Cradle to Grave

Primary CARE – MENTAL HEALTH GUIDE

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NO DISCLOSURES

References at end of powerpoint

Aim for today weave a pathway touching on all ages

- Start with overall development with quick look at stages of development until 4 y/o
- Discuss overview of how children meet milestones of maturity in children
- Depression / adults children from child perspective
- Suicide child and adult : Depression child to adult
- Weave in other topics pertinent of understanding " why we act the way we do?"

Why Do people act - different ?

Stay Tuned! !

Ace -test

A quick and efficient way to get summary of the first 18 Years

Our last stat regarding ACE we now have a survey and total up to date

The test

- The test is ten questions that cover situations;
- Such as sexual and/or physical abuse, neglect, feeling that no one cares, even to provide physician visits, lacking general care , someone going to prison, enough to eat
- To be resilient & score lower number one has to be lucky to receive basics, cared for and not have abuses like sexual,/physical, verbal abuse, feeling of being loved, someone would take you to the doctor if sick, not abandon you, would have enough to eat, positive environment, life as one would expect

All Politics are local !

Local Ace Scores

4894 completed at Medicine clinic

2758 /4894 scored greater than a 4

Scores

0-4 QUESTIONS SCORES

- Questions – 0 – 4
- 0 – (513)
- 1- 3 (608)
- 1121 / 4894 in 0 – 4 range

5 – 10 QUESTIONS SCORES

- (409)Questions 5 – 10
- 4 –(515) 7 – (409) 10 – (155)
- 5 - (543) 8 – (381) 2854 / 4894 are above a 4
- 6 - (486) 9 - (269) 58% over a 4

Stress !

ACE higher than 4 the percentages to aquire a system disorder such as Pulmonary, hepatitis, cardiovascular disease

And Suicide (1400 % geater chance to consider suicide than the score of 0)

80 % of Mental Health First Seen BY Primary Care

EARLY TO LATE DEPRESSION

- Will introduce characteristics common to depression in all ages
- Will give some examples regarding diagnosis and treatment options

"MEDICAL " DISORDERS WITH PSYCHIATRIC CONSIDERATION IN THE TREATMENT

- The need to not forget about mental health needs that may complicate recovery

Remember 2nd leading cause of re-hospitalization for mental illness is non psychiatrists taking people off psychiatry meds & not restarting at the end of the inpatient treatment

Infants and very early childhod

EARLY CHILDHOOD DEPRESSION

- Infants will be less responsive with neglect (cradle cap) cry becomes different than the lively loud irritated or hungry cry.

WHAT TO DUE ?

Be mindful of the mother's mental status – actually check on mental status on each pre-natal visit

Lay ground work for mother child bonding – ASAP of the delivery

Childhood Depression Rating Scale (Checklist)

- Schoolwork
- (performance / consistent with ability)
- Capacity to Have Fun
- (interest and activities realistically appropriate for age)
- Social Withdrawal
- (enjoys friendships with peers and at home)
- Sleep
- (moderate difficulty with sleep – level)
- Appetite or Eating Patterns
- (problems or change in eating patterns)
- Excessive Fatigue
- (excessive complaints of tiredness)

Depression Rating Scale

Continued

- Depressed Feelings
- (unhappy most of the time)
- Morbid Ideation
- (preoccupied with morbid thoughts several times a week)
- Suicidal Ideation
- (recurrent thoughts of suicide)
- Weeping
- (Cries more than peers)
- Depressed Affect
- (looks sad, withdrawn, loss spontaneity)

Types of Speech

- (slow delays an interview)
- Hypoactivity

3 months to 4 years

Milestones few examples

- 3 months recognizes familiar faces and smiles back
- Raises head and chest while lying on stomach
- Brings hand to mouth and begins to babble

- 6 months responds to other people's emotions
- Struggles for things out of reach
- Interested in mirror images
- Responds to their own name

milestones

Not as well met in a depressed situation for the child

- 1 year pulls to stand and walks holding on the furniture
- Uses simple gestures like shaking head to say NO or waiving Bye-bye
- Cries when mother and father leaves
- Explores objects finds hidden objects correctly drinking from a cup, brushing hair, dialing and listening on a phone
- Inflection in their babbling (changes in tone)

milestones

Continuig the normal development

- 2 years repeats word overheard in conversation
- 2-4 word sentences
- Walking without help / plays pretend
- Excited about the company of other children
- Follow simple instructions recognizes familiar people
- 3 years imitates adults and playmates
- Shows affection for playmates / friends
- Sorts objects by shape and colors matches objects to pictures
- Uses pronouns and sometimes plurals and simple phrases or micro sentences to communicate and understands concept of mine / his and hers

milestones

4 years

- Follows three step commands , draws circles and squares, uses sentences of a 5-6 words clear enough for outsiders to understand
- Names some colors and understands the concept of counting
- Shares and takes turns, knows the difference between girls and boys
- Enjoys humor (silly faces or voices) brushes his/her teeth by themselves
- Dresses and undresses without exception except shoelaces
- Pretends in play by role playing
- Knows opposites (hot/cold/big and small)

Depression Children

"normal development from 3 months to 4 years in place"

- 4 years and up
- Depression has to be present depressed mood most of the day, nearly everyday as indicated by either subjective report or observation by others for at least 2 (TWO) weeks
- Symptoms – sad , empty, hopeless, tearful, in children can add irritable, a marked diminished interest or pleasure in all or almost all activities of the day, nearly everyday important symptoms essential to note a depressed mood or loss of interest or pleasure (anhedonia)

DEPRESSION

FIVE OR MORE OF ALL SYMPTOMS LISTED FOR MDD

- SIGNIFICANT WEIGHT LOSS WHEN NOT DIETING OR WEIGHT GAIN
- INSOMNIA OR HYPER SOMINIA NEARLY EVER YDAY
- PSYCHOTOTOR AGITATION OR RETARDATION NEALRY EVERYDAY
- FATIGUE OR LOSS OF ENERGY NEARLY EVERYDAY
- DIMINISHED ABILITY TO THINK OR CONCENTRATE OR INDECISIVENESS NEARLY EVERY DAY
- FEELINGS OF WORTHLESNESS OR INAPPRONEPIATE GUILT NEARLY EVERYDAY
- RECURRENT THOUGHTS OF DEATH, RECURRENT SUICIDAL IDEATION WITHOUT A SPECIFIC PLAN E

Suicide in Kids

Over view of diagnostic tips from DSM-5

Child and adolescent

- Despite it feeling awkward about children and suicide it is essential to have some ideas to help perform
- 15- 25% of adolescents have done some type of self harm and it is the 2nd leading cause of death in this age range
- About 8% admit to suicide attempt
- Risk acuity " have you ever thought about hurting your self or taking your own life? Have you ever done something to harm yourself or tried to kill your self? Do you have any plans now for how you would kill yourself?"
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Suicide

Continuing with hints to interview

- Current triggers "Do you have any recent relationship problems or big disappointments?"
- Current supports " Do you have anyone in your life who helps support you?"
- Access to lethal means "Can you easily get a gun or enough pills that you think could kill you?"
- Major depression "Have you felt really down , depressed, or uninterested in things you used to enjoy for longer than 2 weeks ?

Antidepressants children, adolescents & adults

- Treatment of adolescents with depression, (2004 -2009), NIH, 439 patients from 13 sites, (ages 12-17), 12wk: fluoxetine + CBT. Superior to all other methods – FLX. Alone, CBT alone or PBO and at 36 weeks all but the PBO displayed improvement
- Fluoxetine (Prozac) mostly thought of as the place to start with adolescents and young adults due to long history in this age group since 1988 and multiple studies if not effective switching to another SSRI and or an SNRI ,bupropion (Wellbutrin)

Antidepressants Regarding Child & Adolescents Usage

- Fluoxetine
- FDA indications MDD – 8 years and up, OCD 7 y/o and up, 18 y/o & up bulimia , panic, social anxiety, PMDD
- Typical dose for MDD 20 mg /day,
- younger children with depression start 5 mg / day, 10 mg for older children and 18 y/o & up 20 mg daily to start
- Dose ranges 20 mg to start then – depression, 20 – 60 mg
- children with OCD, 20mg -60 mg
- bulimia, 20 – 60 mg
- panic, 20 mg /d for PMDD

Sertraline (Zoloft)

- Sertraline (Zoloft) , FDA approval 6 y/o for OCD, and 18 y/o for MDD, panic, PTSD, PMDD, social anxiety
- Ages 6- 12 initial dosing 25 mg day, ages 13 – 17 initial dose 25 – 50 mg /day,
- 18 y/0 and up 50 mg / day for MDD, OCD, PMDD,
- 25 mg or lower for panic, PTSD, social anxiety and try to increase to 50 mg in 1-2 weeks

Citalopram (Celexa) Escitalopram (Lexapro)

- Citalopram 20 – 40 mg / day for depression
- Greater than 18 y/o maximum dose 40 mg *
- Escitalopram > 12 year old MDD start 5 – 10 mg may increase to 20 mg

Fluvoxamine (Luvox)

- Fluvoxamine (Luvox) > 8 y/o for OCD
- Ages 8- 17 bedtime dose 25 mg
- May continue incremental changes up to 200 mg
- >18 y /.o 50 mg increments up to 300 mg

Paroxetine (Paxil)

- Paroxetine (Paxil) , 18 y/o: 18 years old for PTSD, GAD MDD, OCD, social anxiety,
- This is the SSRI with most weight gain

Wellbutrin

- Bupropion (Wellbutrin) 18 y/o and up for MDD, smoking session ,seasonal affective disorder
- It can be added to an SSRI to give a dual action chemistry this gives more control /ability to work toward changes as addition to the serotonin influence on the system
- Bupropion excellent for motivation / energy help, and focus, concentration
- The seizure issue with this drug has been re-evaluated and the seizures seemed to be in the non controlled release, people that had an undiagnosed seizure disorder for most part – so we only use the SR or XL types the SR is 12 hour time release and the XL is 24 hour

Mirtazapine (Remeron) Alpha 2-adrenergic agonist

- Mirtazapine approved 18 years and up for MDD
- Dose from 15-45 mg / day (also have dissolvable)
- Different mechanism from other antidepressants boosts neurotransmitters serotonin and norepinephrine / noradrenaline
- Blocks alpha 2 adrenergic presynaptic receptor serotonin neurons increasing serotonin neurotransmission & this is a novel mechanism independent of serotonin and norepinephrine reuptake blockade (SSRI /SNRI)
- This is why when combined with other antidepressants in can be a boost their effectiveness
- More effective for sleep at lower doses biggest issue with this medication is the weight gain

Quick History of Antidepressants

It all started in t he 1950s'

- First generation of antidepressants were discovered serendipitously as the original TCA's have a chemical structure similar to chlorpromazine (Thorazine) so the chemists set out to build on that molecule (imipramine) however they were lousy antipsychotics, they (TCAs) but unexpectedly improved patient's mood
- The MAOIs such as iproniazid were developed as anti - tuberculosis drugs they noticed improved mood but not tuberculosis improvement as hoped
- These medications are helpful for depression improvement(TCA, MAOI) they are lethal in overdose. They can still be helpful in some resistant depression and chronic pain syndromes

TCAs

- TCA's have anticholinergic, antihistaminic and anti-alpha cholinergic effects which were quite unpleasant for the patient
- 1. blurred vision, dry mouth, constipation and urinary retention (anticholinergic)
- 2. sedation, weight gain (antihistaminic)
- 3. orthostatic hypotension, tachycardia (anti – alpha adrenergic)
- 4 Lethal in severe overdose DO NOT PRESCRIBE TO A SUICIDAL PERSON !!

58% above a 4 on the ACE ?

- Children that have grown up under stress elevate their cortisol and adrenaline that places them in a "fight/flight/freeze " most all of the day – compare that to experiencing almost getting in a car crash, or anything that puts you in an acute situation only all day, then picture growing up like that everyday and having to find a "safe place" in your own home everyday
- We ask these children to "act right" how
- Could they come close to being able to trust or ever see the gray in a black and white decision , good / bad, intense/relationships that can turn to total vilifying
- Their greatest fear – fear of abandonment starting to picture the result
- We have to fight to stop this pattern.! Children not threatened or go to bed hungry as 1 in 4 Oklahoma kids do nightly !!

Some evolving concerns

- Frantic efforts to avoid real or imagined abandonment not suicidal or self harmful behavior but can develop
- Unstable relationships, unstable self image
- Impulsivity, affective instability due to marked reactivity of mood, intense mood shifts varying with intense irritability, dysphoria , anxiety feelings can occur quickly
- LASTING USUALLY A FEW HOURS AND RARELY MORE THAN A FEW DAYS MOST LIKELY STARTING AS A REACTION TO A EVENT OR PERCEIVED EVENT (a trigger)
- Inappropriate intense anger or difficulty controlling anger ; feelings of emptiness and sometimes stress related hypervigilance or paranoia

Some new criteria proposed for DSM-5 update

- Borderline personality – areas of proposed modifications
- Identity unstable self esteem, usually poor self esteem criticism, chronic feelings of emptiness, dissociative states
- Self Direction , instability of goals and aspirations,
- Empathy compromised problems recognizing the needs and feelings of others along with hypersensitivity interpersonal (prone tofeel slighted) Intimacy – unstable , intense and conflicted close relationships

TIME –OUT point to clarify Bipolar Disorder

- Bipolar disorder : Criteria for manic state (mania)
- A distinct period of abnormally and persistently elevated, expansive, or irritable and abnormally and persistently increased goal – directed activity or energy, lasting at least ONE (1) week and present most of the day, nearly everyday
- During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represents noticeable change from usual behavior :

The list to pick from

- !. Inflated self esteem or grandiosity
- 2. Decreased NEED for sleep
- 3. More talkative than usual or pressure to keep talking
- 4. Flight of ideas or subjective experience thoughts are racing
- 5. Distractibility (attention too easily drawn to unimportant or irrelevant external stimuli) reported of observed
- 6. Increase in goal directed activity(either socially, at work, school or sexually)
- 7.Excessive involvement in activities that have a high potential for painful consequences, sexual indiscretions, or foolish business investments

Point a Gem to Clarity

- The scenario that is coming together from our previous slides paints a path to follow high ACE involving abuse and abandonment fears but declaring " big mood swings" and "I have the bipolar and manic depressive"
- The important questions to rule out bipolar and lean toward another consideration is : How long does your mood swing last few hours or day at most and if that is The answer and does this mood swing usually occur secondary to something happening?
- Bipolar disorder is purely biological and is not situational

Borderline Personality has a overlap Look at BPD criteria

- A pervasive pattern of instability of interpersonal relationships, self image and affects, and marked impulsivity beginning at early adulthood and present in a variety of contexts as indicated by five or more of the following symptoms:
- 1. Frantic efforts to avoid real or imagined abandonment (not include suicide or self harmful behavior)
- 2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- 3. Identity disturbance: markedly and persistently unstable self – image or sense of self

Borderline (BPD)

- 4. impulsivity in a at least two areas that are potentially self damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)
- 5. Recurrent suicidal behavior, gestures, or threats or self mutilating behavior
- 6. Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- 7. Chronic feelings of emptiness
- 8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of anger, constant anger, recurrent physical fights)
- 9. Transient, stress– related paranoid ideation or severe dissociative symptoms

Taking a History Still Needed to get the Entire Story

- Before you get taken down the ever lurking "rabbit hole". Patient comes in to your clinic and says they've been diagnosed bipolar and no medication ever helped- so never mind what someone else did or didn't do- have them fill out an ACE , gives you some idea about childhood, then take a very detailed history of these "manic spells " remembering the difference in the two criteria. If it comes up more borderline than bipolar, it is time to tell her about how childhood issues can linger and that her disorder needs 80% therapy and 20% medication just to keep her a good baseline with the medication. What kind of therapy dialectical behavioral therapy DBT if available.
- If it is bipolar patient needs two mood stabilizers and its 80%medication. That's why patient's meds haven't helped!

Major Depression Post Cardiac Event

- The symptoms present unusual at times
- The post MI depression is much more prevalent than usually appreciate or include in the magement of the patient.
- Somatic complaints (nonspecific, low energy, fatigue, and effort intolerance, sadness or depressed mood, loss of interest or pleasure (anhedonia) Sleep, appetite, self esteem, concentration, suicide
- Post MI depression creates, according to some studies a greater problem with repeat of another MI and higher chance to be fatal
- SNRI's (not immediate dissolve) venlafaxine, long acting ok, duloxetine no problem
- SSRI.s insignificant Q - t interval issue and they impair storage of serotonin in platelets to maybe reduce the platelets ability, activation and form a clot. SSRI,s & bupropion inhibit CYP2D6 so enhance a beta-blocker

Autistic Spectrum (Asperger)

- Frequently diagnosed as schizophrenia, ADHD only, ODD
- If not ruled out and treated with therapy and medication they have a poor social, relationships, modifying anger, vulnerable to manipulation by poor peer relations
- The medication is usually to help with anger control
- The newer antipsychotics lessen the side effects
- History of treatment for Spectrum and autism is very distrubing

Schizophrenia

- Rare in private primary care but an update might be helpful

  no typing of schizophrenia anymore (paranoid, etc.)

Criteria – two or more of the following for a significant portion of time during a one month period

Must display (1),(2) or (3)

1.Delusions 2. Hallucinations, 3 Disorganized speech, 4. Grossly disorganized or catatonic behavior 5. Negative symptoms

May use schizophreniform for first 6 months while determining the diagnosis

schizophrenia

- Treatment has so improved over last 20 years
- Medications long acting injectable & Clozaril
- Being vigorous regarding to treat early and try for remission .
- We want the voices gone not like prior years huge side effects and still hallucinations so the patient still unable to function in society.
- Today strive for remission so they can function with better quality

References

- American Psychiatric Desk Reference to the Diagnostic Criteria, DSM- 5, American Psychiatric Press, 2013
- DSM- 5 Guide for Child & Adolescent Mental Health, Robert J. Hilt, M.D., Abraham M. Nussbaum, M.D. , 2016
- Child & Adolescent Clinical Psychopharmacology , 6 th edition, 2019, Rick Bowers, M.D., Ryan Mast, M.D, Christina Weston , M.D. Suzie Nelson, M. D.
- DSM – 5 Casebook & Treatment Guide for Child Mental Health , edited Cathryn Galanter, M.D. , 2017
- Textbook of Medical Psychiatry Edit. Paul Summergrad, M.D., Daud Silbersweig, M.D., Philip Muskin, M.D. , John Querques, M.D. 2020