CARDI•OH
Ohio Cardiovascular and Diabetes Health Collaborative

Podcast 20 - The Heart-Mind-Body Connection: Mental Health and Cardiometabolic Conditions

Transcript

[Jazzy instrumental intro music]

[Voiceover] Michael Konstan: Welcome to Cardi-OH Radio, a podcast of the Ohio Cardiovascular and Diabetes Health Collaborative, also known as Cardi-OH. This is Dr. Michael Konstan from the Case Western Reserve University School of Medicine, and I serve as a principal investigator for Cardi-OH, a statewide network of Ohio's seven medical schools. Cardi-OH is funded by the Ohio Department of Medicaid, and shares best practices to improve cardiovascular health and diabetes outcomes and to eliminate health disparities in Ohio's Medicaid population. I hope you enjoy today's podcast.

Larry Witmer: Hi there to all our listeners. I'm Larry Witmer, assistant professor of family medicine at Case Western Reserve University. I practice in Aurora, Ohio for University Hospitals in Northeast Ohio. In this podcast, we're going to explore the connection between mental health, diabetes, cardiovascular disease, and some other topics of interest. We will discuss mental health stigma, how to recognize common mental health diagnoses, how to talk with patients about their mental health, and evidence case interventions to improve patient outcomes. With me today is Dr. Trygve Dolber. Dr. Dolber is an assistant professor of psychiatry and internal medicine at Case Western Reserve University and a member of Cardi-OH's team best practices. His work at University Hospitals focuses on behavioral health integration with a medically high-risisk patient population. I'm so happy to have you here today, Dr. Dolber. I appreciate you being here with me.

Trygve Dolber: Ah, thanks. Glad to be here.

Witmer: So, I know we've talked in the past about this topic and I'm really excited to have you here today because this is something that I as well as so many other primary care providers are seeing often in our practice. So can you tell me what's the prevalence of mental health conditions in patients who have diabetes and or cardiovascular disease and am I underestimating or do you think I'm overestimating this sense of disease processes and is there data to support addressing this concern?

Dolber: Yeah, happy to to fill in there. So there is data patients with a serious mental illness that's been defined as bipolar disorder schizophrenia IA and major depression as well. If someone has serious mental illness, they have a 55% increased risk of developing cardiovascular disease. But even beyond that, any anxiety disorder makes you 27% more likely to develop cardiovascular disease. And we don't know why, but post-traumatic stress disorder in particular makes you twice as likely to develop diabetes. And it's even higher in women. Given that, and the fact that mood and anxiety disorders are so common in primary care practices and even more prev during the pandemic. In 2020, there were studies coming out showing how much the incidence of depression was increasing both in prevalence and severity uh and especially among lower income populations.

So that's why today I was really going to want to focus on depression and anxiety in particular and how those affect cardometabolic health. Yeah, this is going to be an interesting talk today. I mean I often struggle with this, right? Does the anxiety and depression lead to cardiovascular disease and diabetes or is it the other way around? So for instance, is it the chicken or the egg. People ask this question a lot and the more I've thought about it, the more to me it really doesn't actually matter. You think about why do you ask that question, right? It's it's because you want to get to the root problem. Like what came first that means what do I fix that will solve everything? Are they just anxious because of their diabetes? That means we get the diabetes under better control, we can let go of the anxiety. Or the other way around. Well, maybe there was a time a long time ago for any given patient where that was the case. But by the time the patient's in your office, there's already a feedback cycle going on that's been going on most likely between mood and anxiety in one side that's making their medical syndrome worse and then that in turn being worse is feeding back into the mood and anxiety and this cycle has already been going on and you can't at that point just address one thing. You you really have to focus on both. So we you know at that point which came first is less important. The problem is even worse probably than than we realize because a lot of patients especially who are engaged in this kind of cycle uh when they come in they don't want to talk about uh their anxiety or their mood disorder. They tend to focus on the the physical or the medical aspect of things and and you might not be aware that that process is happening.

Witmer: Yeah, I got to tell you, I've definitely noticed that and there seems to be a stigma out there that keeps patients from opening up about these issues. How do we recognize as primary care providers, how do we recognize something like this? So, you're right. Sometimes it's obvious when a patient's nervous, but not always, right? So, what kind of symptoms should I be watching for when these patients come in the door?

Dolber: Yeah, I mean, you're exactly Right. I supervise residents in a internal medicine primary care clinic and there have been times when someone's said to me, "Oh, this patient doesn't seem anxious and I get it. Someone can be sitting there calm and they're not tremulous and having a shaking voice and everything like that." But a lot of times people are really good at hiding their anxiety and they're really good at hiding their depression uh because they're so used to it and don't want people to know about it. So there are things that you can look for. I think there are a lot of different ways you can look for this in a primary care practice regardless of the reason why people avoid discussing these things. It could be religious reasons. It could be cultural reasons. It could be they've had bad experiences before in the health care system. They could be worried about if it's on their record, could that affect their career in a negative way? But one thing that I always look at in in primary care is the physical symptoms because you're looking for those anyway. Think about anxiety or emotional instability. These can exacerbate or even maintain almost any physical symptom. And we could spend the rest of this podcast going through every organ system, but there's a few things that I like to focus on. on chest pain, difficulty breathing. We see people with visits to the emergency department. They get a workup, everything's negative. You know, probably someone's having a panic attack, but they're going in and they're just getting a negative workup and leaving. That's something that we have to be aware of and addressing. We even know that people who have asthma are more likely to have more frequent and severe asthma exacerbations if they have comorbid anxiety. You know, think about 75% of dyspsia is functional, right? or doesn't have a structural uh ideology that we can find. So, irritable bowel syndrome extremely common and thought to be driven in large part by anxiety and mood disorders. And that can be even more

complicating, right, with our patients because that can be comorbid with diabetic gastroparesis. You can just say, “Oh, it’s the diabetes. It’s gastroparesis.” But there could also be other things going on too. There could be an anxiety component that you might be missing. Somatization in general, especially chronic pain syndromes, is really where I’m going with this. Also, obese This is something that we target a lot in our clinics and especially when we’re trying to prevent cardiovascular disease and diabetes. But how often do we look to see could there be a mood or anxiety disorder along with this? Uh and why would you think that there might be? Well, you know, post-traumatic stress disorder is really highly associated with obesity. There has been studies showing odds ratios up to over four in some populations. Binge eating disorder affects 2 to 3% of the population. This is just of everyone. 2 to 3% of people have binge eating disorder. Um, and in patients who are seeking help with weight loss, 30% of them have binge eating disorder. And I really feel like we don’t screen for this very often. There is a fast and really easy way to screen for it. Actually, the most effective screening tool is the VA Bees developed by uh Veterans Affairs. This is the binge eating screener. All you do is ask one question. On average, how often have you eaten extremely large amounts of food at one time and felt that your eating was out of control at that time. And if someone says two or more times per week, that’s a positive screen.

Witmer: Yeah, that’s quite interesting. I mean, I I certainly have a lot of patients like this where we work them up, you know, the symptoms are treated and we never seem to have a resolution, right? I mean, like you said, you go to the emergency room and they get this big work up and still they have no answer. They come to us. You mentioned you’re going to get into this, but how does their anxiety or depression drive this process?

Dolber: I see this in the primary care side so much and it’s a major source of frustration for the residents I work with cuz it makes people feel helpless, right? I think it makes people feel like this is our job as doctors is to take away your suffering and we do all this work and we go through everything we’ve been taught and things aren’t working. So, you know, how does this how does this happen? I think understanding that can really help you get to the bottom of things. And what psychologists have been working on for quite some time is this idea of the fear avoidance cycle. And so what That means is there’s some kind of underlying distress. And you can see this in a normal healthy person, you and me, in any given moment, any given day, we might have the smallest little bit of distress. But imagine instead if you’re someone who feels a lot of distress all the time. So you’ve got some underlying distress or fear or anxiety or whatever it is, the mind’s natural normal response to that is to try and find a way to make it stop. And that can happen in so many different ways. And most of them end up being unhelpful and making things worse. So the way this process is maintained is someone does something to escape what they’re feeling and that gives them a really shortterm maybe partial relief of whatever is going on but that even short-term partial relief counts as a reward and it ends up reinforcing that unhelpful unskillful behavior. So there are a lot of ways that this can happen in people. We were talking about sematization just now and I think people try and suppress things. They try and not feel a certain way. So if I’m feeling distress, I have to hold it down or make it stop. That can cause tension. If someone is worried about having pain, they could be hyper aware of their sensations in a certain area and tend to feel pain more or experience pain more strongly. But you know, these are just the physical symptoms and that’s what we’ve been talking about so far. But there are a lot of other ways that avoidance can lead to behaviors that we can recognize in primary care. So for example, you see people with substance use all the time. Any kind of substance use, and this includes smoking, cannabis, alcohol use, oftentimes this is to self-medicate anxiety. Uh, and this is a way of trying to escape that unpleasant sensation, right? It’s a numbing or an escape. And those things are all on the rise during the pandemic. And actually,

Cardi-OH does have a podcast that gets more in detail. That was back in April 2021. Any other form of impulsive or risky behavior, a lot of times those behaviors are to try and kind of shock people out of what they're feeling. And the more it is effective at making people not feel their distress, the more they're likely to do it. So impulse of risky behavior. How are you going to see this in clinic? This could be people who have frequent sexually transmitted infections is a sign of risky sexual behavior. People getting into car accidents, people having legal troubles. Sometimes when you notice a pattern of that risky behavior, it's something you want to take a little bit more of a close look at. Insomnia, probably one of the most common complaints we get. This is almost always related to anxiety. I recommend people never assume that something is primary insomnia. This is probably something related to distraction. So, people avoid their distress by keeping themselves distracted during the day, whether it's keeping busy, watching TV, but then they lay down at night, it's dark, they're alone, and all those worries and distresses that they've been blocking out all day. There's nothing that they can do to block them out anymore. They come back, they can't sleep. I always ask about that in particular. When you lay down at night, do you have all these thoughts and worries and things that come back and prevent you from sleeping. Also, low engagement with medication or lifestyle recommendations. That ends up being a way that people avoid their distress.

Witmer: Yeah, that's interesting. I mean, so this low engagement is this avoidance why some of my patients with diabetes and cardiovascular disease struggle with long-term lifestyle changes potentially.

Dolber: Maybe not in every case, but I think in a lot of cases it really can be. Some common barriers that I've seen to engagement related to mood or anxiety disorders is if someone's depressed, they don't feel like doing anything, uh their anidonia is high, that's going to prevent them from engaging in those changes. Um, if they have one of those maladaptive coping skills, like they have an avoidance mechanism that's like stress eating or smoking or drinking and they don't have any other way that they know of to deal with their distress, and you're going to tell them that they need to stop doing that thing, I don't know that they're going to be very successful with it because then suddenly their anxiety is going to spike when they try and and stop. Sometimes too, people have severe anxiety about their health. And a lot of times you'll ask and it's someone's had a loved one who died unexpectedly of a medical issue. They internalize that for themselves, they become very afraid of their own health getting worse. Ironically, this ends up making their health worse because anytime they try to engage in some kind of long-term lifestyle change, whether it's to lose weight or stop an unhealthy behavior, the distress that they get from paying attention to their health is so great that they end up procrastinating and pushing it off and just trying to think about something else.

Witmer: This is so real how this happens in our everyday practice life. I'm so happy that we're talking about this and you know, so I noticed some of these things with the patients. I suspect that maybe my patients experiencing a level of stress that's overwhelming their ability to cope or a mental health disorder like anxiety, depression, or post-traumatic stress disorder is is kind of overwhelming them as you alluded to. Yeah. How do I bring this out of the patient in an office? office visit for instance,

Dolber: right? And especially like we were talking about people who don't want to talk about these things and you've gone through everything and you're noticing it. Well, I always start by normalizing it and educating them on it. So, you know, I mentioned before I use this example all the time, the dispsia one. Someone comes in and they're complaining of stomach upset and I think they've also

got some anxiety going on. I'll say, "Listen, 75% of people with dispsia, we never find any kind of medical cause for it. Um, and we think for those people, it's could be related to chronic stress. Uh, which we know has an effect on the nerves. It sends signals between your brain and your stomach. And if you think about it, you know, we use phrases like butterflies in my stomach. And you can think before you've had to do something nerve-wracking, you might have felt nauseous or or something like this. So, normalize it for the patient. And then I say, I know in my mind, this is making sense to the patient. I can say, if you think back over the last couple of weeks, have you felt more nervous, anxious, or on edge? And that's actually the first question of the GAD-7. This is the generalized anxiety disorder screener. And a lot of us are familiar with this now. That and the PHQ-9, the patient health questionnaire. Those are the two screeners that a lot of our practices are being standardized to use to screen for anxiety and depression. And you can use those, you can integrate bits and pieces of those into your interview with a patient to help you gather more information, establish a baseline, uh even to build rapport. It doesn't have to be just a check the box that they do in the waiting room, but something you use to to understand them better and and facilitate them sharing with you.

Witmer: Yeah. But listen, wait a minute. Wait a minute. This is fantastic. But you you alluded to earlier that you precept residents. You're boarded in internal medicine. I live a busy life here. So you understand how time constraints are important. How do I do all this in one visit? Seriously, how do I get through all of this in one?

Dolber: Yeah. No, I know. I know. And I'd be lying if I said there weren't busy clinic days where, you know, normally I'm hyper attuned to this stuff. There are days when I let it go uh when we get really busy. The important thing to remember is you don't have to do all of those things I said at once. This all doesn't have to occur at the same time. If you've got backtoback patients and you you don't have time to get everything done, remember that each one of those little steps can actually be therapeutic. And we have evidence to support this. We know that just allowing the patient, asking them about anxiety and allowing them to open up to you about it, that on its own is therapeutic. Just them sharing it with someone for the first time is therapeutic. You just giving them the psycho education and nothing else. You know, you explain to them like what I talked to you about the the underlying distress and the the avoidance, the fear avoidance cycle. You just explaining that to them without telling them anything about what to do about it on its own has positive outcomes. Um so you just do whatever you have time for. You know, they share their anxiety, they get educated on it, they know that treatment exists and that their doctor is aware of it. They start to think more positive. All these things can be helpful. And the other thing that I would say too that I think about, you know, with with my residents also is this is not a separate issue. You know, we alluded to this before how it's a cycle, right? A cycle between medical problems and uh psychiatric problems and all these things are feeding back into each other. I know that I'm going to get return on my investment in my markers of cardiovascular cardabolic disease prevention by focusing on anxiety. and depression. Um, so what I want to do then is the same thing that I always do whenever a patient comes in and I know a lot of PCPs do the same thing. The patient comes in with their problems and I have my own list of things that I want to address. You know, the patient might say, you know, I have shoulder pain today and that's good. I'm going to I'm going to work up your shoulder, but also your blood pressure is uncontrolled. Uh, and your A1C is nine and we got to do something about this and that's my top concern and we're going to we're going to strike a balance. So you can do the same thing for anxiety and depression. So for example, Example, the patient comes in and they have distress that I think is driving some other processes related to anxiety,

stress, intense emotions. Their top concern might be something different from the anxiety itself. They might not think that they have anxiety. They might not think that their worries are a problem, but they might hate the fact that they have insomnia and they can't sleep. Or they might have specific maladaptive coping behaviors that are directly harmful to them that they want to stop. Like if they want to quit smoking, I can understand help them see that anxiety might be preventing them from doing that or if they have maladaptive coping behaviors that that they don't mind the behavior itself but they know it leads to harmful effects. So if they're drinking more and this is causing them to get angry at their loved ones and damage relationships, you know, that might help me work backwards. Um so even though my concern might be I need to spend time focusing on your blood pressure and your A1C, I can step back, use the things that the patient finds important and thereby control the root underlying anxiety that's a key part of that cycle that we're trying to stop.

Witmer: Yeah, that definitely helps. I mean, knowing that all these things improve outcomes, how do I provide a targeted treatment with such minimal time, right? So, a lot of my patients don't have access to a therapist or even a psychiatrist or prefer not just to see one, right? So, it's me, right? It's primary care. So, how do I truly target that treatment for them.

Dolber: Yeah. And you know, we're talking about busy visits. You don't have time to do therapy. I mean, the therapists that I refer to, that I like to refer to, have an hour a week with a patient, and that's just not something that that we have in a lot of cases. You know, of course, these days it's coming out to an hour every two weeks or an hour a month um because there's so much demand. What you want to do is, and like I said before, I think if you understand how these things are all universalized, you can come up with an approach that works for the patient that makes sense that doesn't take too long to explain and isn't so different from everything else. So we are talking about the fear avoidance model and these days you hear about mindfulness all the time and and this really ties back in with it. So in the fear avoidance model right there's an underlying distress there's an avoidance and the avoidance is usually unproductive maladaptive makes things worse but has a short-term reward. Well the whole idea of mindfulness and this is the underlying factor or a main factor of all really our evidence-based psychotherapy is that you want to stop that process before it starts. And the way you do that is you teach people to open up to and accept and be curious about and make space for that underlying distress they have. See, people usually don't stop to think about it. They think this distress is not something I can control. This is going to overwhelm me, overpower me. I can't deal with it. They might not even had those thoughts explicitly, but on some level in their mind, there's belief. There's a core uh hidden belief that they can't tolerate that distress. And so teaching them to open up to that and give them techniques to do that is going to be the core of any kind of therapeutic intervention. And to do that, you really want to use a patient centered approach. And that means using the patients own language, their own values, their own vocabulary even to kind of frame what I just told you. I'm talking to you about the fear avoidance model and mindfulness and using these buzzwords. that might not be the best way to talk to your patient about it. They might want to they might respond better if you use their own language and their own values. So that can be a great way to start and then you can provide them with any kind of mindfulness resources that are out there like apps and things that they can find online or books that they can read. Relaxation techniques as well can help to buffer that. Sometimes people don't have the energy to open up to their distress. That's just a little bit overwhelming. But what you can do is say if you've noticed that you're engaging in something unhelpful, can you try and relax instead? And you can teach diaphragmatic breathing in the office. It's a quick intervention. Progressive muscle relaxation is a quick intervention you can teach. Recommending exercise, which you're doing anyway, but also helping patients understand that exercise is not just something to

help prevent a heart attack 20 years from now. This is something that's going to in the short term, in a matter of a couple weeks, according to some studies, have a major imp impact on their anxiety and depression. Again, you want to be patient centered about it. As with everything else, what is something that they would actually do? What is an exercise that they would actually enjoy and and like and get excited about? Understanding uh how to reframe thoughts. So, this is something you can do in the office. This is a quick idea. I share this with my patients a lot in my psychiatry visits, which those are also short and we don't really have a chance to get into therapy. So, I just end up dropping nuggets here and there, but Many of our core therapies all reframe thoughts from true or false, factual or unfactual... to helpful or unhelpful. So we we might not be able to control the thoughts we have. Those just arise naturally. But once they arise, we have to decide what to do with them. So if people realize that they're ruminating or worrying or going over a thought or exploring it uh in detail and following the path and all that does is make them feel worse and doesn't help them, achieve any goal then you say even if this is a factual thought this isn't something worth exploring. So things I hear people say you know I'm so fat or like I'm a failure or things like that where there could be some factual basis to the thought but it's not actually helpful to them and all it does is make them feel worse and it doesn't motivate them. It doesn't matter because people will get wrapped up in this but it's true. It doesn't matter you know how factual it is. What matters is having it makes you feel worse and doesn't help you. Uh, and if that's the case, then you want to shift your focus to a relaxation exercise or a mindfulness exercise like we talked about. It could be something that you do to distract yourself like art, music, exercise, work, whatever it is. As long as you don't become dependent on those distractions and end up having insomnia like we talked about before, right? Uh, one that I give people a lot is Mindfulness Coach, which is an app developed by the VA that has some evidence behind it as well. But whatever you choose, as long as it's patient centered, people are choosing what works best for them. setting realistic goals and you're helping to hold them accountable with those goals at subsequent visits. Uh I think that's the main thing.

Witmer: Yeah, I can't tell you how much I appreciate that. Sadly, to all our listeners, we're out of time, but I want to express my sincere gratitude for joining me today. It's been a true learning experience. Seriously, from me and hopefully the primary care world and to all of our listeners, and I really appreciate the understanding of how mental health disorders are increasing, especially due to unhelpful coping during this most unfortunate CO 19 pandemic. Uh as clinician We need to be proactive about identifying and providing resources to patients with diabetes or cardiovascular disease who have an associated mental health coorbidity. And I just want to tell you personally, thank you again so much for joining us today.

Dolber: Well, thank you so much for having me. It's a topic near and dear to my heart.

Witmer: And a special thank you to you, our listeners, for tuning in to Cardi-OH Radio.

[Voiceover] Konstan: This concludes today's podcast. Be sure to visit Cardi-OH.org to learn more about the Ohio Cardiovascular and Diabetes Health Collaborative.

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