Current PSYCHIATRY

CASES THAT TEST YOUR SKILLS

Once sociable and fun-loving, 12-year-old Julie suddenly has depressive episodes, fights with her mother, has trouble sleeping, and is suicidal. For 3 years, psychiatrists can't find the underlying cause. Can you?

The 'date' that changed her life

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HISTORY FROM SOCIABLE TO SULLEN

Julie, a Hispanic/Native American, was adopted by a Caucasian couple when she was 6 weeks old. Before age 12, she had no psychiatric problems and was medically healthy though slightly overweight.

At age 12, Julie started having episodes of brooding depression, verbal and physical aggression, and impulsive suicidal behavior. She also began suffering intermittent migraines and having trouble falling asleep. She insisted on sleeping with her parents or with a nightlight in her room.

Once a sociable girl who enjoyed being in the middle school chorus and band, Julie suddenly became sullen and defiant. She dropped out of after-school activities and stopped socializing with peers except for her best friend, Sheila, age 12, and Mark, age 13, an "almost boyfriend" who lived next door.

Julie also started arguing with her mother, often yelling and screaming when approached with minor requests. Sometimes, Julie hit and pushed her. A psychiatrist diagnosed the 12-year-old with major depressive disorder and prescribed fluoxetine, dosage unknown.

Soon after Julie's symptoms surfaced, her adoptive father, a sales representative, was laid off. He found work in another state; the family left an ethnically diverse city for a predominantly Caucasian rural area. There, Julie completed middle school and her freshman year of high school, and lost contact with Sheila and Mark.

Midway through her freshman year, Julie tried to induce vomiting after eating so that she would lose weight and "fit in better with the other girls." She stopped this at the end of the school year.

The following fall, 5 weeks into her sophomore year, she dropped out of high school and was ultimately enrolled in home school.

TREATMENT 4 HOSPITALIZATIONS IN 3 YEARS

Between ages 12 and 15, Julie was hospitalized four times for outbursts of violence with impulsive self-harm. She "overdosed" on eight aceta-

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minophen/diphenhydramine tablets on one occasion and superficially cut her forearm on another. During these episodes, she said, she heard voices telling her to harm her mother and herself.

During this period, Julie was diagnosed as having schizophrenia, major depressive disorder, attention-deficit/hyperactivity disorder (ADHD), and oppositional defiant disorder (ODD). Numerous antidepressant and mood stabilizer regimens produced no lasting improvement, though her angry and violent episodes became less frequent.

Julie's symptoms suggest:

a) schizophrenia

b) ODD

c) major depressive disorder

The authors' observations

Although Julie's psychotic symptoms might suggest an evolving disorder such as schizophrenia, no clear pattern supports this diagnosis. Also:

- Onset at age 12 is unusual. Schizophrenia typically begins in late teens to early adulthood.
- Julie showed no premorbid personality problems—found in up to one-third of patients with chronic schizophrenia—and no premorbid adjustment difficulties resulting from negative symptoms, cognitive deficits, or poor social function.[1]

Julie's angry behaviors and refusal to stay in school suggest ODD, but this disorder generally presents without self-harm or other impulsive behaviors and occurs apart from psychosis or mood disorder episodes.[1] Her low mood, withdrawal from activities, and suicidal actions may suggest major depressive disorder with psychotic features, but this diagnosis does not explain the sudden dramatic transformation in her baseline personality.

Julie's birth parents' mental health history would offer crucial information, but this was not available.

CONTINUED HISTORY 'I LEFT MY BODY'

Shortly after her 15th birthday, Julie broke down and told her parents that 3 years earlier, four boys had gang-raped her while she was "on a first date" with one of them at a school football game. She said one attacker held a knife to her throat, and they threatened to kill her friend Sheila if anyone was told. Julie said she felt so terrorized that "I left my body and watched what was happening."

After the rape, Julie went home, showered, and went to bed. She said she felt "emotionally numb" for 2 months, during which she threw herself into schoolwork, stopped attending after-school events, and began arguing with her parents. She developed nightmares of the trauma and, eventually, auditory command hallucinations. When stressed, she has "out of body" feelings lasting several minutes.

The parents, though angry at Julie's attackers, did not seek legal counsel or report the rape to authorities because they felt too much time had passed. They sought support from a counselor, who referred their daughter to a male psychiatrist for medication management. Julie, now age 16, preferred to be treated by a woman, so her care was transferred to our clinic.

Based on clinical observations, Julie gets along well with her father. She complains that her mother is overprotective yet Julie cannot bear to be separated from her for even a couple hours. She resents her mother's overinvolvement but relies on it for emotional regulation. Her mother has been treated for major depressive disorder, generalized anxiety disorder, and

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alcohol dependence. These were in sustained remission when Julie presented to us.

At presentation, we diagnosed Julie as having chronic posttraumatic stress disorder (PTSD), recurrent major depressive disorder, and eating disorder not otherwise specified. At 5 feet, 7 inches and 190 pounds, her body mass index is 30 kg/m^2, indicating clinical obesity. She has been taking duloxetine, 60 mg/d, extended-release dextroamphetamine, 20 mg/d, aripiprazole, 20 mg/d, and amitriptyline, 10 mg/d nightly. She also has been taking sumatriptan, 100 mg as needed, for migraines.

Julie symptoms now suggest:

a) major depressive disorder

b) PTSD

c) ODD

The authors' observations

After a life-threatening sexual assault, Julie suddenly became irritable and hostile. She could not keep relationships, yet she feared being alone. She impulsively hurt herself, experienced nightmares, and systematically avoided school activities. These behaviors suggest PTSD,[1] which is prevalent among sexual assault victims (*Box 1*). For 3 years, however, psychiatrists kept missing the diagnosis as Julie kept her shame a secret.

Julie tells us that she re-experiences trauma-related dysphoria when exposed to cues, such as the anniversary of the rape. She endorses avoidance symptoms, including feelings of estrangement from her family and friends. She shuns thoughts, feelings, places, and conversations associated with the trauma, which partly explains her refusal to stay in school. She reports arousal symptoms, including difficulty falling and staying asleep and fears of harm if left alone, even during the day. At night she has rituals for checking windows and doors to ensure they are locked.

Julie's decision to hide her trauma was understandable given her age and developmental phase. For a teenager trying to separate from her parents and fit in at school, the humiliation was overwhelming. She lacked the cognitive tools to process and describe her experience. She was assaulted while on a date, normally a positive rite of passage. Further, as a young Hispanic/Native American, Julie feared disappointing her Caucasian parents by not fitting in at school.

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Box 1

What determines progression from trauma to PTSD?

The National Comorbidity Survey estimates lifetime prevalence of PTSD at 7.8%.[2] Sexual assault victims face a high risk of PTSD among persons exposed to trauma.[3,4]

Factors that may influence whether trauma exposure progresses to PTSD:

- Natural resiliency
- Genetic loading
- Type of trauma
- Whether the trauma is natural or man-made
- Past traumas
- Psychiatric comorbidities

When a patient presents immediately after a life-threatening trauma:

- Ensure physical and psychological safety
- Screen for prior traumas that may increase risk of developing PTSD
- Refer for physical examination, particularly for victims of rape or physical violence

PTSD checklists can help confirm the diagnosis (see *Related resources*, page 91)

Box 2

Evidence supporting psychotherapy models in PTSD

Recommended with substantial clinical confidence (Level I)
Cognitive-behavioral therapy
Psychoeducation
Supportive techniques
Recommended with moderate clinical confidence (Level II)
Exposure techniques
Eye movement desensitization and reprocessing
Imagery rehearsal
Psychodynamic therapy
Stress inoculation
May be recommended in some cases (Level III)
Present-centered group therapy
Trauma-focused group therapy
Not recommended (no evidence)
Psychological debriefings
Single-session techniques

Source: APA practice guideline for PTSD (see *Related resources*)

When a previously well-adjusted teenager presents with sudden-onset behavioral problems, ask about past or recent trauma. Watch for contextual, developmental, and sociocultural factors that may prevent the youth from disclosing embarrassing events.

Also question the diagnosis if several adequate medication trials have failed. Check for comorbidities, lack of adherence, or other circumstances that can hamper response to treatment.

FACTORS THAT MAY SIGNAL PTSD

American Psychiatric Association (APA) practice guidelines for treating PTSD list several factors to consider if you suspect this diagnosis:[5]

Impulsive and episodic aggression can result from an anticipatory bias that increases readiness for "fight, flight, or freeze." For Julie, this turned previously comfortable interactions into dissonance and conflict.

Self-injurious and suicidal behaviors often occur when trauma creates stigma, shame, or guilt. Julie felt these emotions while trying to establish herself in a new community and school. Her obesity and ethnic background further set her apart from peers. She also left behind friends who provided emotional support outside the home and helped her differentiate from her mother.

Trauma during early adolescence can impair age-appropriate development, making it difficult to develop a stable self-image, consolidate and integrate the personality, and form relationships. At age 16, poor self-image and maladaptive coping strategies were an enduring pattern in Julie's life.

Psychiatric comorbidities. Many patients with PTSD develop psychiatric comorbidities that exaggerate symptoms, making the disorder more difficult to detect and treat. Julie's depression increased her avoidance tendencies and reinforced her isolation. Difficulty concentrating—misdiagnosed as ADHD—deterred her from engaging in school. Dissociative symptoms related to PTSD impaired her reality testing, diminishing her ability to interact with others.

TREATMENT MEDICATION CHANGE

We continued extended-release dextroamphetamine, 20 mg/d, as Julie felt the medication helped her focus on her schoolwork. We also:

- weaned her off aripiprazole, which was not helping her symptoms
- stopped amitriptyline and duloxetine because of her history of impulsive overdose and to reduce side-effect risk from polypharmacy
- titrated fluoxetine to 40 mg/d to treat her ongoing chronic depression and added trazodone, 50 mg/d as needed, to help her sleep

- stopped sumatriptan, as the headaches remitted after Julie's eyes were tested and eyeglasses prescribed.

Initially, we managed Julie's medications while she received psychotherapy from her counselor, but she eventually shifted her entire care to us. We then began seeing her weekly for psychoeducation and supportive therapy.

How would you treat Julie's PTSD?

a) prescribe a selective serotonin reuptake inhibitor (SSRI)

b) provide supportive psychotherapy

c) start trauma re-exposure

d) start psychodynamic psychotherapy

The authors' observations

Medication. APA treatment guidelines support using SSRIs to treat all three PTSD symptom clusters—re-experiencing, avoidance, and hyperarousal—as well as coexisting depression. Evidence also supports use of the tricyclics amitriptyline and imipramine and some monoamine oxidase inhibitors (MAOIs).[6-10] Dietary restrictions associated with MAOIs, however, can pose a problem for teenagers.

Benzodiazepines can decrease anxiety and improve sleep, but they can be addictive and their efficacy in treating PTSD has not been established. Alpha-2-adrenergic agonists such as prazosin and clonidine may decrease hyperarousal and trauma-related nightmares.[11,12]

Obtain informed parental consent before starting a child or adolescent on an antidepressant. These medications contain a black-box warning that the drug may increase suicide risk in youths.

Psychotherapy. Varying levels of evidence support psychotherapy models in PTSD (*Box 2*). Julie can benefit from psychoeducation, supportive therapy, psychodynamic psychotherapy, and cautious re-exposure to trauma where possible.

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Psychoeducation provided a safe starting point for Julie's therapy, engaged her parents and select school counselors and teachers, and helped her understand PTSD's effects. This allowed us to teach stress reduction and coping strategies.

Supportive techniques helped Julie contain painful affects. She could then network with community resources such as AlaTeen and a peer support group via a local Native American mental health program. This approach helped us gain Julie's trust, and we anticipate more in-depth work with time.

Trauma re-exposure helps some patients but worsens others' symptoms. For Julie, trauma re-exposure has been minimal because of the many other issues she was facing.

Developing a trusting relationship over time is crucial to successful trauma re-exposure. Re-exposure should be gradual to keep affective arousal moderate. This will minimize dissociation and affective flooding, which can frustrate treatment.

Cognitive-behavioral therapy (CBT) might help Julie understand the automatic thoughts of failure and defeat that flood her when she is stressed. CBT could help her master her feelings and lay a foundation for improved coping.

Psychodynamic psychotherapy may be started later to help Julie verbalize feelings and modulate how she expresses affect. This model could promote her development, improve her self-image, and treat her depression.

Posttraumatic stress disorder (PTSD) can cause behavior changes or developmental regression. It can be missed if the patient does not disclose the precipitating trauma or if symptoms suggest other psychiatric disorders. Assess psychosocial context after a sudden behavior change, and consider PTSD if the patient will not disclose sensitive information during routine history taking.

Bottom Line

FOLLOW-UP BACK TO SCHOOL

After 2 months under our care, Julie begins to show improvement. Because of her progress and the fact that her parents drive 45 minutes each way to get to our clinic, we reduce visit frequency from weekly to biweekly.

Julie now attends school 2 hours daily, is earning additional credits through home study, and plans to graduate early and attend community college. Her depression has lifted, and she continues to take fluoxetine, 40 mg/d and extended-release dextroamphetamine, 20 mg/d. She still struggles with social isolation, failure to reach age-appropriate developmental milestones, and a poor body image.

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Related resources

- American Psychiatric Association. Practice guideline for treating acute stress disorder and posttraumatic stress disorder. www.psych.org/psych_pract/treatg/pg/PTSD-PG-PartsA-B-C-New.pdf
- National Center for Post-Traumatic Stress Disorder. Information on obtaining Impact of Events Scale and Davidson Trauma Scale. www.ncptsd.va.gov/publications/assessment/adult_self_report.html

DRUG BRAND NAMES

Amitriptyline • Elavil
Aripiprazole • Abilify
Clonidine • Catapres
Dextroamphetamine (extended-release) • Adderall XR
Duloxetine • Cymbalta
Fluoxetine • Prozac
Imipramine • Tofranil
Phenelzine • Nardil
Prazosin • Minipress
Sumatriptan • Imitrex
Trazodone • Desyrel

DISCLOSURE

Dr. Matthews is an American Psychiatric Association Bristol-Myers Squibb Co. fellow in public and community psychiatry.

Dr. Mossefin reports no financial relationship with any company whose products are mentioned in this article, or with manufacturers of competing products.

ACKNOWLEDGEMENTS

The authors thank Larry Schwartz, MD, for his help in preparing this article for publication.