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- Depressive, Anxiety, and Bipolar
- Personality Disorders
- ADHD
- Discuss changes from DSM-IV to DSM-5

- Axis I: Clinical Syndromes (Depression, Anxiety, OCD, Bipolar)
- Axis II: Developmental and Personality Disorders (includes Autism and Mental Retardation)
- Axis III: General Medical Conditions (that play a role in the development, exacerbation, or continuance of Axis I and II)
- Axis IV: Psychosocial and Environmental Problems (that impact Axis I and II)
- Axis V: Global Assessment of Functioning (scale 0-100; less than 50 often considered significant impairment)

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- No more Multiaxial Assessment

- Major Depressive Disorder
- Approximately 5% of population
- Female to male 2:1

- 5 of the following for at least 2 weeks duration, of which one is Depressed mood or Loss of interest:
- *Depressed mood
- **S**leep disturbance
- *Loss of **I**nterest (Anhedonia)
- **G**uilt/worthlessness
- Fatigue/loss of **E**nergy
- Difficulty **C**oncentrating
- **A**ppetite/Change in weight
- **P**sychomotor agitation/retardation
- Thoughts of death or **S**uicide (with or without plan)

- All antidepressants have similar efficacy, but different side effect profiles
- TCA’s (Imipramine, Amitriptyline): Anticholinergic, QT prolongation.
- Mirtazapine causes weight gain and somnolence.
- SSRI’s: Sexual side effects, Weight gain (Paroxetine the worst), QT prolongation (Citalopram).
- Less side effects with SNRI’s (Venlafaxine, Duloxetine) and Bupropion

- SSRI first line therapy in most situations
- Black Box Warning: Increased risk of suicidal thoughts or behaviors in children, adolescents, and young adults on SSRI’s
- Fluoxetine only SSRI that is FDA approved in children/ adolescents (ages 8 and older)
- Push the dose prior to switching to different agent
- Can augment with Bupropion, Liothyronine (T3 Cytomel)

- There is a role for cognitive-behavioral therapy

- Electroconvulsive Therapy is an option in refractory depression (memory loss is short-term)

- Combines what was formerly termed “Dysthymia” plus Chronic Major Depression
- Depressed mood is present for most of the day, more days than not and depression has been present for at least two years without a two month hiatus.
- Persistent and pervasive

- 70% of new moms have "Baby Blues"
  - Mild symptoms that resolve within 10 days
- 10-20% have Post-Partum Depression
- 40% recurrence rate with subsequent pregnancies
- Lots of morbidity for mom and baby
- Screen at post-partum check and at 2 month WCC
- Family physician often in best position to screen, diagnose, and treat

- In most patient types, screening is recommended IF adequate resources exist to deal with further diagnosis and treatment.

- Panic Disorder: Recurrent panic attacks during which four of the following symptoms begin abruptly and reach a peak within 10 minutes in the presence of intense fear:
  - Palpitations
  - Sweating
  - Trembling/shaking
  - SOB
  - Choking sensation
  - Chest pain/discomfort

- Nausea
- Dizziness
- Derealization/Depersonalization
- Fear of losing control or going crazy
- Fear of dying
- Paresthesias
- Chills/Hot flushes

- Treatment:
- SSRI’s
- prn Benzodiazepines
- Cognitive behavioral therapy

- Generalized Anxiety Disorder
- Unrealistic or excessive anxiety or worry about two or more life circumstances for at least six months
- Most common anxiety disorder
- Medications (Buspirone, Antidepressants, prn Benzodiazepines) + Cognitive behavioral therapy

- 2-5% of population
- Bipolar I
- One or more Manic episodes
- Commonly accompanied by a history of at least one major depressive episode
- Bipolar II
- One or more major depressive episodes with at least one hypomanic

- Cyclothymia
  - Hypomania and depression (below criteria for MDD)
- Treatment
  - Lithium
  - Anticonvulsants
    - Valproic Acid, Carbamazepime, Lamotrigine, Oxcarbazepine
  - Atypical antipsychotics

- An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
  - cognition (i.e., ways of perceiving and interpreting self, other people, and events)
  - affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
  - interpersonal functioning

- The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

- The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Cluster A	Cluster B	Cluster C
Paranoid	Antisocial	OCPD
Schizoid	Borderline	Dependent
Schizotypal	Histrionic	Avoidant
	Narcissistic	

Odd	Erratic	Anxious
Paranoid	Antisocial	OCPD
Schizoid	Borderline	Dependent
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Weirdo's	Wankers	Weanies
Paranoid	Antisocial	OCPD
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- Schizoid vs. Schizotypal
  - Schizoid: Solitary, indifferent to praise/criticism, low functioning, premorbid condition to schizophrenia?
  - Schizotypal: Magical thinking, ideas of reference, eccentric behavior and appearance.
- Antisocial
  - Cruel to animals as child, Unlawful activity as adolescent/adult, Can’t hold a job
  - Irresponsible, Deceitful, Unremorseful
- Histrionic
  - Exaggerate expression of emotions, uses superlatives, attention seeking

- Treatment: In general, no medication or therapy that is helpful

- 2-16% of school age children
- Child must display 6 of 9 symptoms of inattention, or 6 of 9 symptoms of impulsivity/hyperactivity
- Must be present for more than 6 months
- Must begin before age **12***
- Must occur in more than 1 setting (home and school)

- Inattention
- Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- Often has difficulty sustaining attention to tasks or play activities
- Often does not listen when spoken to directly
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace
- Often has difficulty organizing tasks and activities

- Inactivity
- Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (homework)
- Often loses things necessary for tasks or activities
- Is often easily distracted by extraneous stimuli
- Is often forgetful in daily activities

- Hyperactivity
- Often fidgets with hands or feet, or squirms in seat
- Often leaves seat in classroom or in other situations in which remaining seated is expected
- Often runs about or climbs excessively in situation in which it is inappropriate
- Often has difficulty playing or engaging in leisure activities quietly
- Is often “on the go” or acts as if “driven by a motor”

- Impulsivity
  - Often blurts out answers before questions have been completed
  - Often has difficulty awaiting turn
  - Often interrupts or intrudes on others (butts in on conversations)

- Diagnose with Rating Scales, filled out by parents and teachers (Connors, Vanderbilt, etc.)

- Treat with medications
  - Stimulants first line
  - Atomoxetine (Strattera) second line

- Medication + Behavioral therapy = Medication alone
  - But with combination therapy may be able to use lower dose of

- Childhood ADHD persists into adulthood 30% of the time
- Diagnostic criteria are the same, except only need 5 of 9 symptoms
- Also use Rating Scales, but ones that are unique for adult ADHD (i.e. Wender Utah Rating Scale)
- Stimulants and Atomoxetine (Strattera) first line
- Antidepressants second line

- American Psychiatric Association. Highlights of Changes from DSM-IV-TR to DSM-5; 2013
- Hahn RN, Albers LJ, Reist C. Current Clincal Strategies: Psychiatry. Laguna Hills, CA: Current Clincal Strategies; 1997
- Michels TC, Tiu AY, Graver CJ: Neuropsychological evaluation in primary care. *Am Fam Physician* 2010;82(5): 495-502.
- Little A: Treatment-resistant depression. *Am Fam Physician* 2009;80(2):167-172.
- Gartlehner G, Hansen RA, Morgan LC, et al: Comparative benefits and harms of second-generation antidepressants for

- Carvalho AF, Cavalcante JL, Castelo MS, Lima MC: Augmentation strategies for treatment-resistant depression: a literature review. *J Clin Pharm Ther*. 2007 Oct;32(5):415-28.

- Loganathan M, Lohano K, Roberts RJ, et al: When to suspect bipolar disorder. *J Fam Pract* 2010;59(12):682-688.

- Rader R, McCauley L, Callen EC: Current strategies in the diagnosis and treatment of childhood attention-deficit/ hyperactivity disorder. *Am Fam Physician* 2009;79(8):657-665.

- Post R E, McCauley L, Kuransik SL: Diagnosis and management of attention-deficit/hyperactivity disorder in adults. *Am Fam Physician* 2012;85(9):890-896.

- National Institutes of Health National Institutes of Mental Health: Antidepressant Medications for Children and