup> Worry and rumination are common to anxiety disorders, mood disorders

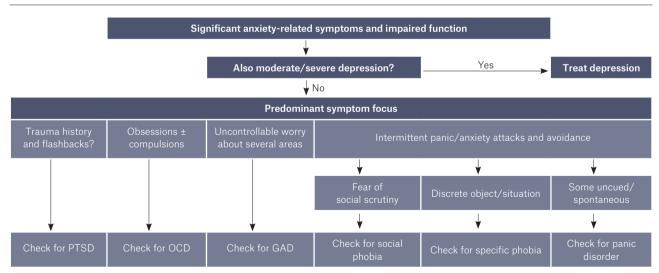


Figure 1. Suggested scheme for exploring a suspected anxiety disorder<sup>14</sup>

GAD, generalised anxiety disorder; OCD, obsessive-compulsive disorder; PTSD, post-traumatic stress disorder

Reproduced with permission of SAGE Publications, Ltd. from Baldwin D, Anderson AM, Nutt DJ, et al, Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: A revision of the 2005 guidelines from the British Association for Psychopharmacology, J Psychopharmacol 2014;28(5):403–39, doi: 10.1177/0269881114525674.

and OCD, as well as many other psychiatric disorders. There are some clues with respect to the specific phenomena of anxiety that can assist to focus further questioning on differential diagnoses (Figure 1).

People with OCD often have intense negative thoughts about their thoughts – a meta-cognitive issue that may predispose to OCD.<sup>3</sup> In psychodynamic terms, this is characterised as 'ego-dystonic' worry: a negative thinking about one's own thinking.<sup>4</sup> Second, often the concepts and concerns that preoccupy the worries of people with OCD and generalised anxiety disorder (GAD) are different. OCD tends to include worries that are extreme or unlikely and specifically focused (eg cancer, invasion by nations, extreme germ exposure), whereas in GAD the concerns are often related to everyday matters traversing a wide range of different concerns (eg money, relationships, career).<sup>5</sup>

These differential features are not definite, and individuals with GAD and OCD may have worries spanning the bizarre to the everyday.

Clarifying the potential for different types of anxiety or OCD disorders is an important step in diagnostic formulation as some treatments and responses to treatment are strongly influenced by the underlying psychiatric disorder.

Diagnosis and management of OCD may be perceived as difficult in the general practice setting, especially considering the overlap with other psychiatric conditions; however, there are discrete dimensions of OCD that make diagnosis more reliable (Box 1). OCD may present initially with high levels of anxiety or comorbidity with other mental illness, requiring targeted questioning. Prolonged treatment timeframes and higher rates of treatment resistance (as high as 60%) to initial therapies may also pose challenges.<sup>6</sup>

# Box 1. Five dimensions of obsessive compulsive disorder<sup>15</sup>

- Obsessions about causing or failing to prevent harm; checking compulsion
- Symmetry obsessions; ordering and counting rituals
- Contamination obsessions; washing and cleaning rituals
- · Repugnant obsessions related to sex, violence, religion
- Hoarding obsessions; compulsions to collect and retain objects

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### **Answer 5**

Wenling presents with a common situation in general practice in which a series of complaints are presented at the initiation of the review. The GP requires an organised approach to integrate the history and examination findings, which will inform investigations and management. Physical illness and syndromes are usually ranked first, followed by psychiatric

diagnoses. In Wenling's case, the differential diagnoses would be ordered as follows:

- hyperthyroidism
- OCD
- · GAD without agoraphobia.

With all presentations involving significant potential psychopathology, it is essential to follow the diagnostic hierarchy and rule in or out any physical illness that may be precipitating symptoms.<sup>7</sup>

Wenling describes a thyroid issue. This requires careful evaluation and investigation given that thyroid dysfunction may contribute to, or precipitate, psychiatric symptoms. The GP must maintain the mantra of 'what else could it be?' to defend against early diagnostic closure and other heuristic biases.<sup>8</sup> The blood test for thyroid antibodies must be followed up as a priority.

### **Answer 6**

Relevant investigations would include:

- TFTs
- · thyroid antibodies
- FBE
- HAM-A;<sup>9</sup> alternatively, if GPs do not have HAM-A on their software, the anxiety component of the Depression Anxiety Stress Scale could be used.<sup>10</sup>

### **Answer 7**

The equivocal thyroid testing, in the absence of symptoms, suggests the need for ongoing monitoring, but normal interval testing for TSH and thyroid antibodies make a diagnosis of thyroid pathology as the primary cause of Wenling's anxiety symptoms worsening less likely. The HAM-A score is very significant and should inform the diagnosis with added weighting.

It is appropriate to commence treatment for a primary anxiety disorder, with ongoing monitoring of Wenling's physical health status.

At this stage, a diagnosis of both OCD and GAD is appropriate.

Differentiating GADs from OCD can be difficult. There are certain features of Wenling's presentation that make the primary diagnosis of OCD an important concern. These features include the ego-dystonic nature of the intrusive worrying thoughts focused on unusual ideas that rapidly escalate in severity to the point of mental distress and distraction that is not responsive to external sources or reassurance. The degree of hand washing and the provocative nature of trying to stop drinking cola are both indicators of compulsive behaviour in excess of what might be defined by an acute anxiety disorder. The natural history of her symptoms also suggests that the OCD symptoms are a more recent

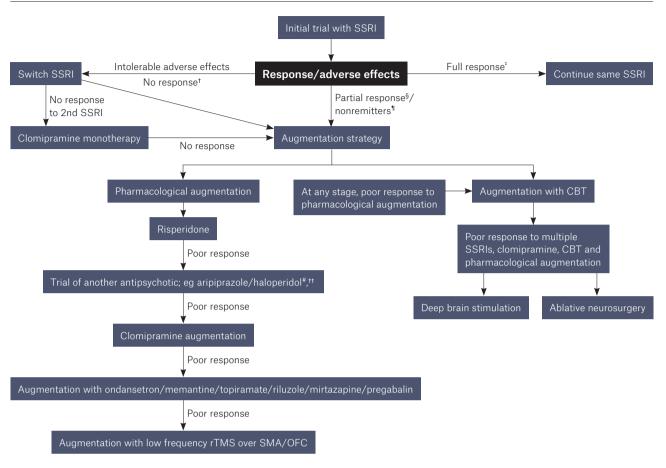


Figure 2. Evidence-based treatment flowchart for obsessive-compulsive disorder<sup>16</sup>

Less than 25% reduction in the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) total score and Clinical Global Impression (CGI)-I of 4 suggests nonresponse to treatment ‡35% reduction in the Y-BOCS score or CGI-I of 1 or 2 suggest full response to treatment.

§Partial response defined as 25-35% reduction in Y-BOCS score despite adequate treatment duration with SSRI.

CBT, cognitive behavioural therapy; OFC, orbitofrontal cortex; rTMS, repetitive transcranial magnetic stimulation; SMA, supplementary motor area; SSRI, selective serotonin re-uptake inhibitor

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development, building on a generalised anxiety matrix from childhood.

### **Answer 8**

Wenling describes disabling anxiety with vegetative symptoms of ego-dystonic intrusive ruminations, poor energy, poor concentration and a moderate-to-severe impact on daily functioning. This level of disability should prompt a trial of medical therapy in parallel with psychological treatments (Figure 2).

### **Answer 9**

A comprehensive biopsychosocial-spiritual approach to managing Wenling's mental health is important. In addition to medical management, lifestyle factors such as diet, exercise, healthy weight management, sleep hygiene and support with her workplace and university responsibilities will create rapport and augment medical and psychological treatment.

Wenling should be referred to a psychologist under a mental health care plan for focused psychological strategies to address the intrusive thoughts and obsessions. Alternatively, GPs with mental health skills training could provide focused psychological strategies such as psychoeducation and interpersonal therapy as part of a comprehensive treatment plan. Wenling had concerns about side effects of medication and obsessional worries that the medication could harm her. Titration from a very low dose with rapid review and up-titration can help manage these worries by reducing the

Have not achieved remission of symptoms (<16 on Y-BOCS) despite adequate treatment with SSRI.

<sup>#</sup>Haloperidol may be especially useful in patients with comorbid tic disorder.

<sup>\*\*</sup>Olanzapine and quetiapine augmentation are options before proceeding to clomipramine augmentation.

risk of side effects early in treatment. While waiting for her first appointment with the psychologist, it would be beneficial to commence fluoxetine 10 mg dispersible tablet, ½ tablet daily. The choice of fluoxetine is guided by treatment recommendations and Wenling's young age, for which SSRIs remain the first-line treatment for OCD and GAD.<sup>11,12</sup> It is important to emphasise to patients that symptoms of OCD typically take 8–12 weeks to respond to treatment with SSRIs.<sup>13</sup>

Because of the high levels of disability, a short course of diazepam 5 mg twice daily can also be commenced for immediate symptomatic control.<sup>11</sup> This treatment should only be used for a maximum of four weeks alongside SSRI up-titration. Patient selection is important when considering the use of potentially addictive medications. However, people with high levels of disability from acute mental illness who are otherwise unlikely to misuse medication, and do not have a history of addiction or misuse, should not be denied access to effective treatments in the setting of a clear medication management plan for duration and cessation of treatment. GPs can consider using weekly pick-up from a pharmacy to help strictly monitor use in low-risk patients. GPs can contact the Prescription Shopping Programme (1800 631 181) to inform their risk assessment of the patient's medication habits.

It is important to complete a risk assessment of Wenling's mental health to look for self-harm or suicidal ideation. Wenling should also be advised that if she has any worries or concerns about her safety, she should contact the GP or state/territory mental health helpline.

### **Answer 10**

It may be tempting to change tack on treatment modalities when a 'failure of treatment' presents to the clinic. In psychiatric practice, however, and especially in treatment of OCD and GAD, a trial of up to six months can often be required before determining treatment efficacy. This prolonged timeframe in treatment is often challenging for families, who may have little experience with mental health issues and expect more immediate results. At this stage of treatment, expert advice can be useful regarding the next best steps in management.

While awaiting a psychiatrist's referral, support may be sought from a psychiatric clinic sponsored by the local health district to provide telephone-based support to GPs. A free national psychiatrist support service for GPs is also available from the GP Psychiatry Support Line (1800 161 718).

### Conclusion

Specialist psychiatric advice is to persist with medication treatment and reinforce psychological strategies for compulsive behaviours. Wenling continues her treatment and, after two months, her obsessional symptoms completely resolve. She returns to the gym, attends university and completes her coursework successfully. She continues to use CBT strategies to help manage her anxiety symptoms.

### **Resources for doctors**

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- GP Psychiatry Support Line, www.gpsupport.org.au

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### **ACTIVITY ID**

### 195009

### Mental health

This unit of *check* is approved for six CPD Activity points in the RACGP CPD Program. The expected time to complete this activity is three hours and consists of:

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### Case 1 - Isabelle

Isabelle, aged 20 years, is a recurrent patient at your practice. One of your practice colleagues would like your second opinion regarding their diagnosis of Isabelle with depression or borderline personality disorder (BPD).

### **Ouestion 1**

Which one of the following features is consistent with BPD?

- A. Chronic feelings of emptiness
- B. Decreased interest/pleasure
- C. Diminished/irritable mood
- D. Change in sleep pattern

### **Further information**

Further history-taking and examination suggests a diagnosis of BPD.

### **Question 2**

Which one of the following therapies was especially designed for BPD?

- A. Cognitive behavioural therapy
- B. Dialectical behaviour therapy
- C. Eye movement desensitisation and reprocessing
- **D.** Interpersonal therapy

### Case 2 - Veronica

Veronica, aged 27 years, has a history of troubling anxiety and occasional panic attacks. She is single, lives alone and has never been involved in a romantic relationship. She has a full-time office job and says her anxiety does not interfere much with her life. Further questioning reveals that she does very little except for going to work – she has few social contacts and prefers to stay at home for fear she will have more panic attacks if she goes out more often. Veronica says she is reasonably happy and she has no wish to end her life; however, she says she would like to have a more interesting life. Veronica has agreed to see a psychologist to help her overcome her anxiety, but there is an eight-week waiting time for affordable face-to-face therapy with a clinical psychologist in your area. You recommend that she commences an online treatment program while she waits for her appointment.

### **Question 3**

Which one of the following is the best option to source an online treatment program to recommend to someone like Veronica?

- A. Ask a colleague
- B. Ask Veronica to do a Google search
- C. Do a Google search yourself
- D. Go to the Head to Health website

### **Question 4**

Which one of the following options is suitable for Veronica now that you have referred her for therapy?

- **A.** Regular weekly visits until she sees the psychologist and during her therapy
- **B.** Occasional follow-up to ensure that she is engaged with her choice of online program and continues to be motivated
- **C.** An invitation to return for follow-up if she thinks it is necessary
- **D.** No follow-up is required as she has a scheduled appointment with the psychologist

### Case 3 - Giuliana

Giuliana, aged 31 years, has been referred to you for further assessment by the local Early Childhood Centre. She scored 16 on the Edinburgh Postnatal Depression Scale at her first visit to the centre with her son, Kyan, aged 4 weeks. Giuliana appears agitated and restless and is pacing around the consultation room trying to settle Kyan, who has been crying vigorously since they arrived at the practice.

### **Question 5**

Which one of the following features is indicative of a diagnosis of perinatal depression?

- A. Disrupted sleep
- B. Frustration with the demands of the infant
- C. Loss of interest or pleasure in everyday activities
- D. Feeling isolated

### **Further information**

Giuliana meets the criteria for perinatal depression, and you discuss the use of antidepressant medications. Giuliana expresses concern about taking an antidepressant while she is breastfeeding.

### **Question 6**

Which one of the following statments is correct regarding the use of selective serotonin re-uptake inhibitors (SSRIs) while breastfeeding?

- **A.** SSRIs should not be used by women who are breastfeeding.
- B. SSRIs can be used by all women who are breastfeeding.
- **C.** SSRIs should be considered on a case-by-case basis for women who are breastfeeding.
- **D.** The safety of SSRIs during breastfeeding is unknown.

### Case 4 - Samuel

Samuel, aged 32 years, is a high school teacher and an infrequent patient of your practice. He has a diagnosis of bipolar disorder and is prescribed quetiapine 100 mg sustained release tablets twice daily as per his medical record. Samuel is accompanied by his colleague Jim, who mentions that Samuel has been increasingly distracted at school. He has also been suggesting unrealistic things in staff meetings. Jim reports that they have noticed this change in Samuel's behaviour over the past 4-5 days. This has not affected his classes as yet; however, the staff are concerned about this change in his behaviour. Samuel reports feeling very well and has great plans for his students. He admits that he has not been sleeping much but still feels refreshed in the morning. You assess him as being not psychotic and low risk for self-harm and harm to others. He admits that his workload at school is stressful. He shows poor insight into his condition with intact judgement.

### **Ouestion 7**

Which one of the following would be the most appropriate diagnosis for Samuel's clinical presentation?

- A. Acute stress disorder
- B. Mania
- C. Hypomania
- D. Thought disorder

### Further information

Samuel denies any substance use. You note that he has been an infrequent visitor to the practice. When you ask him the reason for this, he reiterates that he had been feeling very well and did not feel the need to come in.

### **Question 8**

Which one of the following is the most common cause for relapse in a stable patient with bipolar disorder?

- A. Substance use
- B. Stressful life events
- C. Suboptimal treatment
- D. Medication non-compliance

### Case 5 - Shelby

Shelby, aged 22 years, is a student who has been diagnosed with obsessive compulsive disorder (OCD). You have previously referred Shelby for psychological treatments, but these have had limited effect. You consider commencing Shelby on a trial of medical therapy for her OCD.

### **Question 9**

After behavioural and cognitive modalities, which one of the following is a recommended first-line medication treatment for OCD:

- A. SSRI
- B. clomipramine
- **C.** low-dose atypical antipsychotic (eg quetiapine)
- D. medication is not indicated for OCD.

### **Ouestion 10**

Which one of the following is the timeframe for response to an appropriate dose of SSRI for OCD symptoms?

- A. Two weeks
- B. Four weeks
- C. Six weeks
- D. 12 weeks



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