Understanding and management of mental health crisis:

Acute stress Reaction, Depression, PTSD

Sharing of school support to mental health cases

陳國齡醫生

瑪麗醫院
精神科部門主管
兒童及青少年精神科主管
精神科顧問醫生

香港大學李嘉誠醫學院
精神科學系榮譽臨床副教授

香港精神科醫學院副院長
(常務)

Dr. Chan Kwok Ling, Phyllis

Consultant Psychiatrist
Chief of Service (Psychiatry)
Head of Child and Adolescent Psychiatry
Department of Psychiatry
Queen Mary Hospital

Honorary Clinical Associate Professor
Department of Psychiatry
LKS Medical Faculty
University of Hong Kong

Vice-President (General Affairs)
The Hong Kong College of Psychiatrists

醫院管理局
HOSPITAL AUTHORITY

Trauma and Stressor-Related Disorders

- Acute Stress Disorder(ASD)
- Posttraumatic Stress Disorder(PTSD)
- Adjustment Disorders
- Depression

診斷標準 Diagnostic criteria

- 世界衛生組織 World Health Organization (WHO)
  - 《疾病和有關健康問題的國際統計分類（第10次修訂本）》
  - International Statistical Classification of Diseases and Related Health Problems 10th Revision （ICD-10)
- 美國精神科學會 American Psychiatric Association (APA)
  - 《精神疾病診斷與統計手冊 (第5次修訂本)》
  - The Diagnostic and Statistical Manual of Mental Disorders 5th version (DSM-5)

Post-traumatic Stress Disorder

- **Exposure** to actual or threatened death, serious or sexual violence in one or more of the following ways:
  - Direct experiencing of traumatic event(s)
  - Witnessed in person the events as it occurred to others
  - Learning that the traumatic events occurred to person close to them
  - Experiencing repeated or extreme exposure to aversive details of trauma
  - Others: exclude electronic media, TV , movies or pictures, unless it is work related

Diagnosing PTSD

- **an adult must have all of the following for at least 1 month:**
- At least one ***re-experiencing symptom***
- At least one ***avoidance symptom***
- At least two ***arousal and reactivity symptoms***
- At least two ***cognition and mood symptoms***

PTSD continued

- Presence of 1 or more **intrusive (re-experiencing)symptoms** after the event:
- Recurrent, involuntary and intrusive memories of event
- Recurrent trauma-related nightmares
- Dissociative reactions
- Intense physiologic distress at cue exposure
- Marked physiological reactivity at cue exposure

PTSD continued

- **Persistent avoidance** by 1 or both:
- Avoidance of distressing memories, thoughts or feelings of the event(s)
- Avoidance of external reminders of that arouse memories of event(s) e.g. people, places, activities

Negative alterations in cognitions and mood associated with the traumatic event(s) as evidenced by 2 or more of the following:

- Inability to remember an important aspect of the traumatic event(s)
- Persistent distorted cognitions about cause or consequence of event that lead to blame of self or others
- Persistent negative emotional state
- Marked diminished interest
- Feeling detached from others
- Persistent inability to experience positive emotions

Marked alterations in arousal and reactivity with 2 or more of:

- Irritable behavior and angry outbursts
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance

- Duration of disturbance is more than one month AND causes significant impairment in function
- Specifiers:
- With dissociative symptoms (derealization or depersonalization)
- With delayed expression (don't meet criteria until >6 months after event)

Significant impairment

- looking after yourself
- holding down a job
- maintaining friendships or relationships
- remembering things and making decisions
- your sex drive
- coping with change
- simply enjoying your leisure time.

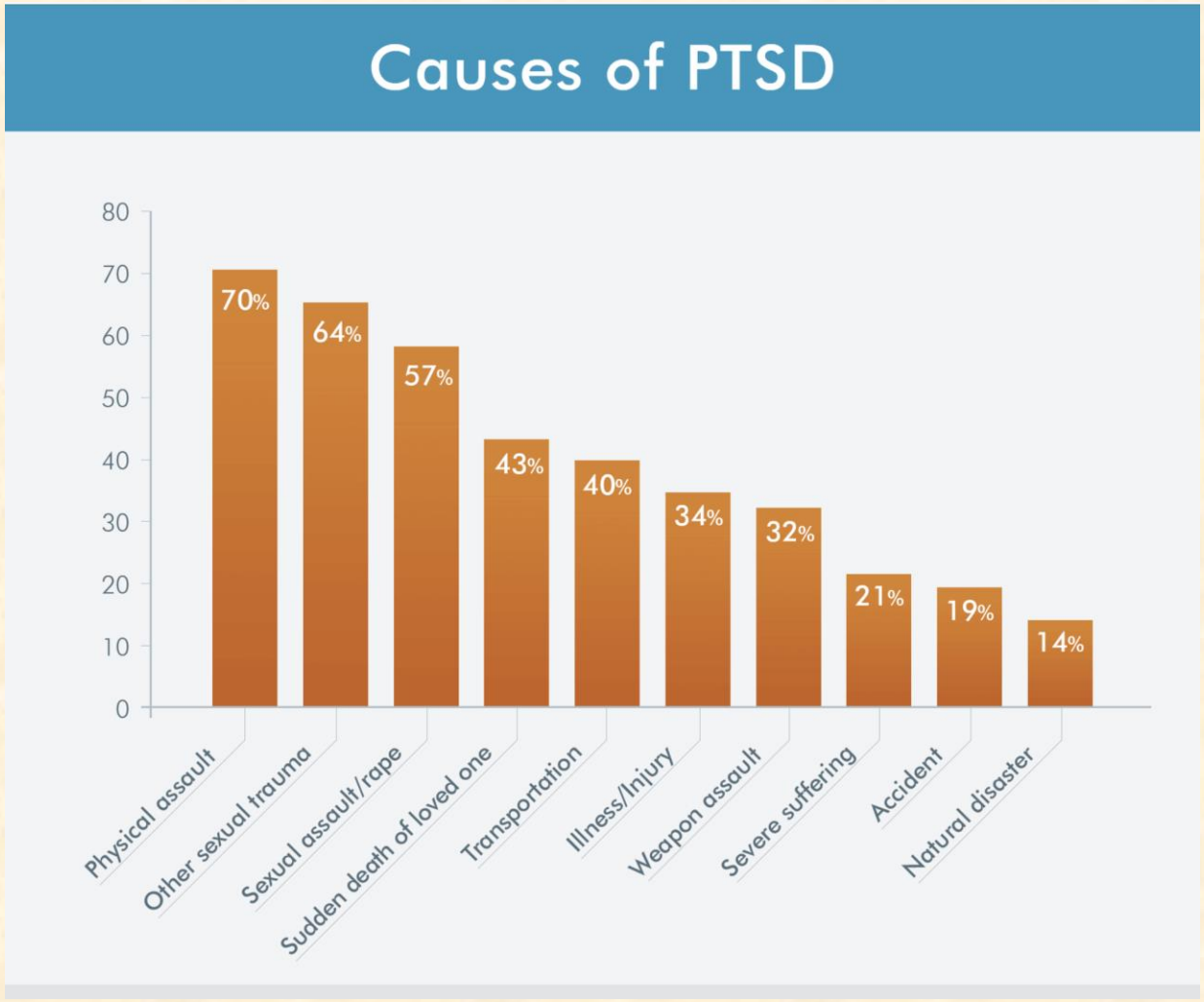
ASD or PTSD

- Acute stress disorder, or ASD
- After a dangerous event, it's natural to have some of the symptoms mentioned on previous pages. Sometimes people have very serious symptoms that go away after a few weeks.
- When the symptoms last more than **a month**, seriously affect a person's ability to function and are not due to substance use, medical illness, or anything except the event itself, the person might be experiencing PTSD.
- Some people with PTSD don't show any symptoms for weeks or months.
- PTSD is often accompanied by depression, substance abuse, or one or more anxiety disorders.

PTSD Epidemiology

- 7-9% of general population
- 60-80% of trauma victims
- 30% of combat veterans
- 50-80% of sexual assault victims
- Increased risk in women, younger people
- Risk increases with “dose” of trauma, lack of social support, pre-existing psychiatric disorder

Causes of PTSD



Do children react differently than adults?

- Children and teens can have extreme reactions to trauma, but their symptoms may not be the same as adults. In very young children (less than 6 years of age), these symptoms can include:
- Wetting the bed after having learned to use the toilet
- Forgetting how or being unable to talk
- Acting out the scary event during playtime
- Being unusually clingy with a parent or other adult
- Older children and teens usually show symptoms more like those seen in adults. They may also develop disruptive, disrespectful, or destructive behaviors. Older children and teens may feel guilty for not preventing injury or deaths. They may also have thoughts of revenge.

Comorbidities

- Depression
- Other anxiety disorders
- Substance use disorders
- Somatization
- Dissociative disorders

Post Traumatic Stress Disorder Etiology

- Conditioned fear
- Genetic/familial vulnerability
- Stress-induced release
  - Norepinephrine, CRF, Cortisol
- Autonomic arousal immediately after trauma predicts PTSD

Risk factors for PTSD include:

- Living through dangerous events and traumas
- Getting hurt
- Seeing people hurt or killed
- Childhood trauma
- Feeling horror, helplessness, or extreme fear
- Having little or no social support after the event
- Dealing with extra stress after the event, such as loss of a loved one, pain and injury, or loss of a job or home
- Having a history of mental illness or substance abuse

Resilience factors that may reduce the risk of PTSD include:

- Seeking out support from other people, such as friends and family
- Finding a support group after a traumatic event
- Learning to feel good about one's own actions in the face of danger
- Having a coping strategy, or a way of getting through the bad event and learning from it
- Being able to act and respond effectively despite feeling fear

PTSD Treatment: self help

- Avoid prolonged media exposure
- Balanced life style and role
- Keep ongoing interaction with family and friends
- Beware of own vulnerability: family history of mental illness, previous childhood abuse or trauma and strong visual memory
- Beware of symptoms like numbness, dissociation and hypervigilance

PTSD Treatment

- Debriefing immediately following trauma is NOT effective
- Cognitive-behavioral therapy, exposure
- Group therapy
- Medications – antidepressants, mood stabilizers, beta-blockers, clonidine, prazosin, gabapentin

Pharmacotherapy for post traumatic stress disorder.
Cochrane Database Sys Rev 2006 Jan 25(1):CD002795

PTSD Treatment

Psychol Med. 2017 Oct;47(13):2260-2274. doi: 10.1017/S0033291717000708. Epub 2017 Apr 7.

Posttraumatic stress disorder in the World Mental Health Surveys.

Koenen KC[1], Ratanatharathorn A[2], Ng L[3], McLaughlin KA[4], Bromet EJ[5], Stein DJ[6], Karam EG[7], Meron Ruscio A[8], Benjet C[9], Scott K[10], Atwoli L[11], Petukhova M[12], Lim CCW[10], Aguilar-Gaxiola S[13], Al-Hamzawi A[14], Alonso J[15], Bunting B[16], Ciutan M[17], de Girolamo G[18], Degenhardt L[19], Gureje O[20], Haro JM[21], Huang Y[22], Kawakami N[23], Lee S[24], Navarro-Mateu F[25], Pennell BE[26], Piazza M[27], Sampson N[12], Ten Have M[28], Torres Y[29], Viana MC[30], Williams D[31], Xavier M[32], Kessler RC[12].

Abstract

METHODS:

Data were analyzed from 26 population surveys in the World Health Organization World Mental Health Surveys. A total of 71 083 respondents ages 18+ participated. The Composite International Diagnostic Interview assessed exposure to traumatic events as well as 30-day, 12-month, and lifetime PTSD. Respondents were also assessed for treatment in the 12 months preceding the survey. Age of onset distributions were examined by country income level. Associations of PTSD were examined with country income, world region, and respondent demographics.

RESULTS:

The cross-national lifetime prevalence of PTSD was 3.9% in the total sample and 5.6% among the trauma exposed. Half of respondents with PTSD reported persistent symptoms. Treatment seeking in high-income countries (53.5%) was roughly double that in low-lower middle income (22.8%) and upper-middle income (28.7%) countries. Social disadvantage, including younger age, female sex, being unmarried, being less educated, having lower household income, and being unemployed, was associated with increased risk of lifetime PTSD among the trauma exposed.

CONCLUSIONS:

PTSD is prevalent cross-nationally, with half of all global cases being persistent. Only half of those with severe PTSD report receiving any treatment and only a minority receive specialty mental health care. Striking disparities in PTSD treatment exist by country income level. Increasing access to effective treatment, especially in low- and middle-income countries, remains critical for reducing the population burden of PTSD.

Acute Stress Disorder

- Similar exposure as in PTSD
- Presence of ≥9 of 5 categories of intrusion, negative mood, dissociation, avoidance, and arousal related to the trauma.
- Duration of disturbance is 3 days to 1 month after trauma
- Causes significant impairment

General treatment approaches

- Self protection and keep normal activities
- Pharmacotherapy
  - Antidepressants
  - Anxiolytics
  - Antipsychotics
  - Mood stabilizers
  - Others
- Psychotherapy- Cognitive Behavior Therapy, trauma-focused
- Eye Movement Desensitization and Reprocessing: EMDR

NICE Guideline on PT

- **The National Institute for Health and Care Excellence (NICE)** – the organisation that produces guidelines on best practice in health care – currently recommends two types of talking treatment for PTSD:
- **Trauma-focused cognitive behavioural therapy (TF-CBT).**
- This is a form of cognitive behavioural therapy (CBT) specifically adapted for PTSD. NICE recommends that you are offered 8–12 regular sessions of around 60–90 minutes, seeing the same therapist at least once a week.
- **Eye movement desensitisation and reprocessing (EMDR).**
- This is a fairly new treatment that can reduce PTSD symptoms such as being easily startled. It involves making rhythmic eye movements while recalling the traumatic event. The rapid eye movements are intended to create a similar effect to the way your brain processes memories and experiences while you're sleeping.

CBT can include:

- **Exposure therapy.**
- This therapy helps people face and control their fear. It gradually exposes them to the trauma they experienced in a safe way. It uses mental imagery, writing, or visits to the place where the event happened. The therapist uses these tools to help people with PTSD cope with their feelings.
- **Cognitive restructuring.**
- This therapy helps people make sense of the bad memories. Sometimes people remember the event differently than how it happened. They may feel guilt or shame about what is not their fault. The therapist helps people with PTSD look at what happened in a realistic way.
- Other talk therapies teach people helpful ways to react to frightening events that trigger their PTSD symptoms. Based on this general goal, different types of therapy may:
- Teach about trauma and its effects
- Use relaxation and anger control skills
- Provide tips for better sleep, diet, and exercise habits
- Help people identify and deal with guilt, shame, and other feelings about the event
- Focus on changing how people react to their PTSD symptoms

To help a friend or relative, you can:

- Offer emotional support, understanding, patience, and encouragement.
- Learn about PTSD so you can understand what your friend is experiencing.
- Listen carefully. Pay attention to your relative's feelings and the situations that may trigger PTSD symptoms.
- Share positive distractions such as walks, outings, and other activities.
- Remind your friend or relative that, with time and treatment, he or she can get better.

How can I help myself?

It may be very hard to take that first step to help yourself. It is important to realize that although it may take some time, with treatment, you can get better.

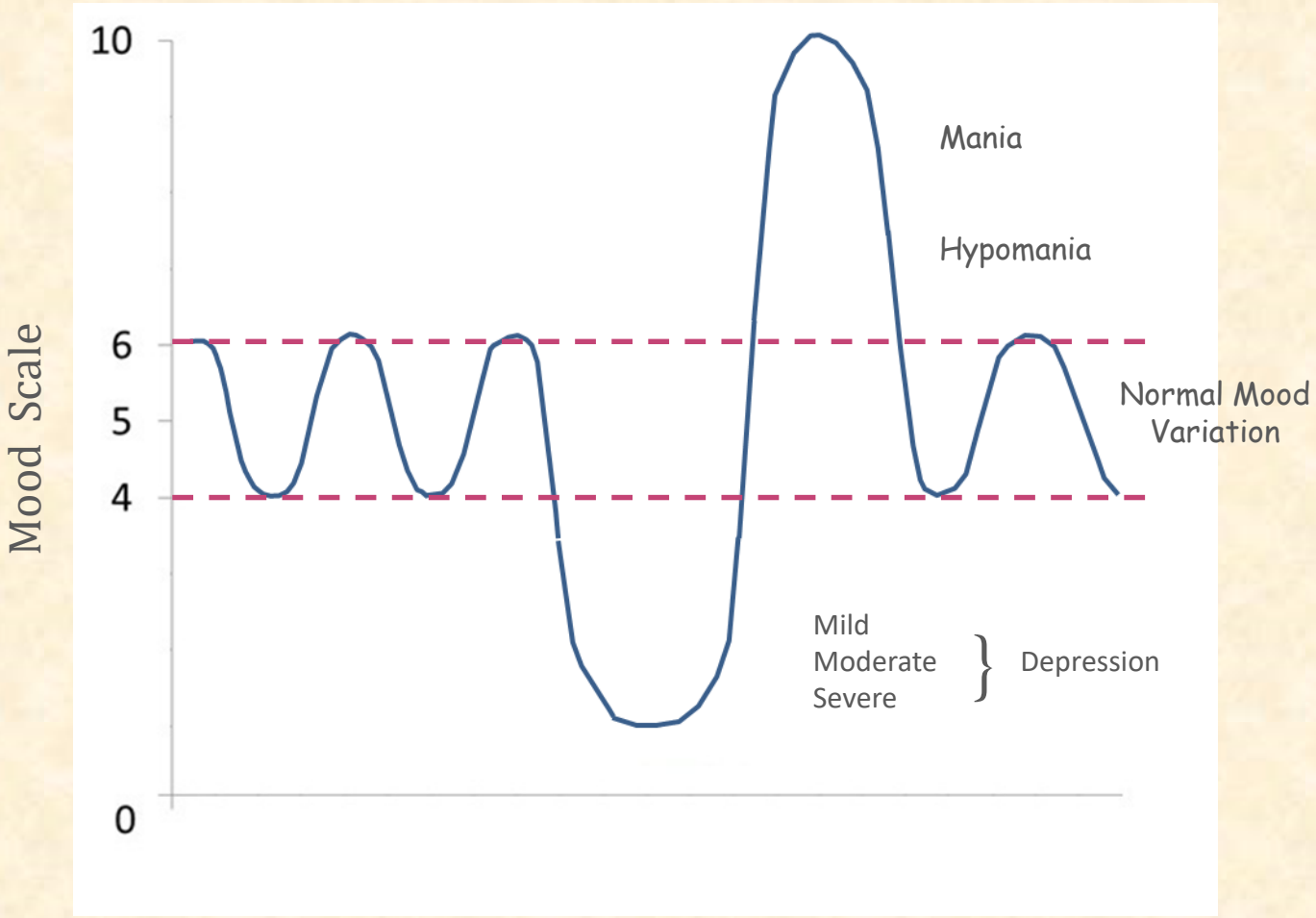
- **To help yourself:**
- Talk with your doctor about treatment options.
- Engage in mild physical activity or exercise to help reduce stress.
- Set realistic goals for yourself.
- Break up large tasks into small ones, set some priorities, and do what you can as you can.
- Try to spend time with other people and confide in a trusted friend or relative.
- Tell others about things that may trigger symptoms.
- Expect your symptoms to improve gradually, not immediately.
- Identify and seek out comforting situations, places, and people.

Depression

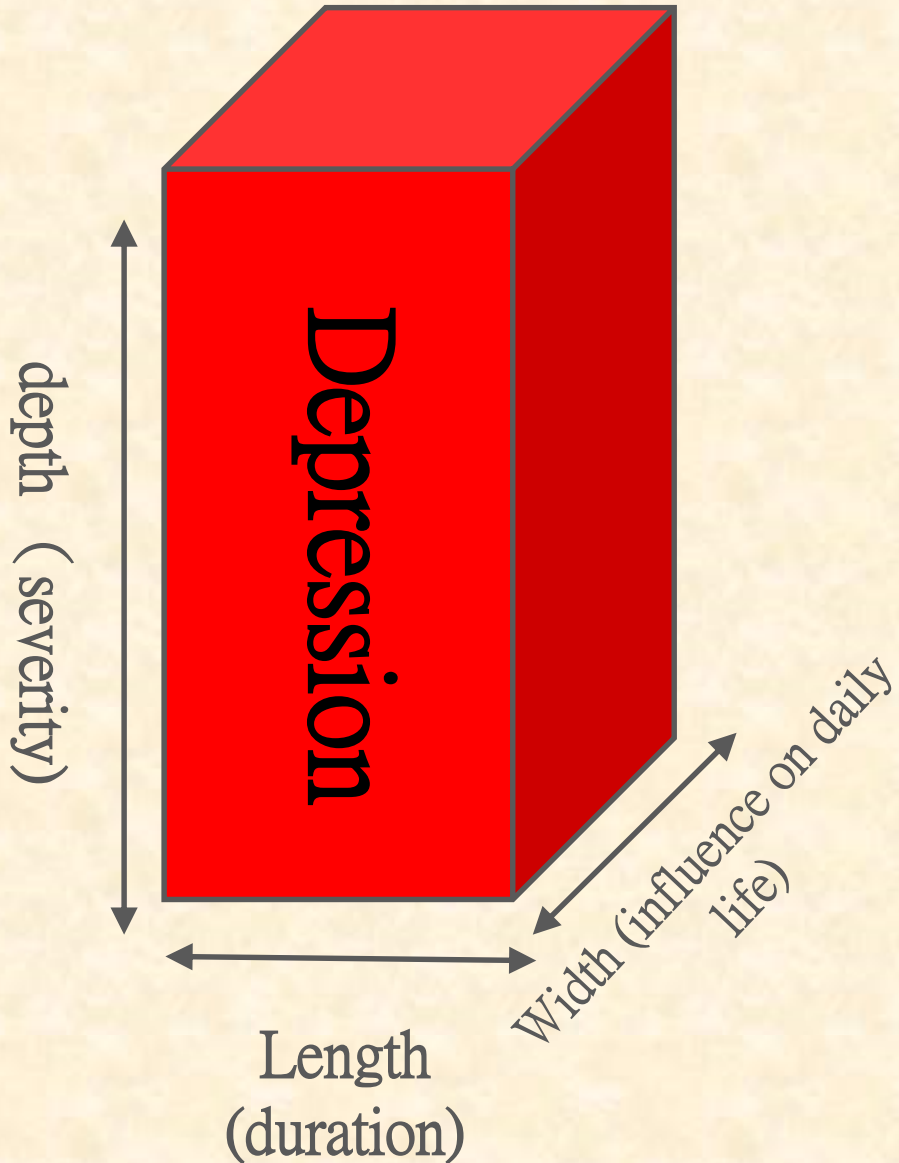
Epidemiology

- Prevalence: 0.9% - 3.4% (using the DSM-IV standard for community surveys of children and adolescents in different countries)
- The proportion of depression among boys and girls is similar during childhood, but the prevalence of depression among adolescent girls is twice that of boys
- Children's clinical manifestations may differ from adolescents. Children may show irritability, separation anxiety and hyperactivity / poor concentration more frequently
- Compared to children, depressed teenagers are more likely to show despair and helplessness, lack of motivation or fatigue, lack of sleep, weight loss, substance abuse, delusions, suicidal ideation and suicidal attempts
- Similar to adults, Major Depressive Disorder (MDD) in adolescents has a chance of recurrence with an average depressive episode of 7 to 9 months
- 60-80% of Mood disorder patients can recover with appropriate treatment

Depressed symptoms: a continuum



Difference between normal mood fluctuation and depression



Depressed s/s: a continuum

- Normal mood variation
- Adjustment disorder
- Dysthymia
- Depressive episode: mild, moderate, severe severity
- Bipolar affective disorder

Symptoms of Depression	
Emotion	➢ Persistent low mood or feeling of emptiness ➢ Loss of interest in previous enjoyable activities ➢ Restlessness and irritability
Biological	➢ Weight loss/ gain, increase/ decrease in appetite ➢ Insomnia/ hypersomnia ➢ Fatigue, low energy level
Cognitions	➢ Sense of hopelessness and guilty feeling ➢ Poor concentration and indecisiveness ➢ Sense of uselessness, worthlessness, meaningless ➢ Suicidal idea and attempt
Psychotic symptoms	➢ Hallucinations and delusions

Depression symptoms in children and adolescents

	Children	Adolescents
Physical	▪ physical discomfort (e.g. epigastric pain, headache)	▪ physical discomfort ▪ fatigue ▪ weight gain or loss
Emotion	▪ irritability	▪ irritability, depressive mood, hopelessness
Thoughts	▪ negative cognitions	▪ low self-esteem, poor confidence ▪ negative cognitions
Behaviours	▪ oppositional, disruptive behaviors, fights	▪ Social withdrawal, deterioration in academic performance, school refusal ▪ *Deliberate self-harm behaviours/ suicidal attempts*

Friedberg, Robert D., McClure Jessica M. (2002). **Clinical Practice of Cognitive Therapy with Children and Adolescents**. *Chapter 11 Working with Depressed Children and Adolescents*. P.181-217

Assessment

- **Clinical assessment**

- Interviews : current symptoms, comorbidities

- Personal history : Developmental, School, Social and Drug Abuse History, Past medical history, Personality
- Family history: family circumstances and patterns of discipline and interaction
- Mental state examination during interview
- Observation and information on other channels (e.g. family members, school, social workers, etc.)
- Assess the impact of symptoms on daily life - such as school performance, work, relationships, etc.
- Physical examination and other tests
- Questionnaires：
  - Beck Depression Inventory (BDI) , Child: CDI
  - Hamilton Anxiety Rating Scale (HAM-A) ,
  - Positive and Negative Syndrome Scale (PANSS)

Differential diagnosis: Adjustment disorder

- Caused by stress of a particular incident
- Usually lasts not longer than three months
- Can clearly identify the reasons
- High risk group: poor stress coping skills, poor social support
- Symptoms resolved when stress decreased
- Counselling and occasionally drug medication can cure the disorder
- If there is delay in diagnosis and treatment, the condition may deteriorate, and even evolve into anxiety or depression

Treatment of Depression

Drug treatment

- Selective Serotonin Reuptake Inhibitor (SSRI), e.g. Fluoxetine (to monitor suicidal risk)
- Other antidepressant: Mirtazapine, Venlafaxine, Desvenlafaxine
- TCA/ MAOI are not used in adolescence
- Patients usually have significant improvement in the first two weeks after taking the medication, but usually take 6 to 8 weeks to take full effect
- More common side effects include: anxiety, indigestion, diarrhoea or constipation, loss of appetite and weight loss, sleep problems (insomnia or drowsiness), dizziness, headache, etc. These side effects usually improve over time
- When patients respond to one or more medications, medications should be taken for 6 to 12 months or longer to avoid recurrence

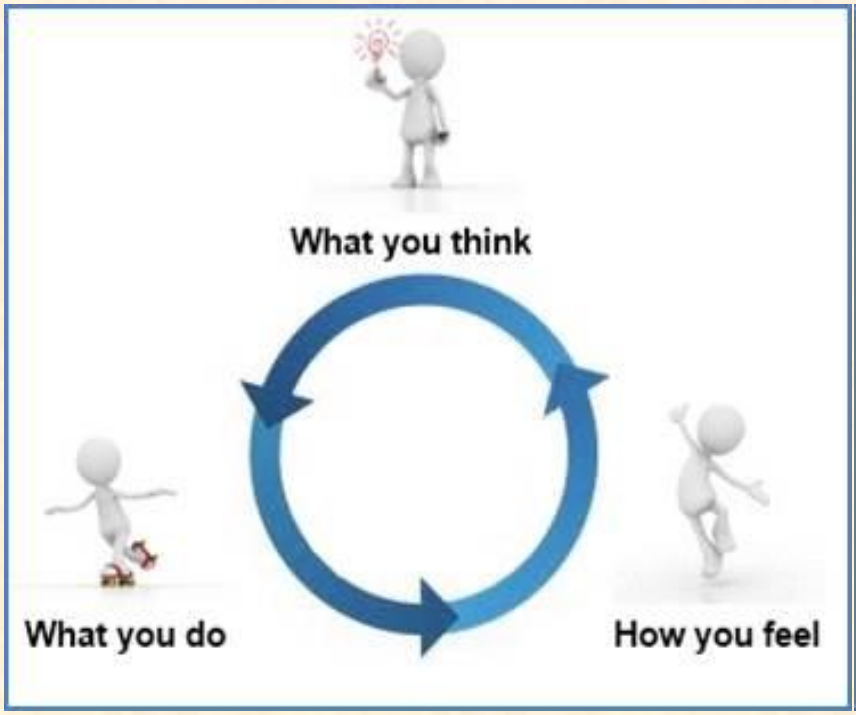
Treatment of Depression

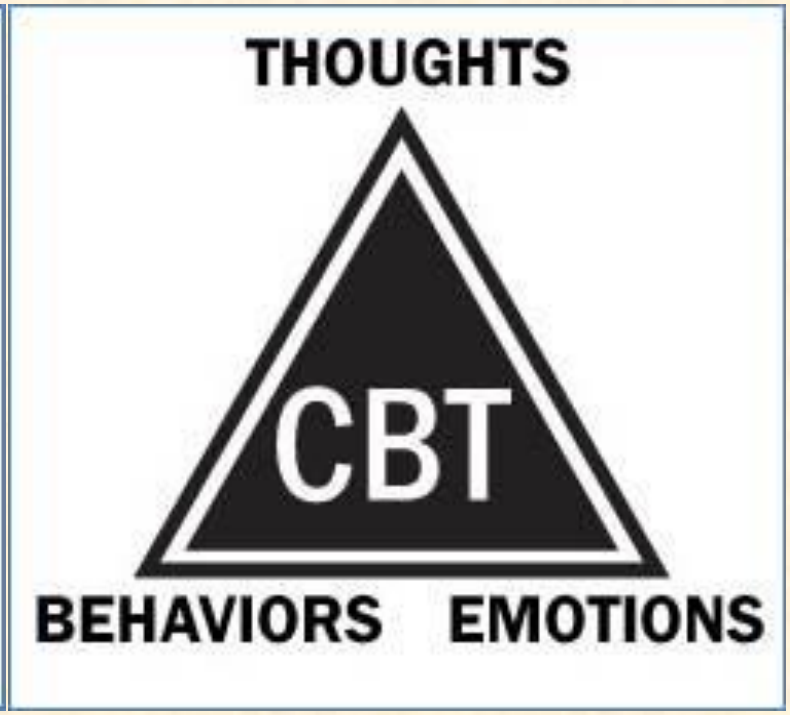
Psychotherapy

- Problem Solving：to handle stress-coping, emotional or peer relationship problems
- Cognitive Behavioral Therapy (CBT)：change inappropriate cognitions and behavioural patterns
- Interpersonal Therapy (IPT-A)：Suitable for suicide adolescents with interpersonal problems, short course of treatment (12-14 weeks)
- Dialectical Behavior Therapy (DBT)：for those with DSH and BPD traits
- Family Therapy：Suitable for adolescents with family problems, strengthening problem solving and conflict resolution capabilities within the family and reducing family members' reproof and adversarial pressure on young people

Cognitive behavioral therapy

The core principle of CBT is that identifying and changing maladaptive thinking leads to change in affect and in behavior





Take Home Message

Depression is a well defined biological illness

Depression is common

Depression is **underdiagnosed**

Depression is **highly treatable with medications**

Newer drugs have fewer side effects and high tolerability

Early detection and treatment of depression is vital due to high suicide risk

Depression causes lots of suffering to patient and family, costs a lot to society (the worst disease) !

Obstacles to treatment: ignorance and stigmatization

Recent social unrest / protests: stressors

- **Huge number, large scale involvement**
  - Nearly all/whole population
  - Different level of involvement/repeated exposure: PTSD = 4 levels
  - Different view: extreme to spectrum / violence vs nonviolence / social media / web
  - Social conflict: HKSAR / mainland / international arena
- **Ongoing acute on chronic stress**:
  - Daily schedule
  - Weekly schedule
  - Monthly level: yearly level
  - Rapidly changing: format, venue
- **Highly emotionally charged leading to high expressed emotion and lack of social support**
  - Family conflict
  - Work conflict
  - School conflict
  - Role conflict
  - **high expressed emotion:**
    - **critical comment, hostility and emotional over-involvement**

Recent social unrest / protests: stressors

- **Sleep deprivation**
- **Unemployment**, economic depression
- Way forward: unforeseeable future, unpredictable, inducing **hopelessness**
  - How long
  - How far
  - How to end
    - Big turn around

How to help our students at difficult times of social unrest

- Caring approach, address the emotion
  - On mental health and well being
- Communication/ discussion: conflict resolution
- Discussion on involvement /participation

Caring approach, address the emotion

- 1 . Just listen first !
- 2. Non judgemental!
- 3. Try to think like him! EMPATHY

Communication/ discussion: conflict resolution

- **Topics:**
- Thinking errors
- Level of violence
- Bullying
- Morality
- Legal issues
- Complexity of politics
- Sense of belonging vs conformity
- Paranoia and extremist
- School policy

Communications

- Ground rules
- No hate language
- Not emotional
- Debate
- Everyone: few points
- Time limited
- Thinking like the other side positive ways
- **School policy**
- No protests ?
- Learning more with expert / leaders

Violence level

- Strict no violence
- Violence if self defense (or breakaway)
- Violence when being attacked/ retaliate
- Violence when being subdued or arrested
- Violence to enemies (police/others)
- Violence to people of opposite view/camps
- Violence to people not supporting (neutral) your view/camps
- Violence to those who block your act/ protests
- Violence as gestures or protests and statements to properties: vandalizing / damage properties
- Random violence

Bullying

- Diversity
- Commonalities
- Cyberbully
- Bully due to different view / affiliation

Legal issues

- Offender/ perpetrator / victim
- Offences, charges and sentences
- Fitness to plead
- Confidentiality, data privacy
- Assessment of mental capacity

Morality issues

- The ends justify the meaning?
- Justice is not served be inflicting injustice?

Discussion on involvement /participation

- What level
- Way in and way out

- Thank You!
- Q & A ?