TRAUMA FOR THE NON-TRAUMATIZED NON-PSYCHIATRIST

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SOURCES OF TRAUMA

- War, combat (soldiers, civilians)
- Disasters, terrorism
- Child abuse
- Violence
- Accidents
- Medical
- Etc.
RELEVANT DSM-5 CATEGORIES

- PTSD
- PTSD for pre-school children
- Acute stress disorder
- Adjustment disorders
- Other trauma/stress related disorders
- Various mood, anxiety disorders, especially persistent depressive disorder, major depressive disorder, panic disorder, social phobia, specific phobias, alcohol use disorder, other SUDs
WHAT IS TRAUMA?
ELEMENTS OF PTSD

• TRAUMA
• INTRUSION, RE-EXPERIENCING
• COGNITIVE/MOOD CHANGES
• SYMPATHETIC AROUSAL
• AVOIDANCE BEHAVIORS
DEFINING TRAUMA

• DSM-5 requires exposure to actual or threatened death, serious injury, or sexual ‘violation’
• DSM-IV required intense fear, helplessness, or horror
• Four types in DSM-5
  • Direct experience
  • Witness of event
  • Repeated or extreme exposure to aversive details
  • Learns that a traumatic event occurred in close family/friend (violent or accidental event)
REPEATED EXPOSURE TO …
INTRUSION SYMPTOMS, RE-EXPERIENCING

- Characteristic nightmares
- Flashbacks
- Intrusive memories
- Reaction to cues (“hit the dirt”)
NEGATIVE CHANGES IN COGNITION, MOOD

- Emotional numbness, estrangement
- Survivor’s guilt
- Exaggerated beliefs regarding badness of self, others, institutions;
- Anhedonia, persistent negative emotional state, inability to feel positive emotions
INCREASED (SYMPATHETIC) AROUSAL

- Hypervigilance
- Irritability, anger
- Sleep disturbance
- Recklessness
- Poor concentration

ROAD RAGE
Get out of the fast lane, sucker!
AVOIDANCE BEHAVIOR

- Avoidance of memories related to traumatic event
- Avoidance of circumstances reminiscent of the traumatic event
A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked psychological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently tuned”).
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotion state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1. Intense behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.
ROLE OF PRIMARY CARE DOC

- RECOGNITION
- REFERRAL TO VA, BEHAVIORAL PSYCHIATRY, PSYCHIATRIST
- INITIAL PSYCHOPHARMACOTHERAPY
PEOPLE WHO HAVE BEEN TRAUMATIZED MAY AVOID TALKING ABOUT IT

• Talking → MORE anxiety
• Fear they are crazy
• Expectation that they won’t be understood
• Guilt
• Notice that many PTSD symptoms are common in absence of PTSD, eg,
  • Sleep disturbances
  • Depression
  • Anxiety/panic
  • Irritability, aggressiveness
• Screening items are more sensitive and specific to PTSD than symptoms commonly reported, especially traumatic dreams
In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?  
   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?  
   YES / NO

3. Were constantly on guard, watchful, or easily startled?  
   YES / NO

4. Felt numb or detached from others, activities, or your surroundings?  
   YES / NO
ROLE OF NON-Psychiatrist
DON’T prescribe benzodiazepines

DO discourage drinking

DO ask about “medical marijuana”

DO attend to comorbid pain
PSYCHOPHARMACOTHERAPY

• For symptoms of irritability, depression, anxiety/arousal, prescribe any SSRI
  • Sertraline, fluoxetine are my first-line, usually will go to maximum dose
  • Venlafaxine second line
  • Other AD or divalproex may be third line
• For nightmares, prazosin often effective
  • Typical titration by 1mg hs every 4-7 days as needed/tolerated up to 10mg + hs; note dizziness
• For sleep in absence of nightmares, trazodone, 50-300mg
EFFEC TIVE PSYCHO THERAPIES FOR PTSD

• Prolonged exposure (PE)

• Cognitive processing therapy (CPT), includes cognitive restructuring

• Other variants of CBT that focus upon other symptoms, such as insomnia

• Eye movement desensitization and reprocessing (EMDR)

• Simple mindfulness exercises may be helpful for some and can be taught within a primary care setting
The inimitable Norman Miller, J D, MD, Psychiatrist, Neurologist, Iconoclast
WHAT HAPPENED TO ADHD?

Jim Dillon, MD
Professor of Psychiatry and Training Director
In the beginning...
There Was MBD

“Let There Be Light”
Minimal brain damage
Minimal brain dysfunction
Minimal cerebral dysfunction
Brain-damaged child syndrome
Hyperkinesis
Hyperactivity
Dyslexia, Dysgraphia, Dyscalculia
Visual perceptual disorders
SYMPTOMS ATTRIBUTED TO MBD

- Hyperactivity
- Poor attention (span)
- Temper tantrums
- Aggression
- Clumsiness
- Learning problems
- Etc.
“EVIDENCE” OF MBD

• Risk factors in pregnancy and birth
• CNS-related illnesses
• Congenital anomalies
• Neurological soft signs
MBD

- High prevalence in general population (10-20%)
- Presumed biological basis
  - Anomalies
  - Soft signs
- Refuted poor parenting dogma
- Offered rationale for non-psychodynamic approach to treatment
“IT HAS BECOME AN ALL-ENCOMPASSING, WASTEBASKET DIAGNOSIS FOR ANY CHILD WHO DOES NOT QUITE CONFORM TO SOCIETY’S STEREOTYPE OF NORMAL CHILDREN.” (SCHMITT, AM J DIS CHILD 129, 1313, 1975)
WHY THE MBD CONCEPT DIED

• No brain damage demonstrable in most cases
• MBD children very heterogeneous
• Risk factors supporting dx often present in “normal” children
• Treatment response diverse and inconsistent
God said...

Genesis 1:2
“LET THERE BE...
WHAT IS A DESCRIPTIVE PROTOTYPE?

THE ‘PERFECT’ CASE THAT EPITOMIZES THE DIAGNOSIS

PROTOTYPE WOULD HAVE MAXIMUM SCORE ON SCALE
“AND HE SAID, ‘WITHIN THE DSM-III MAY ALL THE SYMPTOMS OF ATTENTION DEFICIT DISORDER WITH OR WITHOUT HYPERACTIVITY BE REVEALED. AND IT WAS SO”

- Inattention
- Impulsivity
- +/- Hyperactivity
- Early onset
WHY WAS HYPERACTIVITY “OPTIONAL”?

- Attention the central problem
- The MBD concept replaced by ADD +/- H contained non-hyperactives
- Hypothesis: there is subgroup of children—perhaps girls—who would be otherwise like hyperactives but for the absence of prominent hyperactivity
Hyperactivity and impulsivity NOT distinct categories of symptoms

DSM-III Non-hyperactives often became hyperactive

DSM-III-R had single list of 14 symptoms

DSM-IV, AND DSM-5 identify only two types of symptoms: inattention and hyperactivity/impulsivity
DSM-III: ADD+/− H

DSM-III-R: ADHD

DSM-IV

DSM-5

MBD

Age 7, 6 items, ASD exclusion

Assumption of organicity; spectrum of sx contracts

8/14 sx for dx

Impulsivity; subtypes

Explicit criteria

Age 12, 5 items

3 subtypes: IA, HI, C
6/9 items

8/14 sx for dx

Explicit criteria
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>In non-hyperactives is/are....</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct problems, impulsiveness</td>
<td>Less serious than in hyperactives</td>
</tr>
<tr>
<td>Sluggishness and drowsiness</td>
<td>Common in non-hyperactives</td>
</tr>
<tr>
<td>Social acceptance</td>
<td>Greater than in hyperactives</td>
</tr>
<tr>
<td>Social withdrawal</td>
<td>Greater than in hyperactives</td>
</tr>
<tr>
<td>Depressed mood, anxiety symptoms</td>
<td>More common than in hyperactives</td>
</tr>
<tr>
<td>Neuropsychological function</td>
<td>Similar in severity, though some qualitative differences from hyperactives</td>
</tr>
<tr>
<td>Response to stimulants</td>
<td>Is probably less robust than in hyperactives, who require lower doses</td>
</tr>
</tbody>
</table>
OTHER COMPARISONS OF INATTENTIVE VS. HYPERACTIVE SUBTYPES—CONTRASTS GROW AS CONCEPT CRYSTALLIZES

<table>
<thead>
<tr>
<th>Source</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cantwell &amp; Baker, 1989</td>
<td>80% of DSM-III non-hyperactives received dx of hyperactive 4 years later</td>
</tr>
<tr>
<td>Various</td>
<td>Anatomical correlates different</td>
</tr>
<tr>
<td>Various</td>
<td>Genetics different</td>
</tr>
<tr>
<td></td>
<td>Quality of inattention is quite different</td>
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</tbody>
</table>
Age 7, 6 items, ASD exclusion

Age 12, 5 items

3 subtypes: IA, HI, C
6/9 items

Explicit criteria

Assumption of organicity; spectrum of sx contracts

Impulsivity; subtypes

8/14 sx for dx

DSM-III: ADD+/- H

DSM-IV

DSM-III-R: ADHD

DSM-5

MBD
NO PROTOTYPE POSSIBLE AS DIFFERENT VARIETIES OF ADHD BECAME INCREASINGLY DISPARATE
PSYCHIATRIC DISORDERS ASSOCIATED WITH INATTENTION

- Schizophrenia
- Other psychotic disorders
- Mania, hypomania
- Depression
- Anxiety (as symptom)
- Generalized anxiety disorder
- PTSD
- Other anxiety disorders
- Dementia, delirium
- Intellectual disability
- Tourette’s disorder
- ASD
- Learning disorders
- Language disorders
- Substance disorders/withdrawal
- Sleep disorders
- And others...
PSYCHIATRIC DISORDERS ASSOCIATED WITH OVERACTIVITY AND IMPULSIVITY

- Mania, hypomania
- Depression (agitation)
- Schizophrenia (e.g., catatonic excitement)
- Other psychoses
- Anxiety, stress states
- Tourette’s disorder
- Stereotypies

- Cocaine, stimulant abuse
- Withdrawal states
- Sleepiness, sleep disorders
- Borderline PD, ASPD
CRITERIA FOR FEVER/ BAD-RASH DISORDER

- Fever (at least 3 of the following)
  - Subjective temperature elevation
  - Warmth of skin
  - Shivering
  - Headache
  - Muscle aches
  - Sweating
  - Dehydration
  - Weakness
  - Anorexia

- Bad rash (at least 3 of the following)
  - Red or discolored blotches
  - Red or discolored bumps
  - Red or discolored skin
  - Ring shaped discoloration
  - Scaly or flaky skin
  - Thick and leathery skin
  - Blisters
  - Raised welts
  - Pruritis
  - Oozing sores
FEVER/BAD-RASH DISORDER

SUBTYPES

• Fever subtype
• Bad rash subtype
• Combined fever/bad-rash subtype
VALIDITY OF FEVER/BAD-RASH DISORDER

• All subtypes commonly observed in community and clinic Clinical course usually brief, benign (distinguishing it from conditions like heart-not-beating-anymore disorder) that also present with prostrate, sick-appearing child

• Familial transmission of bad-rash disorder

• Responds to moderate doses of prednisone, IV steroids
TAKE-HOME MESSAGE (1) THERE IS A PROTOTYPE

- Hyperactive early in life, sometimes reportedly so in utero
- Described sometimes as all boy or Tomboy; often ectomorphic build in childhood
- Gross hyperactivity observed seated in school, family meal time
- Athletic
- Gregarious, happy go-lucky young, later burdened by failures
- At risk for aggressive, antisocial behavior
- Reading problems > Math problems
- Reproduces early and often
- Chooses employment that allows him to move around
- Women more anxious, efforts to organize
TAKE-HOME MESSAGE (2): MUCH OF THE RESEARCH ON HYPERACTIVITY APPLIES TO THIS PROTOTYPE: YOU CAN PRESCRIBE RITALIN WITH ABANDON TO SUCH PERSONS!!
TAKE-HOME MESSAGE (3): THE INATTENTIVE SUBTYPE IS ESSENTIALLY WHAT WAS LEFT OF MBD ONCE THE “PROTOTYPE” HYPERACTIVE WAS REMOVED; IT IS HETEROGENEOUS AND LARGELY UNRELATED TO THE PROTOTYPE

TAKE-HOME MESSAGE (4): EVERYBODY IS SMARTER WITH STIMULANTS

TAKE-HOME MESSAGE (5): TREATMENT OF INATTENTIVE SUBTYPE IS LARGELY EMPIRICAL WITH A WEAK EVIDENCE BASE
The End