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WHAT'S NEW

The antidepressant duloxetine is approved for the management of chronic musculoskeletal pain in adults. **2**

Dr. S. Nassir Ghaemi says the APA's new guidelines for treating MDD have four major potential shortcomings. **3**

Dr. Robert T. London wants to see mental health days incorporated into benefits packages. **4**

Dr. Roland Atkinson reviews the best films of 2010 with psychiatric, psychotherapeutic, or broader mental health themes. **6**

A meta-analysis including studies from 16 countries finds that the global rate of paternal depression surpasses 10%. **14**

Adopted children often understand their lives through a prism of grief. **20**

Dr. Nora D. Volkow says two advances in addiction medicine could broaden access to care and improve treatment compliance. **30**

A combination of CBT and exercise eases pain in fibromyalgia. **44**

The GOP takeover of the House is sure to slow implementation of the health care reform law. **55**

HHS has issued a sweeping tobacco control policy that includes graphic warnings. **56**

Role of Combat Trauma In PTSD Is Reinforced

Study looked at 104 Vietnam combat veterans and their nonveteran identical twins.

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

See **PTSD** *page 13*

New Pediatric Diagnoses Proposed for DSM-5

BY MITCHEL L. ZOLER

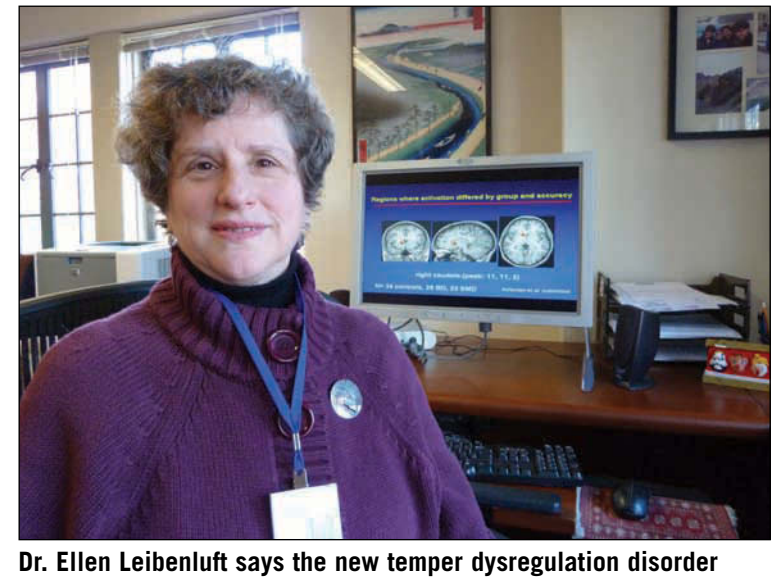
FROM THE ANNUAL MEETING OF THE AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

NEW YORK – The still-in-development DSM-5 contains two new child psychiatric diagnoses.

The Childhood and Adolescent Disorders Work Group designed one of the new diagnoses, temper dysregulation disorder with dysphoria (TDD), to include many children who were previously diagnosed with severe mood dysregulation or pediatric bipolar disorder. The second new diagnosis, from the ADHD and Disruptive Behavior Disorders Work Group, uses nonsuicidal self-injury (NSSI) to distinguish a pattern of self-inflicted damage to the body surface (usually by cutting) vs. suicide attempts. The goal of both new diagnoses is to refine patient identification and better assess appropriate treatments, said work group members in a session on pending changes to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) at the meeting.

Temper Dysregulation Disorder With Dysphoria

Creation of TDD grew from a need to "do something about the severe mood dysregulation and very irritable child, which has had no good home in DSM-IV,"



COURTESY NIMH

Dr. Ellen Leibenluft says the new temper dysregulation disorder diagnosis would create a niche for an important group of patients.

said Dr. Ellen Leibenluft, chief of the Section on Bipolar Spectrum Disorders at the National Institute of Mental Health (NIMH). Lack of a good diagnostic home for this disorder "may be why it is often diagnosed as bipolar disorder," she said.

See **DSM-5** *page 15*

Bipolar Diagnosis 'Misapplied'

DSM-5 *from page 1*

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.

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

DR. PINE

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.

'My hope is that [the new diagnosis of TDD] will decrease the number of kids who get labeled with bipolar.'

DR. SHAFFER

The new diagnosis "will sensitize people to a syndrome that had previously not been recognized or had been very difficult to code. My hope is 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 effectively 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 quite quickly to an antidepressant," Dr. Shaffer said in an interview.

In addition, "what is regrettable about the diagnosis 'bipolar disorder NOS [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, and the new diagnosis definition is an important step toward undertaking systematic treatment studies, Dr. Pine said.

Some psychiatrists in the DSM-5 work group who came up with the TDD diagnosis argued for defining these patients as having oppositional defiant disorder with a specifier for their number of outbursts per week, 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 dysregulation 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.

Reactions are grossly disproportionate in intensity or duration to the provocation and are inconsistent with

Continued on following page

Sweeping Changes to DSM-5 Proposed

Members from various work groups of the fifth edition of 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 drop the "disorders usually first diagnosed in children and adolescents" category. Those disorders now are generally split between the neurodevelopmental disorders group and the disruptive behavior disorders group. Other likely, sweeping changes include eliminating definitions based on etiology and increasing focus on development, said Dr. Pine, who also chairs the DSM-5 Childhood and Adolescent Disorders Work Group.

► **Feeding and Eating Disorders.** The DSM-5 might 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] will be 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" will apply exclusively to the inhibited form, for withdrawn patients 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 level of 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 criteria would change to deal with 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.** Age of onset would increase from 7 years to 12 years. Also, 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, impatience, 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 impulsivity 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 that the presence 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 deficient affect. The ability of clinicians to assess 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 symptom criteria to separate emotional ("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.

Continued from previous page

developmental level.

2. Temper outbursts occur three or more times a week, on average.

3. Mood between temper outbursts is persistently negative: irritable, angry, sad, or any combination of these. The negative mood is observable by parents, teachers, peers, or others.

4. Criteria 1-3 have been present for at least 12 months; during that time, the person was not without criteria 1-3 for more than 3 months at a time.

5. Temper outbursts and negative mood occur in at least two settings, such as home, school, or with peers, and must be severe in at least one setting.

6. Chronological age is at least 6 years old, or an equivalent developmental level.

7. Onset occurs before age 10 years.

8. TDD should be excluded if in the past year there never was a distinct period, lasting more than 1 day, during which an abnormally elevated or expansive mood was present most of the day, and the abnormally elevated or excessive mood was accompanied by onset or worsening of three of the "B" criteria of mania, such as grandiosity or inflated self-esteem, decreased need for sleep, pressured speech, flight of ideas, distractibility, increase in goal-directed activity, or excessive involvement in activities with high potential for painful consequences. (Abnormally elevated mood is distinct from developmentally appropriate mood elevation, such as in the context of a highly positive life event or its anticipation.)

9. The behaviors do not occur exclusively during a psychotic or mood disorder (such as major depressive disorder, dysthymic disorder, or bipolar disorder), and are not better explained by another mental disorder (such as pervasive developmental disorder, posttraumatic stress disorder, or separation anxiety). The diagnosis of TDD can coexist with oppositional defiant disorder, ADHD, conduct disorder, and substance use disorders. Symptoms do not directly result from the physiological effects of a drug of abuse, or are secondary to a medical or neurologic condition.

Nonsuicidal Self-Injury

NSSI involves much less controversy. Currently, the DSM-IV connects self-mutilation to borderline personality disorder and links it with recurrent suicidal behavior, Dr. Shaffer said.

A new diagnostic entity makes sense because about half of these self-mutilation cases do not meet criteria for borderline personality disorder; the self-inflicted damage differs from suicide attempts; misperception of NSSI events as suicide attempts leads to inappropriate treatment; and correct categorization of these patients should aid research.

NSSI episodes and suicide attempts differ by the methods used, a higher repetition rate with NSSI, broader comorbidity with NSSI, a stronger link between NSSI and peer experience, and a difference in lethality (that is, death from NSSI cutting is very rare).

The following four criteria have been proposed for NSSI, according to Dr. Shaffer:

1. On 5 or more days in the past year, the person has engaged in intentional, self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, or pain, using methods such as cutting, burning, stabbing, hitting, or excessive rubbing.

Unlike body piercing or tattooing, the damage is done for purposes that are not socially sanctioned, and with an expectation that the injury will involve only mild or moderate physical harm. Either the patient reports no suicidal intent, or the lack of intent can be inferred by the patient's frequent use of a method known through experience to have no lethal potential. The behavior is not of a common or trivial nature, such as picking at a wound or nail biting.

2. The intentional injury associates with at least two of the following four characteristics:

- Negative feelings or thoughts – such as depression, anxiety, tension, anger, generalized distress, or self criticism – are present immediately prior to the self-injurious act.
- A period of preoccupation with the intended behavior is present prior to engagement in the act.
- There is a frequent urge to perform self-injury, even if the urge is not acted upon.
- The self-injury occurs with a purpose, such as relief from a negative feeling, cognitive state, or interpersonal difficulty or the induction of a positive feeling. The patient anticipates that the relief or positive feeling will occur either during or immediately after the self-injury.

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.

3. The 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 stereotypies.

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, in people who 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 who also intend to commit suicide, meet criteria as 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. ■

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. Prevalence rates rose in almost every state, and in 13 states recent increases reached statistical significance, she said in an interview.

The National Survey of Childrens 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?

Extrapolated survey results showed that in 2007-2008, 4.1 million children and adolescents had a current diagnosis, 7.2% of the 4- to 17-year-old population (less than the 9.5% ever diagnosed with ADHD). 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 Ms. 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 medical treatment for their 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. ■

VITALS

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.

Pages 16a—16h