Celebrating College Days: The Good, The Bad, and The Ugly

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Presented by

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Through a Cooperative Agreement with the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Substance Abuse Treatment, (CSAT) and Center for Mental Health Services, (CMHS) Morehouse School of Medicine established the Historically Black Colleges and Universities Center for Excellence in Behavioral Health (HBCU-CFE), funded as Grant No. TI023447.
OUR GOALS

• Promote student behavioral health to positively impact student retention

• Expand campus service capacity, including the provision of culturally appropriate behavioral health resources

• Facilitate best practices dissemination and behavioral health workforce development
Currently Dr. Muzere is a third-year resident at Morehouse School of Medicine pursuing a career in psychiatry. She is passionate about working with the underserved community. She was the recipient of the APA SAMHSA Minority Fellowship for the 2013-2104 academic year. This federal grant permits her to pursue activities in the community involving the promotion of mental health awareness. She enjoys teaching and has published several articles as well as presented posters at national conferences. She currently serves as a Peer Reviewer for the Residents’ Journal and will be a guest editor in an upcoming issue.

After residency she intends to pursue a fellowship in Child and Adolescent Psychiatry. Her career aspirations involve working in the community as a Child Psychiatrist as well as a Professor in an academic institution.
CELEBRATING COLLEGE DAYS: THE GOOD, THE BAD, AND THE UGLY
1. To identify the symptoms of depression and mania

2. To understand the difference between stress and anxiety

3. To provide education about adverse coping behaviors (ex. drugs and alcohol) and encourage positive coping strategies as well as the utilization of resources such as student health services, The National Suicide Prevention Hotline, and 911.
The Good...
BENEFITS OF GOING TO COLLEGE

- Higher earning potential
- Better opportunities for career advancement
- Make lasting connections
- Expand your horizons
- Learn to think, analyze, and reason

<table>
<thead>
<tr>
<th>Level of Education Achieved</th>
<th>2012 Unemployment Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High School</td>
<td>12.2%</td>
</tr>
<tr>
<td>High School Graduate with no college</td>
<td>8.1%</td>
</tr>
<tr>
<td>Some college or an Associate Degree</td>
<td>6.5%</td>
</tr>
<tr>
<td>Bachelor's Degree or more</td>
<td>3.8%</td>
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United States Department of labor Bureau of Labor Statistics
The Bad...
1 in 4 students will experience a “Depressive Episode” by age 24.

44% of college students reported feeling symptoms of Depression.
In 2011, the American College Health Association—National College Health Assessment (ACHA–NCHA—a nationwide survey of college students at 2- and 4-year institutions)—found that about 30% of college students reported feeling "so depressed that it was difficult to function" at some time in the past year.
66-75% of college students do not talk about or seek help for mental health problems.
STATISTICS

- Nationwide **24%** of individuals will receive treatment.
- Only **16%** of African-Americans will seek treatment from specialty mental health clinics.
ETIOLOGY OF DEPRESSION

- Genetics
- Serotonin, Norepinephrine
- Neuroendocrine Dysregulation
ETIOLOGY OF DEPRESSION

- Environmental Factors
ETIOLOGY OF DEPRESSION - ENVIRONMENTAL FACTORS

- Living away from family for the first time
- Missing family and/or friends
- Feeling alone or isolated
ETIOLOGY OF DEPRESSION - ENVIRONMENTAL FACTORS

- Experiencing conflict in relationships
- Facing new and sometimes difficult school work
- Worrying about finances.
ETIOLOGY OF DEPRESSION - ENVIRONMENTAL FACTORS

- Exposure to new people, ideas, and temptations
- Awareness of your sexual identity and orientation
EPIDEMIOLOGY

- **INCIDENCE**
  - **10%** in primary care patients
  - **15%** in medical inpatients
EPIDEMIOLOGY

PREVALENCE

- **10-25%** for women
- **5-12%** for men
**SEX DIFFERENCES**

- In pre-pubertal children, the rate of depression for boys are greater than the rate for girls.
- Between puberty and age 50 years, the rate in women is two times the rate in men.
- After age 50, the rates of women are equal to the rates of men.
MARITAL STATUS

Rates of Depression increase when an individual is divorced, separated, or has no close personal relationships.
ONSET

Onset of 50% of all cases are between ages 20 and 50
**DURATION**

- Most episodes last **~ 3 months**
- Untreated episodes can last **6-13 months**
PROGNOSIS AND COURSE

- PROGRESSION
  - Increase frequency
  - Increase severity
  - Increase in duration

MEAN NUMBER OF DEPRESSIVE EPISODES:
5-6 in 20 years
**PROGNOSIS AND COURSE**

**RECURRENTE**

- Depression is a chronic illness
- Patients tend to relapse
- An increase in the number of previous episodes = An increase probability of relapse
After one Major Depressive Episode, the relapse rate is 50%.
After there episodes, the relapse rate is ≥ 80%.
After hospitalization, relapse risk is 25% in 6 months, 30-50% in 2 years; 50-75% in 5 years.
SYMPTOMS OF DEPRESSION

- Depressed mood
- Decreased interest or pleasure in activities
- Weight loss/gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
SYMPTOMS OF DEPRESSION

- Fatigue or decreased energy
- Feelings of worthlessness, hopelessness, or inappropriate guilt
- Decreased concentration or indecisiveness
- Suicidal thoughts
**DSM-IV CRITERIA FOR DEPRESSION**

**TABLE 1.**

**DSM-IV-TR Criteria for the Diagnosis of a Major Depressive Episode**

A. At least 5 of the following, during the same 2-week period, representing a change from previous functioning; must include either (a) or (b):  
   (a) Depressed mood.  
   (b) Diminished interest or pleasure.  
   (c) Significant weight loss or gain.  
   (d) Insomnia or hypersomnia.  
   (e) Psychomotor agitation or retardation.  
   (f) Fatigue or loss of energy.  
   (g) Feelings of worthlessness.  
   (h) Diminished ability to think or concentrate: indecisiveness.  
   (i) Recurrent thoughts of death, suicidal ideation, suicide attempt, or specific plan for suicide.

B. Symptoms do not meet criteria for a mixed episode (i.e., meet criteria for both manic and depressive episodes).

C. Symptoms cause clinically significant distress or impairment of functioning.

D. Symptoms are not due to the direct physiologic effects of a substance or a general medical condition.

E. Symptoms are not better accounted for by bereavement (i.e., the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation).

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TREATMENT FOR DEPRESSION

ANTIDEPRESSANTS
- Selective Serotonin Reuptake Inhibitors - 1st line

PSYCHOTHERAPY
TREATMENT FOR DEPRESSION

Top 10 Adverse Reactions

1. Drug Withdrawal Syndrome
2. Drug Exposure During Pregnancy
3. Suicidal Ideation
4. Depression
5. Insomnia
6. Headache
7. Anxiety
8. Nausea
9. Dizziness
10. Drug Ineffective

(Click on Chart for Full List)
Jessica is a 21 year-old African-American female. She is currently a junior majoring in Pre-Med (Biology). She has always been a high achiever. She graduated with top honors in high school. She has very high standards for herself and can be very self-critical when she fails to meet them. Lately, she has struggled with significant feelings of worthlessness and shame due to her inability to perform as well as she always has in the past.
For the past few weeks Jessica has felt unusually fatigued and found it increasingly difficult to concentrate at work. Her coworkers have noticed that she is often irritable and withdrawn, which is quite different from her typically upbeat and friendly disposition. She has called in sick on several occasions, which is completely unlike her. On those days she stays in bed all day, watching TV or sleeping.
At home, Jessica’s boyfriend has noticed changes as well. She’s shown little interest in sex and has had difficulties falling asleep at night. Her insomnia has been keeping him awake as she tosses and turns for an hour or two after they go to bed. He’s overheard her having frequent tearful phone conversations with her closest friend, which have him worried. When he tries to get her to open up about what’s bothering her, she pushes him away with an abrupt “everything’s fine”.

SAMPLE CASE
Although she hasn’t ever considered suicide, Jessica has found herself increasingly dissatisfied with her life. She’s been having frequent thoughts of wishing she was dead. She gets frustrated with herself because she feels like she has every reason to be happy, yet can’t seem to shake the sense of doom and gloom that has been clouding each day as of late.

*Possible diagnosis for Jessica?*
Jessica is a 21 year-old African-American female. She is currently a junior majoring in Pre-Med (Biology). She has always been a high achiever. She graduated with top honors in high school. She has very high standards for herself and can be very self-critical when she fails to meet them. Lately, she has struggled with significant feelings of *worthlessness* and shame due to her inability to perform as well as she always has in the past.
For the past few weeks Jessica has felt unusually fatigued and found it increasingly difficult to concentrate at work. Her coworkers have noticed that she is often irritable and withdrawn, which is quite different from her typically upbeat and friendly disposition. She has called in sick on several occasions, which is completely unlike her. On those days she stays in bed all day, watching TV or sleeping.
At home, Jessica’s boyfriend has noticed changes as well. She’s shown **little interest in sex** and has had difficulties falling asleep at night. Her **insomnia** has been keeping him awake as she tosses and turns for an hour or two after they go to bed. He’s overheard her having frequent tearful phone conversations with her closest friend, which have him worried. When he tries to get her to open up about what’s bothering her, she pushes him away with an abrupt “everything’s fine”.
Although she hasn’t ever considered suicide, Jessica has found herself increasingly dissatisfied with her life. She’s been having frequent thoughts of wishing she was dead. She gets frustrated with herself because she feels like she has every reason to be happy, yet can’t seem to shake the sense of doom and gloom that has been clouding each day as of late.
**EPIDEMIOLOGY**

- 3.5-4% of the population
- Male-to-female ratio 1:1
- Mean age of onset 21 years
- Peak age of onset of first symptoms: 15-24 years
- Highly heritable
SYMPTOMS OF MANIA

- Inflated self-esteem or grandiosity
- Decreased need for sleep
- More talkative than usual or pressure to keep talking
- Flight of ideas or subjective experience that thoughts are racing
SYMPTOMS OF MANIA

- Increase in goal-directed activity
- Distractibility (Attention too easily drawn to unimportant or irrelevant stimuli)
- Excessive involvement in pleasurable activities that have a high potential for painful consequences (shopping sprees, sexual indiscretions, or drug use)
DSM-IV Criteria for a Manic Episode

Bipolar Disorders, Continued

Criteria for a Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
   1. inflated self-esteem or grandiosity
   2. decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
   3. more talkative than usual or pressure to keep talking
   4. flight of ideas or subjective experience that thoughts are racing
   5. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
   6. increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
   7. excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a Mixed Episode.

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatments) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

TREATMENT FOR BIPOLAR DISORDER

MOOD STABILIZERS AND/OR ANTIPSYCHOTICS

PSYCHOTHERAPY
STRESS VS ANXIETY

STRESS

ANXIETY
Brain’s response to a threat in a situation
Can be helpful
Does not affect individuals in the same way
Different types of stress:
  - **Routine stress** related to the pressures of work, family and other daily responsibilities.
  - Stress brought about by a **sudden negative change**, such as losing a job, divorce, or illness.
  - **Traumatic stress**, experienced in an event like a major accident, war, assault, or a natural disaster where one may be seriously hurt or in danger of being killed.
STRESS

- A faster heart rate
- Rapid breathing
- Sweating
- Trembling
- Dizziness
- Nausea
- Abdominal pain
- Headache
Reaction to the stress

It is the process during which a person becomes scared and apprehensive of what lays ahead, and often manifests itself in physical problems like pain, dizziness and panic attacks.

Legitimate mental disorder
- Anxiety symptoms share features of stress symptoms.
The National Comorbidity Study reported that 1 in 4 people met the diagnostic criteria for at least one anxiety disorder.

- 12-month prevalence rate of 17.7%
- Women are more likely to have an anxiety disorder than are men
  - 30.5% lifetime prevalence in women vs 19.2% in men
SIGNS AND SYMPTOMS OF ANXIETY

- Excessive worry
- Irritability
- Sleep disturbance
- Poor concentration
- Restlessness
- Muscle tension
- Fatigue
DSM-IV CRITERIA FOR GENERALIZED ANXIETY DISORDER

**Table 1. Diagnostic Criteria for Generalized Anxiety Disorder.**

The patient reports having excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

The patient has difficulty in controlling worry.

The anxiety and worry are associated with three or more of the following six symptoms (with at least some symptoms present for more days than not for the previous 6 months): restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).†

The focus of the anxiety and worry is not confined to features of other types of psychiatric disorders (e.g., panic disorder, social phobia, obsessive–compulsive disorder, separation anxiety disorder, anorexia nervosa, somatization disorder, or hypochondriasis), and the anxiety and worry do not occur exclusively as part of post-traumatic stress disorder.

The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The disturbance is not due to the direct physiological effects of a medication, substance abuse, or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder.

* Adapted from the American Psychiatric Association.²
† Only one item is required in children.
PANIC ATTACKS

Stop It!
You're Okay
Breathe
Hurry up and go away!
Focus
I have to do this!

You're not going to die
You're almost done
OMG I'm going to faint!
OMG I'm so tired of this!

There's nothing to fear
Help!
Deep breath
Hold.... Exhale

I can't breathe!
Think happy thoughts
Relax

The first 60 seconds of a Panic Attack
Why Me?
You're free to leave
I hope nobody's looking

You can do this
I have to get out of here now!
SIGNS AND SYMPTOMS OF A PANIC ATTACK

- "Racing" heart
- Feeling weak, faint, or dizzy
- Tingling or numbness in the hands and fingers
- Sense of terror, or impending doom or death
- Feeling sweaty or having chills
- Chest pains
- Breathing difficulties
- Feeling a loss of control
TIPS TO MANAGE ANXIETY AND STRESS

- **Take a time-out.** Practice yoga, listen to music, meditate, get a massage, or learn relaxation techniques. Stepping back from the problem helps clear your head.

- **Eat well-balanced meals.** Do not skip any meals. Do keep healthful, energy-boosting snacks on hand.

- **Get enough sleep.** When stressed, your body needs additional sleep and rest.

- **Exercise daily** to help you feel good and maintain your health. Check out the fitness tips below.

- **Take deep breaths.** Inhale and exhale slowly.

- **Count to 10 slowly.** Repeat, and count to 20 if necessary.
TIPS TO MANAGE ANXIETY AND STRESS

- Do your best. Instead of aiming for perfection, which isn't possible, be proud of however close you get.
- Accept that you cannot control everything. Put your stress in perspective: Is it really as bad as you think?
- Welcome humor. A good laugh goes a long way.
- Maintain a positive attitude. Make an effort to replace negative thoughts with positive ones.
- Get Involved. Volunteer or find another way to be active in your community, which creates a support network and gives you a break from everyday stress.
- Learn what triggers your anxiety. Is it work, family, school, or something else you can identify? Write in a journal when you’re feeling stressed or anxious, and look for a pattern.
- Talk to someone. Tell friends and family you’re feeling overwhelmed, and let them know how they can help you. Talk to a physician or therapist for professional help.
TREATMENT FOR ANXIETY DISORDERS

ANTIDEPRESSANTS

- Selective Serotonin Reuptake Inhibitors - 1st line

PSYCHOTHERAPY
The Ugly...
Can exacerbate symptoms of Depression, Mania, and Anxiety

Addictive

Can lead to physical and psychological complications

Alcohol and drug use increases suicidal behavior
SUICIDE

EVERY 40 SECONDS SOMEONE IN THE WORLD DIES BY SUICIDE.

EVERY 41 SECONDS SOMEONE IS LEFT TO MAKE SENSE OF IT.
Suicide is the 2\(^{nd}\) leading cause of death among college students ages 20-24

4 out of 5 young adults that contemplate or attempt suicide exhibit clear warning signs

It is estimated that 40-60\% of persons who commit suicide are clinically depressed.
RISK FACTORS FOR SUICIDE

- History of previous suicide attempts
- Family history of depression or suicide
- History of abuse
- Mental health problem that is untreated
- Alcohol and drug abuse
- Access to firearms
SUICIDE RISK WARNING SIGNS

- Reports feeling very depressed
- Experiences anxiety and/or stress
- Has increased conflicts with friends, roommates, peers, faculty
- Talks about wanting to commit suicide
- Is focused on death and dying
- Writes about death and/or suicide
- Starts giving away possessions
- Withdraws from family, friends, and activities once enjoyed
- Says things like, “I don’t deserve to be here”, “I wish I were dead”, “I am going to kill myself”, or “I want to die”
- Increases their use of alcohol and/or other drugs
- Engages in reckless behaviors
- Secures a firearm or other lethal methods
TAKE SUICIDE RISK SERIOUSLY

- Be honest and express your concerns. For example, “You seem really down lately, is something bothering you?”
- Ask directly about thoughts of suicide. For example, “Have you thought of killing yourself?”
- Listen and offer emotional support, understanding, and patience.
- Convey the message that depression is real and treatable.
- Offer to accompany your friend to see a counselor.
- If suicidal thoughts are expressed it is important to contact Counseling Services as soon as possible.
- If the person is suicidal, do not leave them alone. Call for help or take the person to the hospital emergency room.
WHAT IF I OR SOMEONE ELSE I KNOW IS IN CRISIS?

- If you are in crisis, make sure you are not left alone
- If someone else is in crisis, make sure he or she is not left alone.
- Call your doctor or mental health care provider

Call **911** or go to a hospital emergency room to get immediate help, or ask a friend or family member to help you do these things

Call the National Suicide Prevention Lifeline's toll-free, 24-hour hotline at 1-800-273-TALK (1-800-273-8255) or TTY: 1-800-799-4TTY (1-800-799-4889) to talk to a trained counselor

- Call your college counseling center or student health services
RESOURCES ON CAMPUS

- Peer Leaders
- Counseling Centers
- Active Minds
- Mental Health First Aid
- College Response
- Kognito Gatekeepers
- Threat Assessment Teams
SAMHSA's National Helpline
1-800-662-HELP (4357)
TTY: 1-800-487-4889
Website: beta.samhsa.gov/find-help/national-helpline
Also known as, the Treatment Referral Routing Service, this Helpline provides 24-hour free and confidential treatment referral and information about mental and/or substance use disorders, prevention, and recovery in English and Spanish.

ALCOHOLICS ANONYMOUS
http://www.alcoholics-anonymous.org

NARCOTICS ANONYMOUS
http://www.na.org/
THANK YOU FOR THIS OPPORTUNITY!
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