

CHAPTER 7 – SECTION 2: UNDIAGNOSED AND UNTREATED MENTAL ILLNESS

*What mental health needs is more sunlight, more candor,
and more unashamed conversation.*

Glenn Close (1947-)

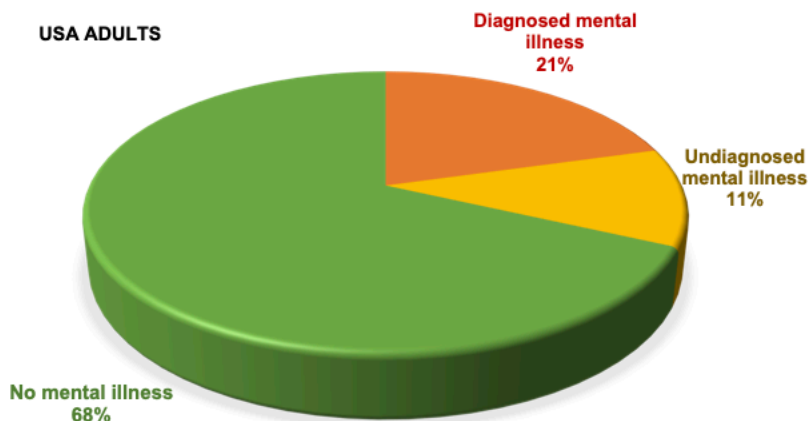
UNDIAGNOSED MENTAL ILLNESS

As introduced in Section 1, the prevalence of diagnosed mental illness among USA adults is 20.6% (SAMHSA, 2020m). The prevalence of those with undiagnosed mental is estimated to be 55% of those who have been diagnosed (Downey et al, 2012) - that is, 11.3% of USA adults.* Given the total number of USA adults is 258.3 million (Census Bureau, 2021f), the number of those with a **diagnosed** mental illness is 53.2 million (20.6%); the number of those with an **undiagnosed** mental illness is 29.2 million (11.3%); the total number of those with a mental illness is 82.4 million (31.9%); and the number of those without a mental illness is 175.9 (68.1%). Refer to **Table 7-2.1. Prevalence of Mental Illness – Diagnosed and Undiagnosed.**

* Interestingly, the estimated prevalence of undiagnosed mental illness (11.3%) is comparable to the estimated prevalence of undiagnosed hypertension, which is 10.1% (Undavalli et al, 2018)



Table 7-2.1. Prevalence of Mental Illness – Diagnosed and Undiagnosed



NEUROTIC, STRESS-RELATED, AND SOMATIC DISORDERS

Disorders within this cluster include phobic anxiety disorder, 'other anxiety disorders' (e.g., generalized anxiety disorder), 'reaction to

severe stress and adjustment disorders,' and obsessive-compulsive disorders (OCDs) (WHO, 2019, F40).

ANXIETY DISORDERS

The anxiety cluster is the most common group of mental disorders in the USA (Penninx et al, 2021). Core features of **anxiety disorders** include excessive anxiety and fear or avoidance of perceived threats that are impairing and persistent (Penninx et al, 2021). Anxiety disorders are caused by a dysfunction in the brain circuits that respond to danger (Penninx et al, 2021). Risk for anxiety disorders is influenced by environmental factors, genetic factors, and their epigenetic relations (Penninx et al, 2021). Anxiety disorders often co-occur with other mental disorders,

particularly depression, and somatic disorders (Penninx et al, 2021). Reducing the burden of anxiety upon society and individuals can be best achieved by "timely, accurate disease detection and adequate treatment administration, scaling up treatments when needed" (Penninx et al, 2021, p914). Evidence-based interventions include psychotherapy - notably cognitive behavioral therapy (CBT) and psychoactive medications, notably serotonin and norepinephrine reuptake inhibitors (SNRIs) such as venlafaxine (Effexor) (Penninx et al, 2021).

GENERALIZED ANXIETY DISORDER (GAD)

In **Generalized anxiety disorder (GAD)** (F54.1) is also an 'other anxiety disorder.' In GAD, anxiety is "generalized and persistent but not restricted to ... any particular environmental circumstances... The dominant symptoms are variable but include complaints of persistent nervousness, trembling, muscular tensions, sweating, lightheadedness, palpitations, dizziness, and epigastric discomfort" (WHO, 201, F41.1). During 2019, 9.5%, 2.4%, and 2.7% of USA adults experience mild, moderate, and severe symptoms of anxiety in the past two weeks (Terlizzi, 2002, para1). Anxiety is highest amongst 18 to 29-year-olds and decreases with age; and is more prevalent in women than men (Terlizzi, 2002).

Application to physical therapy (PT): During visits with your patients, observe and take a mental note of any signs or symptoms of anxiety. As indicated, document your findings. If appropriate, use a standardized test - either written or conversational. A two-question screen for anxiety is provided in **Figure 7-3.3**.

Generalized Anxiety Disorder-2 (GAD-2) (Lowe et al, 2008). A score of three or more points indicates the potential of anxiety and a Brief Teach (e.g., follow-up with their physician) is indicated. The GAD-2 and the **Generalized Anxiety Disorder-7 (GAD-7)** (Lowe et al, 2008), which includes five additional questions to screen anxiety (i.e., worry, fearful, irritable, restless, trouble relaxing), are provided in the **Textbook Supplement** at Wellness Society.org.



POST-TRAUMATIC STRESS DISORDER (PTSD)

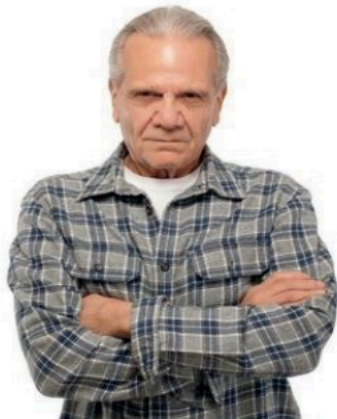
Post-traumatic stress disorder, invariably referred to as **PTSD** (F43.1), is within the anxiety subcluster. The lifetime and past year prevalence of PTSD in USA adults is 6.1% and 4.7%, respectively. The prevalence is higher for younger, white or Native American, formerly married females, who did not have a high school diploma, had a lower income, and lived in a rural community (Goldstein et al, 2016). PTSD is also associated with substance use and disability (Goldstein et al, 2016). The average lapse between disorder onset to treatment is 4.5 years (Goldstein et al, 2016). PTSD stems from an acute, chronic, or delayed reaction to a traumatic event such as physical or sexual assault, military combat, or natural disaster (NIMH, 2019p). The proportion of PTSD that is delayed is

unknown, but can be higher for those who have suffered a traumatic event such as a sexual assault at a younger age (NIMH, 2019p). PTSD is characterized by intrusive, recurring images (flashbacks) and / or thoughts of the traumatic events, a state of hyperarousal, nightmares, angry outbursts, and loneliness (NIMH, 2019p). A person with PTSD might have feelings of guilt for surviving when others were killed or died. PTSD can be short duration (one to three months), but is usually long term (NIMH, 2019p). About one-half of all people experience at least one traumatic event in their life, but most do not develop PTSD (NIMH, 2019p). Why some people do and some do not is unclear. Refer to **Case 7-3.7. John**, who resembles a patient I once treated who had a comorbidity of PTSD.

Case 7-3.7. John

John, a 67-year-old male, was referred to home health status post left below knee amputation (BKA). His comorbidities included PTSD, end-stage renal disease (ESRD) with renal dialysis, diabetes mellitus with diabetic neuropathy, among others. During the course of my examination, I learned his PTSD was secondary to trauma he suffered while serving in the Vietnam War. I screened his cognition with the Short Portable Mental Status (SPMSQ) (Pfeiffer, 1975). He scored 5 errors, which suggested a 'moderate cognitive impairment.' I asked John if he thought he had any problems with his memory and he rebuffed, "I answered these same damn questions for someone at the hospital and it's a stupid test! I have the best memory I've ever had in my lifetime!" Attempting to further discuss the SPMSQ (for instance, evidence of its validity) for the patient's cognitive deficit would have been counter-productive. However, it was indicated to notify the team, including the physician, and I do so after the physical therapy and outside of the patient's presence. The physician's nurse replied they are aware of his memory issues and his occasional

angry outbursts. I refrained from again formally screening his cognition. I addressed his cognitive deficit by providing a significant amount of repetitive patient education, including, of course, written instructions for his home exercise program.



CHAPTER 7 – SECTION 5: THE ROLE OF THE PHYSICAL THERAPIST IN TREATMENT OF PATIENTS WITH MENTAL ILLNESS

The humanity we all share is more important than the mental illnesses we may not.
Elyn R. Saks (1956-)

PROVISION OF PHYSICAL THERAPY TO PATIENTS WITH MENTAL ILLNESS

Mental disorders are not an uncommon comorbidity amongst physical therapy patients. And many additional patients, although not diagnosed with mental illness, present with signs and symptoms of mental illness. Screening for mental illness, taking into consideration the mental status of patients, and, as indicated, referring a patient to their physician and/or provide Brief Teaches (e.g., educate a patient to visit a web-site or consider a support group) are responsibilities of physical therapists.

Physical therapists have participated in the treatment of mental illness, including *serious* mental illnesses, since World War I (Overholser, 1943). In *Physical Therapy's* article 'Recollections and reminiscences from former recon-

struction aides' (1976), the precursors to physical therapists described their provision of therapy to patients who had been wounded in combat, many of whom suffered mental illness in connection with their military service. Early physiotherapists also directly provided hydrotherapy treatment to mentally ill patients in psychiatric hospitals (Overholser, 1943; Probst, 2017). The **International Organization for Physical Therapists in Mental Health (IOPTMH)**, a subsidiary of the **World Confederation for Physical Therapy (WCPT)**, is a good reference for the provision of physical therapy to patients with mental illness, including those with *serious* mental illness who are confined to psychiatric institutions.

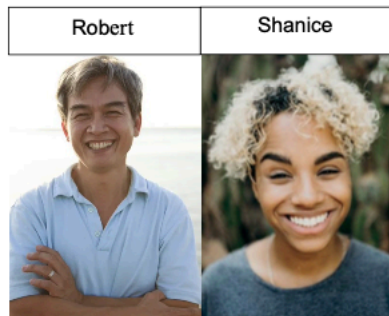
MENTAL ILLNESS SCREENING

To physical therapists to be familiar with mental illnesses and their prevalence because they are among the comorbidities – whether diagnosed or undiagnosed – with which patients present in physical therapy. Although 75% of all chronic mental illness begins by age 24, there are often long delays – sometimes decades – between first appearance of symptoms and when they get help (Kessler, 2010). Physical therapists can help to close this gap as well as decrease the percentage of people who go undiagnosed all together.

Application to physical therapy (PT):

Although it is important to screen all physical therapy patients for mental illness, it would be a high priority to screen which of the two following patients: Robert, a 65-year-old Asian American male, or Shanice, a 24-year-old mixed race female? Why? (If you are puzzled,

refer back to 'Prevalence of Mental Illness' on pages 185-187.) Of the screens we have discussed, which do you think would be the most important to use for Robert and why? And, which do you think would be the most important to use for Shanice and why?



and major depression (Carek et al, 2011; Kvam et al, 2016). A systematic review of research investigating the effective of exercise on the depressive spectrum of bipolar affective disorder found similar results (Melo et al, 2016). Not surprisingly, however, there was some evidence of an association between vigorous exercise and mania, but there was no implication that vigor-

ous exercise contributes to mania (Melo et al, 2016). The recommended exercise regime is three to five sessions per week of moderate-intensity aerobic exercise (Rethorst, 2013; Xie et al, 2021). Mind-body exercises can also be an effective intervention (Xie et al, 2021). If compliance is a problem, group exercise can be an effective option to increase adherence (Xie et al, 2021).

CHAPTER 7 – SECTION 6: USING ANALOGIES TO UNDERSTAND MENTAL ILLNESS

People are like stained-glass windows...
Elisabeth Kubler-Ross (1926-2004)

UNDERSTANDING MENTAL ILLNESS VIA ANALOGIES

When studying mental illness, it is helpful to consider analogies to 'physical' illness, that is 'physical' diagnoses with which you are already familiar, such as diabetes mellitus type 2 (DM-2) and hypertension (HTN). The term 'physical' is being used for illustrative purposes only because, of course, poor physical health and poor mental health can adversely affect each other. For instance, anxiety can elevate blood pressure and HTN can cause

anxiety. Refer to **Figure 7-4.1. Analogies of Physical and Mental Diagnoses.**

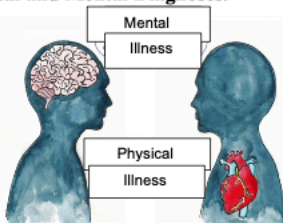


Figure 7- 4.1. Analogies of Physical and Mental Diagnoses

Physical Diagnoses	Mental Diagnoses / Comorbidities
<p>GOAL: A primary goal in the treatment of chronic physical diseases, condition, and injuries is to reduce and well-manage the signs and symptoms. EXAMPLE: A goal in the treatment of HTN is to manage the condition with medication and lifestyle changes such that the blood pressure is within normal limits (WNL) not only at rest, but also during intense physical activity and periods of emotional stress. (In some cases, the HTN is 'cured,' meaning medications are no longer required to ensure the blood pressure is WNL not only at rest, but also during intense physical activity and periods of emotional stress.</p>	<p>GOAL: A primary goal in the treatment of chronic mental disorders and conditions is to reduce and well-manage the signs and symptoms. EXAMPLE: A goal in the treatment of bipolar affective disorder (a chronic condition) is to manage the condition with medication and lifestyle changes such that at any given time it would <i>not</i> be medically indicated to add the diagnosis of an acute presentation of the disorder. Unlike HTN, however, bipolar affective disorder cannot be cured. In the best-case scenario, it is categorized as 'in remission.'</p>