Overview and Critical Assessment of Mood and Anxiety

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Preview

- Become familiar with diagnostic categories of mood and anxiety disorders
- Examine Criteria for diagnosis of Major Depressive Disorder, PTSD, and Mild TBI
- Identify empirically supported treatments for Major Depression, PTSD, and mTBI
- Identify elements of critical psychological/neuropsychological assessment
- Following the practical process of critical examination in a clinic (with case examples - time permitting)
Current Taxonomy System

Mood Disorders

- Major Depressive Disorder
- Depressive Disorder NOS
- Dysthymia
- Cyclothymia

- Bipolar Disorder - multiple iterations
- Mood Disorder Due to . . .
- Mood Disorder NOS

(DSM-IV-TR, 2000)
Major Depressive Disorder

- Defined by one or more Major Depressive Episode - ≥5 symptoms persisting for ≥2 weeks:
  1. Depressed mood most of the time
  2. Marked anhedonia
  3. Significant appetite or weight change (>5% in 1 month)
  4. Insomnia/hypersomnia
  5. Psychomotor agitation or retardation (observable by others)
  6. Fatigue/loss of energy
  7. Severe worthlessness or guilt
  8. Problems with thinking, concentrating, or making decisions
  9. Recurrent thoughts of death or suicidal ideation

Major Depressive Disorder - Changes in DSM-V

- Bereavement no longer an exception, now a risk factor
Major Depressive Disorder - Treatment

- Pharmacotherapy - Variety of treatment options
- Psychotherapy - IPT and CBT longest lasting benefits
- Other
  - Electroconvulsive Therapy - 70-90% improvement
  - Transcranial Magnetic Stimulation - mild improvement


Anxiety Disorders

- Generalized Anxiety
- Phobias - Specific, Social and Agoraphobia
- Obsessive-Compulsive Disorder
- Posttraumatic Stress Disorder (PTSD)
  - Acute Stress Disorder
  - Anxiety Disorder Due to . . .
  - Anxiety Disorder NOS
PTSD - Diagnosis

- A. Exposure to traumatic event: 1) experienced or witnessed involving actual or threatened death/serious injury, and 2) involving intense fear, restlessness, or horror
- B. Event is persistently re-experienced in >1 way
- C. Persistent avoidance of stimuli assoc. with trauma and/or numbing of responsiveness in >3 ways
- D. Persistent symptoms of increased arousal in >2 ways
- E. Symptoms last more than a month (<1 month = probable Acute Stress D/O)
- F. Clinically significant distress or impairment in important areas of functioning.

**DSM states - Malingering should be ruled out in circumstances with 2nd gain**

PTSD - Changes in DSM-V

- Specify event(s) as experienced directly, witnessed, or experienced indirectly
- A 2) involving intense fear, restlessness, or horror eliminated
- Four symptom clusters: C. Persistent avoidance of stimuli assoc. with trauma and/or numbing of responsiveness in >3 ways now separated into
  - Avoidance
  - Persistent negative alterations in cognitions and mood/numbing
- Criterion D now also includes irritable/aggressive and reckless/self-destructive behavior
- Thresholds lowered for minors

**Explicit warning about malingering dropped from description**
PTSD - Treatment

(Watts, et al, 2013)

What Works

- Watch for first month - then treat if symptoms persist
- Medication-SSRI,SNRI
  - May not be as effective in combat-related PTSD
  - Beta blockers?
  - Interferes with psychotherapy?
- Psychotherapy - Cognitive Behavioral Therapy (CBT)
  - Exposure Methods - preferred for combat-related PTSD
    - Imaginal Exposure
    - In Vivo Exposure
    - Prolonged Exposure
    - Exposure with Cognitive Restructuring/Anxiety Mgmt.
- NOTE ON EMDR (Eye Movement Desensitization and Reprocessing)-not indicated for combat-related PTSD at this time.

(Bryant, 2007; Cahill, et al., 2009; Foa, et al., 1995; Bryant, et al. 2008; Ponniah, et al., 2009)
PTSD - Treatment

What Does Not Work
- Critical Incident Stress Debriefings/Management (CISD/M)

The Jury is Still Out
- Psychological First Aid (PFA)

(Malec, et al. 2007)

Mild Traumatic Brain Injury/Concussion - Diagnosis

- Glasgow Coma Scale: 13-15
- LOC: momentary to <30 min
- PTA: momentary to <24 hours
- Depressed Skull Fracture (dura intact)
- No hematoma, Cerebral Contusion, Hemorrhagic Contusion, subarachnoid hemorrhage, Dura penetrating TBI, brain stem injury
- Possible mild TBI any of: dizziness, headache, nausea, dazed, confused, blurred vision, focal neurological sign

(Malec, et al. 2007)
Mild Traumatic Brain Injury - Treatment

- Education regarding the expected outcome and recovery
  - Helps ensure recovery is being monitored
  - Normalizes, Reduces anxiety over experiences
- Recognize that anxiety can perpetuate Sx. - HA
- Currently, rest with gradual return to normal activities
  - Based on Zurich conference guidelines
  - Evidence based support?

(Rohling, et al., 2012; McCrory, et al., 2012; Craton & Leslie, 2014)

Critical Assessment

Dig Deep
“Don’t become a mere recorder of facts, but try to penetrate the mystery of their origin”

-Pavlov (1849-1936)

“Clinicians who strive to learn about and understand the person who has sustained a work-related neuropsychological injury face a challenging task and must draw upon multiple methods, procedures, and sources of information”

-Bush and Iverson (2012)

Critical Assessment - Key Terms

- Maximum Effort
- Performance Validity Testing (PVT)
- Symptom Validity Testing (SVT)
- Secondary Gain
- Malingering/Malingered Neurocognitive Disorder/Slick Criteria

Slick, Sherman, and Iverson (1999)
Base-Rates of SVT/PVT Failure*

  - 39% mTBI Compensation
  - 35% fibromyalgia
  - 31% Chronic Pain
  - 30% Disability - WC claims
  - 29% Personal Injury Litigation
  - 19% Criminal

  - Reviewed 11 published studies
  - Sample of 1363 mTBI cases
  - Overall Base-Rate = ~40%

- Larrabee, Millis, and Meyers (2009)
  - Overall Base-Rate = 40% (+/-10%)

Critical Assessment - Why?

Secondary Gain

Tangible Cause
- Malingered Neurocognitive Disorder

Psychological Cause
- Depression
- Anxiety
- Psychosomatic

Poor Effort/Symptom Overreporting in NON-SEVERE Injuries
Critical Assessment

Superficial/Non-Critical
- Detailed Open-Ended Interview
- Listen to the claimant
- Review the History
- Test the claimant

Critical
- Detailed Open-Ended interview without Leading Q’s
- Listen to the claimant, Follow the data
- Review the History and ask critical Q’s about it
- Test the claimant and use PVTs/SVTs

Critical Assessment - PVTs and SVTs

- “Use of psychometric indicators is the most valid approach to identifying neuropsychological response validity.”
- “Stand-alone effort measures and embedded validity indicators should both be employed.”


“Adequate assessment of response validity is essential in order to maximize confidence in the results of neurocognitive and personality measures and in the diagnoses and recommendations that are based on the results”

-National Academy of Neuropsychology (2005)
Examples of PVTs and SVTs

- PVT
  - Standalone
  - Embedded
- SVT
  - Personality
  - Symptom specific
  - Malingering specific

MMPI-2-RF

MMPI-2-RF Validity Scales

Score Report

MMPI-2-RF™
Minnesota Multiphasic Personality Inventory-2—Revised and Extended

Name:
ID Number:
Age:
Gender:
Marital Status:
Years of Education:
Date Assessed:

Score:
T-Score:
Response %:
Cannot Say (Rate):
Percent True (pl Itemom masked):
36%
Procedures in Our Practice

- Review referral Q’s and case medical history
- Interview with patient/claimant
- Interview with collateral informants (e.g., spouse, care provider, other healthcare provider)
- Test administration
- Questionnaire administration
- Data review
- Report writing
- Feedback (depending on case type)

Case 1

- Workers Compensation Referral; 29 y.o. male, civilian IT contractor in Afghanistan, 3 months after incident.
- Incident: Terrorist explosion, building collapse, followed by continuous explosions and ongoing firefights while claimant was seeking cover.
- Injuries: LOC 1-2 minutes, no PTA, frontal skull laceration, photosensitivity, right arm laceration injury, HA, brain MRI normal.
- Complaints: disorganization, poor concentration, daily headaches, overwhelmed by stimulation, avoiding others, hearing explosions, concern over bomb exploding constantly, triggers causing virtual incapacitation (e.g., busy food court, windshield wiper), mild forgetfulness for recent events, disrupted sleep with nightmares (waking with panic/fear).
- Trajectory of symptoms: mild improvement over interval
- Additional History: physical abuse in childhood
Case 1 - Evaluation Results

- Performance Validity Testing: passed 6/6 measures
  - Decreased immediate verbal memory/learning
  - Decreased processing speed
  - Decreased fine motor speed on right side consistent with arm injury

- Symptom Validity Testing: mild elevation on 1/8 scales
  - Symptoms consistent with PTSD on multiple measures
Case 1

- Diagnoses
  - PTSD
  - concussion/mTBI

- Recommendations
  - Psychotherapy
    - Prolonged Exposure (~12 sessions)
    - Sleep Hygiene Instruction
  - Psychiatric medication
  - Return to work (not in war zone)

Case 2

- Insurance LTD evaluation; 47 y.o. male, IT specialist (Network Analyst) seen ~2.5 years after incident.
- Incident: slipped and fell down stairs at home, hitting head on bannister.
- Injuries:
  - Claimant report: LOC of unknown duration, presentation to ER, inpatient 4 days, PTA 1 month.
  - Records: brief LOC?, brain MRI “<1 cm subdural hematoma”, facial fracture requiring surgery; Neuropsychological evaluation - widespread cognitive deficits and “severe problems with attention and concentration as reported by claimant.” No PVTs or SVTs administered.
- Complaints: Broad-based cognitive complaints 51/56 cognitive items, HA, inability to work or problem solve, loss of photographic memory, limitations in ADLs (e.g., using phone, food preparation, dressing, brushing teeth, writing a check, participate in games/hobbies independently.)
  - Drives without difficulty and lives alone.
- Trajectory of symptoms: Significant worsening over interval
- Additional History: premorbid anxiety, depression, obesity, renal dysfunction, and HTN
- Currently receiving 96K annual disability
Case 2 - Evaluation Results

- Performance Validity Testing: failed 8/8 measures (below chance $x^2$)

- Symptom Validity Testing: elevations on 4/8 measures

- Test performance inconsistent across measures
  - Superior to impaired performance on highly similar measures
Case 2

- Diagnoses
  - Malingering

- Recommendations
  - No recommendations supported

Summary

- Become familiar with diagnostic categories under the umbrellas of mood and anxiety disorders
- Examine Criteria for diagnosis of Major Depressive Disorder, PTSD, and Mild TBI
- Identify empirically supported treatments
- Identify key elements of critical psychological/neuropsychological assessment
- Following the practical process of critical examination in a clinic
- Case examples (time permitting)
Thank You

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