Role of Combat Trauma In PTSD Is Reinforced

BY KATE JOHNSON
FROM THE ANNUAL MEETING OF THE INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES

MONTREAL – Predisposition is an important factor, but a traumatic event remains the necessary trigger in the development of posttraumatic stress disorder, a new study of identical twins indicates.

“Embedded within the diagnostic criteria of PTSD is a presumed causal event, but this assumption has come under scrutiny, as a recent study suggested that the symptoms of PTSD may merely represent general psychiatric symptoms that would have developed even in the absence of a trauma (J. Anxiety Disord. 2007;21:176-82),” explained Dr. Roger Pitman, director of the PTSD and psychophysiology laboratory at Massachusetts General Hospital and professor of psychiatry at Harvard Medical School, both in Boston.

Speaking at the meeting, Dr. Pitman launched new evidence to support the widely held theory that trauma is central to the development of PTSD.

The study comprised 104 Vietnam combat veterans and their nonveteran identical twins. Of the veterans, 50 had PTSD and 54 did not, whereas none of the nonveteran identical twins had the disorder (J. Clin. Psychiatry 2010;71:1324-30).

“If the PTSD-affected veterans had predisposing vulnerability to psychopathology on a genetic or environmental basis, then that ought to be shared by their twins,” he explained.

Psychometric measures — including the Symptom Checklist-90-Revised, the Clinician-Administered PTSD Scale (CAPS), and the Mississippi Scale for Combat-Related PTSD — were used to assess symptoms for all veterans and their twins. For the nonveterans, questions about combat trauma were replaced with questions about their most traumatic experience.

As expected, the evaluations revealed higher scores on all measures for the PTSD-affected veterans, compared with their identical twins. All nonveteran twins had scores similar to those of the veterans without PTSD.

“These results do not support the idea that the people with PTSD would have been symptomatic even without the traumatic experience,” he said.
Bipolar Diagnosis ‘Misapplied’

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But “categorization as a disruptive behavior disorder does not do justice to the mood and anxiety disorders” these patients have. “Physicians diagnose these patients as [having] bipolar disorder and therefore conclude that stimulants and SSRIs (selective serotonin reuptake inhibitors) are ‘contraindicated,’” which leads to the prescription of atypical antipsychotics or—less often—mood stabilizers, Dr. Leibenluft said. But no treatment trial has focused on the patients proposed to have TDD, making its optimal treatment unclear.

The new TDD diagnosis also creates a niche for patients who are “numerous, much more common than [patients with] typical bipolar disorder. They are a very important group that needs psychotherapy, medications, and services.” A diagnosis of oppositional defiant disorder and attention-deficit/hyperactivity disorder does not justify the amount of services they need and does not do justice to their mood and anxiety disorder,” she said.

The new diagnosis “will sensitize people to a syndrome that had previously not been recognized or had been very difficult to code. I hope that [the new diagnosis of TDD] will decrease the number of kids who get labeled with bipolar disorder who may not be at risk for bipolar disorder,” said Dr. David Shaffer, professor of child psychiatry and chief of the division of child psychiatry at Columbia University in New York.

“It will also free up the treatment options in an important way. At the moment, these patients are often denied antidepressants and stimulants with the assumption that it will make them flip into a manic episode, although the evidence for that is very scanty.”

“I think [a diagnosis of TDD] will have an impact on the way these kids are managed, and I suspect they’ll be managed much more aggressively, and the period of their illness will be greatly shortened.”

“Most of us who see these kids for second opinions usually diagnose anxiety or dysthymia, and we usually see a good response quickly quite quickly to an antidepressant,” Dr. Shaffer said in an interview.

In addition, “what is regrettable about the diagnosis ‘bipolar disorder their inter-outburst mood, and their impairment. But this solution has drawbacks, Dr. Leibenluft said: Clinicians don’t use specifiers, the disorder is better categorized in the DSM-5 mood section rather than in the disruptive behavior disorders section, and the relatively high prevalence of the condition justifies a new diagnosis.”

The new diagnosis should also facilitate exploration of the disorder’s etiology, she added.

“Although consensus favors creating the new diagnosis, the name ‘temper regulation disorder with dysphoria’ remains tentative. ‘We’re still in the name market,’ Dr. Leibenluft said. The following nine criteria have been proposed for the new diagnosis:

1. TDD is characterized by severe, recurrent temper outbursts in response to common stressors. Outbursts manifest verbally, in behavior, or both, and include verbal rages and physical aggression.

2. Reactions are grossly disproportionate in intensity or duration to the provocation and are inconsistent with Norris (not otherwise specified) is borrowing a term from another disorder with no evidence of linkage,” he said during the session. “Using the term bipolar disorder, you assign a lifelong diagnosis with many implications for the family and for the future social adaptation of the child. Evidence from retrospective analyses of adult bipolar patients does not support a link.”

“The feeling by members of DSM-5 is that the diagnosis of pediatric bipolar disorder is misapplied and made too loosely,” said Dr. Daniel S. Pine, chief of the Section on Development and Affective Neuroscience at the NIMH. “The fundamental problem is that this is a large group of kids who are not getting services.”

“Until there are systematic treatment studies, we won’t know how to best manage these patients.”

**Continued on following page**

**Sweeping Changes to DSM-5 Proposed**

Members from various work groups contribute suggestions to the Diagnostic and Statistical Manual of Mental Disorders presented the following tentative changes that involve pediatric psychiatric diagnoses:

**Children and Adolescents in DSM-5.** Most fundamentally, the DSM-5 might eliminate the previous diagnosis of ADHD in patients with autism spectrum disorders. The new diagnosis would eliminate the previous category of feeding and eating disorders of infancy or early childhood. All of the specific disorders previously listed in the category would shift into a newly named category: feeding and eating disorders. The category includes pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, binge eating disorder, and “conditions not elsewhere classified,” which will include atypical anorexia nervosa, purging disorder, and night eating syndrome.

Avoidant/restrictive food intake disorder is a new name for what the DSM previously called feeding disorder of infancy or early childhood. The purpose of the change is to reduce the not-otherwise-specified diagnoses, and to give a landing place for a lot of kids who have eating problems but no place to land in DSM-IV,” said Dr. B. Timothy Walsh, professor of pediatric psychopharmacology at Columbia University in New York. “What we’re proposing for this diagnosis includes a heterogeneous collection of patients. A key factor in making the avoidant/restrictive diagnosis is that ‘it has to have significant consequences, because a lot of these behaviors occur normally in kids growing up,’ he said.

**Reactive Attachment Disorders.** This diagnosis now lists two forms: inhibited and disinhibited. Current proposals will change this to two separate diagnoses: ‘Reactive attachment disorder’ and ‘disinhibited reactive attachment disorder’ for those children with emotional unresponsiveness. The disinhibited, indiscriminately social form would receive the new name ‘disinhibited social engagement disorder.’ One reason for such a change is that the disinhibited form is not related to typical social attachment,” said Dr. Charles H. Zeanah, professor and director of child and adolescent psychiatry at Tulane University in New Orleans.

**Posttraumatic Stress Disorder.** The diagnosis would change to allow the large number of preschool children who cannot meet current criteria despite being highly symptomatic. In particular, the work group proposes changing the avoidance and numbing criteria, because until now, few children met those criteria. The revision lists avoidance and numbing separately, and proposes changing numbing to “negative alterations in mood or cognition.”

**Attention-Deficit/Hyperactivity Disorder.** More than half of children from 7 years to 12 years, the revision proposes adding new exemplifications for ADHD symptoms that illustrate behaviors across the life span. Also added would be four new symptoms of impulsiveness: acting without thinking, losing patience, being uncomfortable doing things slowly and systematically, and difficulty resisting temptations or opportunities. The revision sets the threshold for diagnosis as six symptoms of inattention, and six symptoms of hyperactivity and impulsiveness in children and adolescents up to age 16 years; in those aged 17 years and older, the threshold for each diagnosis was set to four symptoms. And the work group removed the exclusion of diagnosing ADHD in patients with autism spectrum disorders.

“No question that 50%-70% of children and adolescents with autism spectrum disorders present with very significant inattention and hyperactivity symptoms,” said Dr. F. Xavier Castellanos, professor of child and adolescent psychiatry at New York University. “Is it the same as ADHD? It’s been a very sore point that you can’t diagnose ADHD in these patients. The vote was to remove the exclusion. It leaves open the question of blurring a boundary” between ADHD and autism spectrum disorders, he said.

**Conduct Disorder.** The work group added a proposed specifier for conduct disorder on callous and unemotional traits. Results from more than 30 studies suggest a high comorbidity of callous and unemotional traits predicts a more severe, stable, and difficult-to-treat conduct disorder, said Paul J. Frick, Ph.D., professor and chair of psychology at the University of New Orleans. It constitutes just a small fraction of all conduct disorder cases. The callous and unemotional specifier requires at least two of these traits: lack of remorse or guilt; lack of empathy; unconcern about performance, and shallow or deflection of feelings. A majority of clinicians to these traits will need testing in a field trial, Dr. Frick said.

**Oppositional Defiant Disorder.** The changes remove an exclusionary criteria for conduct disorder, organize the diagnosis in what symptom clusters (‘often loses temper’) and behavioral (‘often argues with adults’) symptoms, and sets a severity index based on symptom number and setting number, Dr. Frick said.

Dr. Walsh said he has received research support from AstraZeneca. Dr. Pine, Dr. Zeanah, Dr. Castellanos, and Dr. Frick had no disclosures.
Prevalence of ADHD in U.S. Reached 9.5% in 2007-2008

BY MITCHEL L. ZOLER
FROM THE ANNUAL MEETING OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

NEW YORK – The U.S. prevalence of attention-deficit/hyperactivity disorder among children and adolescents rose to its highest level in 2007-2008, with 9.5% of children and adolescents ever diagnosed, according to a federally sponsored national telephone survey covering more than 70,000 American children and adolescents.

Although the reasons behind the increased prevalence of attention-deficit/hyperactivity disorder (ADHD) remain unclear, the increase over the 7.8% rate of ever-diagnosed ADHD in 2003-2004 reached statistical significance and appears real.

"We think something is going on," Melissa L. Danielson said while presenting a poster at the annual meeting of the American Academy of Child and Adolescent Psychiatry.

Explanations might include increased awareness of the diagnosis, and more children and adolescents undergoing formal evaluation, she said. Backing up the national finding are data on ADHD prevalence in each individual state. The trend rose in almost every state, and in 13 states recent increases reached statistical significance, she said in an interview.

The National Survey of Children's Health, run by the Centers for Disease Control and Prevention, receives its primary funding from the Department of Health and Human Services. In 2007 and 2008, a randomly selected sample of U.S. parents answered a telephone survey about their children's health. Parents answered four questions about ADHD: Did they have a child aged 4-17 years who ever received a diagnosis of disorder? Did their child have a current diagnosis? Is the ADHD mild, moderate, or severe? Does the child receive medication?

Epidemiological survey results showed that in 2007-2008, 4.1 million children and adolescents were affected by attention-deficit/hyperactivity disorder. Of these, two-thirds — 2.7 million — received medical treatment for their ADHD, and parents said that 570,000 (14%) of their kids had severe ADHD. About half had mild ADHD, with the remaining patients having what their parents described as moderate disorder. Subgroups with significantly less-severe ADHD included girls and adolescents aged 15-17.

Boys, adolescents aged 15-17 years, and multiracial and non-Hispanic children all had significantly higher prevalence rates of current ADHD relative to their respective comparator subgroups. Gender, race, and ethnicity had no linkage with medication use, but medication treatment occurred less often in the 15- to 17-year-olds, said Melissa Danielson, a statistician on the Child Development Studies team of the CDC in Atlanta. Children aged 11-14 years had the widest medication use, 73%, while adolescents aged 15-17 had the lowest rate of medication, 56%, a statistically significant difference.

Children aged 11-14 years with severe disease had a roughly 90% rate of medical treatment; teens aged 15-17 years with mild ADHD had the lowest medication rate, about 50%.

Children and teens with a concurrent diagnosis of disruptive behavior disorder had a statistically significant, 50% adjusted, relative increased rate of receiving medication for ADHD and also had a significantly higher prevalence of current, severe ADHD. More than 30% of children with the combination of current ADHD and disruptive behavior disorder had severe ADHD.

Major Finding: During 2007-2008, U.S. children and adolescents aged 4-17 years had a 9.5% prevalence rate of ever having attention-deficit/hyperactivity disorder, a significant increase from the 7.8% rate in 2003-2004.

Data Source: The National Survey of Children’s Health, a random-sample telephone survey of parents with data on more than 70,000 U.S. children and adolescents aged 4-17 years run by the Centers for Disease Control and Prevention.

Disclosures: Ms. Danielson said that she had no disclosures.

Their behavior and its consequences cause clinically significant distress or impairment in interpersonal, academic, or other important areas of function. (This criterion is tentative.)

4. Self-injury does not exclusively occur during states of psychosis, delirium, or intoxication. In people with a developmental disorder, the behavior is not part of a pattern of repetitive stereotypes.

The behavior cannot be attributed to another mental or medical disorder, such as psychotic disorder, pervasive developmental disorder, mental retardation, or Lesch-Nyhan syndrome.

The proposed criteria also establish a subthreshold diagnosis, if all other criteria are met but self-injury occurred fewer than five times during the past 12 months. It is also quite frequently think about performing self-injury but infrequently do it.

Patients who meet the NSSI criteria and express an intent of achieving relief or positive feeling, but also intend to commit suicide, meet an 'intent uncertain' form of NSSI.

"The issue is failure to recognize NSSI as benign," Dr. Shaffer said in an interview. "I think [the new diagnosis] will safely avert hospital admissions. Although some of these youngsters will, at certain times, make suicide attempts, an episode of cutting doesn't mean that they need hospitalization, which can be a traumatizing and damaging process."

In addition, keeping patients with NSSI out of hospitals will prevent the contagion that often results. (Introduction of a child or adolescent who has self-mutilated in a hospital ward often leads to an outbreak of similar behavior among others in the ward.)

Dr. Leibenluft, Dr. Pine, and Dr. Shaffer had no relevant financial disclosures.