National Comorbidity Guidelines

Face-to-Face Training Program

Module 4: Anxiety, Depression and Bipolar Disorder

Participant Workbook

Funded by

Australian Government
Department of Health

Delivered by

THE UNIVERSITY OF SYDNEY
Matilda Centre

360edge.

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COMORBIDITY GUIDELINES

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The University of Sydney's Matilda Centre for Research in Mental Health and Substance Use

Anxiety, Depression and Bipolar Disorder

Module 4

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Anxiety, depression and bipolar disorder

Agenda

Understanding anxiety and anxiety disorders

Helping clients with AOD use and anxiety to manage symptoms

What treatments work for clients with AOD use and anxiety

Understanding depression and depressive disorders

Helping clients with AOD use and depression to manage symptoms

What treatments work for clients with AOD use and depression

Understanding bipolar disorder

Helping clients with AOD use and bipolar disorder to manage symptoms

What treatments work for clients with AOD use and bipolar disorder

Clients in AOD treatment

Anxiety 45-70%

Depression 26-60%

Bipolar disorder 4-10%

Marel C et al (2016)

NOTES

Guiding principles

Guiding principles

First, do no harm

Work within your capacity

Engage in ongoing professional development

Recognise that the management of comorbidity is part of AOD workers' core business

Provide equity of access to care

Adopt a 'no wrong door' policy

Guiding principles

Recognise that comorbidity is common and that all clients should be routinely screened for comorbid conditions

Conduct ongoing monitoring of symptoms and assessment of client outcomes

Adopt a holistic approach

Adopt a client-centred approach

Emphasise the collaborative nature of treatment

Have realistic expectations

Guiding principles

Express confidence in the effectiveness of the treatment program

Adopt a non-judgemental attitude

Adopt a non-confrontational approach to treatment

Involve families and carers in treatment

Consult and collaborate with other health care providers

Ensure continuity of care

Understanding anxiety and anxiety disorders

NOTES

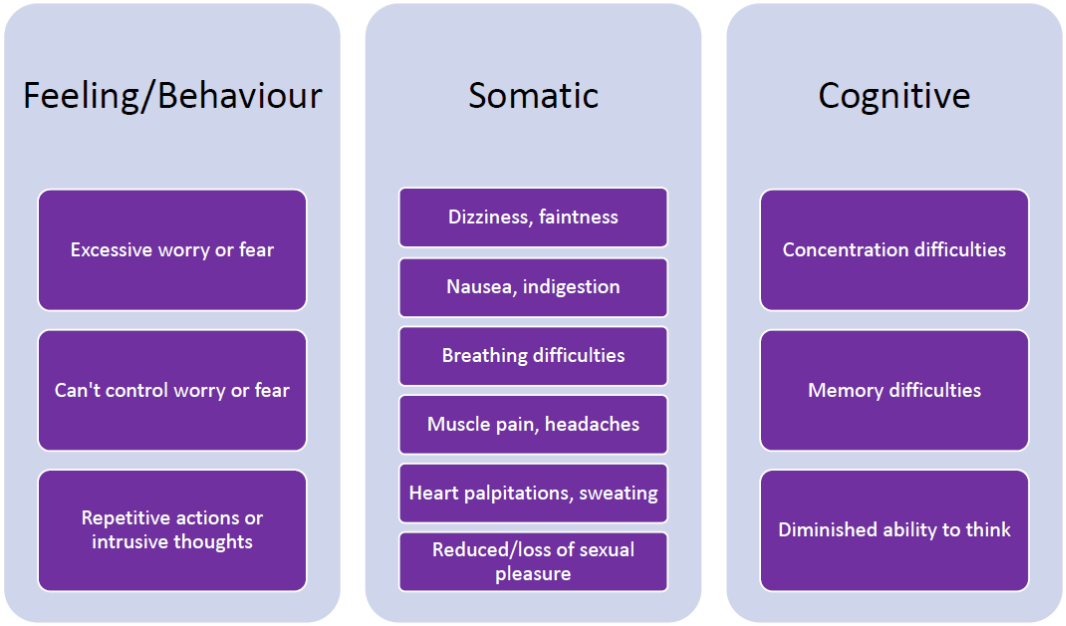
What is anxiety? What is fear?

Anxiety is the anticipation of future threat

Fear is the emotional response to real or perceived imminent threat

NOTES

Symptoms



NOTES

DSM-5 diagnoses of anxiety disorders

Depending on number/types of symptoms experienced by a client, one (or more) of these diagnoses may apply. There are ICD-10 codes to match these DSM-5 diagnoses found in Appendix D of the Comorbidity Guidelines

Specific phobia

Social anxiety disorder (social phobia)

Panic disorder

Agoraphobia

Generalised anxiety disorder (GAD)

Substance/medication induced anxiety disorder

NOTES

Anxiety disorder	Marked fear or anxiety about	Detail
Specific phobia	Specific object or situation	Almost always triggers anxiety, out of proportion to actual danger
Social anxiety disorder (SAD) (social phobia)	One or more social situations involving possible scrutiny	Will be negatively evaluated, humiliated, embarrassed
Panic disorder	Further panic attacks or the consequences	Recurrent unexpected panic attacks
Agoraphobia	Public transport, open spaces, enclosed places, crowds or queues, outside of the home alone (2 or more)	Fear that escape or help for symptoms or their consequences might not be available
Generalised anxiety disorder (GAD)	A number of events or activities	Worry difficult to control, physical symptoms
Substance/medication induced anxiety disorder	Not specified	Panic attacks or anxiety developed during or soon after taking medication or intoxication or withdrawal

NOTES

Module 4 Activity 1: Assessing anxiety

The facilitator will divide you into pairs. Each person chooses two **types of anxiety disorder from the slide on page 12 of your workbook**.

- Each person takes a turn to role play the clinician.
- When you are the client think about the symptoms of these disorders to enable a brief answer as a client. You can inform your clinician which disorders you have.
- The clinician is to ask two questions about each disorder that will specifically elicit information about at least one of the key symptoms of each chosen disorder, as listed in the slide on page 12.

For example, if one person is role playing a client with agoraphobia, the clinician could ask '*Could you tell me about specific places or situations outside the home where you feel most anxious?*'

Chosen anxiety disorder #1:	**Questions asked by clinician:**	**Answers from client:**

Chosen anxiety disorder #2:	**Questions asked by clinician:**	**Answers from client:**

Anxiety and substance use disorders

An anxiety disorder can significantly increase the risk of relapse to AOD use

Entering AOD treatment, reducing substance use, and withdrawal can all increase anxiety

Some clients may experience a reduction in anxiety after a period of abstinence and stabilisation

Clients with an anxiety disorder may not demonstrate reduced anxiety with abstinence, and may experience an increase in symptoms

NOTES

Do's and don'ts for working with clients with symptoms of anxiety

- ✓ Approach the client in a calm, confident and receptive way
- ✓ Move and speak at an unhurried speed
- ✓ Be patient in order to allow the client to feel comfortable to disclose information
- ✓ Minimise the number of staff present and attending to the client
- ✓ Minimise surrounding noise to reduce stimulation
- ✓ Reassure the client frequently
- ✓ Explain the purpose of interventions
- ✓ Remain with the client to calm him/her down

Do's and don'ts for working with clients with symptoms of anxiety

- ✕ Crowd or pressure the client
- ✕ Get frustrated or impatient
- ✕ Panic. The more relaxed you are the more relaxed the client is likely to feel
- ✕ Act shocked by what the client may reveal

Asking about anxiety

It is important for clinicians to develop comfort and familiarity asking about symptoms. This is not to conduct a full mental health assessment or diagnose but to be able to:

- Understand a client's experience
- Understand the relationship between symptoms and AOD use
- Monitor symptoms throughout treatment
- Consider what impact anxiety symptoms might have on treatment engagement and participation

NOTES

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Helping clients with AOD use and anxiety to manage their symptoms – what works?

Progressive muscle relaxation

Controlled or abdominal breathing

Meditative therapies e.g. calming response, visualisation and imagery, grounding

CBT cognitive restructuring

Problem solving and goal setting

CBT based e-health e.g. Mental Health Online (previously Anxiety Online), FearFighter for panic and phobia

NOTES

Module 4 Activity 2: Case study Jack. Comorbid anxiety and substance use

- Jack, 27 year-old male.
- Trained as a nurse, was working part time as a pathology clinic nurse until 6 months ago.
- Sympathetic boss who has given him time off to sort himself out but wants drug screens before Jack can return to work. Jack believed he could sort this on his own but has been unable to reduce his drug use since being off work.
- He is extremely worried about not being able to return to work as he enjoys his work and feels it was a nursing job that suited him and that he was good at it.
- 9 year history of using benzodiazepines, pain killers (previously over the counter codeine but more recently oxycodone if he can obtain it) and cannabis. Mostly daily use until he commenced his nursing job 18 months ago. As he was very worried about appearing drowsy at work he would stop using benzos 1-2 days before every shift. He reported that he was unbearably anxious by the end of a shift and would go home and use extra substances until he felt calmer and could sleep.
- Reports a long history of daily anxiety 'I felt anxious since I was a child.' Describes anxious thoughts and physical symptoms. Reports significant social anxiety. Can manage some small social situations with friends if he self-medicates.
- No previous treatment for anxiety or AOD use.
- Lives with his parents who he describes as supportive of him but not understanding of his anxiety and don't know about his substance use.

Activity continued over page

Module 4 Activity 2: Case formulation worksheet for Jack

Presenting issues (What are the current problems?)	_____
Pattern (of current problems)	_____
Predisposing factors (What factors in the person's history are relevant to the current problems?)	_____
Precipitating factors (How did these problems develop? How do you know this?)	_____
Perpetuating factors (How are these problems maintained? What evidence do you have?)	_____
Protective factors (What factors are relevant to the current problems?)	_____
How do the above factors interact? How do the AOD use and mental health symptoms relate and influence each other?	_____
Prognosis (What is the likely outcome for this client?)	_____

Module 4 Activity 3: Practice

In the same groups as the previous activity, take turns role playing the client (Jack) and the clinician. The person role playing the clinician chooses two of the interventions listed below; one cognitive and one physical.

- Progressive muscle relaxation
- Controlled or abdominal breathing
- Meditative therapies e.g. calming response, visualisation and imagery, grounding
- CBT cognitive restructuring
- Problem solving and goal setting
- CBT based e-health e.g. Mental Health Online (previously Anxiety Online), FearFighter for panic and phobia

Cognitive intervention: The clinician interviews Jack further to identify his anxious thoughts and then introduces a cognitive strategy.

Physical intervention: The clinician interviews Jack further to identify his physical symptoms and then introduces a physical strategy.

Following each round, the client should provide feedback about the intervention and its effect.

The facilitator will let you know when it's time to switch roles as clinician and client.

What other treatments work?

Pharmacotherapy

SSRI's for SAD or GAD alone but caution with panic disorder as can initially worsen panic symptoms

SSRI's for AOD and comorbid SAD

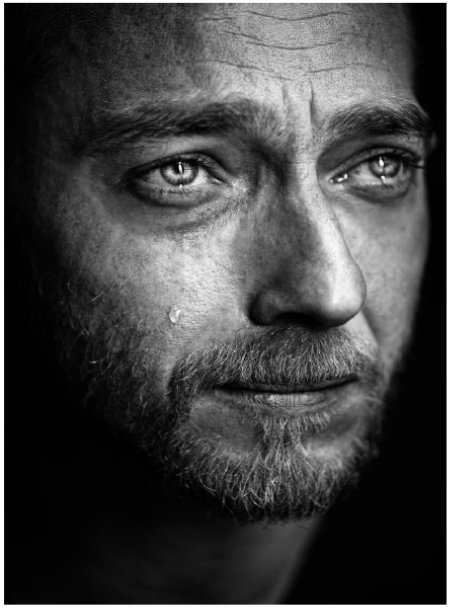
Minimal literature on safety and efficacy of benzodiazepines for AOD and comorbid GAD

Some research supports Buspirone for AOD and comorbid GAD

Refer to Chapter B6 of the Comorbidity Guidelines for more information

NOTES

Understanding depression and depressive disorders



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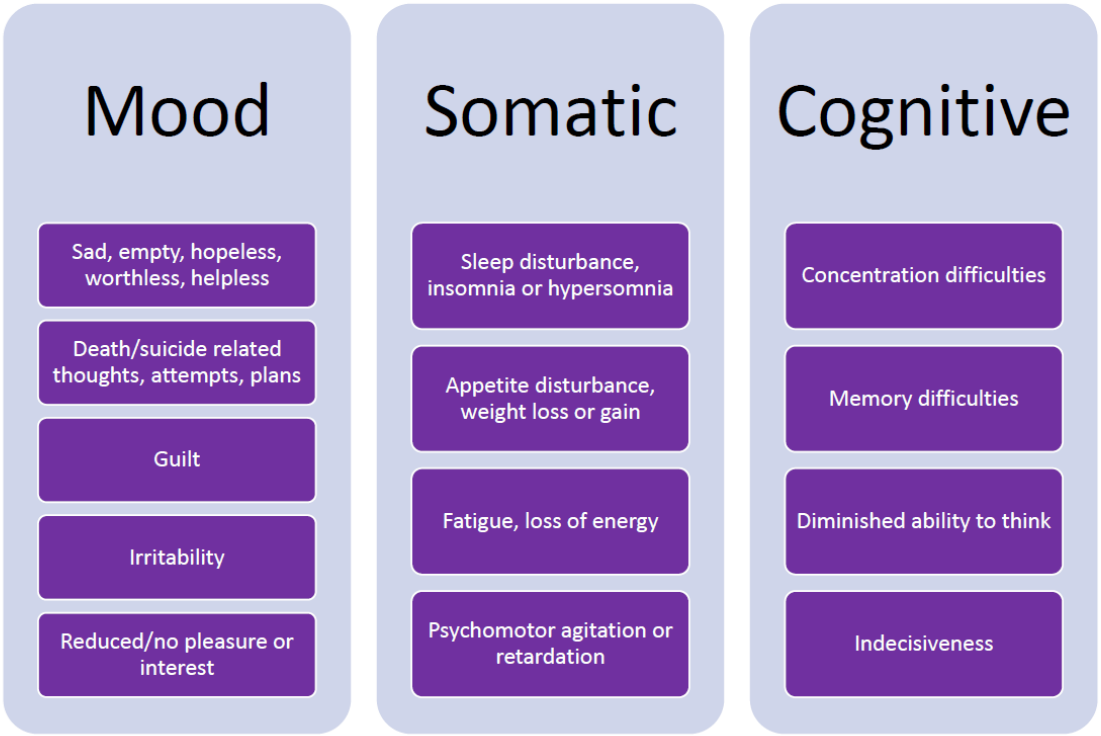
Mood
Sad, empty, hopeless, worthless, helpless
Death/suicide related thoughts, attempts, plans
Guilt
Irritability
Reduced/no pleasure or interest
Somatic
Sleep disturbance, insomnia or hypersomnia
Appetite disturbance, weight loss or gain
Fatigue, loss of energy
Psychomotor agitation or retardation
Cognitive
Concentration difficulties
Memory difficulties
Diminished ability to think
Indecisiveness

NOTES

Module 4 Activity 4: Reflection on current practice

Mood symptoms	Sad, empty, hopeless, worthless, helpless	Death/suicide related thoughts, attempts, plans	Guilt	Irritability	Reduced/no pleasure or interest
Somatic symptoms	Sleep disturbance, insomnia or hypersomnia	Appetite disturbance, weight loss or gain	Fatigue, loss of energy	Psychomotor agitation or retardation	
Cognitive symptoms	Concentration difficulties	Memory difficulties	Diminished ability to think	Indecisiveness	

1. Which of these symptoms do you routinely enquire about with your clients? Make a note of the ones that you don't.
2. How might you ask about these symptoms?

_____

_____

3. What would be the benefit of this? (Case formulation? Treatment plan?)

_____

_____

DSM-5 diagnoses of depressive disorders

There are ICD-10 codes to match these DSM-5 diagnoses found in Appendix D of the Comorbidity Guidelines

Major depressive disorder (including major depressive episode)

Persistent depressive disorder (dysthymia)

Premenstrual dysphoric disorder

Substance/medication induced depressive disorder

Unspecified depressive disorder

In the DSM-5, depressive disorders are separated from bipolar and related disorders

NOTES

Depressive disorder	Key Symptoms	Details
Major depressive disorder	5 or more symptoms nearly every day, depressed mood most of the day	Mild, moderate, severe includes major depressive episode
Major depressive episode	5 or more symptoms in two weeks, nearly every day, depressed mood most of the day	Single episode, recurrent episode
Persistent depressive disorder (dysthymia)	Depressed mood for most of the day, for more days than not, for at least 2 years	Merged DSM-IV chronic major depressive disorder and dysthymia
Premenstrual dysphoric disorder	5 symptoms in the final week before menses onset, improve within a few days after onset, minimal or absent in the week post menses	Was in DSM-IV "for further study" appendix but now considered a specific form of depressive disorder
Substance/medication induced depressive disorder	Prominent and persistent disturbance in mood	Developed during, or soon after, taking medication or intoxication or withdrawal
Unspecified depressive disorder	Symptoms characteristic of a depressive disorder but do not meet full criteria	Includes presentations where insufficient information to diagnose e.g. emergency departments

NOTES

Depressive and substance use disorders

Negative mood and other symptoms of depression particularly thoughts of helplessness, hopelessness and worthlessness can be a trigger to relapse in AOD use

Interventions designed to reduce substance use may have benefits for depressive symptoms and some clients may experience a reduction in depressive symptoms after a period of abstinence and stabilisation

Entering AOD treatment, reducing substance use, and withdrawal can all increase depressive symptoms

Clients with a depressive disorder may not demonstrate reduced symptoms with abstinence, and may experience an increase in symptoms

NOTES

Do's and don'ts of managing a client with depressive symptoms

- ✓ Encourage and emphasise successes and positive steps (even just coming in for treatment)
- ✓ Take everything they say seriously
- ✓ Maintain eye contact and sit in a relaxed position – positive body language will help you and the client feel more comfortable
- ✓ Use open-ended questions such as 'So tell me about…?' which require more than a 'yes' or 'no' answer. This is a good way to start a conversation
- ✓ Constantly monitor suicidal thoughts and talk about these thoughts openly and calmly

Do's and don'ts of managing a client with depressive symptoms

- ✓ Encourage the client to express his/her feelings
- ✓ Be available, supportive and empathetic
- ✓ Offer realistic hope (i.e. that treatment is available and effective)
- ✓ Provide contact details of counselling services and offer to make referrals if required (many depressed people struggle to do this alone)
- ✓ Encourage participation in healthy, pleasurable and achievement-based activities (e.g. exercise, hobbies, work)

Do's and don'ts of managing a client with depressive symptoms

- ✕ Make unrealistic statements or give unrealistic hope, like 'everything will be fine'
- ✕ Invalidate the client's feelings
- ✕ Be harsh, angry or judgemental. Remain calm and patient
- ✕ Act shocked by what the client may reveal

Asking about depression

It is important for clinicians to develop comfort and familiarity asking about symptoms. This is not to conduct a full mental health assessment or diagnose but to be able to:

- Understand a client's experience
- Understand the relationship between symptoms and AOD use
- Monitor symptoms throughout treatment
- Consider what impact depressive symptoms might have on treatment engagement and participation

NOTES

Helping clients with AOD use and depression to manage their symptoms – what works?

- CBT based cognitive restructuring
- Goal setting and problem solving
- Behavioural activation
- Pleasure and mastery events scheduling
- CBT plus contingency management
- Mindfulness based relapse prevention
- CBT based e-health interventions for depression (e.g. Beating the Blues and MoodGYM)
- CBT based e-health interventions for comorbid depression and AOD use (e.g. SHADE and the DEAL Project)
- Physical exercise and yoga improve depression which is a risk factor for AOD use
- It may be useful to consult https://psyberguide.org/apps/ prior to recommending an app to clients to obtain the latest ratings based on researcher reviews

NOTES

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Module 4 Activity 5: Self reflection

Which techniques for managing symptoms of depression are you least familiar with?

_____

_____

_____

_____

Module 4 Activity 6: Case study Li. Comorbid depression and substance use

- Li, 32 year-old female.
- Single, no children.
- Youngest of 2 children. Born in mainland China, the family migrated to Australia when she was 7.
- She reports no family history of mental health conditions but indicates alcohol and violence were present in the family home when she was a child.
- She reports being close to her family, but they are not aware of her current concerns as she doesn't want to worry them and feels they will not understand. Her sister is successful in her career and has a happy marriage with 2 young sons. Li used to spend most of the weekend with her sister and nephews which she enjoyed but has recently withdrawn almost completely.
- Li reports being bullied throughout primary and secondary school. She struggled to succeed academically, unlike her sister.
- Commenced drinking at 16 and smoking cannabis at 17.
- Currently drinking and smoking cannabis nightly until she 'passes out'. Usually doesn't eat an evening meal and eats minimally during the day as often feels nauseated.
- Working part time in an admin role for an importer but reports only getting the job 'because I am bilingual.'
- Describes feeling flat almost all of the time, extremely low in energy, considers herself a failure and doesn't see much of a future. Reports minimal activity outside work.
- Seeking help because her sister has become worried about the lack of contact, her low energy and weight loss and recently forced her to go to the doctor at the local community health service. After Li disclosed some of the above details to the GP, she was referred to your service.

Module 4 Activity 6: Case formulation worksheet for Li

Presenting issues (What are the current problems?)	_____
Pattern (of current problems)	_____
Predisposing factors (What factors in the person's history are relevant to the current problems?)	_____
Precipitating factors (How did these problems develop? How do you know this?)	_____
Perpetuating factors (How are these problems maintained? What evidence do you have?)	_____
Protective factors (What factors are relevant to the current problems?)	_____
How do the above factors interact? How do the AOD use and mental health symptoms relate and influence each other?	_____
Prognosis (What is the likely outcome for this client?)	_____

What other treatments work?

Pharmacotherapy, particularly antidepressants

Naltrexone, acamprosate, disulfiram all tolerated well in clients with comorbid depression

Antidepressants and naltrexone may lead to improved outcomes for clients with depression and excessive drinking

Buprenorphine may have benefits for those with depression and opiate use

Electroconvulsive therapy (ECT) for certain patients with depression

Cautions:

Medication adherence

Interactions between medications and other substances

Contraindications of use, adjustment and withdrawal periods

Refer to Chapter B6 of the Comorbidity Guidelines for more information

NOTES

Bipolar Disorder (BP)

NOTES

How do people with bipolar disorder present?

Depression	• Low mood, somatic symptoms, cognitive symptoms
Mania	• Persistently elevated or irritable mood, increased goal directed activity or energy, grandiosity, flight of ideas, hyperactivity, reduced or no sleep, psychomotor agitation, talkativeness, distractibility
Hypomania	• Similar symptoms to mania but less intense

NOTES

DSM-5 bipolar disorders

Bipolar 1 disorder	• One lifetime manic episode (may be preceded or followed by hypomanic or major depressive episodes)
Bipolar 2 disorder	• Lifetime experience of one hypomanic episode and one major depressive episode
Cyclothymic disorder	• 2 years of hypomanic and depressive periods

There are ICD-10 codes to match these DSM-5 diagnoses found in Appendix D of the Comorbidity Guidelines

NOTES

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Module 4 Activity 7: 'Speed questioning' about bipolar symptoms

Working in pairs, **select one row each of the bipolar disorder symptoms below to focus on.**

I have a low mood	My concentration is poor	I feel irritable	My mood is fantastic	I have so much energy	I'm getting so much done
I've got so many amazing ideas right now	I barely sleep, but don't need to	I can't sit still	I don't need to eat	I am so productive with so many things	My thoughts are so fast

Name one symptom at a time to your partner. Your partner is to quickly ask a question about that symptom.

Examples questions are: 'Can you tell me more about that?' 'Can you give me an example of that?' 'How often do you experience that?'

Reverse roles with your partner and repeating the activity until you have worked through all your chosen row of symptoms.

Do's and don'ts of managing a client with depressive symptoms of bipolar

The same do's and don'ts for depressive symptoms with the addition of:

Do's:

- ✓ Encourage regular sleep, exercise and eating patterns
- ✓ Keep language clear, specific and simple
- ✓ Assist the client to identify warning signs that they may become unwell

Don'ts:

- ✗ Lose hope or become frustrated

Do's and don'ts of managing a client experiencing mania/hypomania

- ✓ Ensure the safety of the client, yourself, and others
- ✓ Assist the client identify warning signs that they may become unwell
- ✓ Help to reduce triggers that aggravate the person's symptoms (e.g., reduce stimulation such as noise, clutter, caffeine, social gatherings)
- ✓ Speak clearly and calmly, asking only one question or giving only one direction at a time
- ✓ Answer questions briefly, quietly, calmly and honestly
- ✓ Use a consistently even tone of voice, even if the person becomes aggressive
- ✓ Encourage regular sleep, exercise and eating patterns
- ✓ Be cautious about becoming swept up by the person's elevated mood
- ✓ Point out the consequences of the client's behaviour. Be specific

Do's and don'ts of managing a client experiencing mania/hypomania

- ✓ If the person is well enough, discuss precautions they can take to prevent risky activities and negative consequences (e.g., give their credit cards and/or car keys temporarily to a trusted family member or friends to prevent reckless spending and driving)
- ✓ If promiscuity or socially inappropriate behaviour is a problem encourage the person to avoid situations in which his/her behaviour may led to negative consequences
- ✓ Encourage the person to postpone acting on a risky idea until their mood is stable
- ✓ Ensure both you and the client can access exits - if there is only one exit, ensure that you are closest to the exit
- ✓ Have emergency alarms/mobile phones, and have crisis teams/police on speed dial
- ✓ If the person is placing him/herself at risk, or they are experiencing severe symptoms of psychosis, arrange transfer to an emergency department for assessment and treatment by calling an ambulance on 000

Do's and don'ts of managing a client experiencing mania/hypomania

- ✕ Argue, criticise or behave in a threatening way towards them. Consider postponing or avoiding discussion of issues that aggravate the client for the time being. Try to talk about more neutral topics
- ✕ Get visibly upset or angry with the client. Remain calm and patient
- ✕ Confuse and increase the client's level of stress by having too many workers attempting to communicate with him/her
- ✕ Get drawn into long conversations or arguments with the person as these can be overstimulating and upsetting. People with elevated moods are vulnerable despite their apparent confidence, and they tend to take offence easily
- ✕ Leave dangerous items around that could be used as a weapon or thrown
- ✕ Laugh (or let others laugh) at the person
- ✕ Act horrified, worried or panic

Asking about bipolar disorder

It is important for clinicians to develop comfort and familiarity asking about symptoms. This is not to conduct a full mental health assessment or diagnose but to be able to:

- Understand a client's experience
- Understand the relationship between symptoms and AOD use
- Monitor symptoms throughout treatment
- Consider what impact bipolar disorder symptoms might have on treatment engagement and participation

NOTES

Helping clients with AOD use and bipolar disorder to manage their symptoms – what works?

Positive findings for an integrated CBT relapse prevention program

Similarities between recovery and relapse processes in bipolar and AOD disorders

Recommended initial pharmacotherapy is mood stabilisers and/or antipsychotics

Medication compliance focused treatments e.g. Improving Treatment Adherence Program

Electroconvulsive therapy (ECT) as a second line treatment when bipolar is severe

E-health interventions in early stages of evaluation e.g. Beating Bipolar

NOTES

www.comorbidityguidelines.com.au