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CHILD PSYCHIATRY

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Joshua D. Feder, MD
Editor-in-Chief

Volume 9 Issue 1

January/February 2018

www.thecarlatchildreport.com

IN THIS ISSUE

Suicide in Children and Adolescents

- Lithium: Practical Considerations for Children With Suicidal Thinking — 1
- Expert Q&A — 1
Cynthia R. Pfeffer, MD
Helping Clinicians Manage Teen Suicide Risk
- Table: Suicide Prevention Resources — 5
- Research Update: — 6
 - Evidence Behind Aripiprazole for the Treatment of Tourette's Disorder
 - Efficacy and Safety of SSRIs and SNRIs for Child and Adolescent Psychiatric Disorders
- CME Test — 7
- Note From the Editor-in-Chief — 8

Learning Objectives

After reading these articles, you should be able to:

1. List the risk factors for suicide in adolescents and teens.
2. Identify some of the benefits and challenges of using lithium to treat children and teens with suicidal thinking.
3. Summarize some of the current findings in the literature regarding psychiatric treatment for children and adolescents.

Lithium: Practical Considerations for Children With Suicidal Thinking

Eve Dreyfus, MD. Pediatric psychiatrist for Beacon Medical Group Behavioral Health, South Bend, IN. Josh Feder, MD. Editor-in-chief of The Carlat Child Psychiatry Report

Dr. Dreyfus and Dr. Feder have disclosed that they have no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Billy, age 10, has periods of intense aggression alternating with moments of wanting to be dead, severe mood swings, poor sleep, and pervasive irritability. He has a family history of bipolar disorder. Other family members have responded well to lithium. Since they want to act assertively to help him, Billy's family is open to medication trials and any other measures.

Continued on page 2

In Summary

- As part of overall clinical management, lithium should be considered in treating children with suicidal thinking and behavior.
- The evidence showing lithium's effectiveness for mania in children is robust.
- Because of lithium's reputation as a serious psychotropic medication, discussing its potential use with parents requires a tactful approach.



Helping Clinicians Manage Teen Suicide Risk

Cynthia R. Pfeffer, MD

Professor of psychiatry and director of the Childhood Bereavement Program at Weill Cornell Medicine, White Plains, NY

Dr. Pfeffer has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CCPR: Thank you, Dr. Pfeffer, for participating in this interview on youth suicide. To start us off, how have clinicians come to understand risk factors for teen suicide?

Dr. Pfeffer: Historically, psychiatrists did not focus on identifying and treating risk factors for child and adolescent suicidal behavior. But after an increase in youth suicide rates in the 1980s, we started doing more research to get clarity about the issues. For example, we became aware that there were clusters of youth committing suicide—doing so in the same community and during the same time period. We suddenly recognized that hearing about a peer committing suicide would raise the risk for that peer's close friends. This caused concern for mental health professionals and those in the community, who became interested in what factors promoted suicide among clusters of young people.

CCPR: Interesting. How different was that from how you were originally taught as a clinician?

Dr. Pfeffer: When I was in training as a child and

Continued on page 3

Lithium: Practical Considerations for Children With Suicidal Thinking

Continued from page 1

You obtain baseline laboratory studies quickly and begin treatment within days, including individual and family therapy, and a starting dose of lithium. Billy responds well; his follow-up lithium levels are stable, as are his renal and thyroid function tests. It appears that the plan has averted potential disaster.

While we occasionally see situations such as the above (a supportive family, a compliant patient, and a positive response to a medication trial), the more common scenario resembles the following:

Billy has been told that his attitude and behavior are bad, and he is often in trouble at school and at home for misbehaving, including failing to go to sleep,

overreacting to peers and adults, and defiance of rules. Billy has been spoken to many times, suspended, and taken to several counselors before coming to see you. He has been treated with stimulants and antidepressants (SSRIs) to no avail, and perhaps even to his detriment. His parents are exhausted, frustrated, and worried, but spent. When you suggest laboratory studies, they say getting blood from Billy will be impossible, and he will not stay still for an EKG. Considering their prior experience with medications, Billy's parents are against further medication trials, particularly with medications that might have even more side effects than the "safe" ones they've already tried. When you mention that lithium might be helpful to consider, Billy's parents look at you aghast for suggesting such a powerful drug—they claim lithium is only used for people who are truly insane, and they openly wonder what you must think of their son.

These challenging situations demand that we stay calm and remain receptive to the frustrations of the family, while at the same time addressing the child's difficulties, chief among them the risk of suicide. This article will cover the judicious consideration and use of lithium in children with suicidal thinking and behavior as part of their overall mental health picture.

Effectiveness of lithium in children

Lithium is FDA approved for the treatment of bipolar disorder in children and adults. It is indicated both for acute mania and maintenance treatment. Studies on lithium's helpfulness for suicidality in adults date back to 1972. Multiple studies, mostly retrospective and some prospective, report 15%–25% reductions in suicide rates for patients taking lithium (Tondo L and Baldessarini RJ, *Epidemiol Psychiatr Soc* 2009;18(3):179–183). Conversely, there are reports of as much as a 24-fold increase in suicide rates when lithium is discontinued (Bocchetta A et al, *J Clin Psychopharmacol* 1998;18(5):384–389).

As lithium has been in use for so long, the evidence showing its effectiveness for mania in children is robust. The largest double-blind placebo-controlled study to date, the Collaborative Lithium

Trials, looked at acute and maintenance treatment and found lithium to be both effective and well tolerated in patients with bipolar disorder ages 7–17 (Findling RL et al, *Pediatrics* 2015;136(5):885–894). There is little data, however, on the reduction of suicide attempts or completed suicides in children and adolescents. Even so, when symptoms include suicidal ideation or behavior, the general consensus of expert panels is to consider lithium for children and adolescents (World Health Organization 2012. See <http://bit.ly/2jv8wHg>).

Prescribing lithium

For bipolar disorder, lithium is typically used when other mood stabilizers—such as valproate, carbamazepine, and lamotrigine—have not been helpful, and after failed neuroleptic trials with medications such as risperidone and aripiprazole. Lithium is also employed in depressive disorders after adequate trials of two or three antidepressants.

Before starting lithium, consider reducing or eliminating medications that might aggravate the condition, such as antidepressants, if there is mood instability; stimulants, if there is sleep disturbance; and benzodiazepines, if there is withdrawal agitation. Once you've made these adjustments, start lithium using the gradual approach described here.

Before starting lithium, you should order baseline studies, including a complete blood count with differential; a comprehensive metabolic profile, including creatinine and blood urea nitrogen; thyroid-stimulating hormone and thyroxine levels; and an EKG. After completing the baseline studies, consider the following:

- In young children, a reasonable starting dose might be 150 mg at night, followed by a trough level after about 5 days, taken 8–12 hours after the dose. The target blood level range should be 0.8–1.2 mEq/L. Dosage increases of 150 mg can be done week by week with serial trough blood tests to check the level.
- In an effort to get more even 24-hour coverage (the half-life of lithium is 18–36 hours, with an average of 24 hours), dosing is typically increased by adding a morning dose, then an

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This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists, and other health care professionals, with an interest in the diagnosis and treatment of psychiatric disorders.

Mailing Information

The Carlat Child Psychiatry Report (ISSN 2473-4217) is published 8 times per year by Carlat Publishing, LLC; 29 Water Street, Newburyport, MA 01950.

Application to mail at periodicals postage prices is pending at Newburyport, MA and additional mailing offices.

POSTMASTER: Send address changes to The Carlat Psychiatry Report, P.O. Box 626, Newburyport, MA 01950

Continued on page 3

Lithium: Practical Considerations for Children With Suicidal Thinking

Continued from page 2

evening dose, and so forth.

- So that the child's behavior and symptoms stabilize at a lower level, it is always wiser to use lower doses when possible. There is then no need to increase the dose to achieve the 0.8–1.2 mEq/L target range.
- For children 13 and older, a starting dosage of 300 mg and dosage increments of 300 mg are more efficient, with the same target trough level.
- If possible, all patients should be formally assessed and monitored at least every six months for abnormal involuntary movements using the Abnormal Involuntary Movement Scale (AIMS). Some children cannot cooperate with this test; if so, clinical observation and history from collateral sources (parents, teachers, etc) must suffice.

Discussing lithium with parents

When a clinician mentions the possibility of lithium, parents often become very concerned, and it's important that we listen to them. If we respond to the high level of complexity and danger by moving too quickly, we lose the opportunity to gain parental trust. Then, they may have a hard time listening closely enough as we work with them to consider possible treatment options.

Before trying lithium, we may need to work with the child and family over a period. This may feel like lost time and may even result in more symptoms, escalation, and a need for more intensive levels

of care. But our steady persistence is necessary to help families work with us on how things are going and what we might try next. That's why you should consider the following while talking to patients and their parents or guardians:

- Talk with families about potential side effects of lithium, such as toxicity, hypothyroidism, renal effects, arrhythmia, tremor, polydipsia and polyuria, and acne, as well as the rare chance of tardive dyskinesia or normal-pressure hydrocephalus. Counsel families about signs of lithium toxicity, such as ataxia, diarrhea, dizziness, nausea, slurred speech, seizures, and coma. Assure them that, with good clinical and laboratory monitoring, most side effects are quite manageable.
- Advise parents to make sure that the child stays hydrated, particularly in hot weather when patients should drink 6–8 glasses of water per day. Many children will be thirsty, and they will need to urinate more often, so provisions should be made, especially at school, to allow them sufficient water and bathroom breaks.
- Tell families to avoid sugary beverages that might contribute to weight gain.
- Let parents know that many children will also have a mild tremor. While not a sign of toxicity, it can nevertheless be disconcerting. This is usually benign, and if the child's psychiatric symptoms remain in check,

it can be lessened by reducing the dose of lithium.

- Thyroid changes might lead to discontinuation; however, supplemental thyroxine can often be used if it is deemed that the lithium itself is beneficial to the child's symptoms. As they can increase lithium levels, it is important for families to understand that non-steroidal anti-inflammatory medications (NSAIDs), such as ibuprofen and naproxen, should not be used concurrently with lithium. Acetaminophen, which is not an NSAID, can be used for fever and pain.

When children cannot cooperate in blood tests and EKGs, as in Billy's scenario, this may preclude the use of lithium and other medications, such as valproate and carbamazepine. Strategies for obtaining blood tests, however, can include special labs, perhaps at a children's hospital (where staff have experience in calming children); through mobile lab services that can come to the home (if a medical setting is problematic and if phlebotomy in the home is not unduly intrusive); and through the use of mild sedation.

CCPR VERDICT: Lithium certainly has its drawbacks, but given its effectiveness for mood disorders and suicidality, consider using it more frequently in your patients.

Expert Interview

Continued from page 1

adolescent resident, we were not taught about child and adolescent suicide. I started my research on this extensive problem when I worked to assess childhood psychiatric emergency cases. Children and their parents reported to me that children—who wanted to die—ran into traffic, attempted to jump off buildings or out of their apartment windows, overdosed, or attempted to hang themselves. People thought young children did not know about death and did not understand that it was permanent. But the issue is not whether these children understand death; it is that they want to die. We've come a long way since then. The National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other foundations have supported research on this mental health issue and educated the community about ways to prevent youth suicide. However, it continues to be a significant problem and requires continued research for prevention.

CCPR: You mention the research that began on risk factors in the 1980s. What has the historical epidemiology on adolescent suicide looked like since then?

Dr. Pfeffer: Rates in adolescents, teens 15–18, were increasing throughout the 1980s, then decreased through about 2004. But the rates have been rising in the past 10 years, including among younger children. The causes for this are still to be determined (Ed note: The 2004 black box warning on antidepressants was associated with a drop in prescriptions and a rise in suicide rates), but suicide rates in prepubertal girls have increased significantly in the past 10 years (Curtin SC et al, *MMWR Morb Mortal Wkly Rep* 2017;66:816). Epidemiology statistics suggest that black American teens living in rural areas, particularly in the South, had a lower suicide rate than those in northern urban regions. A hypothesis was that black youth living in

Continued on page 4

Expert Interview

Continued from page 3

urban areas were dealing with more socioeconomic stressors. Today, while the suicide rates in the black youth population are still lower than those of white youths, they are rising. Additionally, there is evidence of increased rates of suicide among Asian American youth. This epidemiological information suggests that more work is needed to understand and prevent factors related to youth suicide.

CCPR: What is known about youth suicide risk factors?

Dr. Pfeffer: There are several broad categories of youth suicide risk factors: psychiatric disorders, family and social-related risk factors, and biological domains, including developmental, genetic, and neurodevelopmental risk factors. The most significant psychiatric risk factor for suicide or self-harm in children and adolescents is a history of suicidal behavior and ideation. Suicidal acts, especially near-lethal ones, place youth at particularly high risk for future suicide. Psychological autopsy studies point out that 90% of youth who committed suicide had a mental disorder: mostly mood disorders, especially major depression, and substance abuse (Nock MK et al, *JAMA Psychiatry* 2013;70(3):300). Suicidality in depression is heightened when there are psychotic features, such as in bipolar disorder with rapid cycling.

CCPR: Those are very important factors. Are there others we should be thinking about?

Dr. Pfeffer: Recently, Tourette's disorder has been associated with increased suicide risk (Fernandez de la Cruz L, *Biol Psychiatry* 2016;82(2):111-118). There are high suicide rates associated with eating disorders, especially among girls, and other studies show higher rates with conduct disorder and ADHD. Youth suffering from schizophrenia are at significant risk for suicide. These conditions carry different risk levels. Another diagnostic area is autism spectrum disorder (ASD). Some children and adolescents with ASD, especially those who are high functioning, harbor suicidal thoughts and have attempted suicide. Such children and adolescents struggle with social stress and feelings of isolation and inadequacy.

CCPR: What are the family-related risk factors?

Dr. Pfeffer: Family turmoil is another big category, including acrimonious family interactions, separations and losses, and abuse. Family psychopathology is a significant factor, especially transmission of suicidal behavior through family generations. Youngsters are at higher risk when a parent is psychiatrically ill. Abuse is another significant risk factor, including physical abuse, but especially sexual abuse. It is essential to conduct a thorough family history assessment, and to gather this information systematically by asking about each close relative's history of psychopathology. Ask parents if they have been depressed or anxious or had suicidal ideation or behavior, or other emotional problems. Specifically ask this about each close relative. Identifying these risk factors will help in treatment planning for the suicidal child or adolescent. Each family risk factor will elevate risk for suicide among youth.

CCPR: I know that bullying fits into social risk phenomena. Can you tell us more?

Dr. Pfeffer: Bullying is a more recently characterized risk factor in the US. The effect of bullying on suicide is a form of abuse by peers that happens verbally, physically, and through social media. This is observed among prepubertal children and adolescents. In the 1990s, Dr. Vincent Felitti and his colleagues studied the impact of early social stress, termed adverse childhood experiences (ACEs), and found significant impact of ACEs on development of later psychopathology and physical maladies (Felitti VJ et al, *Am J Prev Med* 1998;14(4):245-258).

CCPR: How is suicidal risk different in teens?

Dr. Pfeffer: Because most psychiatric disorders have adolescent onset, suicidal ideation and acts are more prevalent among adolescents. For example, bipolar disorder usually has an onset during adolescence, and it often first manifests as severe depression with intense suicidal ideation or serious suicide attempts. Adolescents have also accumulated more risk factors by that age. Furthermore, the greater developmental social independence that occurs during adolescence has many benefits and drawbacks. For example, adolescents can more successfully escape a hostile home environment. But, by leaving home, they may find themselves in new and vulnerable situations, such as school truancy, drug abuse, and exposure to sexually transmitted diseases. An important and frequent acute stress is the loss of a boyfriend or girlfriend. Another prevalent stressor is related to academic stress, which may be amplified by an unrecognized learning disability or inattention related to an anxiety disorder or attention deficit disorder.

CCPR: Are there specific risks among younger children?

Dr. Pfeffer: Prepubertal children, for better or worse, are more dependent on their parents and other relatives. When there are family problems related to parental psychopathology or other stresses on the parents, young children may be moved out of their parental home to live with relatives or foster families. Such children often suffer intense bereavement with depressive symptoms, longing for their parents, aggression, anxiety, hopelessness, and oppositional behavior. The hopelessness of losing parental nurturing may increase thoughts about dying and lead to kids planning methods to commit suicide.

Continued on page 5

“It’s essential to help children or adolescents and their parents create a safety plan. This is based on the assessment. It must be relevant and meaningful and actionable, including an assured way that, if children think about acting on thoughts of self-harm, they will put themselves into a safer situation, talk with someone, and be with someone.”

Cynthia R. Pfeffer, MD

Expert Interview

Continued from page 4

CCPR: Are there other populations at risk who we haven't mentioned yet?

Dr. Pfeiffer: It is now recognized that the LGBTQ youth population is at high suicide risk, particularly for those who come out about their sexual orientation at an earlier age—by 10 or 11 for boys, or 12 or 13 for girls (Kann L et al, *MMWR Surveill Summ* 2016;65(9):1–202). Coming out as LGBTQ often occurs in mid-late adolescence. However, many LGBTQ teenagers may not want to come out for fear they'll have to endure the social stressors and peer rejection. Those social stressors can lead to an increased risk for suicidal ideation or acts. Shame is a general risk factor for suicidality, which can occur when there is rejection by peers, family, and society. LGBTQ males and females require significant support from parents and school officials, and they may need psychiatric interventions to endure the long process of coming out and adjusting to being open about their sexual orientation.

CCPR: In the office setting, how should we assess suicidal risk?

Dr. Pfeiffer: In the office setting, assessing suicide risk is no different than for emergency service or psychiatric inpatient settings. However, psychiatric assessment is needed, including specific questions about suicidal thinking, planning, and attempts, plus inquiry about other psychiatric, family, social, and neurobiological risk factors. It is important to recognize that younger children will minimize their understanding of risk for death. They might think one aspirin is lethal, and might not think jumping from a window will kill them. Additionally, frequency of suicidal thinking is an estimation of suicidal risk. Those with frequent suicidal ideation may be at higher risk for suicidal acts. Ask questions such as, "How many times in each hour do you think about suicide?" Ask about the amount of time spent, and how often this occurs during the day. Is it once or twice a day? New approaches to track suicidal thinking are in development, such as cell phone apps that catalog, chart, and analyze the timing, frequency, and intensity of suicidal thinking.

CCPR: That's very helpful. Is there anything else we should know about the assessment?

Dr. Pfeiffer: Clinicians need to be methodical, but not tedious in going through all the risk factors. Keep an order in mind while doing this, and use a style that is conversational; however, avoid a checklist approach, which can become stilted and let patients deny or minimize what they are thinking. More information is apparent during a discussion. Child psychiatrists need to be skilled, and this needs to be part of fellowship training with supervision. It is important for the therapist to talk very openly, and it's best to use a stepwise approach in the type of words we use.

CCPR: This is really helpful. Can you tell us how you phrase these questions?

Dr. Pfeiffer: For example, try to ask, "Do you ever think that you want to die? What did you think about?" If a child starts with the word suicide, try to understand what the child means. Do not assume the child is saying what you think is being said. We don't really talk as much about what death means, but rather we think in terms of what the child thought about doing. Ask a child or adolescent, "Tell me more about what you were thinking. When do you have thoughts of suicide? What might help you feel better?" Pursue more specific questions about self-harm. "Did you ever think you wanted to hurt yourself? Tell me more about it. Did you ever think you wanted to do something to cause you to die? Did you ever try to do something to harm yourself or to cause you to die? Did you ever try to commit suicide? Did you think that there was something else you could do instead to feel better?"

CCPR: So, what is the next step following that assessment?

Dr. Pfeiffer: It's essential to help children or adolescents and their parents create a safety plan. This is based on the assessment. It must be relevant and meaningful and actionable, including an assured way that, if children think about acting on thoughts of self-harm, they will put themselves into a safer situation, talk with someone, and be with someone. It's necessary to identify those helping people, but not someone who is difficult to reach. Children or adolescents need someone in proximity who is reliable, someone they are not afraid to tell about their suicidal thoughts or acts, and someone who is not afraid to help them. I have seen examples of an adolescent telling a peer, but subsequently the peer

Continued on page 7

Suicide Prevention Resources

Resource	In summary	Link
2012 National Strategy for Suicide Prevention Special Report	From US Surgeon General. Information on risk factors, and prevention strategies for physicians and family members.	http://bit.ly/2xRDS4d
American Academy of Child and Adolescent Psychiatry	Information on prevention and treatment strategies.	http://bit.ly/1igaOYy
American Foundation for Suicide Prevention	24/7 confidential support for people in distress, plus prevention and crisis information. Resources for "you or your loved ones," and best practices for professionals.	https://suicidepreventionlifeline.org Hotline: 1-800-273-8255
American Association of Suicidology	Resources and strategies for suicide prevention, and a certification program for professionals.	http://www.suicidology.org
The Centers for Disease Control and Prevention (CDC)	Includes a technical package of "policy, programs, and practices."	http://bit.ly/2nGku4H
Suicide Prevention Resource Center	Funded by the Substance Abuse and Mental Health Services Administration. Offers statistics, plus education on prevention strategies.	http://www.sprc.org

Research Updates
IN PSYCHIATRY

TOURETTE'S DISORDER

Evidence Behind Aripiprazole for the Treatment of Tourette's Disorder

REVIEW OF: Sallee F et al, *J Child Adolesc Psychopharmacol* 2017;27(9):771-781

Tourette's disorder (TD) is a movement disorder emerging during childhood that causes persistent motor and vocal tics. TD is treated with a variety of medications, but often with an off-label designation. There are only three medications that are FDA approved for TD: haloperidol, pimozide, and most recently, in 2014, aripiprazole. But how impressive was the evidence for aripiprazole's efficacy? The evidence that formed the basis of aripiprazole's approval was just published, and we took a close look.

This study, a multicenter, randomized, double-blind trial conducted over an 8-week period with children and adolescents ages 7-17 with TD, evaluated the efficacy and safety of low-dose and high-dose aripiprazole for TD compared to placebo. After recruiting 133 patients across 76 sites in the United States, Canada, Hungary, and Italy, the primary outcome measured the change in the Yale Global Tic Severity Scale Total Tic Score (YGTSS-TTS). The patients were randomized in a 1:1:1 fashion to low-dose aripiprazole (patients < 50 kg received 5 mg/day and those ≥ 50 kg received 10 mg/day), high-dose aripiprazole (< 50 kg received 10 mg/day and ≥ 50 kg received 20 mg/day), or placebo. In addition to various scales to monitor for adverse effects, a key secondary outcome was the Clinical Global Impression-Tourette's Syndrome (CGI-TS) improvement scale score.

The study showed a statistically significant improvement in the YGTSS-TTS in both the low-dose (26.7 point improvement, $p = 0.002$) and high-dose (32.8 point improvement, $p < 0.0001$) treatment groups compared to placebo at week 8. In addition, statistically significant differences in both treatment arms were seen at nearly each time point from weeks 1 to 8. The secondary outcome (CGI-TS improvement

score) also demonstrated aripiprazole's superiority, separating from placebo at each time point from weeks 1 to 8.

How about side effects? The study found that 65.9%, 75.6%, and 40.9% of patients in the low-dose, high-dose, or placebo groups, respectively, reported at least one adverse event—most commonly sedation, increased appetite, or fatigue. Due to adverse effects, usually fatigue, 8 patients (9%) in the treatment group discontinued the study, compared to only 1 patient in the placebo group. Seven of the dropouts were in the high-dose, low-weight group.

CCPR'S TAKE

This fairly large clinical trial showed that aripiprazole is indeed more effective than placebo for treating TD. Higher doses (10-20 mg daily) were somewhat more effective than lower doses (5-10 mg daily), but at the cost of more side effects. As in many industry-funded clinical trials, the participants were less complicated (no history of psychotic disorders and no diagnosis of a primary mood disorder or other neurological disorders with abnormal movements) than many of the children we see in clinical practice, so you may or may not see as positive an effect in actual patients.

—Thomas Jordan, MD. Dr. Jordan has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

ANTIDEPRESSANTS

Efficacy and Safety of SSRIs and SNRIs for Child and Adolescent Psychiatric Disorders

REVIEW OF: Locher C et al, *JAMA Psychiatry* 2017;74(10):1011-1020

Since the 2004 FDA black-box warning on all antidepressants for pediatric use, controversy continues over the use of SSRIs and SNRIs in children and adolescents. Both classes of medication are still commonly used for pediatric depressive disorders, anxiety disorders, and obsessive-compulsive disorder. A recently published systematic review and meta-analysis takes another look at the evidence base for these medications.

The authors reviewed 36 randomized, double-blind, placebo-controlled trials with 6,778 participants (48.6%/51.4% boy/girl, average age ~13 years). Each study compared an SSRI or an SNRI versus placebo for children or adolescents with a diagnosis of depressive disorder (17 studies), anxiety disorder (10 studies), OCD (8 studies), or PTSD (1 study). Effect sizes were calculated as standardized mean differences, and risk ratios for adverse events were also addressed. A rule of thumb for interpreting effect sizes is that ≥ 0.8 is considered a large effect, 0.5 a medium effect, and ≤ 0.2 a small effect.

The authors found medium to small effect sizes for the disorders examined: 0.56 for anxiety disorders, 0.39 for obsessive-compulsive disorders, and 0.20 for depressive disorders. (The single study for PTSD showed no statistical effect size.) For all disorders grouped together, the SSRIs and SNRIs were more beneficial than placebo by only a small to medium effect size of 0.32. However, compared with participants receiving placebo, patients receiving an antidepressant reported a statistically significant increase in adverse effects, including headache, nausea, and suicidal thoughts and behaviors, although the clinical significance of these differences is less clear.

CCPR'S TAKE

These results are not particularly surprising. Clinicians have long noticed that serotonergic agents work better for anxiety disorders in kids than they do for depression—in line with the higher effect sizes reported for anxiety disorders (a fairly impressive 0.56) in this study. Especially given the elevated risk for serious side effects, the small effect size of 0.20 for depression is disquieting. This is yet another reminder that we should think carefully before using SSRIs and SNRIs for depression in children.

—Adam Strassberg, MD. Dr. Strassberg has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CME Post-Test

To earn CME or CE credit, you must read the articles and log on to www.TheCarlatChildReport.com to take the post-test. You must answer 75% of the questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be completed within a year of each issue's publication date. As a subscriber to *CCPR*, you already have a username and password to log onto www.TheCarlatChildReport.com. To obtain your username and password, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning Objectives are listed on page 1.

1. You are considering using lithium for your 14-year-old patient. When discussing the medication with the patient's parents, you share the following information: (LO #2)
 - a. Adolescents and teens sell lithium as a street drug at an even higher rate than stimulants
 - b. Non-steroidal anti-inflammatory medications (NSAIDs) rather than acetaminophen should be used for any fever or pain symptoms while taking lithium
 - c. Children and adolescents who take lithium may develop a mild tremor
 - d. Lithium toxicity occurs at twice the rate as that of stimulants
2. According to studies, what percentage of youth who commit suicide have a mental disorder, such as mood disorders or substance abuse? (LO #1)
 - a. 60%
 - b. 70%
 - c. 80%
 - d. 90%
3. Before starting lithium in children or adolescents, it is important to order an EKG among other baseline tests. (LO #2)
 - a. True
 - b. False
4. According to Dr. Pfeffer, which of the following is one of the most significant risk factors for suicide or self-harm in children and adolescents? (LO #1)
 - a. Easy access to lethal methods
 - b. History of suicidal behavior and ideation
 - c. Barriers to accessing mental health treatment
 - d. History of alcohol and substance abuse
5. In a recent study on aripiprazole for Tourette's disorder, side effects such as sedation and increased appetite occurred at the same rate for patients in both the low-dose and high-dose groups. (LO #3)
 - a. True
 - b. False

Expert Interview

Continued from page 5

is afraid to tell a teacher or parent due to fear of creating upset or getting people in trouble. This plan should not only include peers, but also adults with whom the adolescent feels comfortable. In school, a guidance counselor or teacher may be helpful.

CCPR: How do you decide on the level of care needed for a patient to address suicidality?

Dr. Pfeffer: Prevention and intervention are guided by the assessment of risk factors. Level of care is a gradient, and you need to be familiar with what services are available in the community. All planning should include psychotherapy and consideration of treatment with medication. Outpatient care is most common. We need to work carefully on deciding how many times a week the child or adolescent will be seen, plan for work with the parents, and help the family cope. Because of expertise in assessing and treatment planning that could include use of medication, psychiatrists should be on the intervention team.

CCPR: How should we proceed if there has been a serious attempt at suicide?

Dr. Pfeffer: Because hospitalization enhances safety for an acutely suicidal child or adolescent, consider admission to a psychiatric inpatient setting. Psychiatric inpatient services are helpful in providing a comprehensive evaluation of risk factors and starting interventions such as medication, cognitive strategies, family therapy, and planning for outpatient safety strategies. Hospitalization is used to reduce suicidal ideation, symptoms of psychiatric disorders, and family conflicts, as well as to educate the child or adolescent and parents about maintaining safety and compliance with treatment. Psychiatric day hospital programs are also available in some communities. These may give relief from school stress. But because the child or adolescent goes home at the end of the day, it may expose the child or adolescent to situations that could precipitate suicidal ideation or acts. It is essential to have an effective safety plan for children or adolescents treated in less restrictive settings than a psychiatric inpatient hospital.

CCPR: Are there some resources we should be recommending to parents?

Dr. Pfeffer: There are several resources for families, including the American Academy of Child and Adolescent Psychiatry, American Foundation for Suicide Prevention, and American Association of Suicidality. (See Suicide Prevention Resources table on p. 5)

CCPR: Thank you for your time, Dr. Pfeffer.

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This Issue's Focus:
**Suicide in Children
and Adolescents**

Next Time in *The Carlat Child Psychiatry Report*:
Anxiety in Children and Adolescents

Note From the Editor-in-Chief

Suicidal thinking and behavior remains difficult to predict and challenging to address.

As a resident in the mid-1980s, I made an annual trek from Naval Hospital San Diego to UCLA, bringing a year of painful experiences to the renowned Dr. Edwin Schneidman. He taught us his "3 Ps" for intervening in these difficult cases. Dr. Schneidman talked about how to reduce the "**Pain**" the patient was feeling and the "**Press**" the patient was feeling to act on that pain, as well as how to increase the "**Perturbations**" or number of options of how to act. Charismatic and colorful, his ideas were thought-provoking. For instance, Dr. Schneidman offered that a college professor might raise a student's grade to passing if it would save that student's life.

During this same epoch, Dr. Cynthia Pfeffer, who we interviewed for this issue, was doing groundbreaking research on suicide in children and adolescents. Our Q&A covers the history and current ideas about suicide that breathe context into how we address suicide. Also in this issue, Dr. Eve Dreyfus helps us think through using lithium for suicidal episodes in children and adolescents. In addition, we've provided resources on the topic of suicide that I hope you will find useful. As always, I welcome your comments at jfeder@thecarlatreport.com.



Regards,
Josh Feder, MD

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