

Mnemonic possession

I was surprised to see my TRAUMA mnemonic featured in the article “Mnemonics in a nutshell: 32 aids to psychiatric diagnosis” (CURRENT PSYCHIATRY, October 2008, p. 27-33) and attributed to the article by Dr. Khouzam. I created my first mnemonic—TRAMA—for posttraumatic stress disorder (PTSD) in 1992. When the clinically significant distress/impaired functioning criterion was included in DSM-IV, I added the “U” for “unable.” I first presented a copyrighted version of TRAUMA in 1994 during a lecture to medical students at Columbia University. Since then I have presented it on numerous occasions.

The authors also did not include my mnemonics for subcriteria corresponding to the 3 symptom clusters of PTSD:

R3D2 (think *Star Wars* and add an “R”) stands for:

- **Recollections, Recurring, and Re-**activity (physiological) in response to cues of the traumatic event
- **Dreams** (distressing) and **Distress** (psychological).

AFRAID equals:

- **A**void thoughts, feelings, conversations, people, places, or activities associated with the trauma
- **F**oreshortened future
- **R**ecall (inability to)
- **A**ffect (restricted)
- **I**nterest (diminished)
- **D**etachment.

SCARE represents:

- **S**leep (difficulty falling or staying)
- **C**oncentration (difficulty)
- **A**nger (outbursts or irritability)
- **R**eally vigilant
- **E**xaggerated startle response.

Finally, to accurately quote DSM-



October 2008

IV or DSM-IV-TR, the symptoms you listed in the TRAUMA mnemonic need to persist for “more than 1 month” instead of a “month or more.”

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Drs. Caplan and Stern Respond

Although we made a good-faith effort to find the original sources of mnemonics included in our article, we were aware that lore and oral history might not allow us to properly cite the contributions of these innovators. In this case, because to the best of our memory neither of the authors have attended a lecture by Dr. Napoli, our awareness of the TRAUMA mnemonic originated from the cited published article.

Since publication of our article, we also have heard from William Falk, MD, at Massachusetts General Hospital informing us that he created DIG FAST to help remember the criteria for mania. We offer apologies to those ingenious clinicians for not our citing their role in the genesis of these mnemonics, and we are grateful

that they have enhanced the accuracy of the information we provided.

*We also could say: **Some Oversights Shall Occasionally Result in Remorse and Yearning (SO SORRY).***

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Treat dementia holistically

The authors of “Antipsychotics in dementia: Beyond ‘black-box’ warnings” (CURRENT PSYCHIATRY, June 2008, p. 50-65) comment that the list of drugs being taken by Mrs. B is revealing for reasons that, unfortunately, are not rare. If the reasons were rare, this likely would be a much shorter article. Despite repeatedly being catheterized, Mrs. B has bladder distention. She also has fecal impaction. She is said to be getting one-to-one care, so why isn’t staff aware of “input/output” issues? If they were aware, did they communicate this to the treating psychiatrist? It is not surprising that Mrs. B became agitated.

More disturbing is that the care facility obtained informed consent at admission. This is not so much an issue of authority as of having a family member or proxy decision-maker in the loop with a “big picture” perspective.

There may be instances when atypical antipsychotic drugs are indicated. However, my sense is that these drugs have the effect of lowering the volume on a TV set; it’s still turned on.

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