Charmi Patel Rao, MD
Maggie Knight, LMFT

IT'S ADHD. IT'S AUTISM. NO - IT'S TRAUMA!

GROUP ACTIVITY: PART 1

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INTRODUCTION

- Maggie Knight, LMFT
  - Expertise in ECMH
  - Over 150 hours of play therapy instruction

- Charmi Patel Rao, MD
  - Board certified Child & Adolescent Psychiatrist
  - Expertise in ECMH and developmental disabilities and integration of behavioral health into primary care
  - Developing expertise in juvenile forensics

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OUTLINE

- Group activity: Part 1
- Case presentation
- Group activity: Part 2
- Diagnostic criteria
- Distinguishing symptoms
- Why is this important?
- Treatment considerations
- Return to the case
- Summary

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CASE PRESENTATION

4yo boy who presents with impulsivity and aggression leading him to being kicked out of 2 preschools.

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CONDUCTING A THOROUGH ASSESSMENT

- Clinical Interview to gather history
- Assessment in multiple settings including school/daycare and home
- Use of assessment tools (Child Behavior Checklist, Pediatric Symptom Checklist, Trauma Symptom Checklist for Young Children)
- Referral for other assessments if still unsure or other identified concerns (developmental evaluation)

SCREENING QUESTIONS

- Trauma: Exposure to abuse or neglect or losses? Avoidance?
- ADHD: Constant hyperactivity, impulsivity, inattention?
- Autism: Restricted and uncommon interests? Social challenges? Repetitive movements? Rigid patterns of thinking?

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MORE SCREENING QUESTIONS

- Anxiety: Things that s/he worries about or is afraid of? Trouble separating from you?
- Mood: Mood changes out of the blue? Mood symptoms underlying behavioral symptoms? Excessive sadness or anger?
- Sleep Disturbance: Trouble falling asleep or staying asleep? Nightmares?

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WHAT OTHER INFORMATION TO OBTAIN?

- What is happening specifically in the behavioral concern?
- What is happening right before the symptom?
- What are associated symptoms?
- How often to the symptoms occur?
- What makes the symptom better or worse?
- How does the behavioral concern resolve?

TANTRUM VERSUS OUTBURST/MELTDOWN

- Both forms of behavioral dysregulation
- Important to ask what caregivers mean/specific symptoms that are occurring
- **Tantrum** - behavioral dysregulation that occurs if a child is not getting his/her way and stops as soon as caregiver gives in to child's want
- **Outburst/meltdown** - behavioral dysregulation that occurs when there is a trauma or sensory trigger and is not intentional and requires other interventions to resolve

GROUP ACTIVITY: PART 2

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CASE PRESENTATION – SCENARIO 1

- Other symptoms: inattention, hyperactivity, trouble sitting for circle time, trouble sharing toys
- Affecting his academic performance and ability to make friends at school
- The symptoms are more noticeable during unstructured time compared to structured time
- They occur at both home and school and during soccer activity
- Screening for anxiety symptoms, mood symptoms, social concerns and developmental concerns was negative
- Strong family history of ADHD – older sister and father

DC 0-5 ATTENTION DEFICIT HYPERACTIVITY DISORDER

A. Present with at least six symptoms from the inattention cluster or at least six symptoms from the hyperactivity-impulsivity cluster.
   1. Inattention Cluster
   2. Hyperactivity-Impulsivity Cluster
B. Symptoms in criterion A must be excessive when compared with developmentally and culturally expected norms.
C. Symptoms must be confirmed to be present in at least two contexts or within two relationships
D. Symptoms of the disorder, or caregiver accommodations in response to symptoms, significantly affect the child's and family's functioning

CASE PRESENTATION – SCENARIO 2

- Additional History: aggression occurs when there is a change in routine or when a repetitive activity is interrupted
- Other symptoms: trouble with peer interactions during unstructured time, limited eye contact, limited interests, and rigidity in play
- There is no delay in verbal skills but there is some concern about pragmatic language skills
- Can be distracted in his own thoughts but focus otherwise is fine
- No delay in academic performance
- Maternal cousin with Autism

DC 0-5 AUTISM SPECTRUM DISORDER

A. Each of the following three social-communication symptoms must be present:
   1. Limited or atypical social-emotional responsivity, sustained social attention, or social reciprocity as evidenced by at least one of the following:
   2. Deficits in nonverbal social-communication behaviors as evidenced by at least one of the following:
   3. Peer Interaction difficulties as evidenced by at least one of the following:

B. Symptoms in criterion A are not better explained by sensory impairment

C. Two of the following four repetitive and restrictive behaviors must be present:

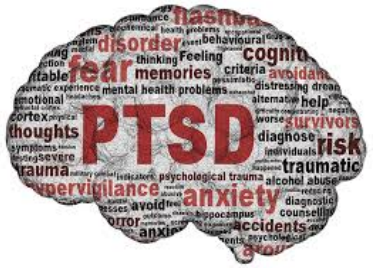
D. Symptoms of the disorder, or caregiver accommodations in response to symptoms, significantly affect the child's and family's functioning

CASE PRESENTATION – SCENARIO 3

- Other symptoms: trouble falling asleep, cries easily, difficult to soothe when upset or hurt, can be hyper at times, frequent meltdowns
- Additional history: foster child, removed one year ago due to parental substance abuse and neglect, has been in 3 different foster placements
- Aggression and impulsivity occur intermittently not constantly
- Screening for developmental and social concerns was negative
- Still has supervised visits with bio parents but unclear if reunification will occur

DC 0-5 POST TRAUMATIC STRESS DISORDER

A. Infant/young child *exposed* to threat or actual trauma
B. Infant/child shows re-experiencing
C. Infant/child attempts to avoid trauma-related stimuli
D. Infant/child experiences a dampening of positive emotional responsiveness
E. After a traumatic event, infant/child may exhibit increased arousal
F. Symptoms significantly affect infant/child's functioning



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BE MINDFUL OF

- Fetal Alcohol Spectrum Disorders (FASDs)
  - In utero exposure to alcohol and drugs can impact regulation, attention, planning, reasoning, speech, etc.

- Disorder of Dysregulated Anger and Aggression/Other mood disorders
  - Tantrums and non-compliance that are based more in irritable/angry moods should be examined closely to avoid mis-diagnosis.

DISTINGUISHING HYPERACTIVITY/IMPULSIVITY

	Trauma	ADHD	Autism
How often does it occur?	intermittent	constant	intermittent
Under child's control?	no	mostly not	mostly not
Associated symptoms	mood or anxiety symptoms	mostly no, happens on its own	poor perspective taking
Antecedents/trigger?	reminder of trauma	unstructured time	sensory

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DISTINGUISHING INATTENTION

	Trauma	ADHD	Autism
How often does it occur?	intermittent	constant	intermittent
Antecedents	reminders of trauma	nonpreferred activities	nonpreferred activities
What it represents	dissociation/anxiety	trouble focusing and concentrating	lost in own thoughts, rigid pattern of thinking

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DISTINGUISHING AGGRESSION

	Trauma	ADHD	Autism
How often does it occur?	intermittent	intermittent	intermittent
Antecedents	reminder of trauma	unstructured time	interrupted repetitive activity, change in routine
What it represents	modeling learned behavior, poor self-regulation	poor frustration tolerance, impulsivity	rigid pattern of thinking

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WHY IS THIS IMPORTANT?

- If we know the symptoms, why can't we just start treating?
- Underlying etiology matters
  - Informs treatment and prognosis
  - Directs psycho-education to families and teachers on expectations and reasons behind behavioral concerns
  - Helps to interpret future behavior and utilize effective strategies
- The same symptoms can be seen in different diagnoses
- Without determining underlying etiology, can delay effective treatment and see limited progress in treatment

TREATMENT: THERAPY

Depending on diagnosis, treatment modality can change.

ADHD: Behavior therapy (PCIT, social skills groups)

ASD: ABA therapy

PTSD: Child Parent Psychotherapy, TF-CBT

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ADHD: INTERVENTIONS

- Use of behavioral therapy techniques can be helpful
  - Reward charts, Chore charts, visual schedules

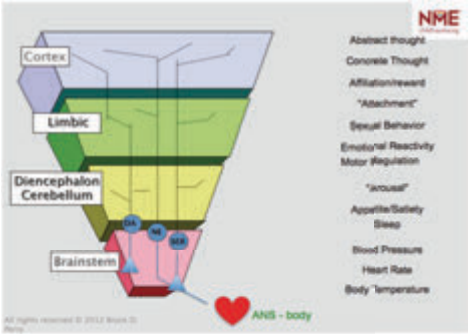
- Games
  - Memory, Red Light Green Light, Puzzles, obstacle course scavenger hunts, What's Different

- Parent Coaching
  - Parent Child Interaction Therapy (PCIT)

PTSD: INTERVENTIONS

- Using the caregiver-child relationship
  - Create safety within the relationship, validate experiences

- Using information on brain development and trauma
  - Incorporating activities that target certain parts of the brain (rocking, water play, etc)



- Creating the trauma narrative
  - Using toys, art, etc.

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TREATMENT: MEDICATION

- Different medications are used for different diagnoses and clusters of symptoms
- Main classes: stimulants, alpha agonists, sleep medications
- Stimulants used for hyperactivity, impulsivity and inattention in ADHD
  - Less effective if underlying anxiety, sensory concerns or in utero drug exposure
  - Side effects also more common
- Alpha agonists used for impulsivity and aggression with underlying anxiety, sensory concerns

BACK TO CASE PRESENTATION: THE "REAL" STORY

- In utero drug exposure
- Early trauma and disrupted attachments
- Adopted
- Hyperactivity, impulsivity, aggression, poor self-regulation
- Asked to leave 3 preschool settings
- Bright and no other developmental delays

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THINKING THROUGH THE DIAGNOSIS

- Initial Diagnosis: PTSD

- End Diagnosis: other disruptive, impulse-control, and conduct disorder
  - Did not give ADHD diagnosis given complex etiology
  - PTSD diagnosis was resolved with treatment

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THINKING THROUGH THE TREATMENT

- Dyadic therapy

- Occupational therapy

- Combination Ritalin (methylphenidate) and Tenex (guanfacine)
  - Initially hesitant to try stimulant given trauma history and sensory concerns and in utero drug exposure but did well on combination at low doses

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SUMMARY

- Different diagnoses can have overlapping symptoms
- Understanding the diagnosis helps with the clinical formulation of the case and informs treatment
- Trauma can pose as ADHD or ASD in young children

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QUESTIONS?