We're So Anxious!! Challenges Faced and Lessons Learned in the Management of Anxiety in Older Adults

AAGP November Webinar
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Introductions

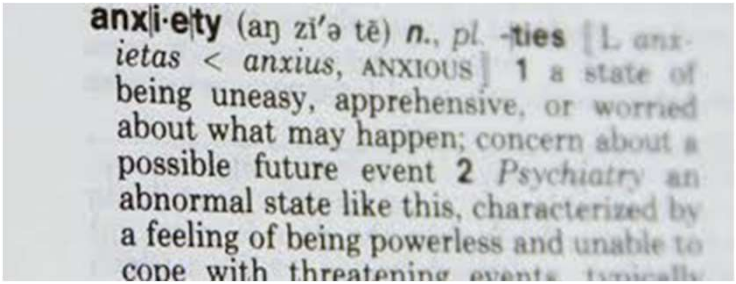
- Erica C. Garcia-Pittman, MD, FAPA
- Tawny L. Smith, PharmD, BCPP
- Alba Lara, MD
- Nicole Scott, MD
- Victoria Nettles, MD
- Victor M. Gonzalez Jr., MD

Learning Objectives

- Explore the similarities and differences between uncomplicated anxiety and a mixed episode of bipolar disorder.
- Review options for safely tapering benzodiazepines in geriatric patients while still managing anxiety
- Discuss complications and subsequent pharmacological management of anxiety and PTSD symptoms in older adults with major neurocognitive disorder.
- Review and recognize a presentation of major depressive disorder mimicking new-onset anxiety disorder

Disclosures

- No financial disclosures
- Will discuss off-label use of medications


anx·i·e·ty (aŋ zī′ə tē) *n.*, *pl.* **-ties** [L. *anxietas* < *anxius*, ANXIOUS] **1** a state of being uneasy, apprehensive, or worried about what may happen; concern about a possible future event **2** *Psychiatry* an abnormal state like this, characterized by a feeling of being powerless and unable to cope with threatening events, typically

LATE-LIFE ANXIETY

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Late-Life Anxiety Is Common

Anxiety disorders are highly prevalent in late life

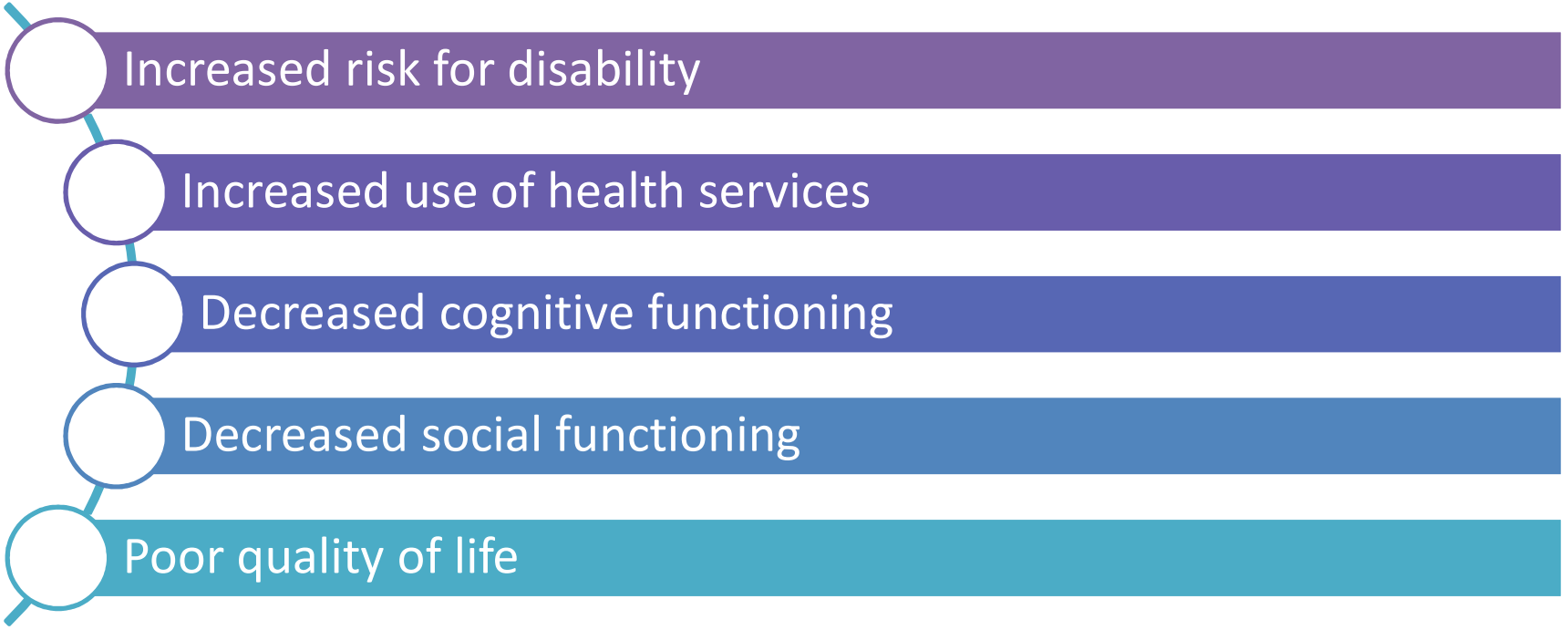
- 12-month prevalence of 10%
- Lifetime prevalence of up to 15.3%

Under-diagnosis and under-reporting is common

Commonly not treated by mental health professionals

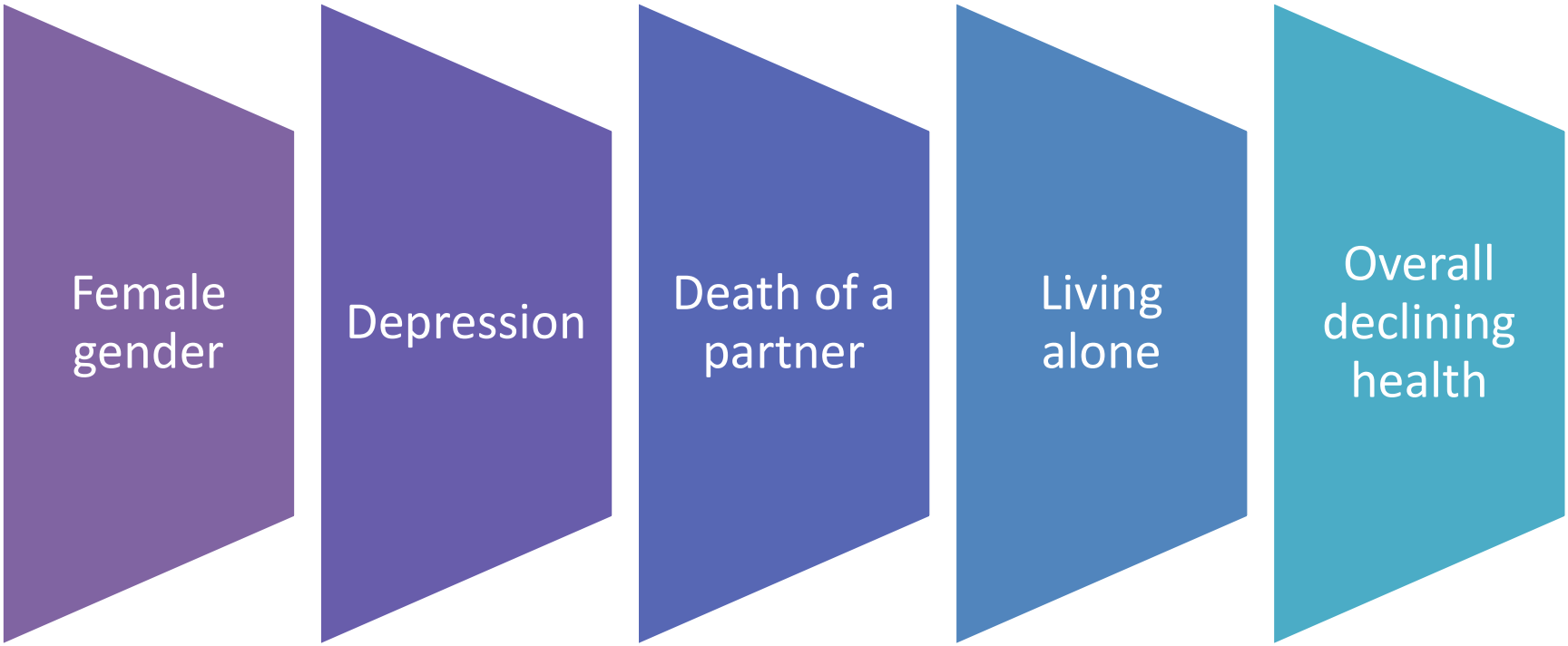
Beaudreau SA, et al. Am J Geriatr Psychiatr. 2008; 16:10: 790-803.
Bower ES, et al. Harv Rev Psychiatry. 2015; 23(5):329-42.

Late-Life Anxiety Is Bad



Bower ES, et al. Harv Rev Psychiatry. 2015; 23(5):329-42.

Risk Factors For Late-Life Anxiety



Doraiswamy PM. J Clin Psychiatry. 2001;62[suppl 12]:30–35

Clinical Presentation

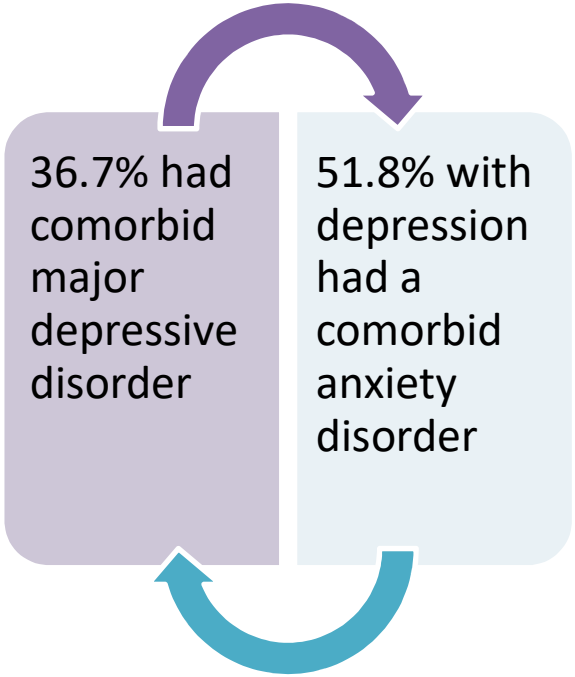
Complex clinical presentation

- Frequent mixed anxiety and depressive symptoms
- High rates of sleep disturbance
- Somatic symptoms are common including health-related worries
- Chronic medical conditions or medications can complicate the presentation

Beaudreau SA, O'Hara, R. Am J Geriatr Psychiatr. 2008; 16:10: 790-803.
Bower ES, et al. Harv Rev Psychiatry. 2015; 23(5):329-42.

Psychiatric Comorbidity

2.8% of adults 55+ experienced co-occurring mood and anxiety disorders



Bower ES, et al. Harv Rev Psychiatry. 2015; 23(5):329-42.

Physical Comorbidity

Older adults with anxiety frequently have comorbid medical conditions

Anxiety symptoms are frequently misattributed to physical illness

The following conditions are significantly associated with anxiety disorders:

- Cardiovascular disease
- Hyperthyroidism
- Diabetes
- Chronic pain
- Lung disease

Bower ES, et al. Harv Rev Psychiatry. 2015; 23(5):329-42.

Late-Onset Anxiety

Late-onset anxiety symptoms are uncommon

Consider other potential causes:

- Acute mood episode
- Neurocognitive disorder (including delirium)
- Chronic medical conditions or medications

Barriers to Diagnosis

Presentation may be different compared to younger patients

More challenging to describe/diagnose

- "Issue" or "concern," instead of "worry"
- "Uncontrollable"

Emphasis on somatic symptoms

Heterogeneity of illness

Less likely to seek mental health services

Bower ES, et al. Harv Rev Psychiatry. 2015; 23(5):329-42.

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- Bower ES, Wetherell JL, Mon T, Lenze EJ. Treating Anxiety Disorders in Older Adults: Current Treatments and Future Directions. Harv Rev Psychiatry. 2015 Sep-Oct;23(5):329-42.

- Doraiswamy PM. Contemporary Management of Comorbid Anxiety and Depression in Geriatric Patients. J Clin Psychiatry. 2001;62[suppl 12]:30–35.

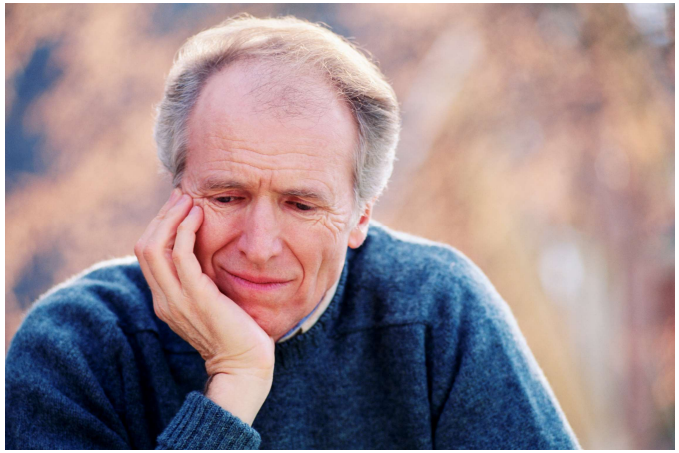
CASE #1: BENEATH THE MASK

Alba Lara, MD
PGY4 Psychiatry Resident
Dell Medical School | The University of Texas at Austin

Meet Mr. M.

CC: “I should have taken my Xanax this morning. I’m very anxious.”

74 year old Caucasian male presented as an emergent referral with abrupt, new onset of severe anxiety for 6 months in the context of perceived poor financial decisions and psychosocial stressors with children.



Clues About Underlying Diagnosis

Excessive ruminations about bankruptcy, “horrible” concentration, severe sleep impairment, weight loss

Multiple trials for anxiety + sleep by PCP unhelpful
On citalopram 40 x 3 wk + alprazolam 0.5 4x/day + temazepam 30 mg

Minimizes low mood but **has SI with plan**. No hx of mania, psychosis, neurocognitive disorder, or prior anxiety disorder

History

PMH: Paroxysmal afib, HTN, dyslipidemia, RLS

FH: No known mood, psychotic, or anxiety d/o

Social Hx: Laid off from work in the last 3-4 months because of mistakes at work. Struggling financially after loaning money to children. Recent withdrawal from social circles. Caregiving for wife.

Mental Status Exam

Clean, groomed, normal weight

Normal rate, **frantic** tone, volume, slight increased amount

Fair EC, engaged, **visibly tremulous** and fidgety

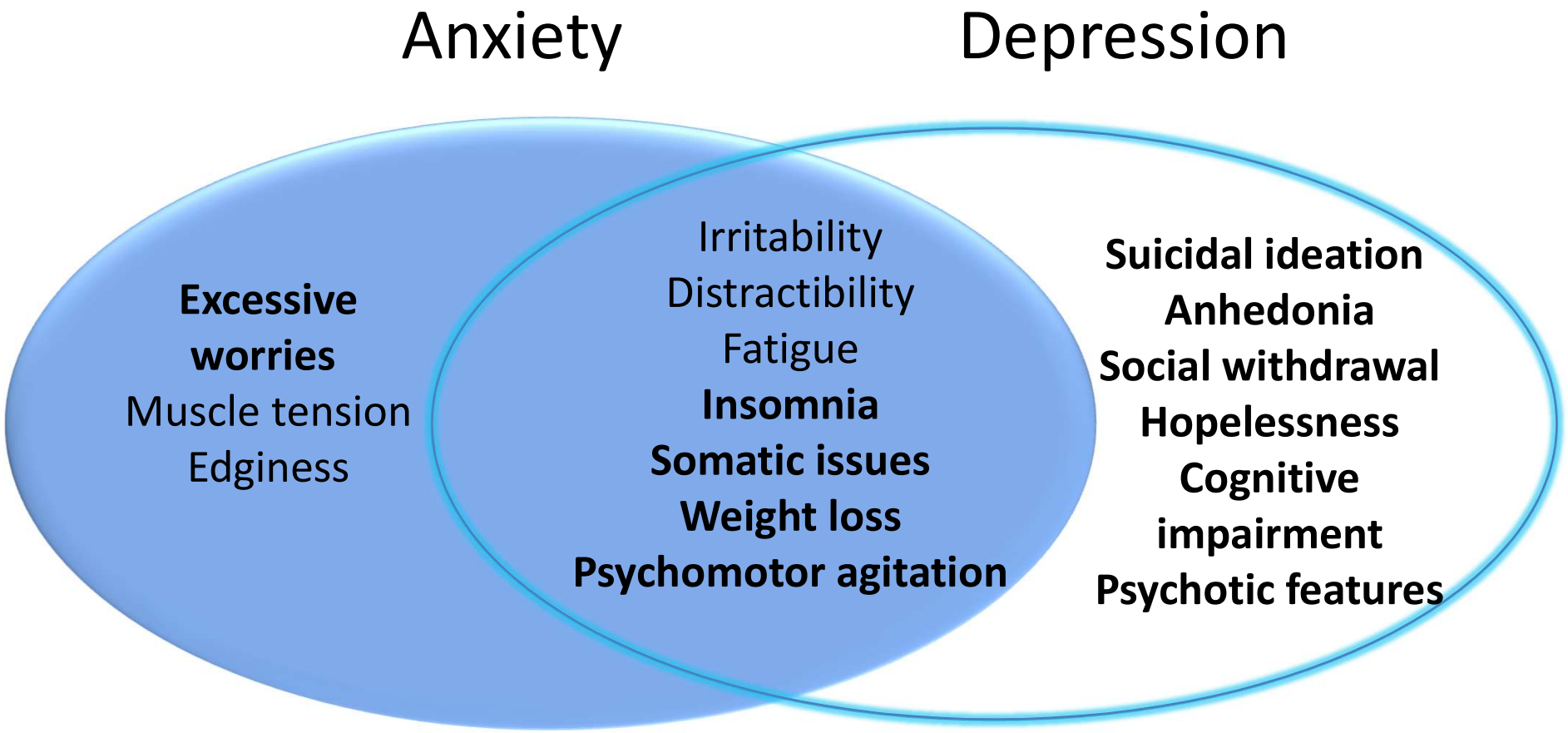
Mood: "Horrible"
Affect: **incongruent; broad, odd**/anxious smile and laughter

Circumstantial**, highly perseverative/fixated, thought disordered**

No SI/HI currently;
+hopelessness + delusions of guilt, catastrophizing

Insight: limited
Judgement: fair

PHQ9 – **23**
MOCA – 24/30
- 2/5 executive function
- 2/3 serial 7's
- 1/ 2 language
- 5/6 orientation



Evers and Marin, 2002

Clinical Importance of Psychotic Depression in Elderly

Nuances of Presentation

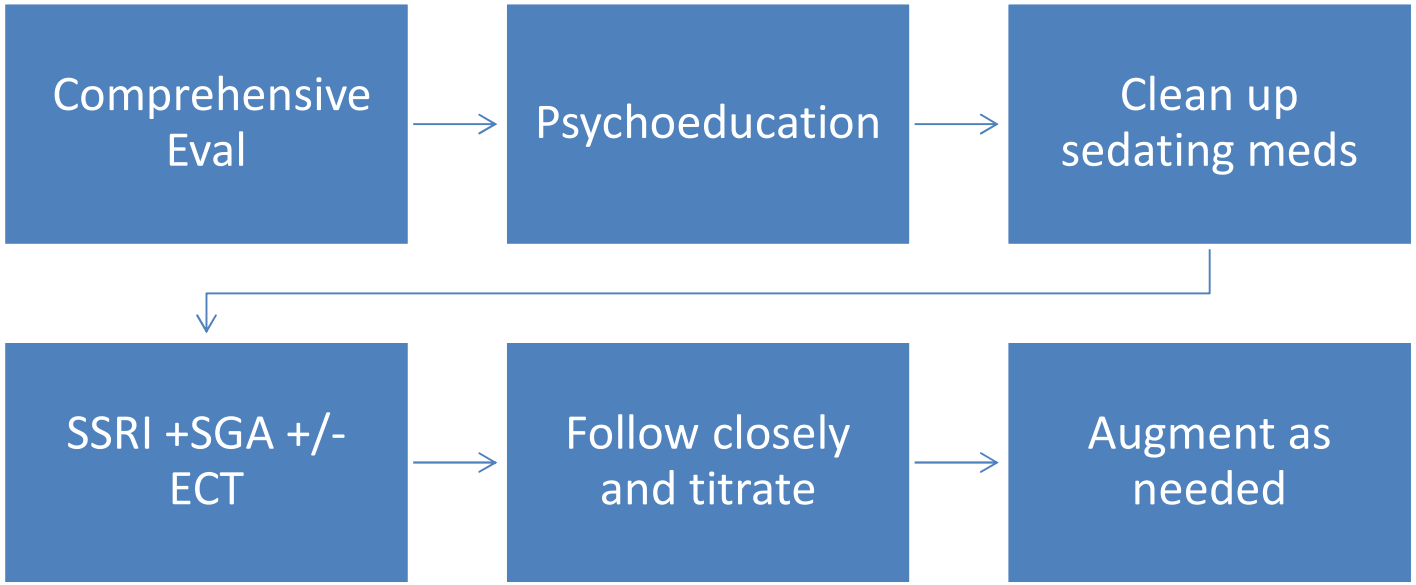
- 45% of elderly depressed patients have delusions
- Delusions of persecution, guilt, sin, somatic, or trivial events
- Higher psychiatric comorbidity, suicidality, functional and cognitive impairment

Potential Pitfalls in Diagnosis

- Subtle delusions may seem like anxiety
- Depressed geriatric patients more likely to focus on somatic symptoms and "concerns" rather than identify mood changes
- Geriatric MDD does have comorbid GAD in ~50% of cases

Targum, 2001
Bower et al, 2015

Evidence-Based Management Approach



Bower et. Al 2015

Outcome of Mr. M. – Unipolar Psychotic MDD

- ECT deferred due to rapid improvement of sx, normal MSE, and PHQ-9 = 0
- Tapered off olanzapine after 6 months in full remission
- Stable on citalopram 40 mg
- Functional impairment resolved

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CLINICAL PEARLS: REVIEW OF STOP-PD II

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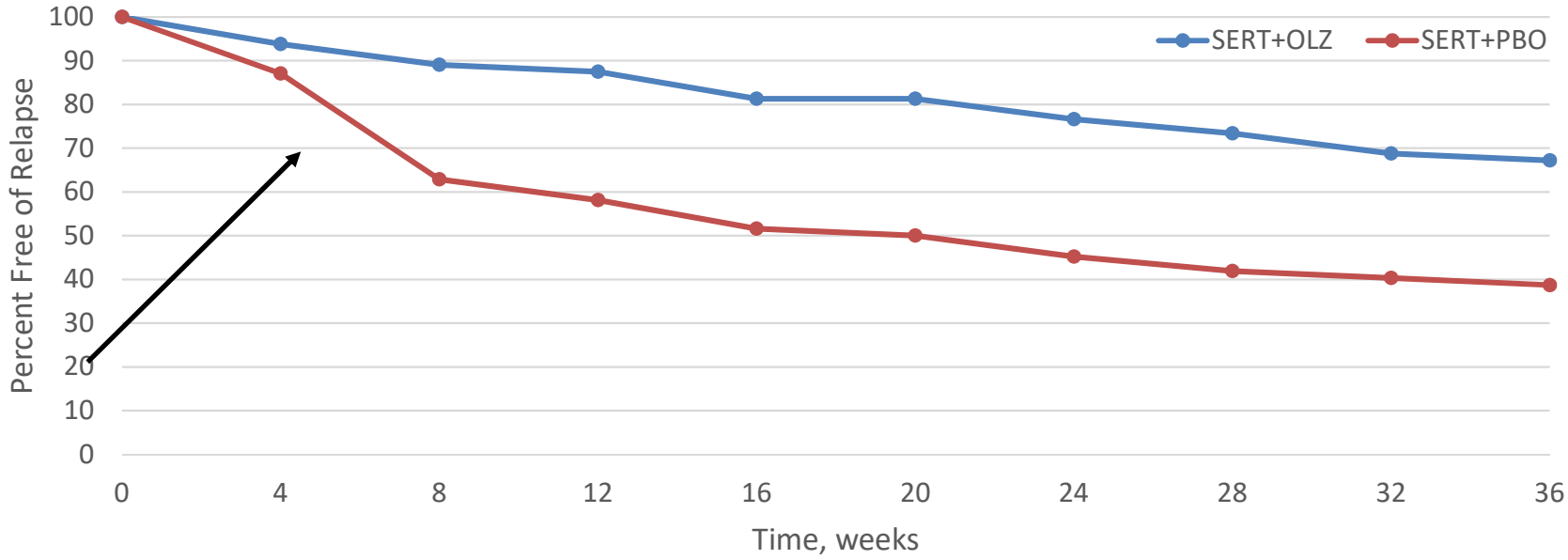
Study of Pharmacotherapy of Psychotic Depression – STOP PD II

- 36 week RCT to determine the clinical effects of continuing OLZ+SERT (n=64) vs. SERT alone (n=62) in psychotic depression.

Flint AJ, et al. JAMA 2019;322(7):622-31.

Relapse Prevention



Flint AJ, et al. JAMA 2019;322(7):622-31.

Impact on Metabolic Parameters
Younger vs. Older

- In the acute and stabilization phase
  - Trajectories for glucose, cholesterol and weight differed between younger vs. older group
    - Both groups experienced increase in weight and total cholesterol, but increase was greater in the younger group
    - Glucose increased in younger group but decreased in older group
- In the randomization portion, there were no differences in any of the measures

Flint AJ, et al. *Am J Geriatric Psychiatry* 2021;29(7):645-54.

Restoration of Weight

	Premorbid to acute phase baseline, mean (SD)	Acute phase baseline to stabilization termination, mean (SD)
Ages 18-59	0.63 (22.4) lbs	16.9 (13.7) lbs
Ages ≥ 60	-14.4 (15.9) lbs	9.5 (13.9) lbs

Flint AJ, et al. *Am J Geriatric Psychiatry* 2021;29(7):645-54.

Summary

- Combination of AD+ AP for the continuation phase of psychotic depression
- Continuation of the AP
  - At least 4 months, probably longer
  - Monitor for metabolic side effects (and tardive dyskinesia!)
    - Take into consideration premorbid weight

CASE #2: ALL MIXED UP

Nicole Scott, MD
PGY4 Psychiatry Resident
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The Case of B.G.

"I have very deep anxiety."

66 year old South Asian man presented to clinic with complaints of low mood and anxiety that was only partially responsive to treatment.

Describes feeling depressed, increase appetite, guilt, low energy, and hopelessness.

Endorses severe anxiety dating back to childhood; it can happen at any time, and it frequently keeps him at home.

Extensive past medication trials in all classes of antidepressants with little benefit; presented on escitalopram 30mg and aripiprazole 15mg.

History

Other medical problems are GERD, hyperlipidemia, and BPH.

Family history includes both son and daughter with depression and anxiety, and a niece and nephew who separately completed suicide.

Tends to isolate and spend most of his free time at home. He has a strained relationship with wife who he describes as a hoarder. He works in computer science.

History

He describes symptoms of depression and anxiety and denies history of classically manic behavior

+

Lack of treatment response to antidepressants and anxiolytics

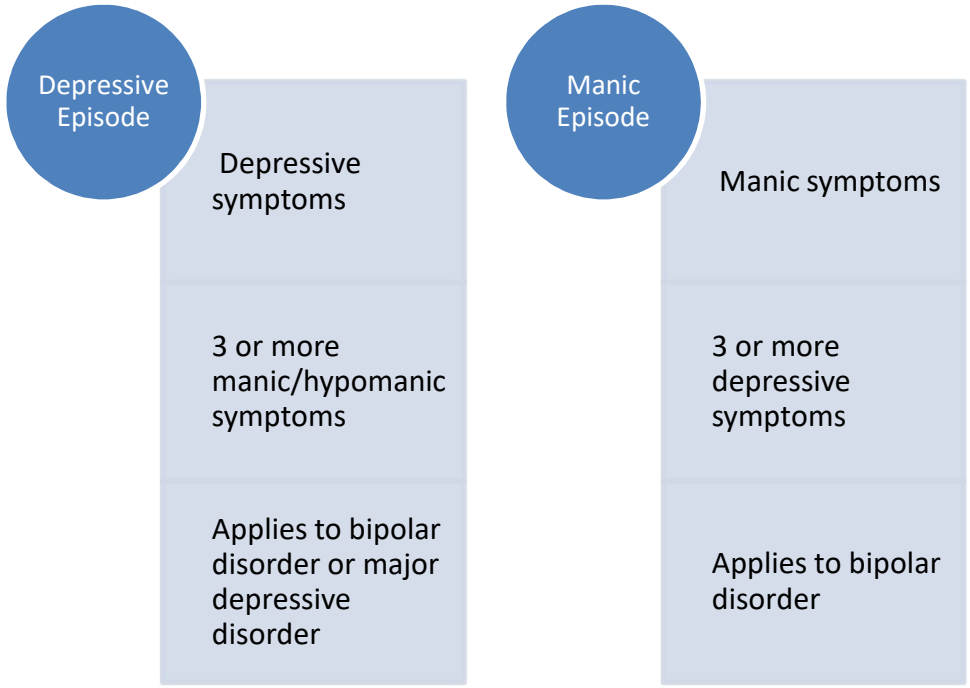
=

Bipolar disorder??

On further nuanced discussion, found a subtle history of hypomania including

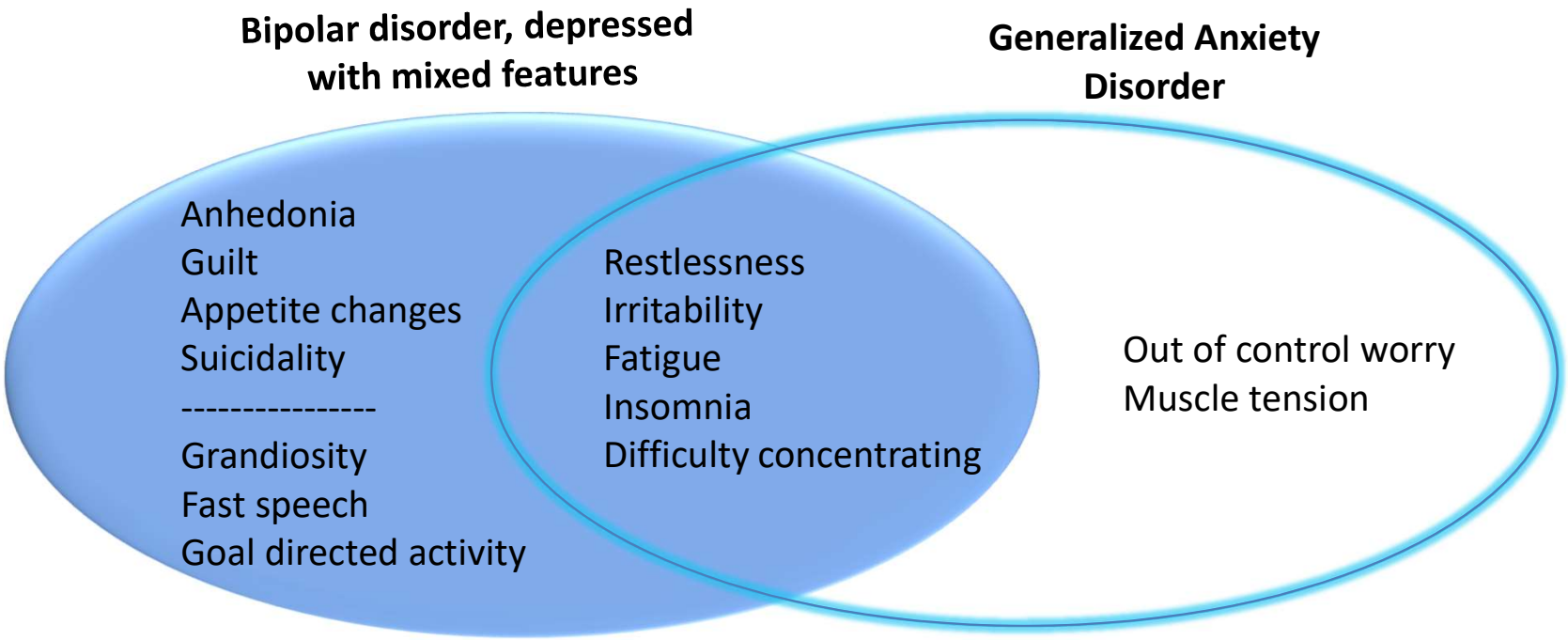
- history of racing thoughts
- sleeping 3-4 hours/night
- working excessively in his job as a computer scientist

Mixed Episodes



Without a good history of bipolar disorder, select mixed symptoms can sound just like “treatment resistant” MDD or GAD!

Overlapping Symptoms



PsychEducation (2014)

Clinical Impact of Mixed Symptoms

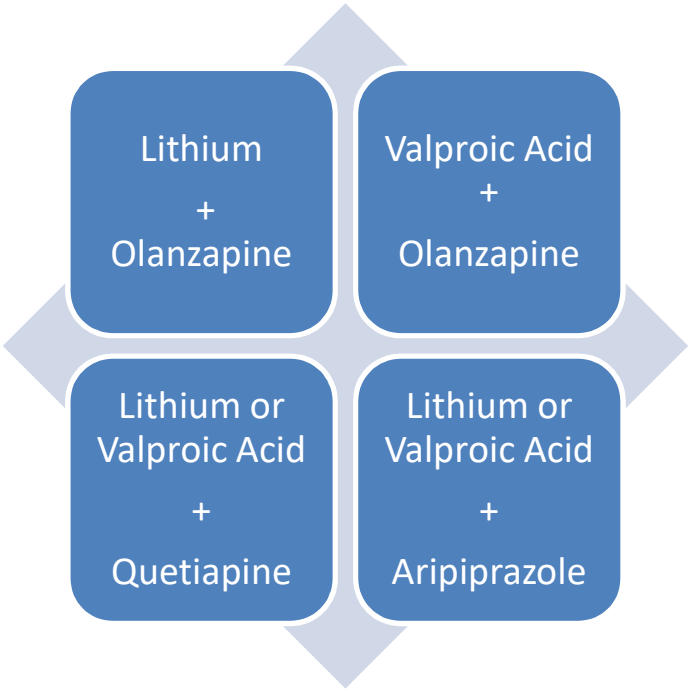
- Increased severity of episodes
- More prone to rapid cycling
- More prone to anxiety which can lead to more substance abuse to self-medicate
- More frequent suicidality
- Worse psychosocial functioning

Ott (2018)

Treatment for Mixed Features

- 2+ meds is the rule rather than the exception
- Focus on mood stabilizers, antipsychotics and combinations
- Avoid antidepressant monotherapy

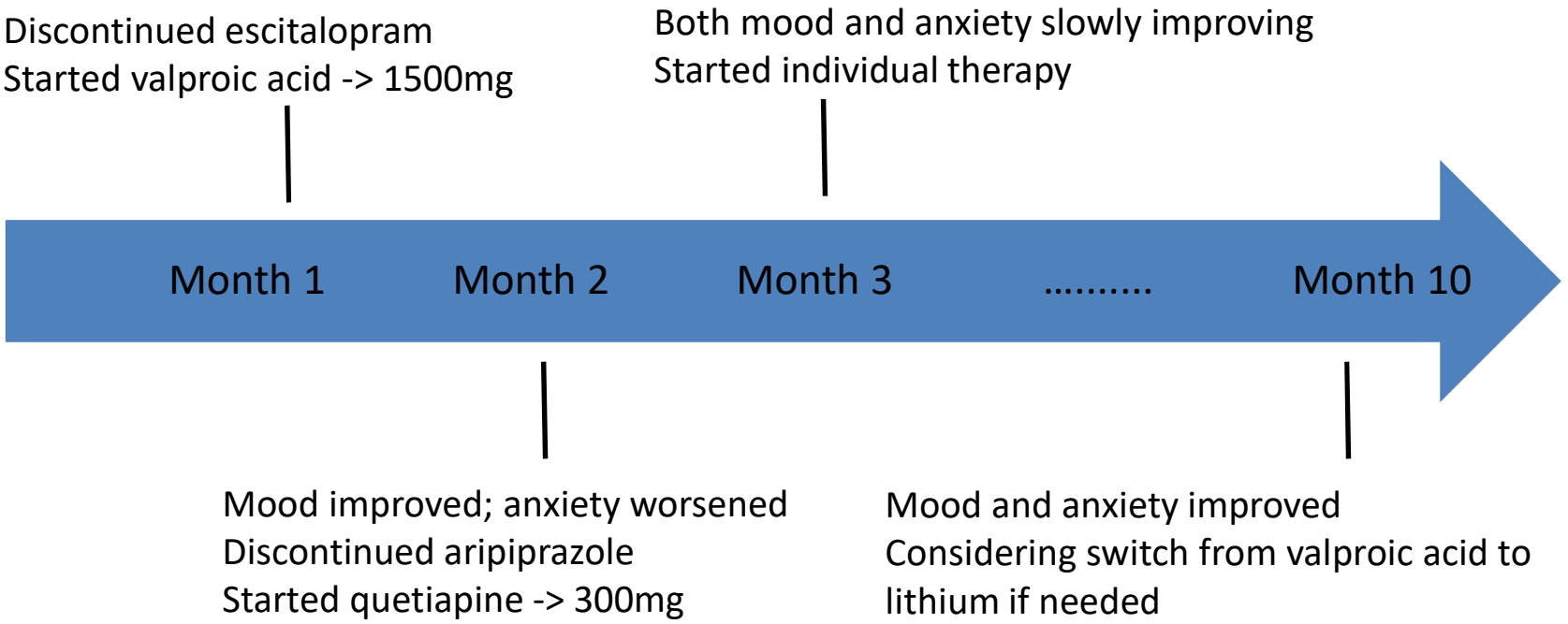
Treatment



ECT in refractory cases

Muneer (2017)

The Case of B.G.



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CLINICAL PEARLS: USE OF ANTIDEPRESSANTS IN MIXED STATES

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General Principles of Mood Disorders with Mixed Features

- No FDA approved medication includes this specifier
- ~20-40% experience mixed sxs
  - More common in females
- Associated with:
  - Poorer clinical outcomes
  - More frequent relapse
  - Greater risk of affective switch
  - Greater risk of suicide
  - Higher comorbidity

Rosenblatt JD, McIntyre RS. *CNS Spectrum.* 2017;22:147-154

Antidepressants in BD w/ Mixed Features
What do the Experts Say?

- Antidepressant-induced 'activation syndrome' is 4x more frequent in BD II & NOS vs unipolar depression
- Antidepressants may aggravate the mixed state or induce it

Mixed Mania or Hypomania	Mixed Depression
Avoid antidepressants	Only use antidepressants as a last resort
If on an antidepressant, taper off	Use an antidepressant that is less likely to cause an affective switch and use for a minimal duration and dosage.

Rosenblatt JD, McIntyre RS. *CNS Spectrum.* 2017;22:147-154; Grunze H, et al. WFSBP Treatment Guideline. *W J Bio Psychiatr.* 2018;19(1):2-58; Wang D, Osser DN. *Bipolar Disord* 2020;22(5):472-89

Role of Antidepressants in MDE w/ Mixed Features

- May not respond as well to antidepressant monotherapy
  - More likely to experience irritability and mood lability
  - Higher rates of treatment resistance
- Pharmacologic treatment interventions have focused on SGAs
  - RCTs with lurasidone and ziprasidone

Rosenblatt JD, McIntyre RS. *CNS Spectrum.* 2017;22:147-154; Perugi G, et al. *Eur Neuropsychopharmacol*. 2019 Jul;29(7):825-834; Shim IM, et al. *Clin Psychopharmacol Neurosci*. 2018;16(4):376-82.

CASE #3: MORE MEDS, MORE PROBLEMS

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Patient Case

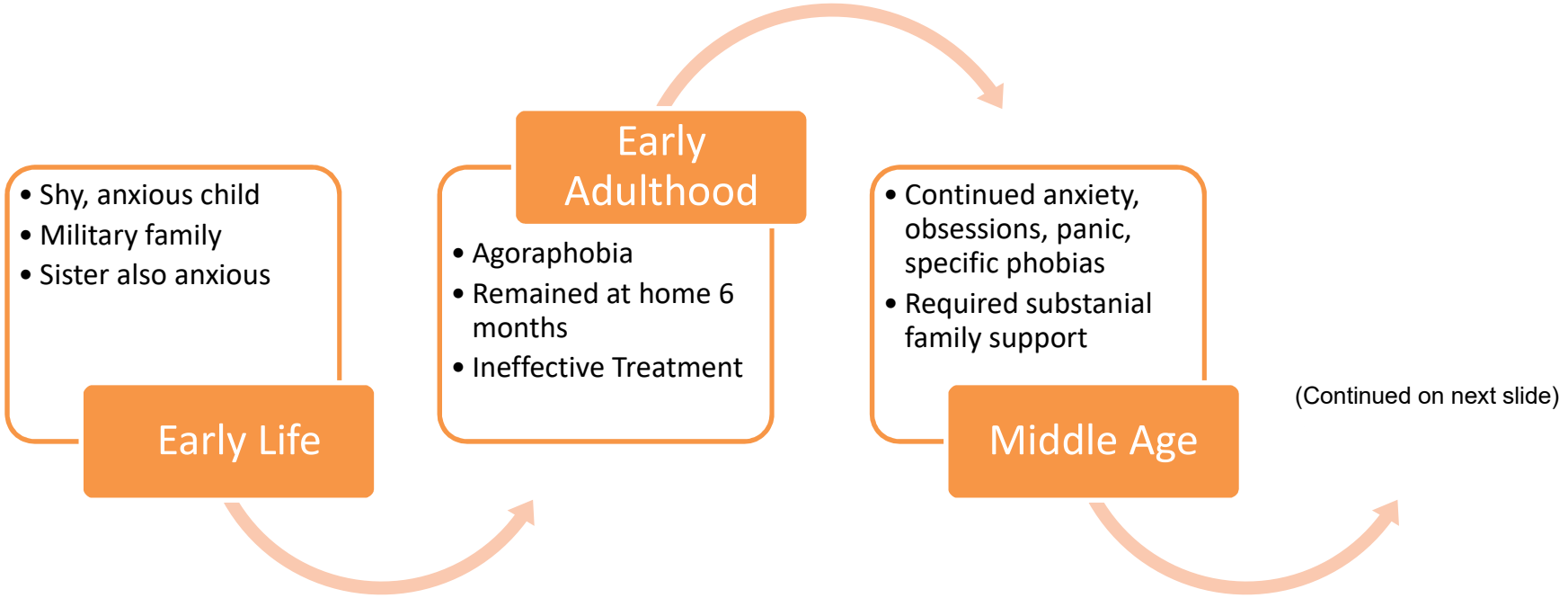
CC: "This visit was prompted by the government telling my physician that he couldn't prescribe the amount of Klonopin that he was."

68 y/o Caucasian man with GAD, OCD, and panic disorder with agoraphobia

Referred to geriatric psychiatry when previous provider advised by Medicare to reduce sedative/hypnotic dose load

Treated by PCP last 5-6 years with reported complete symptom resolution

Symptom Timeline



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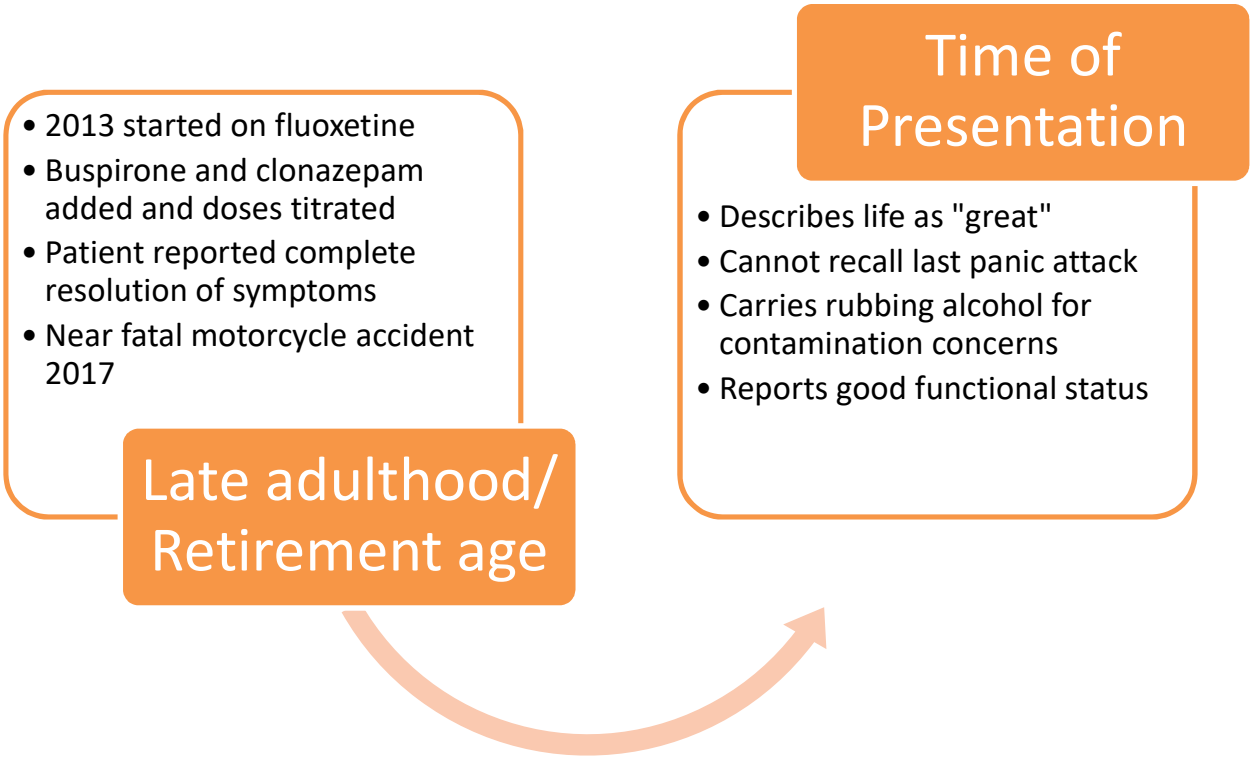
Symptom Timeline (cont'd)



Patient Case Cont.

Medication Regimen:

- Clonazepam 4mg PO QID
- Fluoxetine 80mg PO qAM & 40mg PO qHS (with option for additional 20mg PO qHS PRN panic)
- Buspirone 30mg PO TID

Lives independently, retired, manages own IADLs with exception of medication management

Treatment Considerations

What are safety concerns of current medication regimen?

How to safely taper?

How to manage emergent symptoms?

Risks of Benzodiazepines in Elderly Adults

Madhusoodanan, S. and Bogunovic, O. "Safety of Benzodiazepines in the Geriatric Population." *Expert Opinion on Drug Safety*, 3(5), pp.485-493.

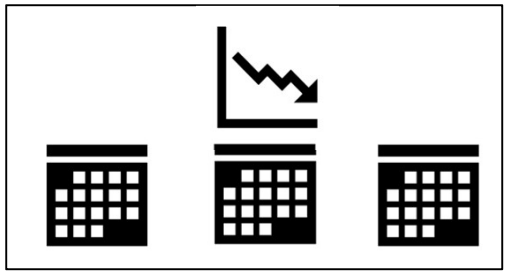
Dublin, Sascha, et al. "Use of Opioids or Benzodiazepines and Risk of Pneumonia in Older Adults: A Population-Based Case-Control Study." *Journal of the American Geriatrics Society*, vol. 59, no. 10, 2011, pp. 1899–1907.

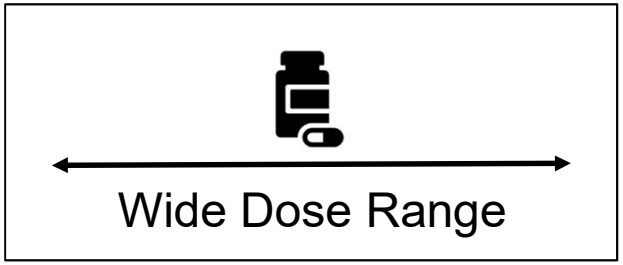
Canadian Benzodiazepine Receptor Agonist Deprescribing Recommendations

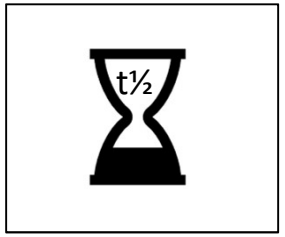
- Decrease dose ~25% every two weeks
- Slow taper to ~12.5% dose reduction every two weeks “near end” of taper

Limitation: recommendations for patients with insomnia rather than anxiety disorders

Considerations for Tapering Benzodiazepines



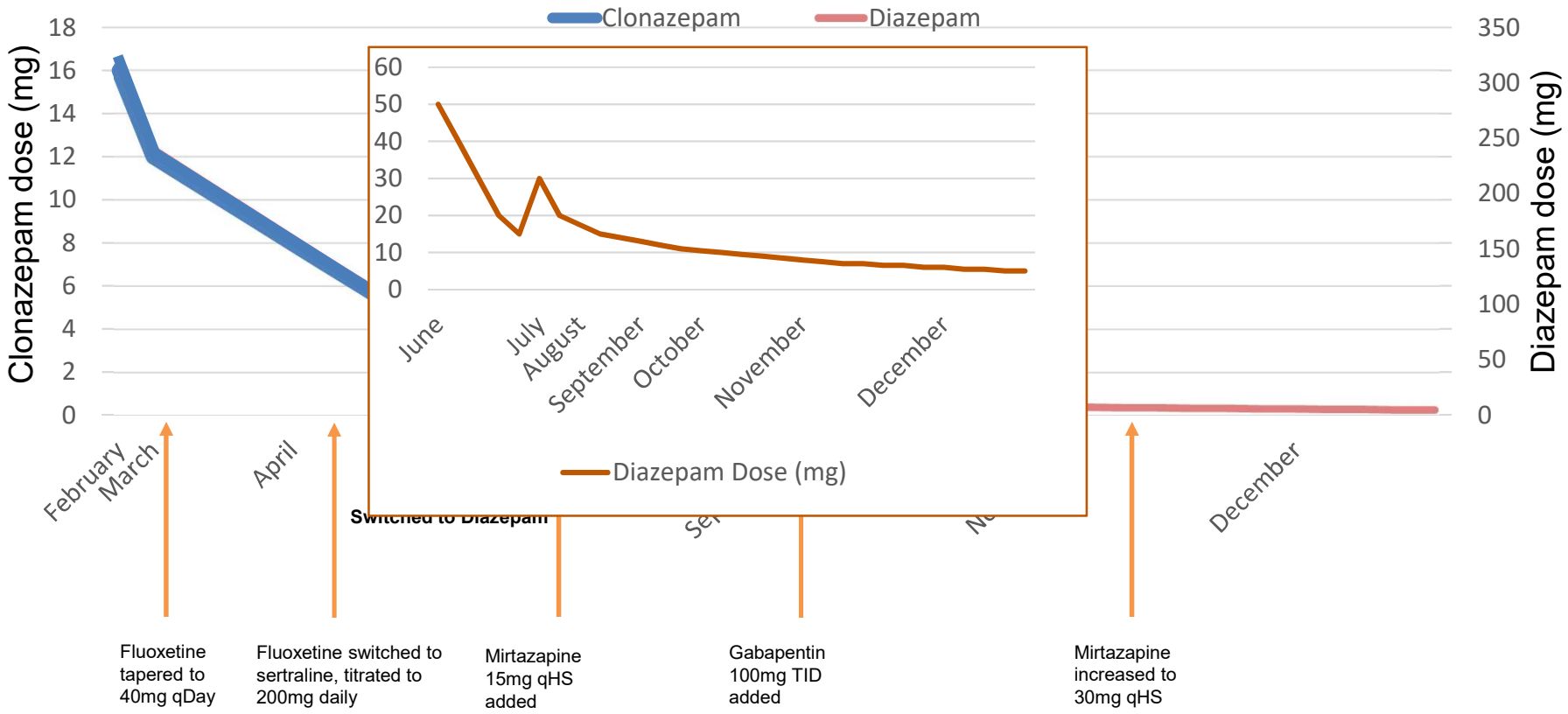




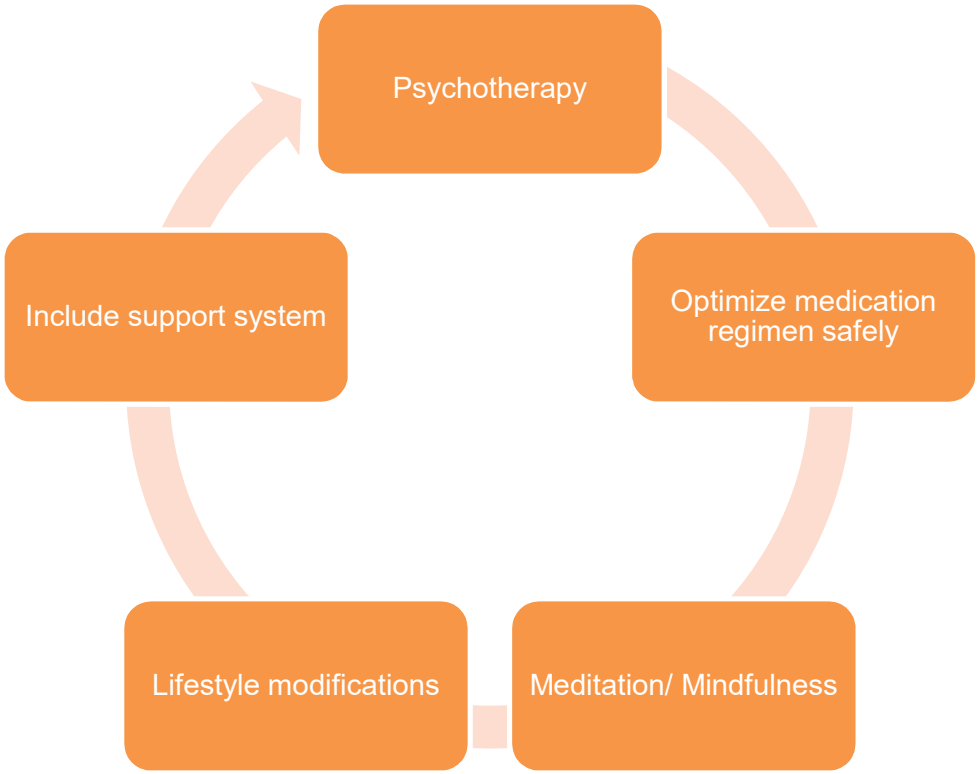
Equivalencies

- Clonazepam 0.5mg
- Diazepam 10mg
- Lorazepam 1mg
- Alprazolam 0.5mg
- Temazepam 20mg

Treatment Course



Managing Emergent Anxiety



"Take a Multifaceted Stepwise Approach When Deprescribing Benzodiazepines in Older Patients." *Drugs & Therapy Perspectives*, vol. 35, no. 2, 2018, pp. 72–76., doi:10.1007/s40267-018-0578-z.

Most Recent Medication Regimen

- Sertraline 200mg PO qDay
- Buspirone 30mg PO TID
- Mirtazapine 30mg PO qHS
- Gabapentin 100mg PO TID
- Diazepam 3mg PO BID

References

1. Curran, H. V., et al. “Older Adults and Withdrawal from Benzodiazepine Hypnotics in General Practice: Effects on Cognitive Function, Sleep, Mood and Quality of Life.” *Psychological Medicine*, vol. 33, no. 7, 2003, pp. 1223–1237.
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4. Madhusoodanan, S. and Bogunovic, O. "Safety of Benzodiazepines in the Geriatric Population.” *Expert Opinion on Drug Safety*, 3(5), pp.485-493.
5. Paquin, Allison M, et al. “Risk versus Risk: a Review of Benzodiazepine Reduction in Older Adults.” *Expert Opinion on Drug Safety*, vol. 13, no. 7, 2014, pp. 919–934.
6. Pottie, Kevin, et al. “Deprescribing Benzodiazepine Receptor Agonists.” *The College of Family Physicians of Canada*, The College of Family Physicians of Canada, 1 May 2018.
7. “Take a Multifaceted Stepwise Approach When Deprescribing Benzodiazepines in Older Patients.” *Drugs & Therapy Perspectives*, vol. 35, no. 2, 2018, pp. 72–76.

CLINICAL PEARLS: BENZODIAZEPINE TOLERANCE WITH LONG TERM USE?

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Benzodiazepine Tolerance

Therapeutic Effect	Tolerance?
Anxiolysis	?
Anticonvulsant	Y
Cognitive	N
Risk for Falls	N
Sedation	Y

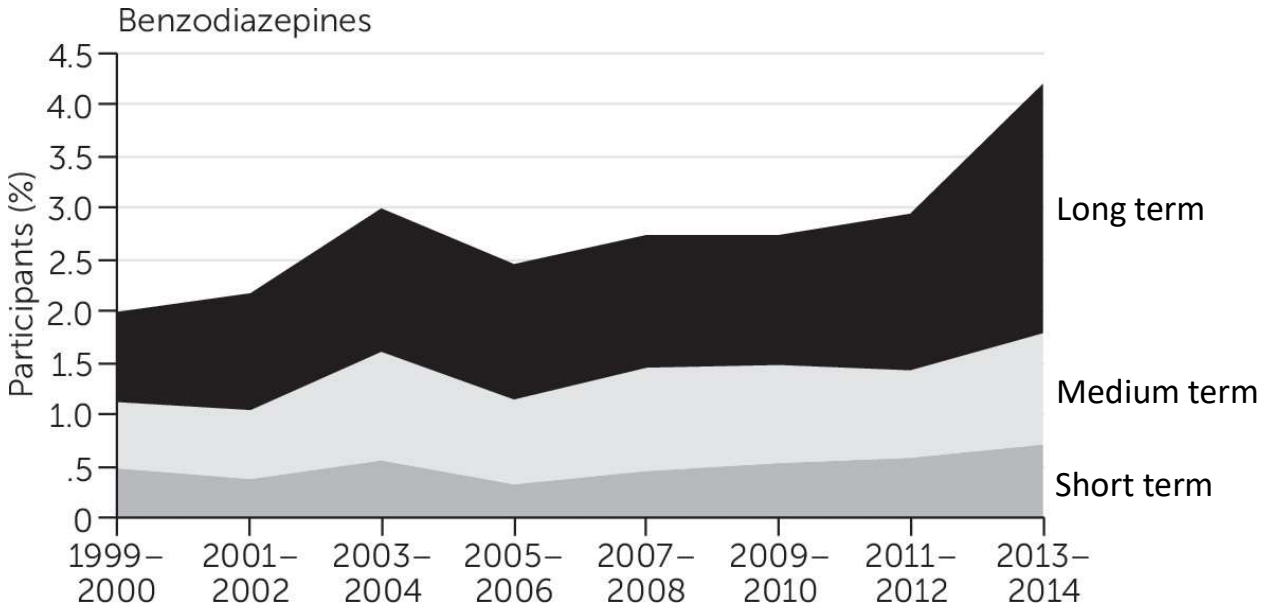
Cheng T, et al. Neuropsychiatr Dis Treat 2018;1:1351-61. Barker MJ, et al. *CNS Drugs*. 2004;18:37–48; Lader M. *Br J Clin Pharmacol*. 2014;77(2):295–301. doi:10.1111/j.1365-2125.2012.04418.x; Vinkers CH, Olivier B. *Adv Pharmacol Science*. 2012: doi:10.1155/2012/416864

What Do Current Guidelines Recommend?

- SSRIs/SNRIs are considered 1st line
- BZDs are reserved for short term use (<4 weeks) and
- Should be reserved for severe cases that do not respond to 1st line interventions

British Association for Psychopharmacology 2014 – Anxiety Disorders, PTSD and OCD
Canadian Guidelines for Anxiety, PTSD and OCD 2014

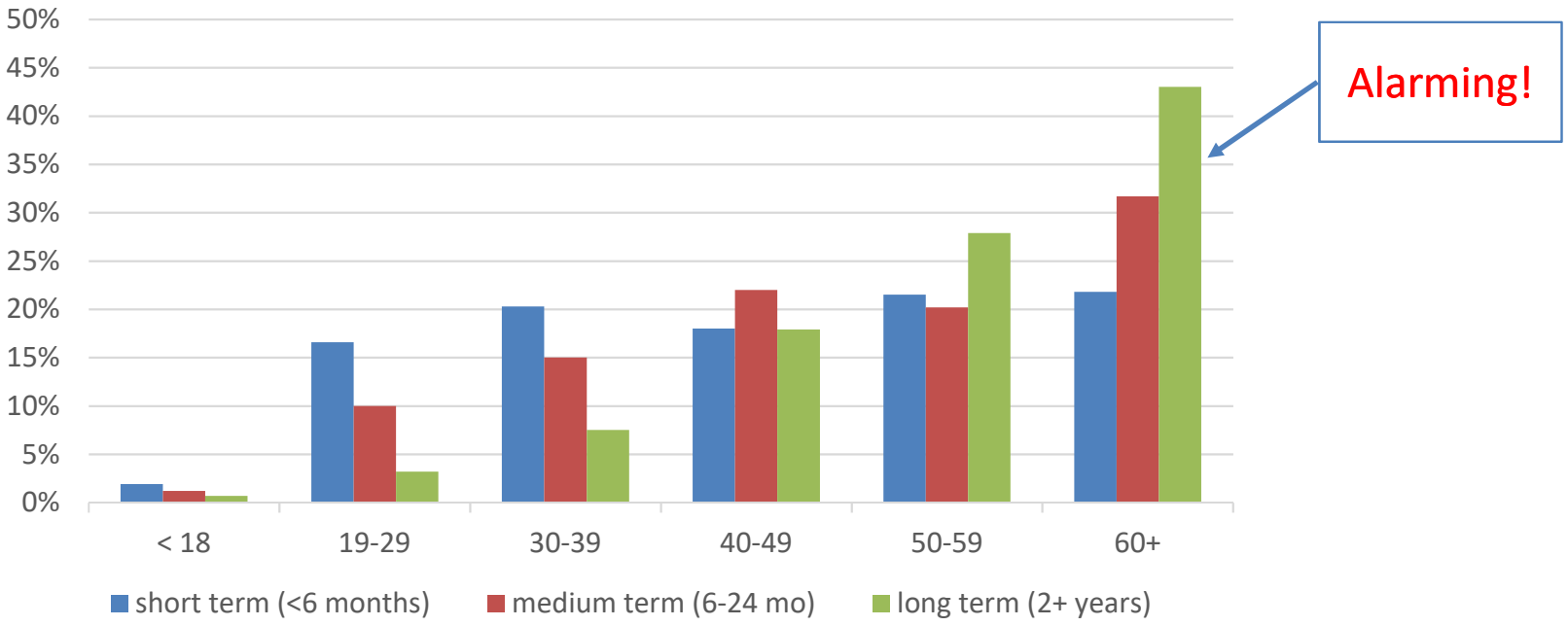
Benzodiazepine Prescribing Trends, 1999-2014



Trends in short-term (less than six months), medium-term (six to 24 months), and long-term (more than 24 months) use of benzodiazepines and nonbenzodiazepine hypnotics, 1999–2014

From: Kaufman CN et al. *Psychiatric Serv 2018:69(2):235-8.*

Long Term Benzodiazepine Use, 1999-2014



Kaufmann CN et al. *Psychiatric Serv 2018:69(2):235-8.*

Any Signals?

US Study

- Retrospective cohort of long-term BZD users in NJ Medicaid population
- Evaluated the frequency dose changes and dose escalation
- No relationship between long term use and escalating doses
  - Only 1.3% showed patterns of dose escalation

Netherlands Study

- Observational study of long-term BZD use (>6 mo) from 19 family practices
- Primary objective was the mean change in prescribed daily doses per 3-month period out to 2 years
- Doses of BZD did not change over time

Soumerai SB, et al. *Psychiatr Serv* 2003;54:1006-11; Willems IAT, et al. *Family Pract* 2013;30:404-10.

Long-Term Use in "Anxious Outpatients"

- Continuous use (for up to 22 weeks) of diazepam (15-40 mg/day) of chronically anxious outpatients (n=180)
- No indicators of tolerance noted

Rickels K, et al. *JAMA.* 1983;250(6):767-771. doi:10.1001/jama.1983.03340060045024

Long Term Use in Anxiety

- 16 week RCT of alprazolam vs. lorazepam vs. placebo
  - Mean daily doses at 16 weeks:
    - Alprazolam 3.3 mg
    - Lorazepam 5.1 mg
- Both BZDs were superior to placebo in improving anxiety sxs as measured by the HAM-A

Cohn JB, Wilcox CS. *Pharmacotherapy* 1984;4(2):93-8

Panic Disorder - Maintenance Treatment

- Responders to either alprazolam vs. imipramine vs. PB in the 8 week trial were continued for an additional 6 months
- All patients in the alprazolam remained panic free at the end of 8 months
  - Average daily dose = 5.7 mg
  - No dose increase required

Schweizer E, et al. *Arch Gen Psychiatry.* 1993;50(1):51-60. doi:10.1001/archpsyc.1993.01820130053009

Long-term Clonazepam for Panic Disorder

36 week, open label trial of paroxetine vs. clonazepam

	Baseline	End of acute treatment	Mean over long-term treatment
Mean (SD) Panic Attacks per month			
Clonazepam Ave daily dose 1.9 mg (n=47)	5.1 (2.5)	0.3 (0.4)	0.12 (0.17)
Paroxetine Ave daily dose 38.4 mg (n=37)	5.4 (2.4)	0.2 (0.4)	0.16 (0.13)

Nardi AE, et al. J Clin Psychopharmacol 2012;32(1):120-6 doi: 10.1097/JCP.0b013e31823fe4bd

Benzodiazepine Tolerance

Therapeutic Effect	Tolerance?
Anxiolysis	N
Anticonvulsant	Y
Cognitive	N
Risk for Falls	N
Sedation	Y

Cheng T, et al. Neuropsychiatr Dis Treat 2018;1:1351-61. Barker MJ, et al. *CNS Drugs*. 2004;18:37–48; Lader M. *Br J Clin Pharmacol*. 2014;77(2):295–301. doi:10.1111/j.1365-2125.2012.04418.x; Vinkers CH, Olivier B. *Adv Pharmacol Science*. 2012: doi:10.1155/2012/416864

High Risk Patients

Group	Comments
Pregnant or breastfeeding women	NAS; sedation in breastfed infants
Geriatric	Increased risk of falls and cognitive impairment
Current or past substance use disorders	Risk of misuse or dependence
Currently prescribed opioids	Increased risk of respiratory depression and death
COPD or OSA	Increased risk of adverse respiratory outcomes
Comorbid PTSD or OCD	No proven efficacy in treating PTSD or OCD

CASE #4:
BEWARE OF THE DARK MAN

Victor M. Gonzalez Jr., MD

Assistant Professor
The University of the Incarnate Word School of Osteopathic Medicine – San Antonio

Former Geriatric Psychiatry Fellow
The University of Texas Health Science Center – San Antonio

UT Health
San Antonio

The Case:

"I'm afraid of the dark man."

An 84 year old Caucasian woman in a nursing home was asked to be evaluated for increased anxiety and panic attacks in the setting of declining cognitive function.

Family expressed concern of anxiety with daily panic attacks, hypervigilance, nightmares, and visual hallucinations.

Experienced living in Japanese concentration camp in Indonesia at age 8 where she was physically abused and saw others tortured. Dealt with depression and anxiety throughout her life, resulting in one prior psychiatric hospitalization.

Previously trialed various antidepressants and benzodiazepines with moderate effectiveness.

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Patient Case Cont.

Patient living in her own home with caregiver assist, able to perform ADLs, increased assistance with IADLs

Admitted to hospital in July 2019 due to multiple falls, subsequently discharged to rehab facility.

Transferred to nursing home in August 2019, experiencing steep decline in ability to perform ADLs and IADLs; MoCA 13/30

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Patient Case Cont.

Current psychotropic medications:
Fluoxetine 20mg Qday
Sertraline 50mg Qday
Metoprolol 12.5mg BID
Buspirone 5mg TID
Trazodone 100mg QHS
Lorazepam 0.5mg Q6hrs
Alprazolam 0.5mg Q6hrs PRN
Other medications:
Potassium 20mEq Qday
Montelukast 10mg Qday
Vit D3 5000 unit Qday
Levothyroxine 50mcg QAM

Medical Hx:
Hyperlipidemia
Hypertension
Atrial fibrillation
Neuropathy
Chronic low back pain
Hypothyroidism

Psychiatric Diagnoses:
Major Depressive Disorder
Generalized Anxiety Disorder

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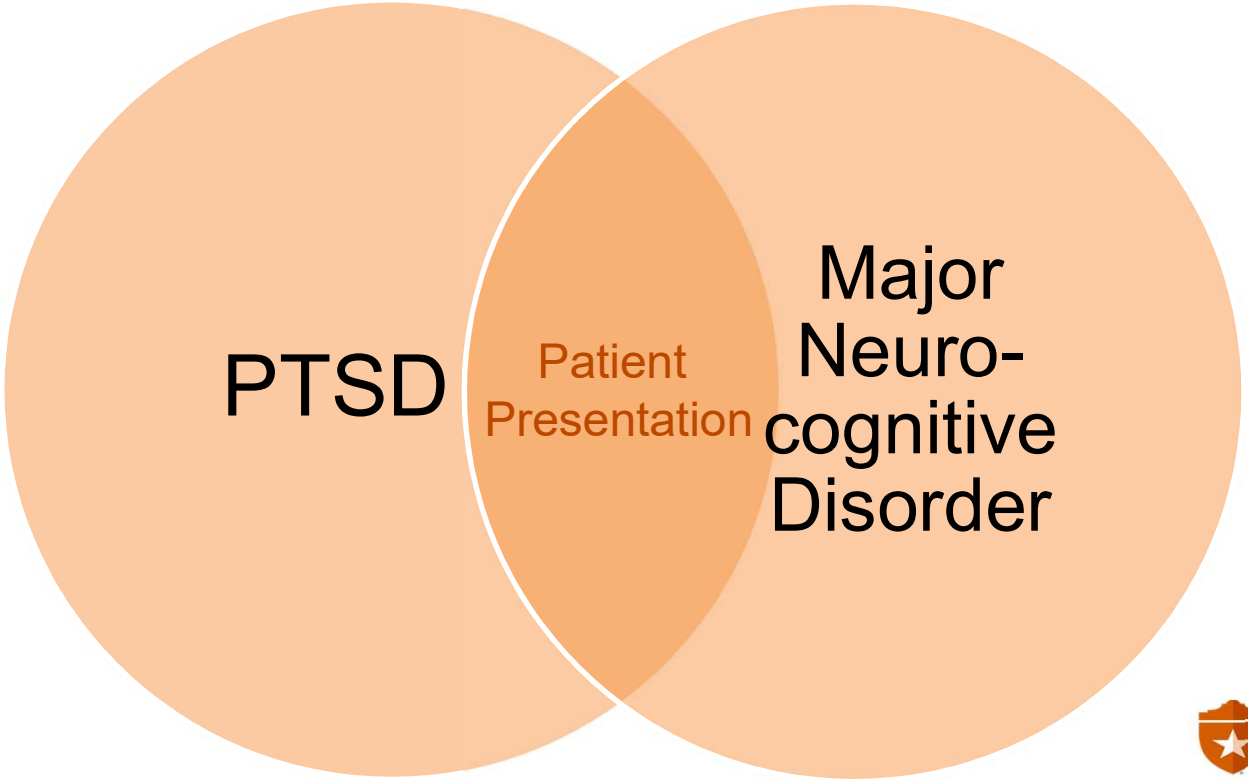
Establishing a Diagnosis



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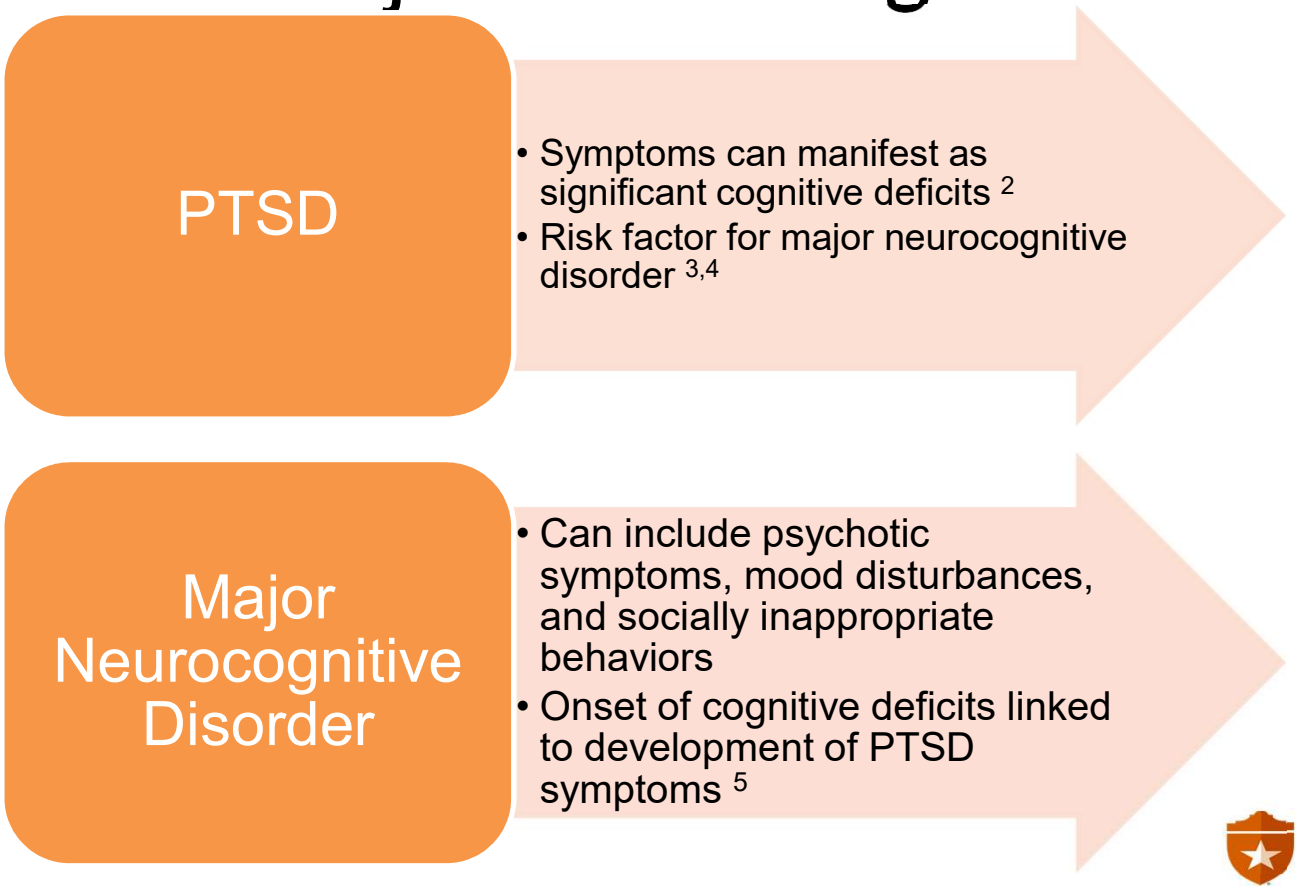
PTSD and Major Neurocognitive Disorder



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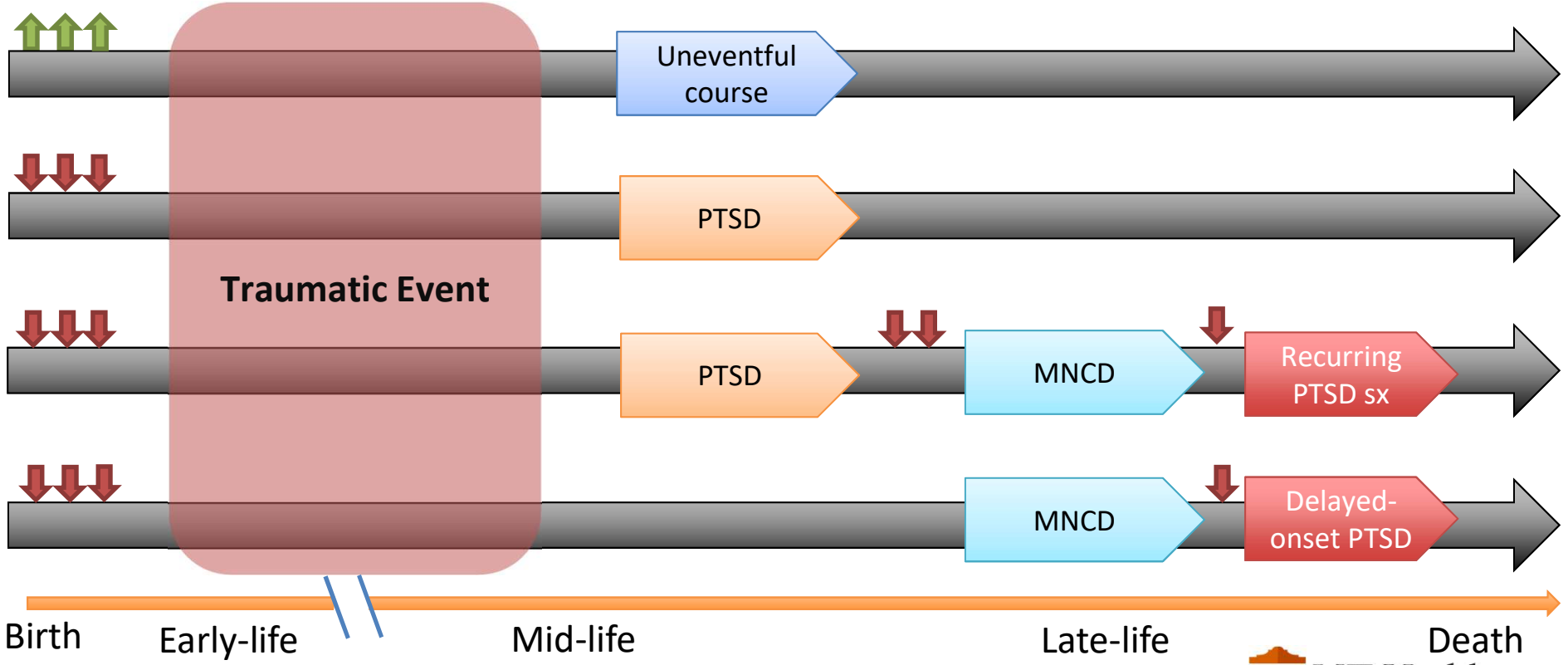
Possible Trajectories Following a Major Traumatic Event



Adapted from: P Desmarais, D Weidman, A Wassef, *et al. The interplay between post-traumatic stress disorder and dementia: A systematic review*. Am J Ger Psych, 28 (2020), pp 48-60.

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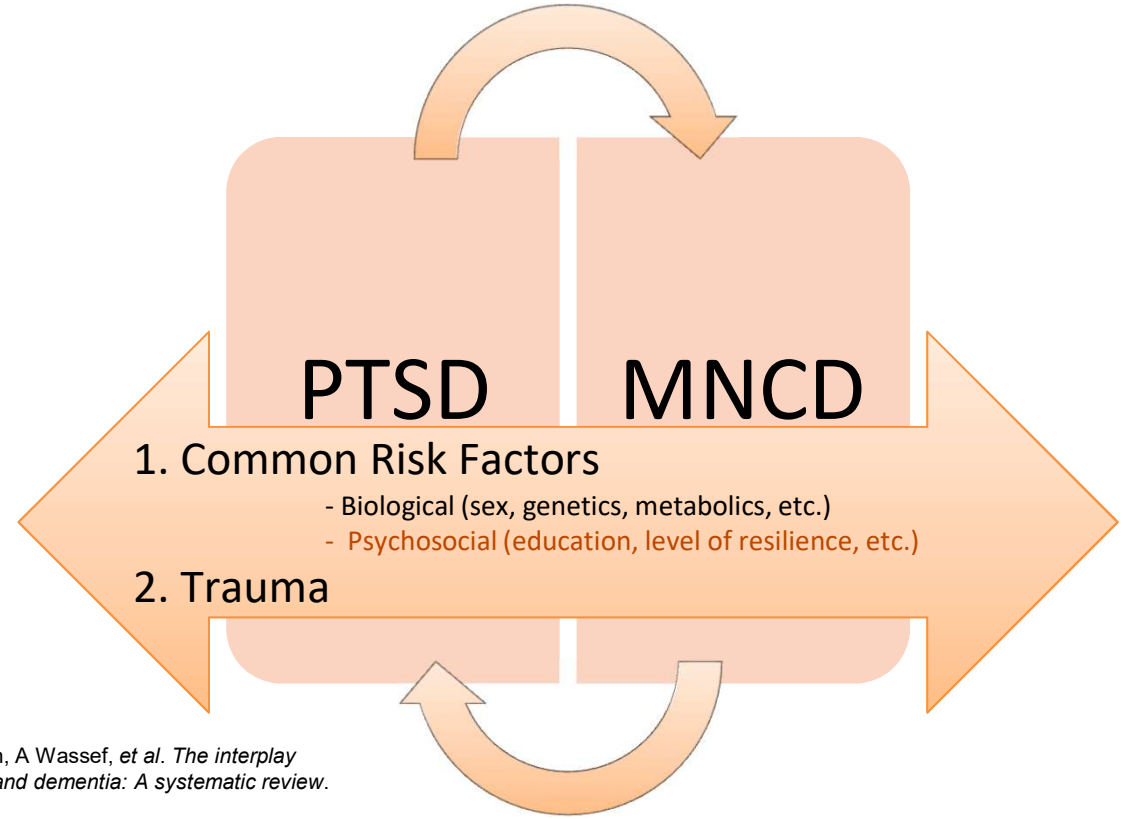
Relationship Between PTSD and Major Neurocognitive Disorder



Adapted from: P Desmarais, D Weidman, A Wassef, *et al*. *The interplay between post-traumatic stress disorder and dementia: A systematic review*. Am J Ger Psych, 28 (2020), pp 48-60.

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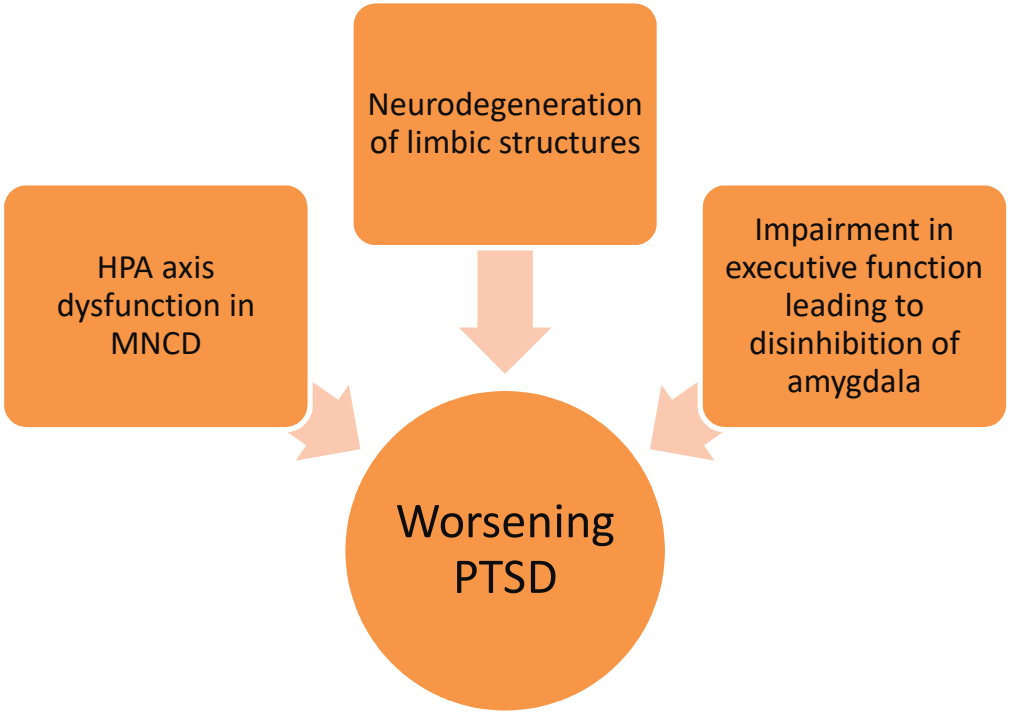
Worsening PTSD Symptoms in the Setting of Major Neurocognitive Disorder



P Desmarais, D Weidman, A Wassef, *et al*. *The interplay between post-traumatic stress disorder and dementia: A systematic review*. Am J Ger Psych, 28 (2020), pp 48-60.

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Patient Case - Treatment Approach

MNCD symptoms

- Behavioral interventions to assist adjustment to new nursing home environment
- No medications initiated for MNCD at that time

PTSD/Anxiety

- Titrated sertraline to 150mg qday for mood/anxiety
- Titrate trazodone to 150mg qhs for sleep
- Continue Lorazepam 0.5mg q6hrs for anxiety (eventual taper)
- Reduce polypharmacy
  - Discontinue alprazolam
  - Discontinue buspirone
  - Discontinue fluoxetine

➡ Overall improvement in PTSD/anxiety symptoms and performance of ADLs

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DISCUSSION

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Anxiety Treatment Guidelines

Psychoeducation

1st line treatment

- Discontinuation of harmful or inappropriate medication
- SSRI, SNRI, relaxation training and CBT

Frequent follow-up

Gradual medication titration

Maintenance treatment

Katzman et al. BMC Psychiatry 2014, 14(Suppl 1):S1.

Treatment Guidelines (continued)

Augmentation

- Insufficient evidence to guide
  - Buspirone
  - Mirtazapine
  - Gabapentin/Pregabalin
  - TCAs
  - Antipsychotics
- CBT

Benzodiazepines are not a preferred long-term treatment strategy

Katzman et al. BMC Psychiatry 2014, 14(Suppl 1):S1.

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Questions?

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