DEAR DR. JEFF
By Jeffrey Nichols, MD, CMD

Get Moving on Constipation

Dear Dr. Jeff: Recently our facility had a patient who complained of abdominal pain and vomiting. She was sent to the emergency department where she received a Fleet enema and was returned with a diagnosis of “fecal impaction.” The family complained to surveyors who cited us for a Level G deficiency and imposed a $5,000 fine. The facility leadership has focused on the decision to transfer the resident to the hospital as the problem, but it seems to me that more needs to be fixed. Any suggestions?

Dr. Jeff responds:
You are absolutely correct that there are larger issues than the systems that allowed a problem — which certainly could have been treated in the facility with readily available treatments and staff — to evolve into a painful but preventable condition for a resident. There appear to have been major issues in assessment and probably care planning for this resident. The nursing home’s administration may focus primarily on the reportable status of an emergency department (ED) visit, the fine itself, the potential effect of the deficiency on the facility’s federal Star rating, or perhaps the facility’s reputation at the local hospital. But the “actual harm” included as a necessary component of a Level G deficiency was not the transfer to the ED but the suffering your resident experienced and the delay in identification and relief. The interdisciplinary team, and particularly medicine, nursing, dietary, and consulting pharmacist, should do a root cause analysis or its equivalent to examine the nursing home’s care processes and consider potential improvements to protect your residents from similar problems in the future.

Constipation is not the sexiest issue on most lists. In the COVID-19 era, infection control has surged into an overarching concern, and other major concerns such as skilled nursing facility management of congestive heart failure, federal and state concentration on the potential overuse of psychotropic medications, the role of opioids in pain management, sliding-scale insulin regimens, accurate diagnosis of urinary tract infections, polypharmacy, communication with distressed families, fall prevention, and improving dementia care have all taken a back seat. But even in calmer times bowel management was at the bottom of the list. It is easy to make bad puns about bowel movements (feel free to fill in your favorite potty humor here), but bowels are a major quality of life issue for many residents. They are also a paradigm for quality geriatric care.

Initial Evaluation
Even though the event prompting a new admission might be first stroke, fracture, pneumonia, or urosepsis, everyone has a history of bowel activity since childhood. Chronic constipation is almost never listed as a diagnosis, yet multiple studies have documented a high prevalence of

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constipation complaints in community-dwelling older persons. So the evaluation for constipation should begin on admis-
sion during the history and physical.

Transfer documents are rarely help-
ful for this evaluation, particularly as
many medication reconciliations do not
include “as-needed” medications or they
faithfully reproduce the common hospi-
talist order sets with as-needed orders for
both diarrhea and constipation without
any record of whether they were ever
needed or used. Also, few home medi-
cine cabinets lack one or more laxative
preparations used anywhere from daily
to rarely. Whatever regimen a particular
patient used at home, it is unlikely to
have been included on their admission
medication list because these were not
prescription medications — and some-
times aren’t medicine at all.

Most geriatricians are familiar with
the prominent role that prunes and
prune juice play in the lives of many
older patients. Prunes are, of course, a
high-fiber preparation, and fiber is the
laxative of choice for most mildly con-
stituted individuals regardless of age.
Prunes also contain a significant amount
of sorbitol, which is an osmotic laxative
like lactulose. Sorbitol is actually sold
in powdered and liquid forms to be
used as a laxative, and it is used in some
facilities as a less expensive alternative
to its pricer cousin. Questions regard-
ing prune usage should be part of the
dietary history as well as included in an
overall medical review of past medicine
use, along with determination of prior
laxative use or abuse.

It is by no means unusual for patients
to have routinely manually disimpacted
to themselves at home, a habit that is
unlikely to be shared unless a discussion
of bowel habits occurs. Many admission
physical examinations barely mention
the abdominal examination, and rectal
exams are routinely avoided by both
practitioners and nurses, even when the
resident has been rolled on the side to
test the sacrum for breakdown.

Clearly the approach to a patient who
has been taking several different prepa-
rations daily along with frequent home
enemas would be different from that to
a laxative-naïve individual. Diagnoses
that may require younger individuals
to be placed in long-term care, such as
multiple sclerosis and traumatic paraple-
gia or quadriplegia, are often associated
with bowel constipation as well.

Potential Causes
Some restrictive diets provide inadequate
quantities of fiber and may need modifi-
cation wherever possible. Poor oral intake
inhibits the gastrocolic reflex, through
which stretching the stomach triggers
lower-bowel motility. Physical mobility
encourages bowel peristalsis, adding an
additional concern when the resident is
mobility impaired. Of course, decreased
activity may be related to underlying
medical conditions, but often it reflects
insufficient attention to or compliance
with ambulation schedules. Also, the
use of bedpans, while occasionally nec-
 essary, presents anatomic and emotional
barriers for many residents who wish to
defecate.

The most common cause of poten-
tially preventable constipation is medica-
tions. Heading the list are opioids and
related preparations such as tramadol.
There is a common slogan in palliative
care that says the hand that writes the
narcotic prescription must write the laxa-
tive order (sometimes revised to be more
threatening; the fingers that write the
opioid prescription should be prepared
to be do the disimpaction). Pain relief
regimens are, of course, absolutely nec-
sary for many patients, particularly those
with recent surgery, but every clinician
should be aware that decreased bowel
activity is an inevitable pharmacologic
aspect of opioid therapy, not an oc-
casional side effect.

Many other commonly prescribed
medications are constipating as well.
Frequently these are newly added medi-
cations during a recent hospitalization
intended for either temporarily or long-
term use. Among the most common are
iron and calcium.

Iron supplementation is often neces-
sary after acute significant blood loss to
replenish the body’s iron stores. However,
iron supplementation is not useful to
prevent anemia (unless it is iron-deficiency
anemia). Nor is supplementation helpful

IMPORTANT SAFETY INFORMATION – CONTINUED

WARNINGS AND PRECAUTIONS
• Orthostatic Hypotension, Falls, and Syncope: Syncope and orthostatic hypotension tend to occur within the first week
of therapy but can occur at any time during treatment, particularly after dose increases
• Serotonin Syndrome: There is increased risk when coadministered with other serotonin agents (e.g., SSRIs, SNRIs, triptans), but also when taken alone. Monitor all patients taking Drizalma Sprinkle™ for the emergence of serotonin syndrome. If it occurs, discontinue Drizalma Sprinkle™ and initiate supportive treatment
• Increased Risk of Bleeding: Duloxetine may increase the risk of bleeding events. A post-marketing study showed a higher incidence of postpartum hemorrhage in mothers taking duloxetine. Concomitant use of NSAIDs, aspirin, other anticoagulants, drugs, warfarin, and antiplatelet agents may increase this risk
• Severe Skin Reactions: Severe skin reactions, including erythema multiforme and Stevens-Johnson Syndrome, can
occur with duloxetine. Drizalma Sprinkle™ should be discontinued at the first appearance of blisters, peeling rash,
mucosal erosions, or any other sign of hypersensitivity if no other etiology can be identified
• Discontinuation Syndrome: Adverse reactions after discontinuation of serotonergic antidepressants, particularly after abruptly discontinuing, include nausea, sweating, dysphoric mood, irritability, agitation, dizziness, sensory disturbances (e.g., paresthesias, such as electric shock sensations), tremor, anxiety, confusion, headache, lethargy, emotional lability, insomnia, hypomania, tinnitus, and seizures. A gradual reduction in dosage rather than abrupt cessation is recommended when possible
• Activation of Mania or Hypomania: In patients with bipolar disorder, treating a depressive episode with duloxetine or another antidepressant may precipitate a mixed/manic episode. Use cautiously in patients with bipolar disorder. Prior to initiating treatment with Drizalma Sprinkle™, screen patients for any personal or family history of bipolar disorder, mania, or hypomania
• Angle-Closure Glaucoma: Duloxetine may trigger an angle-closure attack in patients with anatomically narrow angles
who do not have a patent iridectomy. Avoid use of Drizalma Sprinkle™ in patients with anatomically narrow angles
• Seizures: Drizalma Sprinkle™ should be prescribed with caution in patients with a history of seizure disorder
• Blood Pressure: Monitor blood pressure prior to initiating treatment and periodically throughout treatment
• Hyponatremia: Can occur in association with SAIHG. Cases of hyponatremia have been reported
• Glucose Control in Diabetes: In diabetic peripheral neuropathic pain patients, small increases in fasting blood glucose and HbA1c have been observed

ADVERSE REACTIONS
The most common adverse reactions (≥5% and at least twice the incidence of placebo patients) were nausea, dry mouth,
somnolence, constipation, decreased appetite, and hyperhidrosis.

DOSEDING AND ADMINISTRATION
Drizalma Sprinkle™ may be taken with or without food. Drizalma Sprinkle™ may be swallowed whole (do not crush or chew
• Lactation:

USE IN SPECIFIC POPULATIONS
• Hepatic Impairment: Avoid use in patients with mild, moderate, or severe hepatic impairment
• Renal Impairment: Avoid use in patients with severe renal impairment
• Pregnancy: Advise patients to notify their healthcare providers if they become pregnant or intend to become pregnant
during treatment with Drizalma Sprinkle™. Third trimester use may increase risk of symptoms of poor adaptation
(respiratory distress, temperature instability, feeding difficulty, hypotonia, tremor, irritability) in the neonate. Advise
patients that Drizalma Sprinkle™ use during the month before delivery may lead to an increased risk for postpartum
hemorrhage and may increase the risk of neonatal complications requiring prolonged hospitalization, respiratory
support and tube feeding
• Lactation: Advise breastfeeding women using duloxetine to monitor infants for sedation, poor feeding and poor weight
gain and to seek medical care if they notice these signs

To report SUSPECTED ADVERSE REACTIONS, contact Sun Pharmaceutical Industries, Inc. at 1-800-818-4655 or FDA at
1-800-FDA-1088 or www.fda.gov/medwatch.

Please see accompanying Brief Summary of Full Prescribing Information, including BOXED WARNING.


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for the frequently occurring blood loss into soft tissues after a trauma such as a hip fracture — the iron in that blood remains in the body and it is mobilized to create replacement red blood cells. Even when iron is needed, it should not be prescribed beyond the maximum that the body can absorb, which is typically one standard dose per day rather than the routinely recommended three times daily regimens.

Calcium supplementation is frequently provided to patients after fractures or other orthopedic procedures. A new fracture often identifies untreated osteoporosis or osteopenia, which in turn leads to the introduction of supplemental calcium. However, the role of additional calcium to promote bone healing for otherwise healthy bone is controversial; some studies suggest it might delay fracture healing, particularly when given with other preparations designed to interfere with bone remodeling. Among calcium preparations, calcium carbonate is the most constipating. Considerable attention has been paid to the potential adverse effects of anticholinergic medications on cognition and memory. However, even those that are claimed not to cross the blood-brain barrier will decrease bowel motility, so they deserve careful attention when used for residents with multiple other risk factors for constipation. The list of medications with anticholinergic side effects is exceptionally long and includes many medicines common in the elderly, such as antipsychotics, some selective serotonin reuptake inhibitors, antihistamines such as diphenhydramine, and amantadine and furosemide.

Constipation may be part of a cycle in which one medication is added, then a second to treat the side effects of the first, then a third to treat the side effects of the second, and so on. There are multiple indexes of anticholinergic burden downloadable from the internet. Consulting pharmacists can help with the process of simplifying and de-prescribing in complex drug regimens.

A Common Language

The language to describe bowel activity can create confusion for practitioners. Constipation technically refers to decreased frequency of bowel movements, but there is no “normal” here. Some older patients expect to move their bowels daily and will experience distress if a day goes by without stool production. This is often tied to popular health concepts of “regularity” and the need to rid the body of harmful substances. These notions have moved into New Age enthusiasm for various detoxification regimens such as coffee enemas. By contrast, some patients who have two bowel movements on the same day will describe it as diarrhea, which is a term referring to stool consistency rather than frequency. Some clinicians have prescribed inappropriate antidiarreahicals for patients without determining whether the patient actually has diarrhea.

Most residents will become symptomatic if they do not move their bowels regularly, with symptoms including abdominal distention or lower abdominal cramping, sensation of a need to void, and decreased appetite. Cognitively intact residents can usually describe these symptoms, but many residents cannot. All too often, rectal distention places pressure on the bladder outlet and induces urinary retention. Acute urinary retention is extremely uncomfortable. Simply relieving the urinary retention, typically with a catheter, should be accompanied by a digital rectal exam to exclude rectal etiologies, rather than reflex attribution to urinary infections as the etiology.

Symptomatic constipation (sometimes referred to as obstipation) defines those residents whose infrequent bowel movements have progressed to a more serious stage and should be promptly addressed. This is probably what your resident had, particularly as a Fleet enema would be unlikely to relieve a fecal impaction. Fecal impaction refers specifically to circumstances where stool buildup completely or partially obstructs the bowel. Radiographic evidence of stool and gas do not, of themselves, determine impaction, particularly when present throughout the colon. Although impaction is usually

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Brief Summary of Prescribing Information for Drizalma Sprinkle™ (duloxetine delayed-release capsules). This Brief Summary does not include all the information needed to use Drizalma Sprinkle™ safely and effectively. See full Prescribing Information for Drizalma Sprinkle™.

WARNING: SUICIDAL THOUGHTS AND BEHAVIORS

See full prescribing information for complete based warning.

Increased risk of suicidal thinking and behavior in pediatric and young adult patients taking antidepressants. Closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors.

INDICATIONS AND USAGE

Drizalma Sprinkle™ (duloxetine delayed-release capsules) is a serotonin and norepinephrine reuptake inhibitor (SNRI) indicated for:

- Major Depressive Disorder (MDD) in adults
- Generalized Anxiety Disorder (GAD) in adults and pediatric patients aged 7 to 17 years old
- Diabetic Peripheral Neuropathic Pain (DPNP) in adults
- Chronic Musculoskeletal Pain in adults

CONTRAINDICATIONS

Serpotin Syndrome and MAOIs: Do not use MAOIs intended to treat psychiatric disorders with Drizalma Sprinkle™ or within 5 days of stopping treatment with Drizalma Sprinkle™. Do not use Drizalma Sprinkle™ within 14 days of stopping an MAOI intended to treat psychiatric disorders. In addition, do not start Drizalma Sprinkle™ in a patient who is being treated with linezolid or intravenous methylene blue.

DOSEAGE AND ADMINISTRATION

- Drizalma Sprinkle™ can be taken with or without food.
- Drizalma Sprinkle™ may be swallowed whole (do not crush or chew capsule); opened and sprinkled over applesauce; or administered via nasogastric tube.
- Missed doses should be taken as soon as it is remembered. Patients should not take two doses of Drizalma Sprinkle™ at the same time.
- There is no evidence that doses greater than 60 mg/day confer additional benefit, while some adverse reactions were observed to be dose-dependent.

WARNINGS AND PRECAUTIONS

- Hepatotoxicity: Hepatic failure, sometimes fatal, has been reported in patients treated with duloxetine delayed-release capsules. Duloxetine delayed-release capsules should be discontinued in patients who develop jaundice or other evidence of clinically significant liver dysfunction and should not be resumed unless another cause can be established. Drizalma Sprinkle™ should not be prescribed to patients with substantial alcohol use or evidence of chronic liver disease.
- Orthostatic Hypotension, Falls, and Syncope: Cases have been reported with duloxetine delayed-release capsules therapy.
- Serotonin Syndrome: Increased risk when coadministered with other serotonin agents (eg, SSRIs, SNRIs, triptans), but also when taken alone. If it occurs, discontinue Drizalma Sprinkle™ and initiate supportive treatment.

- Increased Risk of Bleding: Duloxetine may increase the risk of bleeding events. A post-marketing study showed a higher incidence of postpartum hemorrhage in mothers taking duloxetine. Concomitant use of NSAIDs, aspirin, other antiplatelet drugs, warfarin, and anticoagulants may increase this risk.

- Severe Skin Reactions: Severe skin reactions, including erythema multiforme and Stevens-Johnson Syndrome, can occur with duloxetine. Drizalma Sprinkle™ should be discontinued at the first appearance of blisters, peeling rash, mucosal erosions, or any other sign of hypersensitivity if no other etiology can be identified.

- Discontinuation Syndrome: Taper dose when possible and monitor for discontinuation symptoms.
- Activation of Mania or Hypomania: Use cautiously in patients with bipolar disorder. Cautions patients about the risk of activation of mania/hypomania.

- Cognitive Glaucome: Avoid use of antidepressants, including Drizalma Sprinkle™, in patients with untreated anatomically narrow angles.
- Seizures: Prescribe with care in patients with a history of seizure disorder.
- Blood Pressure: Monitor blood pressure prior to initiating treatment and periodically throughout treatment.

- Hypotension: Can occur in association with SIADH. Cases of hyponatremia have been reported.

- Glucose Control in Diabetes: In diabetic peripheral neuropathic pain patients, small increases in fasting glucose and HbA1c have been observed.

ADVERSE REACTIONS

Most common adverse reactions (≥5% and at least twice the incidence of placebo patients) nausea, dry mouth, somnolence, constipation, decreased appetite, and hyrerdrosis.

DRUG INTERACTIONS

- Potent CYP3A4 Inhibitors: Avoid concomitant use.
- CYP2D6 Substrates: Consider dose reduction with concomitant use.

USE IN SPECIFIC POPULATIONS

- Hepatic Impairment: Avoid use in patients with mild, moderate, or severe hepatic impairment.
- Renal Impairment: Avoid use in patients with severe renal impairment.
- Pregnancy: Third trimester use may increase risk of symptoms of poor adaptation (respiratory distress, temperature instability, feeding difficulty, hypotonia, tremor, irritability) in the neonate. Advise patients that Drizalma Sprinkle™ use during the month before delivery may lead to an increased risk for postpartum hemorrhage and may increase the risk of neonatal complications requiring prolonged hospitalization, respiratory support and tube feeding.

- Lactation: Advise breastfeeding women using duloxetine to monitor infants for sedation, poor feeding and poor weight gain and to seek medical care if they notice these signs.

Buoyancy Amid the Pandemic: Resilience in Rough Waters

By Joanne Kaldy

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There is a toy for kids that is an inflatable punching bag with a weighted bottom — when the bag is knocked down it bounces right back up. Many post-acute and long-term care leaders and team members have felt that way during the pandemic. They’ve been challenged, stressed, and sometimes overwhelmed, but their resilience has helped them remain buoyant and weather the storm.

It’s important to share these stories of resilience, but it’s also essential to understand that it’s not unusual to run low on resilience during a crisis. It’s also important to understand how people can recharge themselves and help others who are struggling.

What Is Resilience?
The American Psychological Association defines resilience as “the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress,” such as family and relationship problems, serious health problems, and workplace and financial stressors. The scientific methods to measure resilience generally focus on what is going right and wrong in an individual’s life. More specifically, they measure strengths rather than limitations.

One way to bolster our resilience is to increase awareness about what we are experiencing in the moment. “Our mind and our body give us clues when we are in struggle — when we are distressed or feeling overwhelmed,” said Paige Hector, LMSW, a clinical distressed or feeling overwhelmed,” said Paige Hector, LMSW, a clinical distressed or feeling overwhelmed,” said Paige Hector, LMSW, a clinical distressed or feeling overwhelmed,” said Paige Hector, LMSW, a clinical distressed or feeling overwhelmed,” said Paige Hector, LMSW, a clinical distressed or feeling overwhelmed,” said Paige Hector, LMSW, a clinical distressed or feeling overwhelmed,” said Paige Hector, LMSW, a clinical distressed or feeling overwhelmed,” said Paige Hector, LMSW, a clinical distressed or feeling overwhelmed,” said Paige Hector, LMSW, a clinical distressed or feeling overwhelmed,” said Paige Hector, LMSW, a clinical distressed or feeling overwhelmed,” said Paige Hector, LMSW, a clinical distressed or feeling 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