AAIM 2025 Triennial

Mental Health Workshop

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AAIM 2025: Mental Health Workshop Objectives

- Depression: Identify high- and low-risk features
- Review treatments and tools
- Differentiate major depression, persistent depressive disorder (dysthymia), and grief
- Bipolar Disorder: Understand components and compare with major depression
- Assess high-risk behaviors and suicide risk
- Evaluate generalized anxiety disorder, panic disorder, and post-traumatic stress disorder (PTSD)
- Discuss co-existing psychiatric diagnoses and dual diagnosis with substance abuse

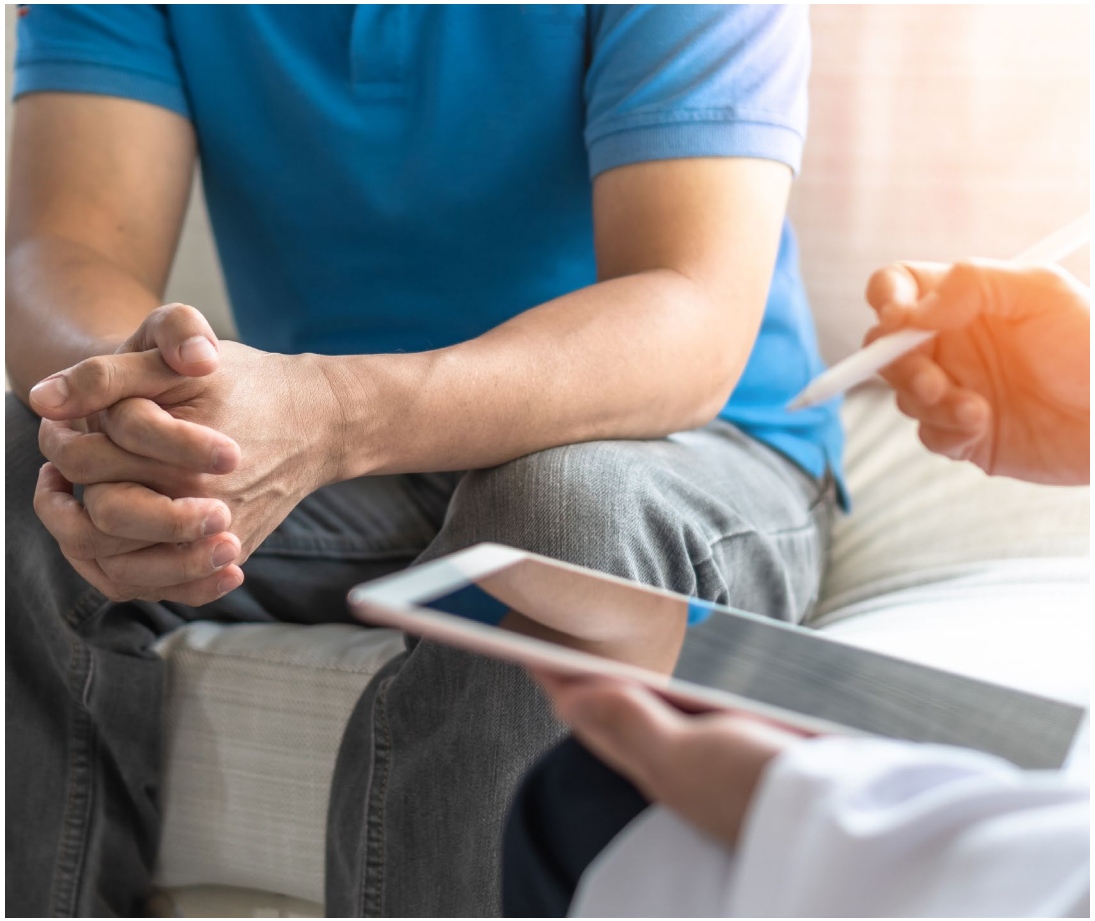
Case 1

37-year-old male, applying for $1M in 01/2025

Discloses depression on the application treated with Venlafaxine 150 mg daily, Aripiprazole 10 mg daily.

1. Initial thoughts regarding his disclosed depression?

2. Do you need more information?



Case 1

- APS:
  - 10/2021
  - Self referral to psychiatrist
  - Immigrated to US in 2018
  - Was taking antidepressant medication prior to 2018 but stopped since his move to the US
  - Works as a veterinarian – experiencing considerable stress at work
  - Describes feeling upset with himself becoming angry with his girlfriend – admits he was verbally abusive and unfair to her
  - MSE: dysphoric mood, congruent affect, no evidence of a formal thought disorder
  - Psychiatrist assessment: Severe Recurrent Depressive Disorder without Psychosis
  - Commenced on Venlafaxine

Case 1

- APS:
  - 06/2024
  - PCP referral to psychiatrist for anxiety, anger, sadness and loneliness
  - Anxiety since junior year in high school, describes himself as quiet anxious child from earliest memory.
  - Suicide attempt in 2009 – overdose on Digoxin, admitted to medical ward for initial management, no psych admission.
  - On Venlafaxine from 2009 to 2015
  - Difficult relationship with mother
  - Family psych history – mother diagnosed with bipolar mood disorder and later with borderline personality disorder. No family history of suicide
  - Substance use: 1-2 beer or wine per week, no illicit substances
  - Symptoms:
    - Little interest or pleasure in doing things
    - Feeling down and hopeless, feels bad about himself
    - Trouble initiating and maintaining sleep – feels tired with little energy
    - Difficulty concentrating
    - Anxious, unable to control worrying, restlessness

Assessment: Severe Recurrent Depressive Disorder without Psychosis

Case 1

3. List the unfavorable findings

4. List the favorable findings

5. Regarding the suicide risk – list the factors that increase his risk of suicide

6. Are there any factors that are protective of suicide risk in this case?

Case 1

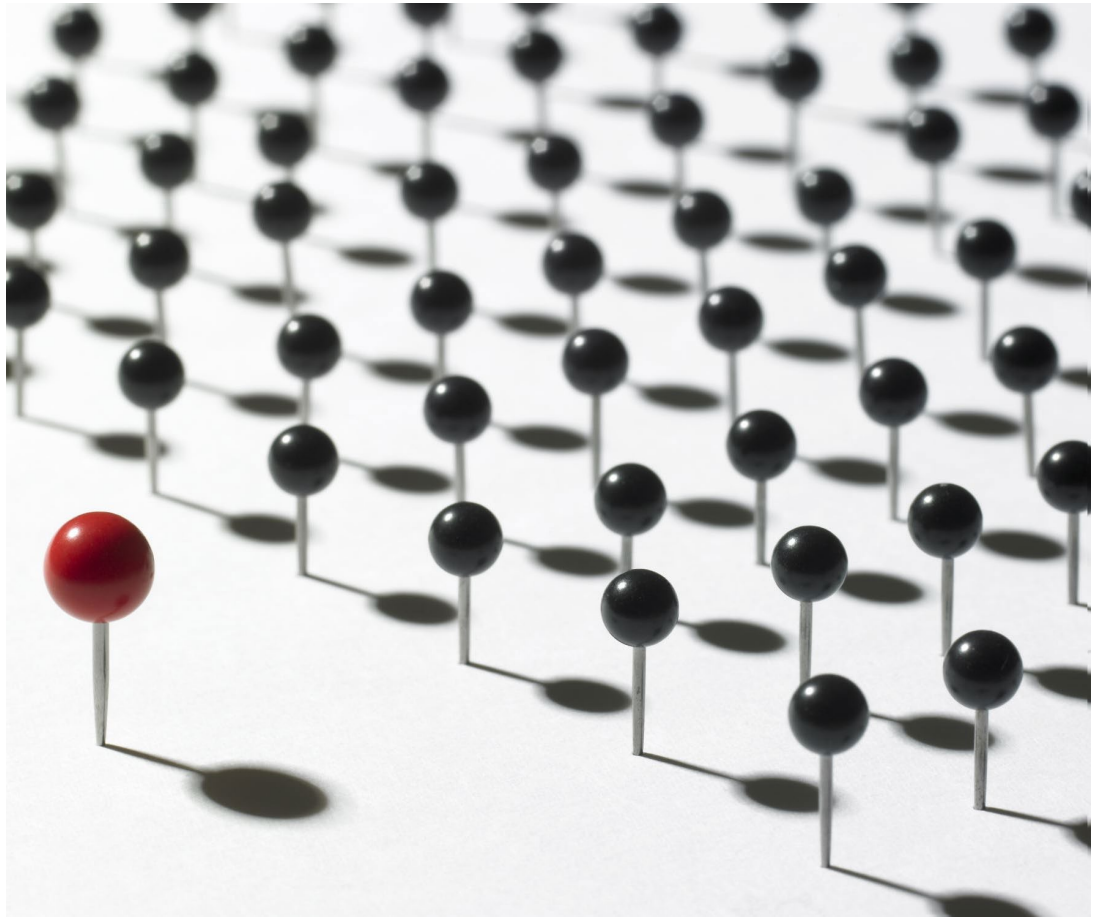
- APS:
  - 08/2024
  - F/up: intermittent suicidal ideation, but no plan
  - 12/2024
  - F/up: Treatment
    - Venlafaxine XR 225 mg daily – rates improvement 9/10 of depression on medication
    - Abilify 10 mg – depression augmentation
    - Topamax 100 mg - nightmares
    - Psychotherapy – PHQ-9 Score of 0

7. What is your assessment of his mortality risk?

Depression

High risk features[3]

1. History of early life adversity – trauma or abuse
2. Family history of depression, bipolar disorder, alcoholism, suicide
3. Substance use (alcohol, drugs)
4. Past suicidal or self-harming behavior, current suicidal ideation
5. Chronic or serious medical illness
6. Comorbid psychiatric illness – anxiety, eating disorders, personality disorders, PTSD
7. Recent life event – bereavement, relationship breakdown, financial hardship
8. Social isolation or lack of support
9. Persistent or severe or recurrent mood disorder



Depression

Low risk features – favorable prognosis[3]

1. No history of trauma or abuse
2. No family history of psychiatric disorders
3. No substance use
4. Generally healthy
5. Stable employment & relationships, good social support
6. Mild brief mood disorder
7. Positive coping skills, evidence of resilience
8. Early treatment and intervention

Depression Symptoms: Risk Factor Association

Variables	N	M	SD	F	df	p	Cohen's d
Gender							
Female	115	2.08	0.78	6.39	1.115	0.01	0.48
Male	44	1.66	0.88				
Civil Status							
Without partner	96	18.73	11.88	0.01	1.124	0.93	0.01
With partner	34	18.53	11.96				
Educational Level							
Lower educational level	43	21.54	11.44	4.08	1.124	0.05	0.36
High educational level	86	17.08	17.08				
Actual physical disease							
Yes	25	23.88	10.64	4.29	1.104	0.04	0.41
No	81	18.14	12.54				
Genetic/hereditary factor							
Yes	67	19.90	11.14	2.70	1.133	0.10	0.28
No	72	16.69	11.50				
Adverse childhood experience							
Yes	47	23.38	12.17	13.65	1.150	<0.001	0.60
No	113	16.35	10.20				

https://www.frontiersin.org/journals/psychology/articles/10.3389/fpsyg.2020.594698

Suicide Risk Factors

1. Prior history of attempted suicide
   - Strongest predictor of suicide
2. Psychiatric disorder
3. Hopelessness
4. Family history of suicide
5. General medical conditions
   - Chronic disorders, chronic pain, neurologic disorders
6. Childhood adversity (abuse, neglect)
   - Risk 2 – 4 x greater
7. Occupation
   - Risk greater in unskilled occupations
8. Marital status
   - Higher if not married

Suicidal Ideation (SI) Risk Assessment

1. New or chronic SI
   - If chronic – increase in frequency and intensity
2. Active versus passive SI
3. Intent or plan present
4. Assessment of means and access to means
5. Severe agitation or psychotic symptoms
6. Expressions of hopelessness
7. Any history of impulsivity
8. Substance use

Depression: Recurrence

- Major depressive disorder is highly recurrent.[4,5]

- 35% of MDD patients will have a recurrence.

- Predictors of recurrence:
  - Prior history of recurrence (most predictive)
    - 1 recurrence → 50% chance of another recurrence
    - 2 recurrent episodes → 70 to 80% of third recurrence
    - 3 recurrent episodes → > 80% of further recurrence
  - Residual depressive symptoms
  - Childhood adversity

Case 2

45 M, non-smoker, BMI 25, healthcare professional applying for $5M (8/2024)

Discloses history of anxiety and depression currently taking Lamotrigine

1. Initial thoughts regarding his anxiety and depression disclosure?

2. Do you need more information?

Case 2

- APS from psychiatrist dated 9/2022
  - History of depression, anxiety and insomnia since 5th grade
  - No childhood abuse or neglect
  - Continued to struggle with anxiety and depression since childhood
  - Number of medication trials but anxiety and depression have never fully resolved
  - Depression at time of assessment rated at 6 to 7 out of 10
    - Symptoms include low motivation, feelings of isolation, guilt, helplessness and hopelessness. Occasional feelings of desperation and feeling overwhelmed.
  - Anxiety
    - Worries about many things most days. Often feels restless, on edge and irritable. Rates anxiety currently 7 out of 10
    - No history of panic attacks
  - In addition to anxiety and depression identifies episodes of elevated mood
    - Cyclical pattern every 1 to 3 months lasting several days to week
    - Increased irritability, high energy leading to increased disorganization
    - Increased sexualized thoughts and indulgence in pornography
    - Increased “epiphanies” during which he feels “quite brilliant”
    - During this time sleep goes down to 3-4 hours/night for several days, appetite not affected

Case 2

- APS from psychiatrist dated 9/2022 (cont.)
  - Social history:
    - Married with children, runs successful healthcare practice
    - No history of substance use
    - No legal history
  - Family psych history:
    - Suicide attempts in sister and brother, a cousin has committed suicide
    - Siblings all struggle with depression
    - Mother had “breakdowns with hysteria”, panic attacks and depression
    - No psych history of father’s side of family
  - Past psych medication trials:
    - Citalopram – effective initially then stopped working
    - Trials of Fluoxetine and Bupropion respectively but did not like the way these medications made him feel
  - Current medication:
    - Lamotrigine 300 mg daily, (increased from 1 year ago)
  - MSE:
    - Mild to moderately depressed mood with congruent affect
    - Normal motor function, no formal thought disorder, no hallucinations
    - Good insight, psychologically minded

Case 2

- APS from psychiatrist dated 9/2022 (cont.)
  - Diagnostic evaluation
    - Cyclothymic Disorder
    - Generalized Anxiety Disorder
    - Attention Deficit Disorder, Combined Type
  - Treatment plan:
    - Continue Lamotrigine
    - Add Adderall
    - Consider adding Lithium
  - Psychiatrist additional remarks:
    - Episodes of elevated mood come very close to hypomanic episodes
    - Clear evidence of cycling between depressed and elevated moods
    - No evidence of psychosis
    - Significant family history
      - No known bipolar mood disorder or schizophrenia

Case 2

1. List the unfavorable findings.

2. List the favorable findings.

3. Given his diagnosis of cyclothymia, which type of bipolar mood disorder would be included in his differential diagnosis?

4. Comment on his treatment regimen.

5. Would he benefit from psychotherapy?

6. What is your assessment of his mortality risk?

Cyclothymic Disorder

- “Milder and chronic variant of bipolar disorder”.[19,20]
- Hypomanic symptoms that do not meet criteria of hypomanic episode
- Depressive symptoms that do not meet the criteria for a major depressive episode
- Recurrent symptoms of at least 2 consecutive years
  - Asymptomatic for at least half the time
  - Not symptom free for more than 2 consecutive months

Cyclothymic Disorder

- Up to a third of individuals with cyclothymic disorder may progress to a full bipolar disorder
- Lack of studies reporting all-cause mortality in patients with cyclothymic disorder (often included in Bipolar Disorder NOS)
- Significantly underdiagnosed – estimated that 30% of major depression patients are cyclothymics.
- Treatment with psychoeducation and if required antimanic drug or Lamotrigine
- Be cautious with the use of antidepressants

Bipolar Disorders: Important Distinctions

	Bipolar I Disorder	Bipolar II Disorder
Manic episodes	Yes	No
Hypomanic episodes	Occur but are not required for diagnosis	Yes
Major depressive episodes	Occur but are not required for diagnosis	Yes

Manic Episode	Hypomanic Episode
Severe risk-taking behavior	Mild to moderate risk-taking behavior
Psychotic symptoms may occur	Psychotic symptoms do not occur
Usually requires hospitalization	Hospitalization not required

Bipolar Disorders

High Risk Features

- Recent hospitalization within past 5 years
- Bipolar I subtype → greater symptom severity associated with high-risk behavior; increased cardiovascular mortality risk associated with mania/hypomania symptom severity.[14]
- Rapid cycling → at least four episodes during a 12-month period.[15]
  - Poorer response to pharmacotherapy compared to non-rapid cycling bipolar
- Unstable medication use or recent medication changes
- Previous suicide attempt or current suicidal ideation
- Mixed mood episodes – mania, hypomania and major depression with significant symptoms of opposite polarity.[18]
  - Increased risk of psychiatric comorbidity (anxiety disorder, substance use)
  - Poorer response to treatment compared to pure mania or major depressive episode
- Comorbid psychiatric disorders
  - Majority of bipolar patients have at least one comorbid psychiatric diagnosis
  - Comorbidity is often associated with a worse course of illness in bipolar disorder, including earlier age of onset, more recurrent mood episodes, and more suicide attempts.

Bipolar Disorders

Treatment considerations

- Acute mood episode treatment versus maintenance therapy
- First line Rx for mania, hypomania or major depression is:
  - Antimanic drug
- Antimanic drugs include:
  - Lithium
  - Anticonvulsants
    - Valproate
    - Carbamazepine
  - Second generation antipsychotics:
    - Quetiapine, olanzapine, risperidone, aripiprazole, lurasidone, cariprazine

Case 3

29 M US military veteran applying for $500k life cover (6/2025)

- Discloses PTSD and ongoing cognitive behavioral therapy

1. Do you need more information?

Case 3

VA medical records:

- Service history: Deployed twice to Afghanistan, with honorable discharge at age 26 in 2022
- Diagnosed with post-traumatic stress disorder (PTSD) at age 24 in 2020 shortly after traumatic combat exposure
- History of alcohol abuse beginning shortly after discharge for which he was referred for treatment
  - Drinking every day 3 - 4 beers
  - Regular binges over weekends

- Treatment history:
  - PTSD – referred to CBT for trauma-focused counselling. Offered to also start Citalopram but patient declined.
  - Alcohol abuse: Completed a 12-month outpatient rehabilitation program at age 27 in 2023; currently attends weekly therapy and participates in a veterans' peer support group

- Social history:
  - Employed as a security supervisor; abstinent from alcohol for 24 months, as verified by regular counseling records and negative alcohol screenings
  - Married – wife is supportive; has 1 young son
  - Happy childhood, no family history of psychiatric illness

Case 3

- Last f/up 12/2024:
  - PTSD in symptomatic remission, mental state examination unremarkable
  - Maintains alcohol abstinence
  - Continues CBT

- Paramed & labs wnl

- No other medical history

Case 3

2. List the unfavorable factors

3. List the favorable factors

4. Regarding his treatment for PTSD
   - Are you concerned about the ongoing CBT?
   - Is psychotherapy superior to pharmacotherapy in the treatment of PTSD?
   - Is combination intervention for PTSD with psychotherapy and pharmacotherapy superior to either modality alone?

5. What is your assessment of his mortality risk?

Posttraumatic Stress Disorder (PTSD): DSM-5-TR

- DSM-5-TR
  - PTSD in individuals older than 6 Years
  - PTSD in children 6 years and younger

- PTSD is characterized by intrusive thoughts, nightmares and flashbacks of past traumatic events, avoidance of reminders of trauma, hypervigilance, and sleep disturbance, all of which lead to considerable social, occupational, and interpersonal dysfunction.

- PTSD is often a chronic disorder.[21]
  - ⅓ recovered after 1 year
  - ⅓ still symptomatic 10 after trauma exposure
  - Some evidence to show early treatment prevents chronicity

Posttraumatic Stress Disorder (PTSD)

Treatment considerations[22,23,24,25]

- First line treatment with trauma-focused psychotherapy or Serotonin Reuptake Inhibitor (SRI) - either SSRI or SNRI
- Psychological treatment versus pharmacological treatment largely comparable with some advantage toward psychotherapy
- No good evidence to suggest combination therapy with psychotherapy and SRI is superior to treatment with either intervention alone
- Effective treatment should continue for at least 6 months to 1 year
- Psychotherapy
  - Trauma-focused CBT
  - Exposure-based therapy
  - Eye movement desensitization and reprocessing therapy
- Treatment resistance
  - Combination of psychological and pharmacological interventions may benefit some
  - Augmentation with second generation antipsychotics – quetiapine or risperidone

Case 4

- 31 F applying for $500k life cover (06/2025)
- Psych APS (Nov 2024):
  - Started on antidepressant medication (sertraline 50 mg) in September 2024 for postpartum depression/anxiety. Gave birth in May 2024.
  - Current complaints:
    - Depressed mood
    - Loss of interest
    - Excessive guilt
    - Loss of energy
    - Poor concentration
    - Poor sleep (nursing 4x per night)
    - Denies suicidal ideation
    - Patient describes symptoms as severe and worsening

Case 4

- Psych history
  - Generalized anxiety disorder – experiences panic attacks couple of times per year.
  - Currently experiencing excessive worrying and irritability. Symptoms currently severe and worsening
  - ADHD – mixed type. Diagnosed before age 12. Has been treated with stimulants in the past.
  - Symptoms described as mild and unchanged.
- Family psych history
  - Father abused alcohol
  - Mother diagnosed with anxiety disorder, also suspected bipolar disorder but never confirmed.
  - Sister also has ADHD
- Social history
  - Married with 4 children – currently a stay-at-home mother
  - Former smoker – quit between each pregnancy
  - Occasional alcohol, no other drug use

Case 4

- Patient admits to not taking Sertraline (makes her feel ill)
- Started on Lexapro 10 mg/day
- Psychotherapy offered but not taken up as she does not have time for it
- APS (December 2024):
  - Significantly improved
  - Current symptoms
    - Excessive guilt
    - Loss of energy
    - Poor concentration
    - Poor sleep
    - Patient describes symptoms as moderate
  - GAD much improved
    - Much less worrying
    - Irritability has resolved
  - Meds:
    - Bupropion 150 mg/day added to improve libido

Case 4

- APS (May 2025)
  - Symptoms continue to improve- most symptoms at initial presentation now resolved
  - Bupropion stopped (due to side effects), and Lexapro increased to 20 mg/day
  - Patient continues describes her symptoms currently as moderate
  - Treatment plan to continue Lexapro and regular 3 to 6-month follow-up

Case 4

1. What goes into severity assessment of MDD?

2. Based on the information of this case how would you assess her MDD severity?

3. What is your assessment of her mortality risk?

MDD Severity Determination

Mild

Individuals with mild major depression have ≥5 symptoms of depression and a PHQ-9 score of 5 to 9. They generally do not have:

- Marked distress or significant functional impairment
- Frequent suicidal or homicidal ideation or plans
- Psychotic features (delusions or hallucinations)
- Catatonic features (immobility, mutism, excessive purposeless motor activity)
- Significant aggressiveness

Moderate

Individuals with moderate major depression have ≥5 symptoms of depression and a PHQ-9 score of 10 to 19. They may have suicidal or homicidal ideation. They generally do not have:

- Psychotic features (delusions or hallucinations)
- Catatonic features (immobility, mutism, excessive purposeless motor activity)
- Marked distress or functional impairment

Severe

Individuals with severe major depression have ≥7 symptoms of depression or a PHQ-9 score of ≥20 or any of the following:

- Psychotic features (delusions or hallucinations)
- Catatonic features (immobility, mutism, excessive purposeless motor activity)
- Marked distress or functional impairment
- Very likely to have suicidal or homicidal ideation and behavior (ie, a specific plan and intent to act upon it)

Patient Health Questionnaire (PHQ-9)

- Symptoms in last 2 weeks
- Scoring:
  - 0 (Not at all)
  - 1 (Several days)
  - 2 (More than half the days)
  - 3 (Every day)

1. Little interest/pleasure in doing things
2. Feeling down/depressed, hopeless
3. Sleep problems
4. Feeling tired/little energy
5. Appetite changes
6. Feeling like a failure
7. Trouble concentrating
8. Moving slowly or being fidgety
9. Suicidal thoughts

Score:

- 1-4 Minimal
- 5-9 Mild
- 10-14 Moderate
- 15-19 Moderately severe
- 20-27 Severe

DSM-5-TR

Area	DSM-5-TR (2022) compared to DSM-5 (2013)
New Diagnoses	Added Prolonged Grief Disorder Addition of Unspecified Mood Disorder Addition of Stimulant-Induced Mild Neurocognitive Disorder
Diagnostic Criteria	Revised/clarified for several conditions (e.g., autism spectrum disorder, major depressive disorder, attenuated psychosis syndrome, PTSD in young children)
Language/Terminology	Modernized language; terms updated for cultural sensitivity and accuracy
Coding	Updated ICD-10-CM codes and alignment
Text & References	Descriptive text and references extensively updated with recent studies and clinical guidance
Other Changes	Diagnostic criteria updated, plus clarifications to reduce ambiguity and correct typographical errors

Thank you!

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