

CHILD MALTREATMENT and the MISUNDERSTANDING OF MENTAL ILLNESS



Jeffrey B. Gordon, MD, MPH

David Corwin, MD

paradocs21@gmail.com

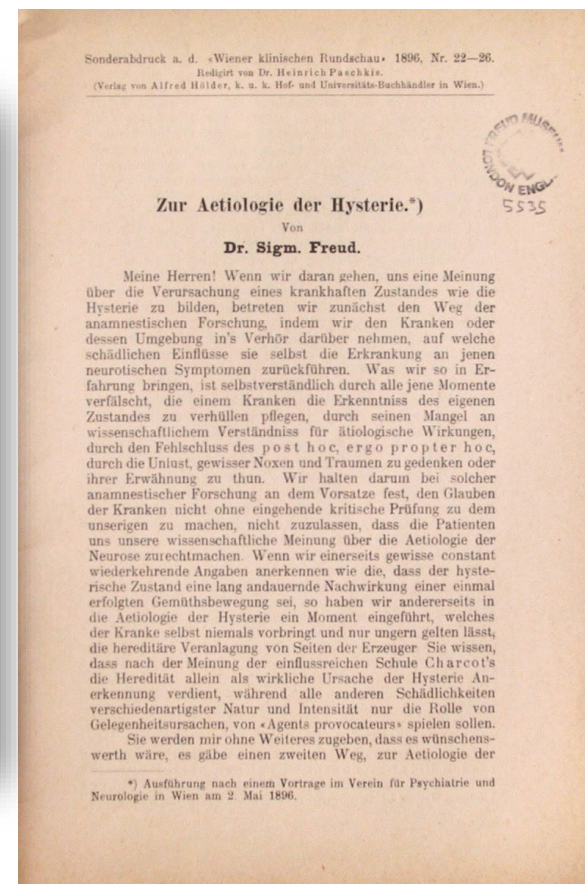
AVA SUMMIT, Dallas, Texas

October 28, 2022

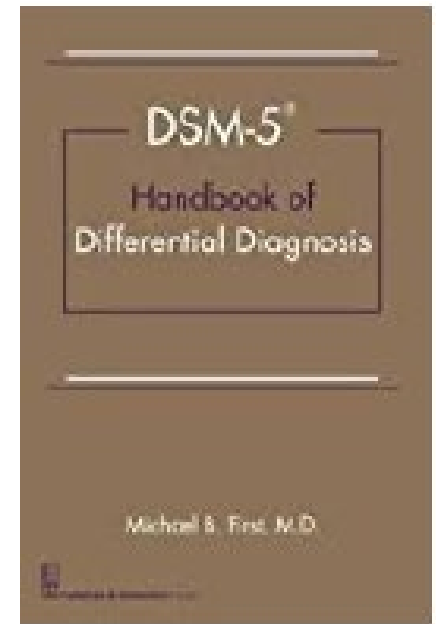
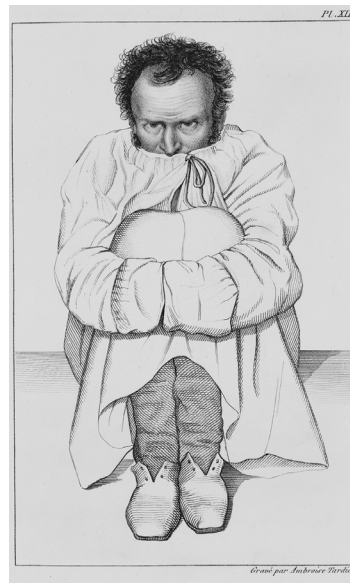
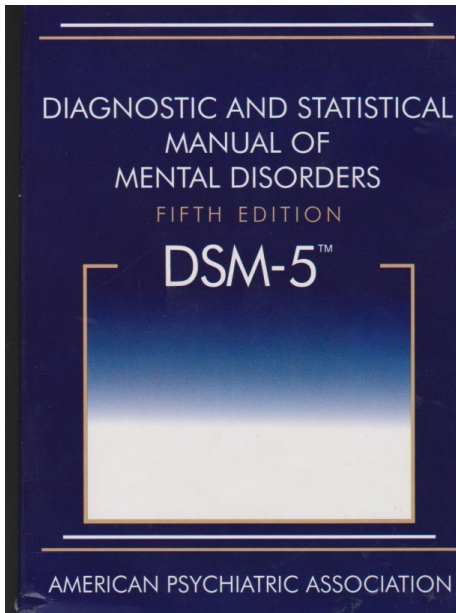


---- April of **1896** paper for the Society for Psychiatry and Neurology in Vienna

Freud says he has observed this in all 18 cases of **hysteria** he has analyzed, 6 men and 12 women. **Patients are visibly distressed when they uncover the childhood sexual encounter, which is evidence that the remembered events are real.** The encounters are sometimes sexual assaults committed by adults, and sometimes sex between children. **Hysterical people appear to overreact to things only because we cannot see the real stimulus;** for example, a girl touched innocently on the hand may become hysterical if she was touched similarly on the hand during a traumatic experience. **Freud speculates that childhood sexual abuse may also play a role in other disorders, like paranoia or obsession.**



*The study of incest as an actual phenomenon rather than as a fantasy is a relatively recent event. As recently as **1975**, Henderson D. writes in Incest, Freedman A, Kaplan H, Sadock B, eds. Comprehensive Textbook of Psychiatry. 2nd ed. Baltimore: Williams & Wilkins; 1975:1530-1539 **that the incidence of father-daughter incest in the United States was 1 in a million families.***



Other Condition That May Be a Focus of Clinical Attention

This discussion covers other conditions and problems that may be a focus of clinical attention or that may otherwise affect the diagnosis, course, prognosis, or treatment of a patient's mental disorder. These conditions are presented with their corresponding codes from ICD-9-CM (usually V codes) and ICD-10-CM (usually Z codes). A condition or problem in this chapter may be coded if it is a reason for the current visit or helps to explain the need for a test, procedure, or treatment. Conditions and problems in this chapter may also be included in the medical record as useful information on circumstances that may affect the patient's care, regardless of their relevance to the current visit.

The conditions and problems listed in this chapter are not mental disorders. Their inclusion in DSM-5 is meant to draw attention to the scope of additional issues that may be encountered in routine clinical practice and to provide a systematic listing that may be useful to clinicians in documenting these issues.

Relational Problems

Key relationships, especially intimate adult partner relationships and parent/caregiver-child relationships, have a significant impact on the health of the individuals in these relationships. These relationships can be health promoting and protective, neutral, or detrimental to health outcomes. In the extreme, these close relationships can be associated with maltreatment or neglect, which has significant medical and psychological consequences for the affected individual. A relational problem may come to clinical attention either as the reason that the individual seeks health care or as a problem that affects the course, prognosis, or treatment of the individual's mental or other medical disorder.

Problems Related to Family Upbringing

V61.20 (Z62.820) Parent-Child Relational Problem

For this category, the term *parent* is used to refer to one of the child's primary caregivers, who may be a biological, adoptive, or foster parent or may be another relative (such as a grandparent) who fulfills a parental role for the child. This category should be used when the main focus of clinical attention is to address the quality of the parent-child relationship or when the quality of the parent-child relationship is affecting the course, prognosis, or treatment of a mental or other medical disorder. Typically, the parent-child relational problem is associated with impaired functioning in behavioral, cognitive, or affective domains. Examples of behavioral problems include inadequate parental control, supervision, and involvement with the child; parental overprotection; excessive parental pressure; arguments that escalate to threats of physical violence; and avoidance without resolution of problems. Cognitive problems may include negative attributions of the other's intentions, hostility toward or scapegoating of the other, and unwarranted feelings of estrangement. Affective problems may include feelings of sadness, apathy, or anger about the other individual in the relationship. Clinicians should take into account the developmental needs of the child and the cultural context.

ings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss. The bereaved individual typically regards the depressed mood as "normal," although the individual may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of "normal" bereavement vary considerably among different cultural groups. Further guidance in distinguishing grief from a major depressive episode is provided in the criteria for major depressive episode.

Abuse and Neglect

Maltreatment by a family member (e.g., caregiver, intimate adult partner) or by a nonrelative can be the area of current clinical focus, or such maltreatment can be an important factor in the assessment and treatment of patients with mental or other medical disorders. Because of the legal implications of abuse and neglect, care should be used in assessing these conditions and assigning these codes. Having a past history of abuse or neglect can influence diagnosis and treatment response in a number of mental disorders, and may also be noted along with the diagnosis.

For the following categories, in addition to listings of the confirmed or suspected event of abuse or neglect, other codes are provided for use if the current clinical encounter is to provide mental health services to either the victim or the perpetrator of the abuse or neglect. A separate code is also provided for designating a past history of abuse or neglect.

Coding Note for ICD-10-CM Abuse and Neglect Conditions

For T codes only, the 7th character should be coded as follows:

A (initial encounter)—Use while the patient is receiving active treatment for the condition (e.g., surgical treatment, emergency department encounter, evaluation and treatment by a new clinician); or

D (subsequent encounter)—Use for encounters after the patient has received active treatment for the condition and when he or she is receiving routine care for the condition during the healing or recovery phase (e.g., cast change or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow-up visits).

Child Maltreatment and Neglect Problems

Child Physical Abuse

Child physical abuse is nonaccidental physical injury to a child—ranging from minor bruises to severe fractures or death—occurring as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or any other method that is inflicted by a parent, caregiver, or other individual who has responsibility for the child. Such injury is considered abuse regardless of whether the caregiver intended to hurt the child. Physical discipline, such as spanking or paddling, is not considered abuse as long as it is reasonable and causes no bodily injury to the child.

Child Physical Abuse, Confirmed

995.54 (T74.12XA) Initial encounter

995.54 (T74.12XD) Subsequent encounter

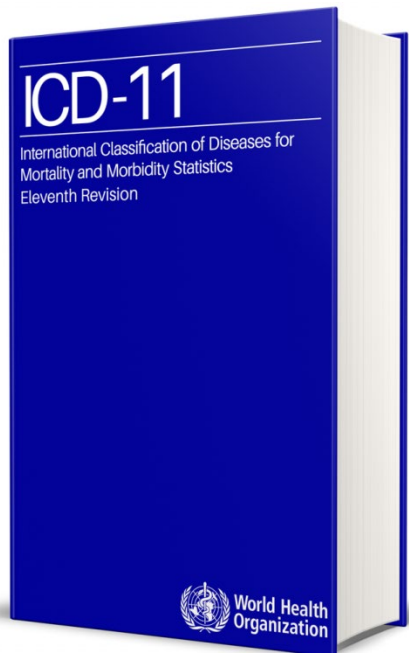
Child Physical Abuse, Suspected

995.54 (T76.12XA) Initial encounter

995.54 (T76.12XD) Subsequent encounter







- QE70 Problems related to primary support group, including family circumstances
 - QE70.0 Inadequate family support
 - QE70.1 Disruption of family by separation or divorce
 - QE70.2 Dependent relative needing care at home
 - QE70.Z Problems related to primary support group, including family circumstances, unspecified
 - ▽Problems associated with harmful or traumatic events QE80 Victim of crime or terrorism
 - QE81 Exposure to disaster, war or other hostilities
 - ▽QE82 Personal history of maltreatment
 - QE82.0 Personal history of physical abuse
 - QE82.1 Personal history of sexual abuse
 - QE82.2 Personal history of psychological abuse
 - QE82.3 Personal history of neglect
 - QE82.Y Other specified personal history of maltreatment
 - QE82.Z Personal history of maltreatment, unspecified
 - QE83 Personal frightening experience in childhood
 - QE84 Acute stress reaction
 - QE8Y Other specified problems associated with harmful or traumatic events
 - QE8Z Problems associated with harmful or traumatic events, unspecified
 - ▽Problems associated with upbringing QE90 Inadequate parental supervision or control
 - QE91 Parental overprotection
 - QE92 Altered pattern of family relationships in childhood
 - QE93 Removal from home in childhood
 - QE94 Institutional upbringing
 - QE95 Inappropriate parental pressure or other abnormal qualities of upbringing
 - QE96 Events resulting in loss of self-esteem in childhood
 - QE9Y Other specified problems associated with upbringing
 - QE9Z Problems associated with upbringing, unspecified

[International Journal of Clinical and Health Psychology](#), [Volume 16, Issue 2](#), May–August 2016, Pages 109-127
Disorders specifically associated with stress: A case-controlled field study for ICD-11 mental and behavioural disorders Using a vignette-based experimental methodology, 1,738 [international mental health](#) professionals diagnosed standardized cases designed to test key differences between the proposed diagnostic guidelines for ICD-11 and corresponding guidelines for ICD-10. **Across eight comparisons, several proposed changes for ICD-11, including the addition of [Complex PTSD](#) and Prolonged Grief Disorder, *produced significantly improved diagnostic decisions* and clearer application of diagnostic guidelines compared to ICD-10.**



IMPACT



RESEARCH

Open Access

Personal agency and borderline personality disorder: a longitudinal study of outcomes



Talia Hashworth¹, Samantha Reis¹, Michelle Townsend^{1,2}, Jessica O'Garr³ and Brin F.S. Grenyer^{1,2*} 

Low personal agency is the concept of attributing successes and failures to external factors rather than personal characteristics. Patients ($N = 57$, age 18–72, 91.5% female) were assessed at intake, after three months of DBT treatment, and 12 months follow up on measures of symptoms and personal agency.

Results

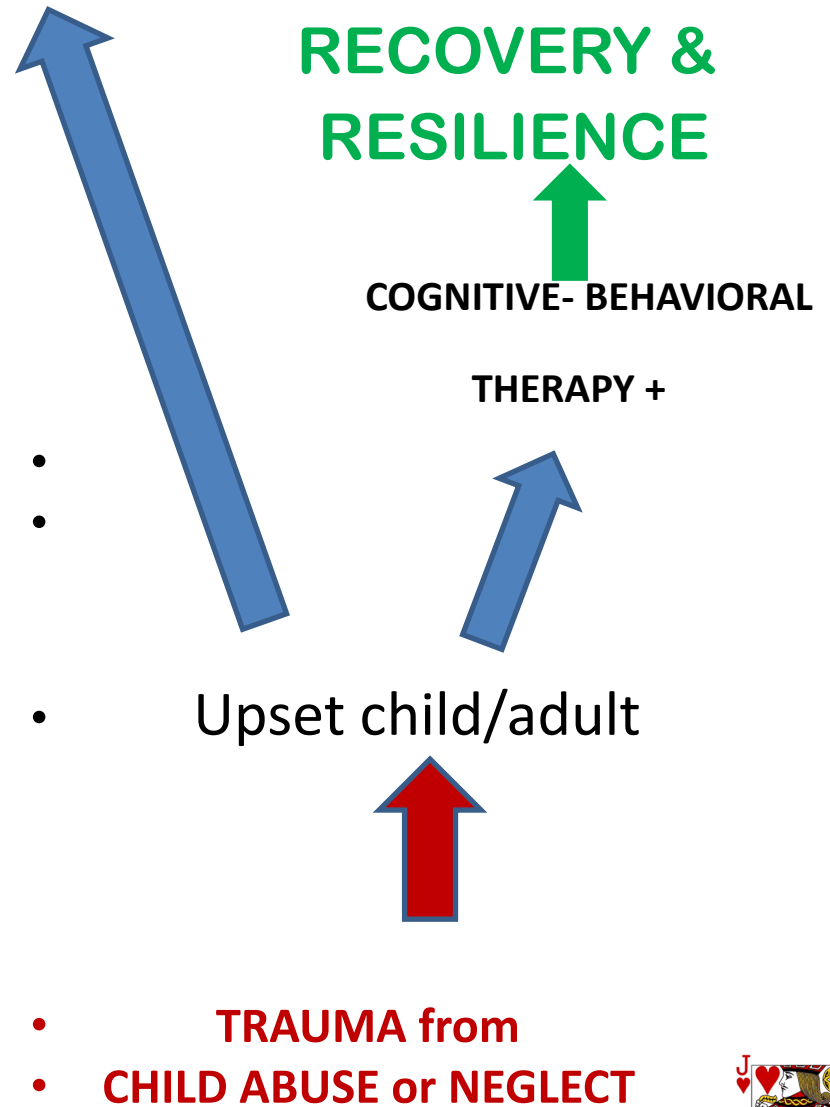
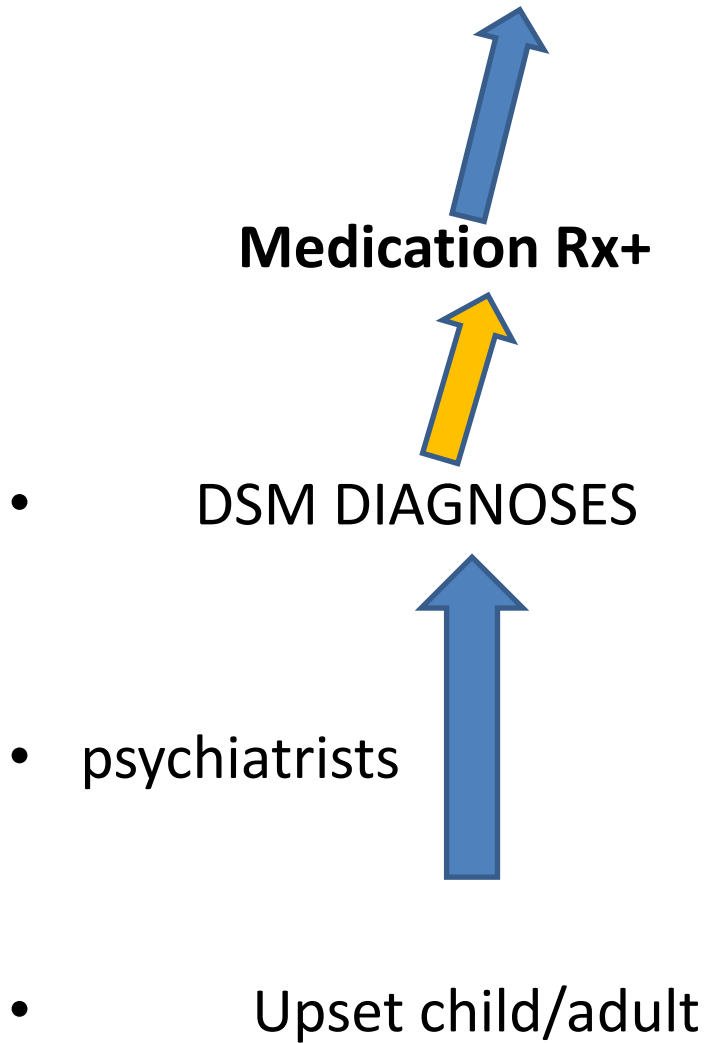
BPD symptoms were significantly reduced as a result of DBT treatment and were maintained at follow-up. However, **47% of participants continued to meet BPD criteria 12 months later, despite treatment.** Low personal agency at intake was associated with higher BPD symptom severity at post-treatment and 12 month follow up. Low personal agency at intake was associated with greater levels of negative affectivity at post-treatment. Personal agency did not relate to levels of depression and anxiety.

Conclusions

Despite the reductions in BPD symptomology, personal agency did not significantly change over time.



LIFE LONG MORBIDITY





Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication

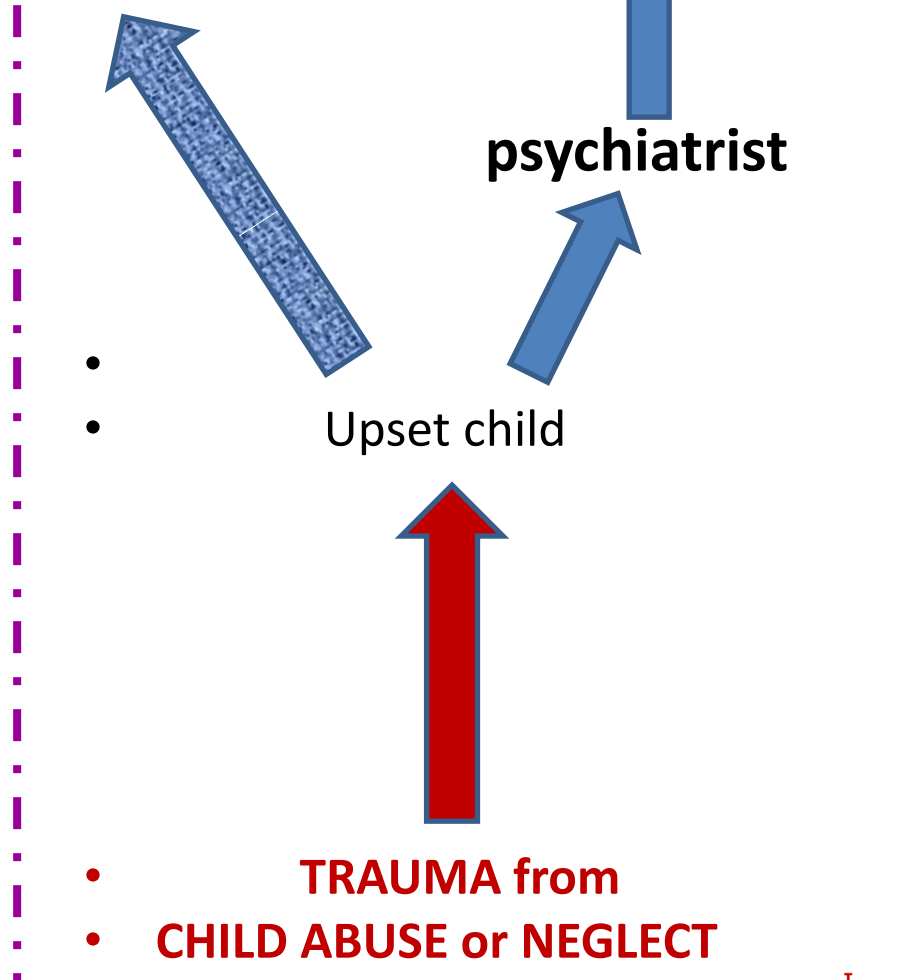
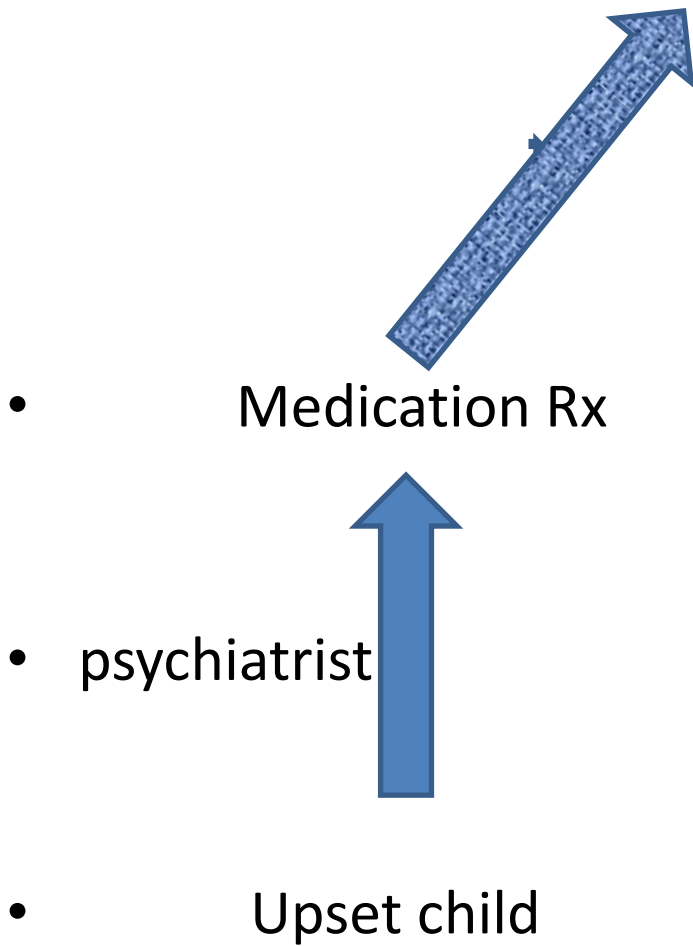
Brooks Keeshin, MD, FAAP;^a Heather C. Forkey, MD, FAAP;^b George Fouras, MD, DFAACAP;^c
Harriet L. MacMillan, GM, MD, MSc, FRCP;^d AMERICAN ACADEMY OF PEDIATRICS, COMMITTEE ON CHILD ABUSE AND
NEGLECT, COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY,
COMMITTEE ON CHILD MALTREATMENT AND VIOLENCE, COMMITTEE ON ADOPTION AND FOSTER CARE

- Pediatrics
- 2020 Feb;145(2):e20193751.
- doi: 10.1542/peds.2019-3751.
- Epub 2020 Jan 21.

“Sometimes, in an attempt to preserve existing foster care placements and reduce failure of care giving arrangements, providers will turn to psychotropic medication in an attempt to control disruptive behaviors that threaten a placement.... primary care providers are often not in a position to provide integrated mental health care, **nor do they necessarily have access to evidence based trauma-focused interventions for maltreated children.** This **lack of access may lead to underuse of trauma-informed, evidence-based psychotherapies and may be one of many factors leading to the increased prescription of psychotropic medication among maltreated children and adolescents....** Maltreated children are more likely to have complex trauma including multiple or chronic traumatic experiences that result in a **wide range of cognitive, emotional, and behavioral changes that do not easily fit into common diagnostic categories. Unidentified complex trauma may lead to children and adolescents being given multiple psychiatric diagnoses in an effort to capture the many manifestations of the trauma.**”



SUICIDALITY



Clinical Profiles and Health Services Patterns of Medicaid-Enrolled Youths Who Died by Suicide

JAMA Pediatr. doi:10.1001/jamapediatrics.2020.0002

Published online March 23, 2020.

Cynthia A. Fontanella, PhD; Lynn A. Warner, PhD; Danielle Steelesmith, PhD; Jeffrey A. Bridge, PhD; Helen Anne Sweeney, MS; John V. Campo, MD

This population-based case-control study used **Medicaid (BILLING) data from 16 states** merged with mortality data. **Suicide cases (n = 910)** included all youths aged 10 to 18 years who died by suicide from January 1, 2009, to December 31, 2013. **Three hundred seventy-six suicide decedents** (41.3%) **had a mental health diagnosis** in the 6 months before death compared with 1111 controls (17.5%; $P < .001$). A greater proportion of suicide decedents than controls used services in 6 months before the index date (687 suicide decedents [75.5%] vs 3669 controls [57.8%]; odds ratio 2.39. **Suicide risk was highest among youths with epilepsy** (OR, 4.89; $P < .001$), *depression* (OR, 3.19; $P < .001$), *schizophrenia* (OR, 3.18; $P < .001$), *substance use disorder* (OR, 2.65; $P < .001$), and *bipolar disorder* (OR, 2.09; $P < .001$). More mental health visits within the 30 days before the index date were associated with decreased odds of suicide (OR, 0.78; $P = .005$).

CONCLUSIONS AND RELEVANCE This study found that among youths aged 10 to 18 years who were enrolled in Medicaid, clinical characteristics and patterns of use of health care services among suicide decedents were distinct from those of nonsuicide controls. Implementation of suicide screening protocols for youths enrolled in Medicaid, targeted based on the frequency of visits, psychiatric diagnoses, and epilepsy, **may have the potential to decrease suicide rates.**



Suicides Among American Indian or Alaska Native Persons — National Violent Death Reporting System, United States, 2015–2020

Deborah Stone, ScD¹; Eva Trinh, PhD¹; Hong Zhou, MPH¹; Laura Welder, DrPH¹; Pamela End of Horn, DSW²; Katherine Fowler, PhD³; Asha Ivey-Stephenson, PhD³

THERE IS NO MENTION OF CHILD ABUSE OR NEGLECT IN THE WHOLE REPORT

TABLE 2. Circumstances preceding suicide of American Indian or Alaska Native persons compared with non-American Indian or Alaska Native persons — National Violent Death Reporting System, United States, 2015–2020

Circumstance	No. (%) ^a		Chi-square p-value [†]	aOR (95% CI) [§]
	AI/AN (n = 3,397)	Non-AI/AN (n = 179,850)		
Decedents with known circumstance[‡]	2,926 (86.1)	160,165 (89.1)	<0.001	0.8 (0.7–0.9)**
Suicide event or history				
Left a note	737 (25.2)	52,401 (32.7)	<0.001	0.7 (0.6–0.8)**
Disclosed suicidal intent	825 (28.2)	37,837 (23.6)	<0.001	1.2 (1.1–1.3)**
History of suicidal thoughts or plan	1,122 (38.3)	54,972 (34.3)	<0.001	1.1 (1.0–1.2)**
History of suicide attempts	634 (21.7)	31,608 (19.7)	0.009	1.0 (0.9–1.1)
Relationship problem or loss				
Any relationship problem or loss	1,607 (54.9)	67,542 (42.2)	<0.001	1.4 (1.3–1.6)**
Intimate partner problem	1,062 (36.3)	42,912 (26.8)	<0.001	1.4 (1.3–1.5)**
Family relationship problem	377 (12.9)	13,993 (8.7)	<0.001	1.2 (1.1–1.3)**
Other relationship problem (nonintimate)	121 (4.1)	3,467 (2.2)	<0.001	1.4 (1.2–1.7)**
Victim of interpersonal violence within previous mo	42 (1.4)	684 (0.4)	<0.001	2.7 (1.9–3.7)**
Perpetrator of interpersonal violence within previous mo	105 (3.6)	3,642 (2.3)	<0.001	1.6 (1.3–2.0)**
Suicide of friend or family member	123 (4.2)	3,787 (2.4)	<0.001	1.6 (1.3–1.9)**
Other death of friend or family member	180 (6.2)	10,122 (6.3)	0.711	1.1 (1.0–1.3)
Argument or conflict preceded death ^{††}	762 (26.0)	25,620 (16.0)	<0.001	1.6 (1.5–1.7)**
Injury occurred during argument	164 (21.5)	5,674 (22.1)	0.682	1.0 (0.9–1.2)
Injury occurred ≤24 hrs, but not during argument	502 (65.9)	15,721 (61.4)	0.012	1.1 (1.0–1.3)
Injury occurred >24 hrs after argument	57 (7.5)	2,715 (10.6)	0.006	0.7 (0.5–0.9)**
Other life stressor				
Any life stressor	1,640 (56.0)	94,851 (59.2)	0.001	1.0 (0.9–1.1)
Victim in custody	132 (4.5)	4,037 (2.5)	<0.001	1.7 (1.4–2.0)**
Released from institution within previous month ^{§§}	196 (6.7)	11,232 (7.0)	0.509	1.0 (0.9–1.2)
Jail, prison, or a detention facility	70 (35.7)	1,822 (16.2)	<0.001	2.5 (1.8–3.3)**
Hospital	55 (28.1)	4,559 (40.6)	<0.001	0.7 (0.5–1.0)
Psychiatric hospital or other psychiatric institution	36 (18.4)	3,589 (32.0)	<0.001	0.4 (0.3–0.6)**
Long-term residential health facility	2 (1.0)	126 (1.1)	1.000	1.6 (0.4–6.5)
Supervised residential facility related to alcohol or substance use treatment	18 (9.2)	622 (5.5)	0.028	1.5 (0.9–2.5)
Other ^{¶¶}	15 (7.7)	514 (4.6)	0.042	1.6 (1.0–2.8)
Criminal legal problem	347 (11.9)	12,384 (7.7)	<0.001	1.6 (1.4–1.8)**
Civil legal problem	127 (4.3)	5,391 (3.4)	0.004	1.4 (1.1–1.6)**
Physical health problem	366 (12.5)	3,4291 (21.4)	<0.001	0.8 (0.7–0.9)**
Job problem ^{***}	179 (6.6)	15,092 (9.8)	<0.001	0.6 (0.6–0.8)**
Financial problem ^{***}	160 (5.9)	13,097 (8.5)	<0.001	0.8 (0.6–0.9)**
School problem ^{†††}	53 (17.5)	1,586 (21.6)	<0.001	0.8 (0.6–1.1)
Eviction or loss of home	93 (3.2)	5,638 (3.5)	<0.001	1.0 (0.8–1.3)

Circumstance	No. (%) ^a		Chi-square p-value [†]	aOR (95% CI) [§]
	AI/AN (n = 3,397)	Non-AI/AN (n = 179,850)		
Mental health or substance use				
Any current substance use problem	1,340 (45.8)	47,285 (29.5)	<0.001	2.0 (1.9–2.2)**
Alcohol problem	918 (31.4)	29,109 (18.2)	<0.001	2.3 (2.1–2.5)**
Other substance use problem	778 (26.6)	27,403 (17.1)	<0.001	1.6 (1.5–1.7)**
Reported alcohol use in hrs preceding death	902 (30.8)	31,185 (19.5)	<0.001	1.9 (1.7–2.0)**
Any current diagnosed mental health problem	1,215 (41.5)	78,744 (49.2)	<0.001	0.7 (0.7–0.8)**
Depression or dysthymia	859 (29.4)	58,580 (36.6)	<0.001	0.7 (0.7–0.8)**
Bipolar disorder	146 (5.0)	11,776 (7.4)	<0.001	0.6 (0.5–0.8)**
Schizophrenia	100 (3.4)	4,714 (2.9)	0.133	1.1 (0.9–1.4)
Anxiety disorder	219 (7.5)	15,810 (9.9)	<0.001	0.7 (0.6–0.8)**
Posttraumatic stress disorder	92 (3.1)	4,235 (2.6)	0.095	1.2 (1.0–1.5)
Attention deficit hyperactivity disorder	37 (1.3)	2,161 (1.3)	0.694	0.5 (0.4–0.7)**
Current depressed mood (not diagnosis)	986 (33.7)	55,385 (34.6)	0.320	1.0 (0.9–1.1)
Mental health or substance use treatment				
Current mental health or substance use treatment	569 (19.4)	41,894 (26.2)	<0.001	0.6 (0.6–0.7)**
History of mental health or substance use treatment	862 (29.5)	56,260 (35.1)	<0.001	0.7 (0.7–0.8)**
Crisis within previous 2 wks or anticipated in upcoming 2 wks				
Crisis related to mental health ^{§§§}	930 (31.8)	475,96 (29.7)	0.015	1.1 (1.0–1.2)
Crisis related to alcohol problem ^{§§§}	21 (2.3)	2,679 (5.6)	<0.001	0.4 (0.2–0.6)**
Crisis related to substance use ^{§§§}	74 (8.0)	2,718 (5.7)	0.004	1.6 (1.3–2.0)**
Crisis related to intimate partner problem ^{§§§}	33 (3.5)	1,619 (3.4)	0.807	1.0 (0.7–1.4)
Crisis related to family relationship problem ^{§§§}	417 (44.8)	18,278 (38.4)	<0.001	1.2 (1.0–1.3)**
Crisis related to other relationship problem ^{§§§}	68 (7.3)	3,589 (7.5)	0.794	0.7 (0.5–0.9)**
Crisis related to criminal legal problem ^{§§§}	140 (15.1)	5,536 (11.6)	0.393	1.4 (1.1–1.6)**
Crisis related to civil legal problem ^{§§§}	31 (3.3)	1,628 (3.4)	0.885	1.0 (0.7–1.5)
Crisis related to physical health problem ^{§§§}	85 (9.1)	7,067 (14.8)	<0.001	1.0 (0.8–1.2)
Crisis related to job problem ^{***,§§§}	34 (4.0)	3,509 (7.7)	<0.001	0.5 (0.3–0.7)**
Crisis related to financial problem ^{***,§§§}	16 (1.9)	2,069 (4.5)	<0.001	0.5 (0.3–0.8)**
Crisis related to school problem ^{†††,§§§}	12 (12.8)	404 (17.7)	0.218	0.7 (0.4–1.3)
Crisis related to eviction or loss of home ^{§§§}	25 (2.7)	2,290 (4.8)	0.003	0.6 (0.4–1.0)**
Crisis related to recent suicide of friend or family ^{§§§}	39 (4.2)	442 (0.9)	<0.001	3.8 (2.7–5.3)**
Crisis related to other death of friend or family ^{§§§}	38 (4.1)	1,710 (3.6)	0.424	1.3 (0.9–1.8)
Abbreviations: AI/AN = American Indian or Alaska Native; aOR = adjusted odds ratio.				
^a Denominator includes all suicide decedents.				
[†] Pearson's chi-square test result for difference between AI/AN and non-AI/AN populations; Fisher's exact test when one or more of the cell counts in a 2x2 table is <5.				
[§] aORs measure the association between the decedent having the precipitating circumstance present and the race of the decedent being AI/AN. Each aOR used Non-AI/AN as the referent group and controlled for age group and sex.				
[‡] Denominator includes only suicides with one or more precipitating circumstance, unless otherwise noted. Sum of percentages in columns might exceed 100% because a suicide could have more than one precipitating circumstance.				
^{**} p<0.05 for aOR significance test.				
^{††} Denominator includes only those suicides in which argument or conflict preceded death.				
^{§§} Denominator includes only those decedents released from an institution within the previous month.				
^{¶¶} Supervised residential facilities not related to alcohol or substance use treatment, and other or unknown type of institution.				
^{***} Denominator includes only decedents aged ≥18 years with at least one known circumstance.				
^{†††} Denominator includes only decedents aged 10–17 years with at least one known circumstance.				
^{§§§} Denominator includes only those suicide decedents with any crisis within the past or upcoming 2 weeks.				



Association of Childhood Maltreatment With Suicide Behaviors
Among Young People
A Systematic Review and Meta-analysis

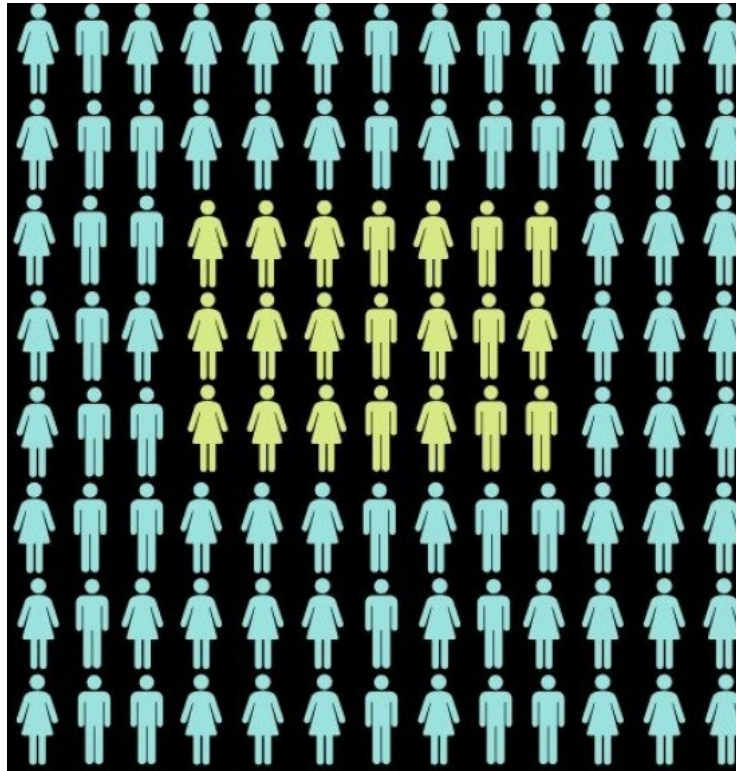
Ioannis Angelakis, PhD; Jennifer L. Austin, PhD; Patricia Gooding, PhD

JAMA Network Open. 2020;3(8):e2012563.
doi:10.1001/jamanetworkopen.2020.12563

Seventy-nine studies with **337 185 young individuals** (mean [SD] age, 15.67 [2.11] years; 63.19% female) were included. The findings demonstrated that **sexual abuse** (odds ratio [OR], 3.41), **physical abuse** (OR, 2.18), **emotional abuse** (OR, 2.21), **emotional neglect** (OR, 1.93), **physical neglect** (OR, 1.79), and **combined abuse** (OR, 3.38) were significantly associated with higher rates of suicide attempts. **Core types of childhood maltreatment were also associated with as much as 2.5-fold greater odds for suicide ideation, and sexual abuse with a 4.0-fold increase for suicide plans.** Studies based on community samples ($P = .04$) or with lower methodological quality ($P = .03$) were associated more strongly with suicide attempts in those reporting experiences of sexual abuse, whereas young age was associated with both suicide attempts ($P = .03$) and ideation ($P = .03$).

CONCLUSIONS AND RELEVANCE These findings suggest that policy actions should focus on raising public awareness and offering proactive suicide prevention therapies for children and young adults who have experienced abuse and/or neglect.





THEORETICAL DRUG (HappieR) STUDY for a mental illness

- N = 104 50 pts improved on RX $50/104 = 50\%$ In control group of 100, 40 pts improved on Placebo $40/100 = 40\%$ RB 50/40 %
- 21 pts had child abuse trauma and none responded to RX
- N = 83 50 pts improved on RX $50/83 = 60\%$ In control group 40 pts improved on Placebo $40/100 = 40\%$ RB 60/40 %



Lancet. 2018 Apr 7; 391(10128): 1357–1366.

doi: [10.1016/S0140-6736\(17\)32802-7](https://doi.org/10.1016/S0140-6736(17)32802-7)

PMCID: PMC5889788

PMID: [29477251](https://pubmed.ncbi.nlm.nih.gov/29477251/)

Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis

[Andrea Cipriani](#), MD,^{a,b,*} [Toshi A Furukawa](#), Prof, MD,^{d,†} [Georgia Salanti](#), PhD,^{e,†} [Anna Chaimani](#), PhD,^{f,g,h}

We did a systematic review and network meta-analysis. We included placebo-controlled and head-to-head trials of **21 antidepressants** used for the acute treatment of adults (≥ 18 years old and of both sexes) with **major depressive disorder** diagnosed according to standard operationalised criteria. **Findings:** We included **522 trials** comprising **116 477 participants**. **In terms of efficacy, all antidepressants were more effective than placebo**, with ORs ranging between **2·13** for amitriptyline and **1·37** for reboxetine. When all trials were considered, differences in ORs between antidepressants ranged from 1·15 to 1·55 for efficacy and from 0·64 to 0·83 for acceptability. 46 (9%) of 522 trials were rated as high risk of bias, 380 (73%) trials as moderate, and 96 (18%) as low; and **the certainty of evidence was moderate to very low.**

Interpretation: All antidepressants were more efficacious than placebo in adults with major depressive disorder. Smaller differences between active drugs were found when placebo-controlled trials were included in the analysis, whereas there was more variability in efficacy and acceptability in head-to-head trials. **These results should serve evidence-based practice and inform patients, physicians, guideline developers, and policy makers on the relative merits of the different antidepressants.**



ORIGINAL ARTICLE

Childhood trauma predicts antidepressant response in adults with major depression: data from the randomized international study to predict optimized treatment for depression

LM Williams^{1,2,5}, C Debattista^{1,5}, A-M Duchemin³, AF Schatzberg¹ and CB Nemeroff⁴

The international Study to Predict Optimized Treatment for Depression (iSPOT-D) is a randomized clinical trial with enrollment at eight academic and nine private clinical settings in five countries. Patients (**n = 1008**) meeting DSM-IV criteria for MDD and 336 matched healthy controls comprised the study sample. **Randomization was to 8 weeks of treatment with escitalopram, sertraline or venlafaxine with dosage adjusted by the participant's treating clinician per routine clinical practice. Exposure to 18 types of traumatic events before the age of 18 was assessed using the Early-Life Stress Questionnaire.** Impact of early-life stressors—overall trauma 'load' and specific type of abuse—on treatment outcomes measures: response: ($\geq 50\%$ improvement on the 17-item Hamilton Rating Scale for Depression, HRSD17 or on the 16-item Quick Inventory of Depressive Symptomatology—Self-Rated, QIDS_SR16) and remission (score ≤ 7 on the HRSD17 and ≤ 5 on the QIDS_SR16). **62.5% of MDD participants reported more than two traumatic events compared with 28.4% of controls.** The higher rate of early-life trauma was most apparent for experiences of interpersonal violation (emotional, sexual and physical abuses). **Abuse and notably abuse occurring at ≤ 7 years of age predicted poorer outcomes after 8 weeks of antidepressants,** across the three treatment arms. In addition, the abuses occurring between ages 4 and 7 years differentially predicted the poorest outcome following the treatment with sertraline. **Specific types of early-life trauma, particularly physical, emotional and sexual abuse, especially when occurring at ≤ 7 years of age are important moderators of subsequent response to antidepressant therapy for MDD.**



NIH RePORT: Estimates of Funding for Various Research, Condition, and Disease Categories (RCDC) Table Published: May 16, 2022

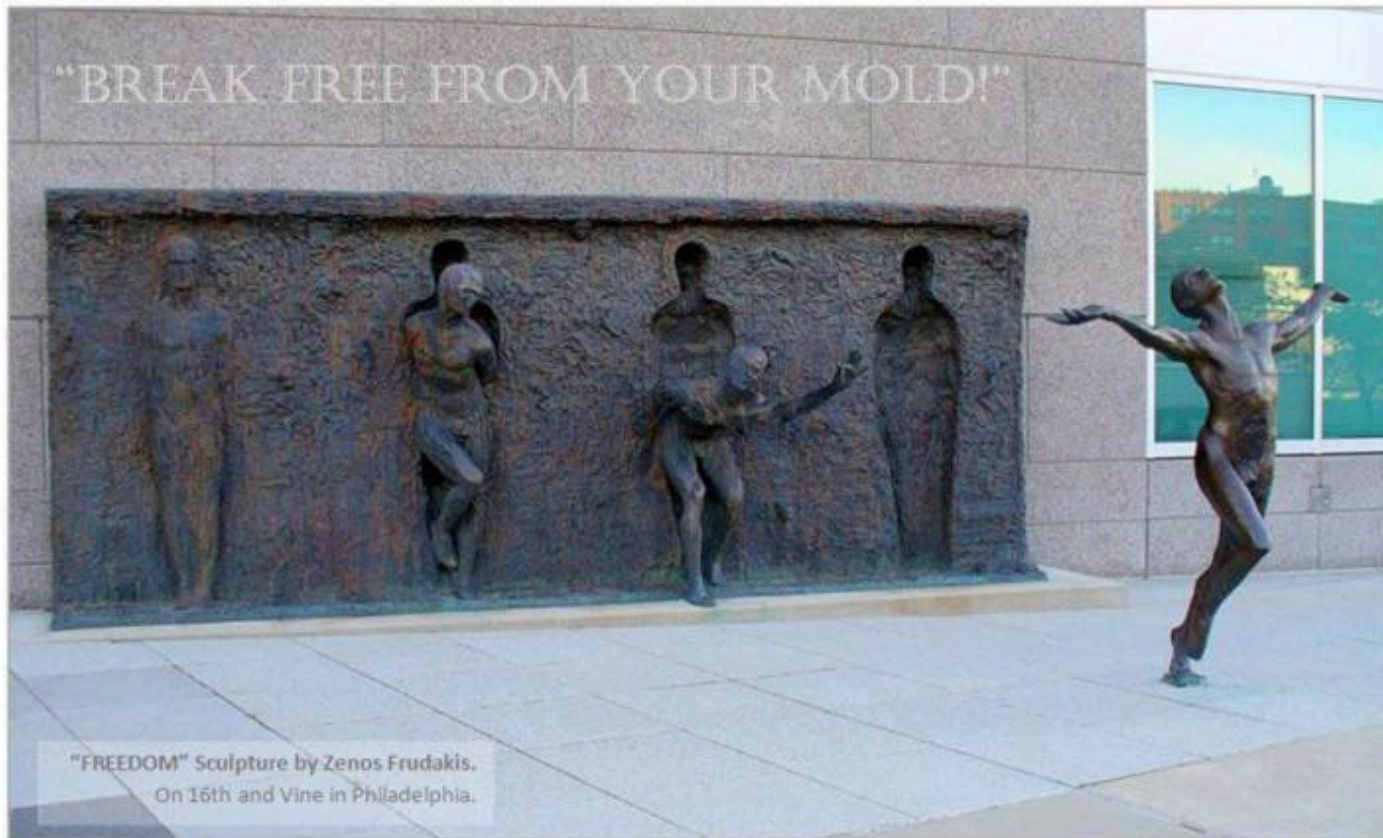
Research/Disease Areas (Dollars in millions and rounded)	2014	2015	2016	2017	2018	2019	2020	2021	2022 Estimated	2023 Estimated
Cervical Cancer	\$116	\$99	\$99	\$114	\$112	\$106	\$113	\$120	\$126	\$124
Charcot-Marie-Tooth Disease	\$14	\$14	\$11	\$10	\$12	\$13	\$15	\$17	\$18	\$17
Child Abuse and Neglect Research	\$30	\$27	\$29	\$29	\$41	\$43	\$50	\$40	\$43	\$41
Childhood Injury ³⁴	\$35	\$39	\$47	\$60	\$145	\$169	\$220	\$260	\$273	\$268
Childhood Leukemia	\$105	\$155	\$151	\$177	\$197	\$178	\$181	\$240	\$254	\$247
Childhood Obesity	+	+	+	+	\$245	\$266	\$270	\$255	\$272	\$273
Pediatric Cancer	\$276	\$342	\$351	\$433	\$514	\$546	\$579	\$664	\$700	\$681
Cystic Fibrosis	\$77	\$80	\$89	\$91	\$83	\$82	\$94	\$89	\$92	\$92



Childhood Cancer Data Initiative (CCDI) is building a community centered around childhood cancer care and research data. Through enhanced data sharing, we can improve our understanding of cancer biology to improve preventive measures, treatment, quality of life, and survivorship, as well as ensure that researchers learn from every child with cancer. *While childhood cancers represent the leading cause of death in children over the age of 1,* they are collectively rare, comprising approximately 1%–3% of cancers diagnosed annually in the United States. CCDI is a **\$50 million federal investment made in each fiscal year** (FY) 2020 and FY 2021, with **an additional \$50 million proposed each FY for the next 8 years.**







CORRECT DX CREATES NEW INSIGHTS



"FREEDOM" Sculpture by Zenos Frudakis.
On 16th and Vine in Philadelphia.

EXPERT REVIEW

Recognizing the importance of childhood maltreatment as a critical factor in psychiatric diagnoses, treatment, research, prevention, and education

Martin H. Teicher ^{1,2}, Jeffrey B. Gordon ³ and Charles B. Nemeroff ^{4,5,6} 

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Childhood maltreatment is the most important preventable risk factor for psychiatric disorders. Maltreated individuals typically develop psychiatric disorders at an earlier age, have a more pernicious course, more comorbidities, greater symptom severity, and respond less favorably to treatments than non-maltreated individuals with the same primary DSM-5 diagnosis. Furthermore, maltreated individuals have alterations in stress-susceptible brain regions, hypothalamic-pituitary-adrenal response, and inflammatory marker levels not discernible in their non-maltreated counterparts. Hence, maltreated and non-maltreated individuals with the same primary DSM-5 diagnoses appear to be clinically and neurobiologically distinct. The failure to embody this distinction in DSM-5 has interfered with our ability to discover novel treatments, to recommend currently available treatments most likely to be efficacious, and has been a largely unrecognized confound that has thwarted our ability to identify the biological basis for major psychiatric disorders. Incorporating this distinction into DSM will help transform this sign and symptom-based classification system to a more etiologically informed nosology. We discuss several diagnostic alternatives and recommend the inclusion of a Developmental Trauma Disorder diagnosis for severely dysregulated individuals, of all ages, with numerous comorbidities, who experienced interpersonal victimization and disruptions in attachment, such as emotional maltreatment or neglect. For less severely affected maltreated individuals, we suggest using conventional diagnostic categories, such as major depression, but with an essential modifier indicating a history of childhood maltreatment, or early life stress, to delineate the ecophenotypic variant. Implementing this strategy should improve our ability to effectively diagnose and treat individuals with psychiatric disorders and to accelerate discovery.

Molecular Psychiatry; <https://doi.org/10.1038/s41380-021-01367-9>



OBSERVATIONS

- (1) CM is **highly prevalent**, Struck et al reported that **15.0%** of adult participants with no history of psychiatric illness reported having experienced any type of moderate-to-severe CM. In contrast, **56.1%** of people with schizophrenia or schizoaffective disorder, **56.3%** of people with bipolar disorder, **57.1 %** of individuals with major depression, and **75.4%** of individuals with persistent depressive disorders reported this level of exposure.
- (2) CM is **the most important risk factor for many different psychiatric disorders in medically healthy individuals**. Applying **population attributable risk** gives the estimation that childhood adversity is responsible for **30%** of anxiety disorders, **45%** of childhood onset psychiatric disorders, **54%** of depression, **64%** of addiction to illicit drugs, and **67%** of parenteral drug use. Further, retrospectively reported exposure to 5 or more types of CM or household dysfunction increased the prospectively assessed risk of receiving an anxiolytic by **2.1** fold, an antidepressant by **2.9** fold, an antipsychotic by **10.3** fold or a mood stabilizer by **17.3** fold.



(3) There are many forms of CM and **all types of maltreatment are associated with important differences in clinical presentation** including: earlier onset; more severe symptoms; more pernicious course; increased risk for suicide; diminished quality of life and more psychiatric comorbidities.

(4) Psychiatrists need to know that **patients with histories of CM have a poorer response to most contemporary treatment modalities** than non-maltreated individuals with the same primary DSM-defined diagnosis.

(5) CM is associated **with substantial effects on brain structure, function, connectivity and network architecture (and other physiologic parameters, including epigenetics)**. CM appears to result in neuroplastic adaptations that may protect a child living under abusive conditions by attenuating sensory processing of (and/or increasing physiologic responses to) specific adverse experiences leading to the development of behavioral problems later in life.



(6) These CM-associated brain differences in stress-susceptible structures (along with an array of other molecular and physiological differences) are present in maltreated individuals with psychiatric disorders but not necessarily in their non-maltreated controls, suggesting that **maltreated and non-maltreated individuals with the same primary DSM diagnoses are clinically and neurobiologically distinct.**

(7) There are a substantial number of individuals with CM histories who appear to be relatively **resilient** (an absence of pathology or 'better than expected outcome'). **The whole complement of maltreatment-associated brain changes have been reported in maltreated individuals without overt psychopathology.** This suggests that asymptomatic CM individuals are not unaffected but are effectively compensating through other neurobiological mechanisms.



RECOMMENDATIONS

- (1) It is essential that clinicians **obtain a maltreatment history** when assessing or treating individuals with psychiatric disorders. Maltreatment is also a major risk factor for a host of medical disorders including cancer as well as heart, liver, digestive and respiratory disease, so a maltreatment history should be an essential part of everyone's medical history.
- (2) **As maltreated and non-maltreated cohorts with psychiatric disorders are so vastly different this needs to be fully incorporated into diagnostic nosology (i.e. the DSM), preferably with a specific code to delineate the CM-associated ecophenotype.**
- (3) All investigators conducting **epidemiology, genetic risk studies and treatment trials** for psychiatric disorders must **collect data on CM** and analyze the data to indicate the extent to which CM moderates response. The most effective way to do this would be for psychiatry and clinical psychology journals to strongly advocate this practice.
- (4) **Clinical research studies** on the biological basis of psychiatric disorders should, in almost all instances, **collect data on CM as a key biological variable.** Researchers would not consider conducting a study without controlling for the influence of sex or psychiatric medications. In general, maltreatment is a much more powerful confounding factor. Journals should take the lead in advocating this position along with the NIH.
- (5) Maltreatment is such a potent risk factor there should be **a concerted effort to reduce exposure** and a major effort to develop strategies to preempt the emergence of psychiatric disorders in youths who have been exposed. The NIMH, NIDA, NIAAA and NICHD must make these high priority areas and place much more emphasis on prevention and preemption.



POGO:

WE HAVE MET
THE ENEMY
AND HE IS US



Walt Kelly