

THE CARLAT REPORT

CHILD PSYCHIATRY

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UNBIASED INFORMATION FOR CHILD PSYCHIATRISTS

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Editor-in-Chief

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Learning objectives for this issue:

1. Describe psychotherapies that are effective for trauma in children and adolescents. 2. Appropriately determine when and which medications to prescribe for trauma. 3. Detail EMDR therapy for children and adolescents. 4. Explain the neurobiology of trauma. 5. Define trauma focused cognitive behavioral therapy. 6. Understand some of the current findings in the literature regarding psychiatric treatment.

Psychotherapy for Pediatric PTSD

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Dr. Gerson has disclosed that she has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

Karina's foster mom brought her to my office last year for irritability and "mood swings." A soft-spoken

fourteen year old, Karina (and her nine year old brother) had been with the family for three months, and her foster family reported that "little things" set her off into explosive anger. Sometimes she seemed tense or didn't want to go out, but at other times she seemed fine, and she was eating and sleeping normally and doing okay in school. When talking to Karina, I learned that prior to being placed in foster care, she had been

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Medications for PTSD

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Dr. Tien has disclosed that she has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

Trauma-focused psychotherapies are the gold standard for treating PTSD in children and adolescents, as recommended in the 2010 AACAP practice parameters. Many studies support the use of psychotherapy in contrast to the lack of research for medications. First line treatment of PTSD should always consist of psychotherapy but medications are often used in the hopes of further improving symptoms.

SSRIs

Two medications are FDA approved for the treatment of PTSD in the adult population, the SSRIs sertraline (Zoloft) and paroxetine (Paxil). No medications are FDA approved for treating children with PTSD. Out of the handful of randomized controlled trials looking at medication use in children and adolescents for PTSD, two include the use of sertraline (Cohen JA et al, *J Am Acad Child Adolesc Psychiatry* 2007;46(7):811-19 and Robb A et al, *J Child Adolesc Psychopharmacol* 2010;20(6):463-71). While they both demonstrated some improve-

ments, they were not significant. The Cohen study was limited to 24 girls with sexual abuse trauma, and the only difference found was in the Child Global Assessment Scale for the sertraline plus therapy group. The Robb study was larger, with 131 patients, but showed no significant benefit with sertraline. In fact, there was a higher dropout rate in the medication group. In another RCT study, no differences were found between fluoxetine (Prozac), imipramine (Tofranil), and placebo for acute stress symptoms, but this study was extremely short (seven days) and several patients received other anxiolytic meds such as benzodiazepines and beta-blockers (Robert R et al, *Burns* 2008;34(7):919-28). While it may be helpful to use SSRIs for some children, the benefits are not well established and it is important to monitor for tolerability, particularly in the post black box world. The dosing in this case would be the same as for depression.

Non-SSRI Antidepressants

If you are starting to feel uncomfortable about the lack of evidence-based data, get ready for more uncharted territory. While adult studies have shown some efficacy of non-SSRI antidepressants including MAOIs, SNRIs, TCAs, trazodone (Oleptro), nefazodone (Serzone), and mirtazapine (Remeron), there is very little evidence to generalize this to children. One RCT found imipramine

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Psychotherapy for Pediatric PTSD

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physically abused by her father after he relapsed on alcohol. In that first meeting, she insisted that she “never” thought about what happened and didn’t want to talk about it.

In the US, 60% of children report exposure to violence, abuse or other trauma in the past year (Finkelhor D et al, *Pediatrics* 2009;124:1–13). Traumatized children like Karina can present to treatment with a range of symptoms, including anxiety, irritability, disruptive behaviors, mood dysregulation, and developmental regression. Approximately one third develop posttraumatic stress disorder (PTSD). Without treatment, PTSD symptoms persist (Scheeringa MS et al, *J Am Acad Child Adolesc Psychiatry* 2005;44:899–906), and may increase risk for aggression and suicidality (Vivona JM et al, *J Am Acad Child Adolesc Psychiatry* 1995;34(4):434–44; Lipschitz DS et al, *J Am Acad Child Adolesc Psychiatry* 1999;

38:385–392), so recognizing and treating PTSD is critical.

Assessing Pediatric PTSD

While careful assessment is important for any pediatric disorder, it is particularly so for PTSD. Karina’s foster mother came in asking about depression or bipolar disorder; parents may be less likely to present asking about PTSD, because of its low profile and because often parents are unaware of their child’s traumatic experience. Children are often afraid or embarrassed to disclose abuse or trauma, and their PTSD symptoms may be missed or mistaken for other disorders.

Adding further complication, PTSD in children (particularly young children) looks different from that in adults. Pre-adolescent children often are not sophisticated enough to recognize and report their own avoidance symptoms; instead they may just deny any trauma and refuse to speak about it. Re-experiencing symptoms in children can show up as trauma-themed play or as nightmares that are not specific to the traumatic event (PTSD Practice Parameter, *J Am Acad Child Adolesc Psychiatry* 2010;49(4):414–430). Children are also more likely than adults to present with reckless or self-destructive behaviors, cognitive distortions, guilt, anger, and shame (Cohen JA and Mannarino AP, *Curr Op Pediatrics* 2010;22:605–609).

But not all symptoms can be attributed to PTSD, and careful assessment of comorbidities is needed as well. In Karina’s case, her presentation was concerning for a mood disorder, so collateral was needed to confirm the absence of cyclic mood episodes and associated symptoms, and to discover that many of her outbursts were triggered by subtle reminders of her abuse.

Approaches to Psychotherapy for Pediatric PTSD

Once trauma is recognized, the first step is to ensure the child is safe. If not, that is the first priority. If so, treatment can begin. Psychotherapy is the first-line treatment for PTSD, and the best evidence is for cognitive behavioral therapy (CBT) specifically targeting trauma symptoms. Play therapy, art therapy, and psy-

chodynamic psychotherapy have been tried, but there is not sufficient evidence to recommend them (Wetherington HR et al, *Am J Prev Med* 2008;35(3):287–313).

There are a number of CBT therapies for pediatric PTSD, but all share common features. The core components of CBT for pediatric PTSD include psychoeducation, teaching of coping and emotion regulation skills for managing stress, gradual exposure to trauma memories or reminders, and cognitive restructuring (Cohen JA et al, *J Interpers Violence* 2000;15:1202–1223).

Working with Young Children

While infant psychotherapy is daunting for many of us, child-parent psychotherapy (CPP) has proved effective in one randomized controlled trial and several non-randomized controlled studies of infants and young children exposed to family trauma, domestic violence, and traumatic loss (Lieberman AF, *J Am Acad Child Adolesc Psychiatry* 2005;44(12):1241–1248). As suggested by the name, it is conducted jointly with parent and child, and helps parents to understand and interpret the child’s feelings and actions, improve empathy and emotional support between parent and child, model appropriate protective behavior, and develop a joint narrative about the family trauma.

For toddlers and preschoolers, trauma-focused CBT (TF-CBT) has been shown to work in children as young as three. TF-CBT is the most widely used CBT therapy for PTSD for kids and has been shown to be effective in several randomized controlled trials in kids aged three to 17 (PTSD Practice Parameter, *J Am Acad Child Adolesc Psychiatry* 2010;49(4):414–430). (For a detailed guide to TF-CBT, see this month’s interview with Judith Cohen, MD.) The version to use in young kids (age three to six) has several age-appropriate adaptations (including increased parent involvement) and can also be found free at www.infant institute.com.

School-Age Kids and Teens

For school-age kids and teens with

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EDITORIAL INFORMATION

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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.

PTSD, several well-studied treatments are available. For individual therapy, TF-CBT is still the best choice, and in Karina's case, that is what we chose. Other treatments with similar core features to TF-CBT have been specifically adapted for different kinds of trauma, such as single-incident trauma (CBT for PTSD) and traumatic loss (trauma and grief component therapy). For teens with substance use, the Seeking Safety protocol provides step-wise treatment for PTSD and risk reduction for the substance use (PTSD Practice Parameter, *J Am Acad Child Adolesc Psychiatry* 2010;49(4):414-430).

Group therapies are also useful in treating traumatized kids and teens. Some of the individual therapy protocols mentioned above, including trauma and grief component therapy and seeking safety, can also be used in a group format.

The most widely used group protocol, however, is CBITS (cognitive behavioral intervention for trauma in schools). Delivered in school settings, CBITS follows a model similar to TF-CBT and has been shown to be effective in multiple controlled trials. Exposure and trauma narrative are done in individual sessions, the other modules are covered in the group setting, and an additional component of trauma psychoeducation is added for teachers. In schools where mental health professionals are not available, a modified version of CBITS called the support for students exposed to trauma (SSET) protocol can be used with kids by teachers, guidance counselors, or other school staff. SSET is not as well studied as CBITS, but pilot studies suggest it's an effective option. SSET can be found free online at <http://bit.ly/ubYrd3>.

Engaging Families

The social environment of a traumatized child is often itself traumatic (through family or community trauma, or vicariously through the child's experience) or traumatizing (dangerous or frankly abusive). If the child is not safe and/or the environment unable to protect and support the child, therapy is basically useless. Trauma systems therapy (TST) is a step-wise treatment for traumatized children that shares many aspects of

Psychotherapies for PTSD

- **Child-Parent Psychotherapy (CPP):** Proven effective in infants and young children; conducted jointly with parents and children.
- **Trauma Focused Cognitive Behavioral Therapy (TF-CBT):** Most widely used CBT; proven effective in ages three through 17.
- **Seeking Safety:** For teens with substance abuse.
- **Trauma and Grief Component Therapy:** Based on TF-CBT; can be used in group format.
- **Cognitive Behavioral Intervention for Trauma in Schools (CBITS):** Most widely used group therapy in schools; similar model TF-CBT.
- **Trauma Systems Therapy (TST):** Shares aspects of TF-CBT, but specifically targets environmental triggers for kids.
- **Stress Inoculation Training:** Best for kids who remain in stressful, traumatizing environments; promotes resilience and coping.
- **Eye Movement and Desensitization and Reprocessing (EMDR):** Type of CBT focused on exposure techniques; proven effective in adults, insufficient evidence in children.
- **Not Well Supported:** play therapy, art therapy, psychodynamic therapy.

TF-CBT but also specifically targets environmental factors that may trigger the child's symptoms. TST joins the mental health team with case managers, lawyers, families, and patients themselves for integrated and efficient care and stabilization of the child's environment (Saxe GN et al, *Psych Annals* 2005;35(5):443-448).

Even in the most stable and supportive home, parents may not understand or know how to respond to the child's PTSD symptoms, and may become overly permissive or protective because of guilt that their child experienced a traumatic event. It comes as no surprise then that involving parents in treatment has been shown to be more effective than treating the child alone (PTSD Practice Parameter, *J Am Acad Child Adolesc Psychiatry* 2010;49(4):414-430). In Karina's case, engaging her foster mother in treatment allowed the foster mother to better understand and respond to Karina's symptoms at home. If parents have PTSD symptoms of their own (either from direct or vicarious trauma), they need treatment too, as their symptoms can trigger the child's (Feldman R, Vengrober A, *J Am Acad Child Adolesc Psychiatry* 2011;50(7):645-658).

Special Populations

What do you do when you can't protect a child from ongoing trauma, like children in war zones or neighborhoods

with significant community violence? Stress inoculation training is a promising option in these cases, and while it is similar to the above CBT therapies, it aims not to directly treat PTSD symptoms but instead to promote resilience and enhance future coping. For children who are refugees from war-torn or traumatized areas, eye movement desensitization and reprocessing (EMDR) and narrative exposure therapy (NET, or KID-NET) have been shown to be effective (Ehnholt KA and Yule W, *J Child Psychiatry Psychology* 2006;47(12):1197-1210). [For more on EMDR, see the article "EMDR for Children and Adolescents" in this issue.] For non-refugee children belonging to specific linguistic or cultural groups, several adaptations of TF-CBT and CBITS are available.

A final note of special consideration is needed for children who have undergone chronic maltreatment or developmental trauma. These children may present with more complex symptoms than those captured in the PTSD diagnosis, and may require more intensive, integrated, phase-based treatment than CBT alone can provide.

Trauma and PTSD in kids is common but can be hard to catch. Screen carefully, use an age-appropriate manualized CBT treatment, and involve parents and other caregivers whenever possible.



Q & A
With
the Expert

Expert Interview

The Neurobiology of Trauma Janina Fisher, PhD

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Dr. Fisher has disclosed that she has no relevant relationships or commercial interests in any companies related to this educational activity.

CCPR: Dr. Fisher, you specialize in the treatment of trauma from a neurobiological perspective. Please tell us about that.

Dr. Fisher: I am part of the branch of the trauma treatment field that is looking to use neuroscience research as the jumping off point for decisions about treatment, with the idea that if we understand how the brain and body are perpetuating traumatic experiences then our treatment methods will be more successful.

CCPR: For those of us who work with kids and teenagers who have had traumatic experiences, what do you think the most important thing to remember is?

Dr. Fisher: Probably the most important thing to remember is that the brain and body are designed to assume the worst. If a child has been neglected, abused, subjected to domestic violence, or developed an attachment disorder from parents who may not have been abusive but angry, critical, reactive, and in other ways frightening to the child, the child's mind and body have, within a relatively short time, become adapted to those conditions. And what happens is that the child might want help, but his or her mind and body react to human beings as potential threats rather than potential sources of help.

CCPR: You talk about symptoms that people may see as "bad behavior" but that are really rather driven by neurobiological factors. Can you talk a little bit more about that?

Dr. Fisher: Starting in infancy, in the face of danger or threat, a child's body reacts with animal defense survival responses, which are patterns that we are all born with. These responses include the fight or flight response, the freeze response, and what is known as the "cry for help." So typically what we see in kids as a manifestation of trauma is acting out behavior, which is related to fight/flight and cry for help responses.

CCPR: And then there are also the children with the submissive responses.

Dr. Fisher: Right. What is called "learned helplessness" and submission go hand in hand. Kids who are chronically depressed, apathetic, or "checked out" tend to be manifesting the submission response. They also come to attention of mental health professionals, but usually not with the same urgency as our fight/flight kids. Most children have the learned helplessness/submission response or the freeze and fear response until they reach adolescence and then the fight/flight response kicks in because the body actually becomes capable of effective fight or flight in teenagers. Five year olds can fight, but a grown-up can subdue a five year old. A teenager has the physical strength to fight and flee or even to live on the streets as some of our homeless teens do.

CCPR: The fight/flight kids often come to the attention of child psychiatrists because they are always getting into trouble, are in jail, or as you said, sometimes homeless.

Dr. Fisher: For reasons we don't fully understand, some kids start fighting and fleeing in very early childhood and end up in either residential programs or incarcerated. The difficulty is that when this behavior, which is really an animal defense survival response, is treated as "bad" it actually intensifies the responses.

CCPR: How do you mean?

Dr. Fisher: If a teenager is feeling threatened and acts out in response and then everybody turns on him and says, "That was bad, that was inappropriate, you put yourself at risk, you put others at risk," this is going to further increase his sense of danger and threat. Because not only has he been threatened, but now he is being punished for his response to that threat.

CCPR: That makes sense. People can get quite confrontational when presented with a raging teen.

Dr. Fisher: Yes—but people need to recognize that fight/flight responses come from fear. When children kick, bite, and lash out, they are coming from a bodily sense of fear.

CCPR: So how do we best address this?

Dr. Fisher: There is a big problem in just being "nicer" to these kids, because for most children trauma is interpersonal and it occurs at the hands of those they are closest to. In fact, 90% of child abuse occurs at the hands of immediate family. So what happens then is that as children start to feel close to adults, whether those are residential counselors, teachers, or therapists, those adults start to feel threatening, because their experience is if you love someone you will either be neglected or abused or both.

CCPR: Now there is an argument that putting these kids in restraints is the only way to calm them down.

Dr. Fisher: The difficulty with restraints is that they are very effective in the short term, but when you put the child in restraints you induce the helplessness or submission response. So in the long term, what happens is a vicious circle because if you restrain a child, you induce the submission response, and right on the other side of that submission response is a heightened fight response. There is actually a small minority of children and adults who seek that; they act out until they get restrained, which induces that submission response. The safest time for a child is right after an act of abuse. So in some sense they induce the abuse, which is a known quantity, and then they can relax because there won't be anything for a while. And many of our patients learn to submit in order to not be restrained, and their behavior improves and their functioning improves. However, there is a subset who get worse the more they are restrained. And even with those who benefit from restraints the dilemma is that they have benefited because they are now more checked out, more docile, but they haven't actually done a piece of recovery.

CCPR: So what is a better approach?

Dr. Fisher: Almost 20 years of neurobiological research shows that trauma-related feelings and body responses are so intense and overwhelming that they actually cause the frontal lobes to shut down. This is really important for people who work with kids to understand: when kids are threatened and their frontal lobes shut down, they have no way to access the contract they agreed to, the behavior plan they endorsed, and the skills that they practiced. All of that goes out the window because accessing those skills or those commitments is a frontal lobe cognitive act.

CCPR: So based on that, how can we stop the restraint cycle?

Dr. Fisher: The real challenge in treating traumatized children, teenagers, and adults is helping them to learn how to regulate their nervous systems so that they have reactions that are more appropriate for peacetime than for trauma and danger. We are talking about this as an inpatient restraint/seclusion problem, but this is equally true for parents of children who have been traumatized, perhaps adoptive parents or foster parents.

CCPR: So how can we help parents do this?

Dr. Fisher: We need to teach parents to regulate their nervous systems in response to the child. Because one of the things that is so difficult is that if you have a child who is autonomically stimulated, then *your* heart starts pounding, you start pumping adrenaline, and the whole situation kind of amps up. So what happens to parents is that the child's arousal level escalates, then the adult's arousal level escalates, and things go from bad to worse. I try to tell parents, "Anybody would be upset by how the child has acted, but the difficulty is that if your nervous system goes out of the optimal arousal zone—if you get worked up in response—your intervention will escalate the child rather than helping the situation." We know from the research that in order for children to have mature nervous systems, those that care for them to have well regulated nervous systems.

CCPR: So we need to counsel our patients' parents, and sometimes their therapists and other caregivers, to calm down. To lend the kids our frontal lobes, so to speak.

Dr. Fisher: Exactly. As much as we would wish children to not be dependent on *our* nervous systems, the fact is that they are.

CCPR: You have some techniques to help kids when they recognize that they are going into these states of fight or flight. Could you give us a quick overview?

Dr. Fisher: A technique for decreasing anger and anxiety is for the child to put a hand over the heart. Anger and anxiety are driven by a rapid heart rate fueled by adrenaline, and for some reason if you put a hand over the heart it slows the heart rate. This is a very simple technique that has been taught in Attica State Prison in New York to violent offenders as a way to help them learn how to regulate.

CCPR: Sounds pretty simple. Any other techniques?

Dr. Fisher: Another technique that is being used by some of my child colleagues is drumming. This is especially useful for kids who have trouble verbalizing their feelings. We tell them to drum what they are feeling and then there is also the option of drumming what would make them feel better. A final technique that I am very fond of, which is really good for kids who are kind of checked out and in that learned helplessness state, but can also paradoxically work with kids who are more hyperdefensive and hypervigilant, is asking them to "get taller." The adult language for this is "lengthen the spine" from the middle of the back.

CCPR: And how does this work?

Dr. Fisher: This counteracts learned helplessness. If you think about how aggressive behavior is fueled by fear, the "getting taller" approach actually helps with that because it is a way of reminding the body that it is powerful.

CCPR: Good advice. Anything else?

Dr. Fisher: Most parents and most staff members I have worked with have a tendency to get very serious and a little stern when kids act out, which, unfortunately, if you are a child of neglect and abuse, is actually going to be triggering. We will have more of an impact if we are lighter, if we are more playful, if we are more positive.

CCPR: Thank you, Dr. Fisher.

Q & A
With
the Expert

Expert Interview

Trauma-Focused Cognitive Behavioral Therapy
Judith Cohen, MD

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Dr. Cohen has disclosed that she receives book royalties from Guilford Press. Dr. Carlat has reviewed this article and found no evidence of bias in this educational activity.

CCPR: Dr. Cohen, you are a developer of trauma-focused cognitive behavioral therapy (TF-CBT) for children and adolescents and their parents or caregivers. Can you give us some of the background?

Dr. Cohen: We have been developing and testing TF-CBT for almost 30 years. It is the most tested trauma treatment for children and adolescents—nine randomized controlled trials thus far. When my colleagues Esther Deblinger, PhD, and Tony Mannarino, PhD, and I wrote the TF-CBT book (*Treating Trauma and Traumatic Grief in Children and Adolescents*, Cohen, Mannarino & Deblinger, 2006, available from www.guilford.com), our goal was to deliver it to as many providers with as much fidelity as possible. So we chose a user friendly, simple description of TF-CBT rather than a more nuanced, in-depth one, sacrificing complexity for acceptability and ease of dissemination. TF-CBT is sometimes viewed as a simplistic, “cookie cutter” model as a result—but on the other hand, more than 100,000 mental health providers have taken our free web-based course, in 110 different countries (available at www.musc.edu/tfcbt). TF-CBT has strong evidence of improving a wide variety of problems, including PTSD, depression, anxiety and fear, behavior problems, and trauma-related shame, as well as improving parental functioning. We are now evaluating TF-CBT in a variety of different settings including residential treatment and foster care.

CCPR: Can you describe your treatment approach?

Dr. Cohen: We start by realizing that most of our patients have experienced multiple traumas, and are often manifesting complex trauma outcomes. They don’t necessarily fit into a DSM-4 diagnosis of PTSD. We are more interested in understanding the nature of the traumatic impact on their lives.

CCPR: You use the mnemonic PRACTICE (pronounced “practice”) to describe the treatment. Please go through it with us.

Dr. Cohen: The first part of the treatment model provides skills for youth and parents to cope with and gain mastery over the negative impacts of trauma. We emphasize the use of **gradual exposure** throughout TF-CBT. This involves helping youth learn to apply certain skills when they experience trauma reminders or triggers. The first P is for **psychoeducation**. We want both the parents and the children to understand the impact of trauma, how common it is, and that their responses are not atypical. We provide information that families often don’t know, such as that one out of four girls experience sexual abuse, or that 20% of kids experience domestic violence. A father might be wondering why his son is so afraid all the time after a trauma, and I’ll use the analogy of service members who have been fighting. When they come back from war, they have a startle reflex when they hear a car backfire. Some fathers need to hear this to know that their sons are not “sissies.”

CCPR: How do you gear psychoeducation specifically for kids?

Dr. Cohen: When a child is really fearful and worries that scary things are about to happen, I say something like, “When we were cavemen, we were attacked by wild animals, and those who were on alert for lions or tigers or bears were more likely to protect themselves and their children. You have the same kind of jumpiness as our caveman ancestors because of what happened to you. But now that the person who abused you is no longer in your life, the scary part is over, and we have to help you learn how to get rid of the fear, because it’s not helping you. We need to tell your brain there are no more lions to worry about anymore.” We also educate kids about trauma triggers, things in their environment that are continuing to remind them of the trauma and are making them scared. The fear doesn’t come out of the blue, so identifying the triggers helps to provide a meaning and a context.

CCPR: You actually identify two Ps for PRACTICE.

Dr. Cohen: The second P is for the **parenting component**. In TF-CBT, parents or other caregivers receive the same amount of time as the youth. We initially provide individual, parallel sessions for youth and parents, and later have conjoint youth-parent sessions. Parents receive information about all of the components described in the PRACTICE acronym, including effective parenting skills. Many parents have experienced their own personal traumas along with the youth’s traumas, and/or they are vicariously traumatized by the youth’s experiences. Some parents focus on the youth’s negative behaviors and we need to help them see that the youth is not bad, but is responding to bad things that have happened to him or her. So, encouraging parents to think about “what has happened to my child” rather than “what is wrong with my child” is an important tool that can help them to become more supportive. We teach and model the use of effective praise, selective attention, and effective behavioral management strategies while trying to increase the positive interactions between youth and parents.

CCPR: The R is for relaxation. How do you teach kids to relax?

Dr. Cohen: I ask kids, “What makes you happy, or what makes you laugh?” For some kids, that’s knitting, or basketball, or whatever they think is fun. Recently one girl liked to visualize a favorite toy and for some reason it always made her laugh. So she can use that

when she experiences a trauma trigger.

CCPR: And now the A.

Dr. Cohen: That is for **affective** expression and modulation. Kids who have been traumatized sometimes have difficulty expressing how they feel, or how to modulate difficult emotions. For example, I saw a girl who had been raped by her father from the time that she was a baby. Her mother was a drug addict—my patient would say, “please mommy, stop him,” but she was too strung out on drugs to respond or to protect her daughter. The girl learned to keep her mouth shut and to hold her feelings inside, but the feelings don’t go away. Her feelings came out as anger, and one day she hit a kid at school, and that night her father beat her up. When she came to school the next day black and blue, social services was called, and this was how the abuse was originally discovered.

CCPR: So how do you help a girl with this kind of history?

Dr. Cohen: Once we identified that one of her problems was an inability to appropriately express any emotion, we practiced doing just that, especially with safe adults. Now she is in foster care, and we are working both with her and her foster parents. She needs help expressing difficult emotions to her foster parents, and her foster parents need to respond positively when she expresses feelings in adaptive ways rather than through aggression. For example, if she talks about being sad or asks for help with these upsetting feelings, they stop what they are doing and respond positively to this rather than ignoring her until she becomes aggressive, as they had previously done. This teaches her that expressing feelings is a useful strategy for dealing with upsetting feelings. We also use the well-known technique of distraction—and while this can be overused, in general, if a kids turns on the TV or does a puzzle, that’s a lot better than getting into a fight.

CCPR: So now we’re up to the PRA in the treatment mnemonic. What’s next?

Dr. Cohen: C is for **cognitive** coping. Often kids who have experienced trauma have never considered that their thoughts might have an impact on their feelings. They have maladaptive automatic thoughts about themselves, others, and their place in the world. We start with everyday cognitive coping at this point, and save trauma-related cognitive processing for later. For example, if a child was not invited to a party, his assumption might be that it was because, “no one likes me.” If he did poorly on a test, it might be because, “I’m stupid.” We try to come up with alternative explanations: maybe he wasn’t invited to the party because there was only room for a small number of kids and many other kids were also not invited. Maybe he didn’t do well on the test because he studied the wrong things or because it was just a really tough test. If these other explanations were true, how would the child feel, and how would these feelings affect his behavior compared to the original thought? This component allows children and parents to understand that their automatic thoughts are not the only possible ways of viewing the world; suggesting other perspectives opens the door to other possibilities that may help the child and parent feel better and have more choices about their behaviors.

CCPR: T must stand for Trauma.

Dr. Cohen: The T is for **trauma** narrative and processing. Based on children’s feedback, this is often the most meaningful part of the treatment, and generally takes up about one-third of the total treatment time. We have kids talk in detail about personal trauma experiences. We’ve found that many therapists who are not providing a specific trauma-focused treatment model wait for kids to bring up the trauma, on the theory that they don’t want to rush them. But kids are avoidant and when not directly encouraged to address their traumatic experiences they rarely spontaneously talk about these experiences.

CCPR: What is the point of having kids recount the trauma? How is that inherently therapeutic?

Dr. Cohen: Trauma memories are generally incoherent and disjointed, and recounting their trauma experiences helps kids develop a more coherent and accurate understanding of what happened. They have been walking around saying to themselves, “I’m a bad person, I don’t deserve to be loved,” and this is a theme that colors their lives. For example, one child who was sexually molested said, “I didn’t tell anyone because I wanted it to happen.” Her abuser had told her that she liked it and wanted it too. So she lived with tremendous guilt and a feeling of being a bad, immoral person. But as she recounted her trauma narrative, a light bulb went off—she remembered that she didn’t like it, that she was terrified, and that her abuser threatened that he would abuse her sister if she ever told. She had suppressed that memory because it was so scary, and it was in some ways easier for her to believe that she had control over the situation and that she “wanted” it to happen. So this was the belief that she held onto, even though it came along with negative feelings and guilt, until she went back and remembered what actually happened. Once she did, she was able to say, “I didn’t tell anyone because I was afraid he would do it to my sister.” The retelling of the narrative allowed her to repair her distorted thoughts and it allowed her parents to understand why she didn’t disclose the abuse sooner, and why she had some very negative behaviors during the time before she told. Kids who have been traumatized develop a thesis about who they are because of the trauma, and it becomes a theme, such as “adults don’t protect me, they hurt me.” We work on replacing these themes with positive ones.

CCPR: And the final “ICE” stands for what?

Dr. Cohen: The I is for **in vivo** mastery of trauma reminders. Kids might avoid bathrooms or schools, depending on where the trauma happened. We come up with a graded hierarchy of triggers and encourage kids to expose themselves in order to master their fears. The C is for **conjoint sessions**. We bring the parent into the room and the child shares the narrative with parent and

Trauma-focused cognitive behavioral therapy treatment process: PRACTICE

- Psychoeducation
- Parenting Education and Skills Training
- Relaxation
- Affective Expression and Modulation
- Cognitive Coping
- Trauma Narrative and Processing
- In Vivo Mastery of Trauma Reminders
- Conjoint Sessions with Parents
- Enhancing Safety (developing a family safety plan)

EMDR in Children and Adolescents

Sara Brewer, MD
Assistant clinical professor
Tufts University School of Medicine

Dr. Brewer has disclosed that she has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

EMDR stands for “Eye Movement Desensitization and Reprocessing.” Created by psychologist Francine Shapiro in 1989, EMDR was first used for posttraumatic stress symptoms associated with military combat and sexual assault, and the treatment has a strong base of support. For instance, it was recommended with “moderate clinical confidence” by the American Psychiatric Association’s 2004 Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder, and it was “strongly recommended” for the treatment of trauma by the Department of Veterans Affairs / Department of Defense’s 2004 Clinical Practice Guideline for the Management of Post-traumatic Stress. Data show that the treatment eases the emotional sequelae of interpersonal violence, accidents, witnessed violence and natural disasters.

EMDR can best be described as a type of cognitive behavioral therapy with an emphasis on exposure techniques. However, it has atypical features that are not shared with other well-known treatments, features that can be off-putting to the uninitiated. The typical treatment course for adults includes eight sessions and the following components:

1. The treatment is introduced, a therapy target (typically a trauma memory) is chosen and maladaptive beliefs associated with the target are stated.
2. The client selects a “safe place,” a past experience or image associated with comfort and well-being, that is called upon when needed.
3. A negative thought is identified that is associated with the memory along with a positive thought—an empowering self-statement that the individual wishes to believe in.
4. The client is asked to focus on the traumatic memory, the negative

thought, and any associated sensations or emotions while engaging in side-to-side eye movements. The client reports a distress level, and the procedure continues until the distress level fades.

5. Any new emotions, sensations, or images that arise during the treatment above or between sessions are subjected to the procedure described in step 4.
6. The identified positive thought is assessed and strengthened.
7. Sessions close with relaxation exercises as needed to help clients return to a state of equilibrium.

Whether EMDR works as well in children as it does in adults is unclear. The 2010 AACAP Practice Parameters for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder say the evidence is insufficient. In practice, most therapists treat children slightly differently, using bilateral hand tapping rather than eye movements (due to developmental difficulties with eye coordination in young children), children’s drawings rather than images as representations of traumatic memory, sets of examples of negative and positive thoughts for children to choose from, and visual analogue scales for distress ratings.

Case reports have described the benefits of EMDR for children after hurricanes, car accidents, bullying, and sexual assault. Larger but uncontrolled studies have examined EMDR for refugee children with associated traumas in Sweden, children temporarily buried after an earthquake in Italy, children who had persistent PTSD symptoms following a major hurricane in Hawaii, and children in a general clinic population. While compelling, these reports are limited based on their design (for a recent review, see Adler-Tapia R and Settle C, *J EMDR Pract & Res* 2009;3(4):232–247).

A few more sophisticated studies have compared EMDR to waitlist controls, to CBT, or to other active treatments. When compared to waitlist controls in one study, EMDR was shown to

improve child-rated PTSD symptoms after motor vehicle accidents at three and 12 months follow-up. However, no improvements were seen on measures of anxiety, depression or global function (Kemp M et al, *B.Clin Child Psychol Psychiatry* 2010;15(1):5–25).

A comparison of EMDR with CBT for children who experienced a fireworks factory explosion in Amsterdam found similar benefit for both treatments (de Roos C et al, *Eur J Psychotraumatol* 2011;2). Another CBT vs EMDR study compared 12 sessions of each treatment for sexually abused Iranian girls. Again, both treatments were associated with significant clinical improvements, with large effect sizes on trauma measures and smaller effect sizes for more general mood and behavioral measures (Jaberghaderi N et al, *Clin Psychol & Psychoth* 2004;11:358–368).

These studies suggest that EMDR is most helpful for PTSD-specific symptoms. Supporting this conclusion, the one available negative study compared children with a wide range of diagnoses who received EMDR in addition to standard therapy (play therapy, family work, group therapy) with a group who received the standard therapy alone. No differences were found between groups on the Achenbach Child Behavior Checklist, a global behavioral measure not specific to PTSD (Rubin A et al, *Res Soc Wrk Pract* 2001;11:435–457).

Readers should know that EMDR is a treatment that stirs controversy. Many call the most unique feature of EMDR, the eye movements, a smokescreen covering what is essentially a simple, exposure-based treatment. Others have developed detailed neurobiological theories related to memory processing to explain the eye movements and other bilateral stimulation techniques in EMDR. While one case study reported increased suicidality and panic attacks after EMDR treatment (Kaplan R and Manicavasagar C, *Aust & N Zeal J Psych* 1998;32:731–732), EMDR seems to be a safe form of treatment, overall, with a strong following among clinicians and a growing body of supporting empirical evidence, particularly for PTSD symptoms related to discrete trauma episodes.

Medications for PTSD

to decrease acute stress disorder symptoms in pediatric burn patients; however this was another short study with no placebo comparison, and no follow up beyond seven days (Robert R et al, *J Am Acad Child Adolesc Psychiatry* 1999;38(7):873–82).

Antipsychotics

The use of atypical antipsychotics has increased exponentially in children, and there is evidence that suggests an increase in dopamine in children with PTSD (De Bellis MD et al, *Biol Psychiatry* 1999;45(10):1271–84). Some improvements were noted through a report on three children treated with risperidone (Risperdal), a case series of six boys with quetiapine (Seroquel), and even treatment with clozapine (Clozaril), but further evidence is needed. The clozapine study was retrospective, limited to a residential population, and only had 19 patients with a PTSD diagnosis (Kant R et al, *J Child Adolesc Psychopharmacol* 2004;14(1):57–63). The sedating effects and dopamine blocking may be helpful with fear response and intrusive symptoms of PTSD but the potential benefits must be weighed carefully with the metabolic and extrapyramidal side effects. Typically, you would give these medications at a lower dose compared to treating psychotic disorders.

Antiadrenergics

The use of alpha and beta-adrenergic agents, such as clonidine (Catapres), guanfacine (Tenex), and propranolol (Inderal), has also demonstrated some response in children through a smattering of case studies and one randomized control study of propranolol in 29 children. These medications may help address hyperarousal symptoms in children and the noradrenergic dysregulation that is found with PTSD. Clonidine would start at 0.05 mg at bedtime with an increase in dose frequency of two or three times a day due to the short half life. Recent research has looked at the alpha-antagonist prazosin (Minipress) through case studies in children. Prazosin would be given 1 mg per day at bedtime up to a dose of 4 mg per day and can be particularly helpful with sleep.

Mood Stabilizers

When considering complex PTSD

Medications for PTSD

Medication	Dosage Information (if available)	Notes
Carbamazepine (Tegretol)	100 mg twice a day for ages 6-12; 200 mg twice a day for ages 13 and up, increase aiming for levels around 10–11.5 mcg/mL.	Open label study showed improvement.
Clonidine (Catapres)	0.05 mg daily at bedtime initially. Increase to two to three times a day due to short half life.	Some effectiveness found, further research needed.
Clozapine (Clozaril)	Dose lower than for psychotic disorders.	Retrospective study showed effectiveness, further evidence needed.
Cyproheptadine (Periactin)	4 mg per day at bedtime, up to 12 mg per day.	Case studies have shown improvement in nightmares.
Divalproex (Depakote)	30-60 mg/kg/day divided in two to three doses for ages 10 and up; increase and aim for levels between 5–120 ng/ml.	RCT showed symptom improvement at high blood levels.
Fluoxetine (Prozac)	10–20 mg per day. (Same as for depression.)	No proven effectiveness.
Guanfacine (Tenex)	0.5 mg twice a day. Increase to total dose of 1-3 mg daily.	Some effectiveness found, further research needed.
Imipramine (Tofranil)	1–3 mg/kg/day divided in three doses for ages 6 to 12; up to 75 mg per day for those over 12. (Same as for depression.)	One small RCT found imipramine decreased acute stress symptoms in pediatric burn patients.
Morphine	Dose as needed for pain management.	Naturalistic study found reduction in PTSD for burn victims treated with morphine. No indication for treatment or prevention of PTSD alone, rather in conjunction with pain management.
Paroxetine (Paxil)	10–60 mg per day. (Same as for depression.)	No proven effectiveness.
Prazosin (Minipress)	1 mg daily at bedtime initially. Dose up to max of 4 mg per day.	Case studies have shown effectiveness. May help with sleep.
Propranolol (Inderal)	10 mg three times a day. Increase up to 80 mg per day.	One RCT showed effectiveness, further research needed.
Quetiapine (Seroquel)	Dose lower than for psychotic disorders.	Small case report showed effectiveness, further evidence needed.
Risperidone (Risperdal)	Dose lower than for psychotic disorders.	Small case report showed effectiveness, further evidence needed.
Sertraline (Zoloft)	25 mg per day for ages 6 to 12; 50 mg per day over age 12. (Same as for depression.)	FDA approved for PTSD in adults. Has not shown significant effectiveness in kids.

and the emotional dysregulation that is often present, the use of mood stabilizers seems reasonable. Studies in children include an RCT for divalproex sodium (Depakote) which showed symptom improvement at higher blood levels (Steiner H et al, *Child Psychiatry Hum Dev* 2007;38(3):183–93), and an open label study for carbamazepine (Tegretol) which also showed some improvements (Looft D et al, *J Am Acad Child Adolesc Psychiatry* 1995;34(6):703–4). The divalproex study used data from a previous trial and was limited to 12 incarcerated, conduct disorder boys, while the Looft study included 28 children, of whom several also received other psychotropic medications. Adult studies have shown some efficacy with lamotrigine (Lamictal), tiagabine (Gabitril), and topiramate

(Topamax). Overall, the results have not been as promising as expected, and further research is needed.

Benzodiazepines

As PTSD falls under the DSM category of anxiety disorders, the use of benzodiazepines may be considered. However, there are essentially no studies that look at the efficacy of benzodiazepines in children for PTSD. This may be due to several reasons, including the increased risk of disinhibition in children, the limited amount of research in treating children with benzodiazepines for any indication, and the lack of evidence supporting its use in adult patients with PTSD. Another consideration is the significant rate of comorbid substance abuse with PTSD.

Continued on page 12

Research Updates IN PSYCHIATRY

BEHAVIOR

Does Co-Sleeping Cause Behavior Problems?

Research has shown that regular routines can benefit kids in numerous ways. However, little research has been done specifically on bedtime and nighttime routines. Recently a group of Rhode Island-based therapists examined whether certain sleep habits and routines can have an effect on daytime behavior.

Data was gathered from parents of 704 patients in Rhode Island pediatricians' offices. Parents of patients ages two to 13 filled out short 14-question multiple choice surveys on nighttime habits and daytime behavior. Researchers compared the 14 variables for associations and came up with a number of strong associations.

Surveys showed that 68% of kids often or usually go to bed at the same time every night, and 70% of kids usually sleep in their own beds. However, researchers found that children who do not go to bed at the same time every night and those who sleep with their parents are more likely to have tantrums, act physically aggressive toward their parents, and have behavior problems at school than those who do go to bed at the same time every night and in their own beds. For example, 54% of kids who slept with their parents "usually or always" acted physically aggressive toward a parent (hitting, kicking, and/or pushing) and parents of 33% of these kids reported having been told their child needed medication for behavioral or learning problems (Pressman RM and Imber SC, *Am J Fam Ther* 2011;39:404-418).

CCPR's Take: This study finds a correlation between behavior problems

and inconsistent bedtime routines and/or co-sleeping, but the methodology doesn't convincingly tell us what comes first, the sleep problems or the behavior problems. Perhaps kids with ADHD and other behavioral problems resist bedtime and sleeping alone as part of their conditions—not the other way around, as is argued by the authors. The authors don't explore whether changing bedtime routines has any effect on daytime behavior. Nonetheless, sleep hygiene is important for all kids, so taking a brief sleep history with families could be helpful in your evaluation of all of your patients.

EATING DISORDERS

Risperdal not Effective for Anorexia Nervosa

Anorexia nervosa, defined as an intense fear of gaining weight and a refusal to maintain one's weight above 85% of expected body weight, is notoriously difficult to treat. Clinical trials of both antidepressants and the antipsychotic olanzapine (Zyprexa) have yielded disappointing results, with no clear benefit of medications over placebo for the core symptoms of anorexia. Nonetheless, we still often try medications in anorexia, if only to treat associated symptoms such as depression, anxiety, or irrational thinking. Risperidone (Risperdal) is on the short list of medications often attempted in this population, but until now there was no controlled study to evaluate its effectiveness.

In a study conducted in the eating disorders program at Children's Hospital Colorado in Denver, 40 adolescent females with anorexia nervosa were randomly assigned to either risperidone (n = 18) or placebo (n = 22). Patients began

as either inpatients or day patients, and were transitioned to care as usual over time. They received the multidisciplinary care typical in such programs, with an emphasis on parents taking charge of meal planning and supervision.

Patients who were assigned to risperidone started with 0.5 mg/day, and were titrated up in weekly 0.5 mg increments until they left the study, either because of a response (defined as reaching the target weight of 90% of ideal body weight for one month), a worsening, or no response despite being on the maximum dose of 4 mg for four weeks. The mean risperidone dose was 2.5 mg, and the mean duration of treatment was nine weeks. Patients who were already taking antidepressants were allowed to continue them, but no other medications were permitted.

At study endpoint, 33% of the risperidone group reached the target weight, vs. 45% of the placebo group (not a statistically significant difference). Patients taking risperidone did show significant improvements relative to placebo in the Eating Disorder Inventory 2 Drive to Thinness scale over the first seven weeks, but this difference disappeared by study endpoint. Risperdal was well tolerated—the only difference in side effects was elevated prolactin in the drug group. The study was limited by difficulties recruiting enough patients into the study to achieve high statistical power—which is an occupational hazard common to all anorexia studies (Hagman J et al, *JAACAP* 2011;50:915-924).

CCPR's Take: This is another disappointing result in the world of anorexia research. While there was a signal that risperidone might ease some of the disordered thoughts of anorexia, the antipsychotic is probably ineffective for the key outcome of weight restoration.



Expert Interview

we address other positive communication with parents. As TF-CBT draws to a close the therapist wants the youth and parent to be able to directly talk about trauma and other important topics without needing the therapist. Finally, the E is for **enhancing safety**. Trauma is a violation of safety, so it is important for youth and parents to know that there is a plan for assuring safety in the future. The therapist may work together with the family to develop a family safety plan during the conjoint sessions. Additional areas of focus may include healthy sexuality and helping kids with drug refusal skills. At the end of TF-CBT treatment we have a graduation ceremony to acknowledge the progress youth and parents have made.

CCPR: Thank you, Dr. Cohen.

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CME Post-Test

CME Notice: The test below is intended to be for **practice only**. All subscribers must take their tests online at www.thecarlatchildreport.com. If you cannot take your test online, please call 866-348-9279 or email info@thecarlatreport.com.

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Below are the questions for this month's CME 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. According to a 2009 study, what percentage of American kids report exposure to violence, abuse, or trauma in the past year (Learning Objective #1)?
 a. 10% b. 20% c. 50% d. 60%
2. The most widely used group therapy for trauma in children and adolescents is which of the following (LO #1)?
 a. trauma focused cognitive behavioral therapy (TF-CBT) b. child parent psychotherapy (CPP)
 c. cognitive behavioral intervention for trauma in schools (CBITS) d. trauma systems therapy (TST)
3. Which of the following medications is approved for the treatment of PTSD in children (LO #2)?
 a. sertraline (Zoloft) b. paroxetine (Paxil)
 c. imipramine (Tofranil) d. no medications are approved for the treatment of PTSD in children
4. The 2010 AACAP Practice Parameters for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder say the evidence that EMDR is effective for trauma in children is insufficient (LO #3).
 a. True b. False
5. Neurobiological research has shown that trauma-related feelings and body responses are so intense and overwhelming that they actually cause the frontal lobes to shut down (LO #4).
 a. True b. False
6. The "cognitive coping" component of trauma focused cognitive behavioral therapy involves which of the following (LO #5)?
 a. Helping parents and children understand the impact of trauma, how common it is, and that their responses are not atypical.
 b. Helping parents change their focus from "what is wrong with my child" to "what has happened to my child?"
 c. Helping children and their parents understand that maladaptive automatic thoughts are not the only possible ways of viewing the world.
 d. The child recounting the traumatic event.
7. The Pressman et al study of co-sleeping found what percentage of kids who slept with their parents "usually or always" acted physically aggressive toward a parent (LO #6)?
 a. 33% b. 54% c. 68% d. 70%
8. At the end of the Hagman et al study of risperidone for anorexia, what percentage of the risperidone treated group reached target weight (not a statistically significant difference from the 45% in the placebo group who reached target weight) (LO #6)?
 a. 33% b. 38% c. 44% d. 50%

Opiates

While on the topic of potential substances of abuse, a naturalistic study looked at the use of morphine and the development of PTSD in hospitalized children with acute burns and found a reduction in PTSD symptoms with higher doses of morphine (Saxe G et al, *J Am Acad Child Adolesc Psychiatry* 2001;40(10):915–21). This may be due to an association with fear conditioning and memory consolidation. While this study followed the 24 children six months out, it would be difficult to sell the use of morphine in children without physical pain.

Other Possible Agents

Other medications that have been considered include cyproheptadine (Periactin), an antihistamine and 5-HT2 antagonist, with several case reports in adults and one case report in children. Improvements were found in intrusive symptoms, specifically nightmares. Dysregulation of the HPA axis suggests possible use of medications that act on corticotrophin-releasing

CCPR'S VERDICT: There is a huge need for more studies to guide our use of medications for PTSD in the child and adolescent populations. SSRIs can be helpful in combination with psychotherapy, and their use is reasonable for patients with comorbid depression and anxiety. For more severe cases, mood stabilizers and antipsychotics may possibly be effective but should be used judiciously.

November 2011

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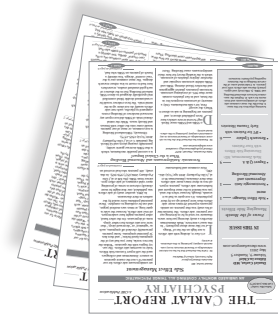
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