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CHILD PSYCHIATRY

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IN THIS ISSUE

Anxiety in Children and Adolescents

- What to Do About School Refusal? A Conversation With Two Experts — 1
- Expert Q&A — 1
Moira Rynn, MD
Anxiety Everywhere: Grappling With a Pervasive Symptom
- Wilderness Therapy: Dangerous Waste of Money or an Effective Therapeutic Intervention? — 5
- Research Updates: — 6
 - How Effective Are Medications for Pediatric Anxiety?
 - Suicide Rates in College Students
- CME Test — 7
- Note From the Editor-in-Chief — 8

Learning Objectives

After reading these articles, you should be able to:

1. Assess and treat school refusal in school-age children and adolescents.
2. Evaluate the effectiveness of treating anxiety with pharmacological, psychotherapy, and/or combination treatments.
3. Summarize some of the current findings in the literature regarding psychiatric treatment for children and adolescents.

What to Do About School Refusal? A Conversation With Two Experts

Amalia Londono Tobon, MD. Chief Resident PGY-5, Solnit Integrated Training Program at Yale Child Study Center. Wendy K. Silverman, PhD, ABPP. Professor of Child Psychiatry and Director at Yale Child Study Center Program for Anxiety Disorders.

Drs. Londono Tobon and Silverman have disclosed that they have no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Editor's note: School refusal is a common problem, affecting up to 5% of schoolchildren. Even so, there are few clear guidelines on how to manage this problem. After seeing their article on the subject, we were able to talk with a child psychiatrist and a clinical child psychologist who focus a significant portion of their work on treating school refusal.

CCPR: Thank you both for joining me today. We all see kids who won't go

In Summary

- Treating school refusal involves identifying the factors behind the behavior, such as social or other anxiety disorders or depression.
- Psychotherapy and, if necessary, pharmacotherapy can be beneficial in treating underlying conditions for school-refusal patients.
- Utilizing both family and school accommodations can help decrease anxiety levels in patients with school refusal.

to school. How do we help the child, family, and school in this situation?

Dr. Silverman: School refusal has been difficult to conceptualize—people have trouble distinguishing delinquent cutting

Continued on page 2

Q&A With the Expert

Anxiety Everywhere: Grappling With a Pervasive Symptom Moira Rynn, MD

Chair for the Department of Psychiatry and Behavioral Sciences at Duke University School of Medicine, Durham, NC.

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

CCPR: Can you tell us a little about your background?

Dr. Rynn: I've been doing clinical research examining new medications for children with anxiety disorders. My passion is working with children who have failed first-line, evidence-based treatments. How do we help these children? What are our options? I look at new treatments or changing the intensity of treatments. We do have good treatments available—it's just that they don't work 100% for everybody.

CCPR: Tell us about your take on anxiety.

Dr. Rynn: For us to advance the field beyond the treatments that we have available, we need to think about these illnesses in a different way, understanding more of their biology and expression depending on the environment in which they occur. Children don't present with just one anxiety or anxiety-related disorder;



Continued on page 3

What to Do About School Refusal? A Conversation With Two Experts

Continued from page 1

from more innocently playing hooky. In other words, we didn't distinguish between children who didn't want to be in school, versus children who did want to be in school but were unable to go due to psychological emotional problems (eg, anxiety and depression). Further muddying the issue was the term "school phobia," implying that the problem was something specific to school—we now know that's not the case. Also, people mistakenly assumed that if the issue wasn't school phobia, it stemmed from separation anxiety.

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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.

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CCPR: So how might we better think about the problem?

Dr. Silverman: It's heterogeneous. Some children stay away from school to reduce their anxiety or depression. School avoidance is maintained by the negative reinforcement—ie, the relief of not being at school. Other children stay home doing things that feel good, like watching TV or gaming—ie, positive reinforcement. It is important to look at both aspects when planning treatment.

Dr. Londono Tobon: In our review, we found that truancy and school refusal behavior due to anxiety, depression, or other psychiatric or psychological problems can also be mixed. Therefore, it is important to look at all problems.

CCPR: For child psychiatrists, are there some specific things to consider in assessment?

Dr. Londono Tobon: School refusal affects over 15% of child psychiatric patients. Silverman and Kearney wrote a questionnaire that helps clinicians identify factors affecting school refusal: learning difficulties, anxiety about speaking to other children in school or trouble making friends, difficulty in the family dynamics or separating from family members, specific days of the week that are more difficult, feelings of embarrassment, and challenging relationships with teachers and other school personnel, among others (Kearney CA & Silverman WK, *J Clin Child Psychol* 1993;22(1):85-96). Bullying and school shootings have also raised increasing worries for children and families.

CCPR: What is your approach to assessment and treatment?

Dr. Silverman: Dig in. Don't assume that the child has separation anxiety or a phobia. What is the child avoiding? For some children, it's related to a social anxiety disorder. For other children, it's the need to be perfect and worrying about mistakes relating to generalized anxiety disorder. Some have separation anxiety. This is important in cognitive behavioral therapy (CBT), because CBT involves exposure to feared anxiety-provoking stimuli. You do a different exposure with someone avoiding school for social anxiety reasons vs for separation anxiety. Also, the more chronic and severe the case, the more important it is to involve all the stakeholders, because the school

setting must be addressed. Teachers can help with treatment.

CCPR: Parents sometimes say, "Let's just let him stay home so we don't upset him."

Dr. Silverman: Look for family accommodation. Parents with anxious children want to reduce their child's anxiety, so they allow the child to avoid situations that cause the anxiety, but they need other ways of solving the problem. We have data that we are writing up showing that accommodation levels are higher in the parents of children who are both anxious and avoiding school, vs children who are anxious but attending school. This suggests targeting parent accommodation to help children get to school.

CCPR: Do we have data showing that parent guidance to reduce accommodation is effective?

Dr. Silverman: In uncontrolled research by Kennedy in the 1960s, parents were told to get the child to school. This is probably more helpful in acute cases than chronic ones.

Dr. Londono Tobon: It's important to think developmentally or you could make things worse. Also, sometimes the school fit is not good. I had one patient who ended up going to another school that was a better fit, after which the patient had no problem with school refusal.

CCPR: Can you elaborate on your thoughts about developmental differences?

Dr. Londono Tobon: Forcing adolescents to go may be less effective—you have to get their buy-in. You may need to work with younger children to process their fears, not just put them in school.

Dr. Silverman: The issues are probably more pronounced now because of school shootings creating an added level of realistic anxiety.

CCPR: What about medications?

Certainly, SSRIs for a specific anxiety disorder, maybe for depression. Otherwise, do we treat it like PTSD with central alpha-agonists or maybe propranolol?

Dr. Londono Tobon: We did a systematic review of pharmacologic treatment studies for school refusal and anxiety (Londono Tobon A et al, *J Child Adolesc Psychopharmacol* 2018;28(6):368-378).

Continued on page 3

What to Do About School Refusal? A Conversation With Two Experts

Continued from page 2

There's not a lot of literature, and the bigger trials in anxiety and depression have not looked at children with school refusal. In many of the existing studies, the control arm also had behavioral intervention, so it was difficult to tell if pharmacologic interventions were helpful. Many of the studies had children with comorbid anxiety and depression symptoms. These studies showed that fluoxetine, imipramine, and clomipramine all have pre- and post-benefits in

depression, anxiety, and school refusal symptoms, but not always group differences. The bottom line is to target the underlying psychiatric condition with psychotherapy and pharmacotherapy if needed. There are many CBT manuals now for school refusal, and many engage the school and parents.

Dr. Silverman: But even the CBT trials for school refusal are few in number, small in sample size, and have limited follow-up.

CCPR: Thank you both for your time.

CCPR VERDICT: While there is little guidance for specific medication approaches in school refusal, we can have an impact if we dig deep to understand the behavior, treat underlying conditions where possible, and work closely with the child, family, and school.

Expert Interview

Continued from page 1

it's often more than one. The brain does not recognize our DSM-5 criteria. The circuits that are involved overlap across those disorders, and the environmental interaction brings forth what you see in the child. Under Tom Insel's leadership, NIMH put forth a multilevel analysis approach, the Research Diagnostic Criteria (RDoC), to examine the range of symptoms—from genomics to circuits and behaviors. It is important to think about core symptoms that can be very problematic for children or adults, cutting across different disorders.

CCPR: Child psychiatrists see patients who report anxiety as a symptom and then typically look for specific diagnoses and then appropriate treatments for these diagnoses. Why is it important to also look at anxiety as a symptom that cuts across diagnostic categories vs differentiating it into specific DSM diagnoses?

Dr. Rynn: Anxiety presents as a core symptom across disorders—mood disorders, disruptive behaviors, and autism, to name a few. Anxiety affects nearly everyone we treat. So, while we need to treat the definable disorders, we also need to figure out how to treat anxiety as a part of these other conditions or situations.

CCPR: How do we address anxiety in all these circumstances?

Dr. Rynn: You need a good assessment that examines all contributors to the symptoms, such as environmental reasons for anxiety; the relationship between anxiety and other problems, for instance anxiety in ADHD when a child is unable to complete homework; and the presence of definable anxiety disorders for which we have defined treatments.

CCPR: And we treat those definable anxiety disorders as we would usually do?

Dr. Rynn: It may depend on the specific child and circumstances, but yes, I would consider applying the usual treatments, as they may have the best chance of helping the anxiety aspect of the situation.

CCPR: We often find in our practices that the parents of the patient have strong or even differing views on medication vs therapy (as well as the patient depending on age). Can you speak to this? How do you decide to go with medication or therapy?

Dr. Rynn: You have to be willing to meet the patient and the parents in their thinking. If they are not comfortable with your recommendations and they come in with their own experiences, that will inform their thoughts about treatment. It is not uncommon for parents to have an anxiety disorder themselves, or for an extended family member or acquaintance to have one: an aunt, uncle, friend, teacher, coach, or clergy member. So keep in mind that a range of people give input to families and children about treatment.

CCPR: How do you speak with parents, knowing there might be this type of preconceived input surrounding treatment?

Dr. Rynn: I like talking to parents about the literature. We know a lot about outcomes if you elect to use a medication vs cognitive behavioral therapy (CBT) vs a combination of these treatments. I want the parents and children to feel empowered to consider their treatment options.

CCPR: Are there any particular studies that you refer to?

Dr. Rynn: The most well-known study—a great accomplishment for the field and NIMH—is the Child/Adolescent Anxiety Multimodal Study (CAMS) study (Walkup JT et al, *N Engl J Med* 2008;359(26):2753–2766). This was a large, multisite study of 488 children and adolescents that focused on the triad anxiety disorders and mild OCD. We compared sertraline alone (as a representative SSRI, nothing specific about sertraline), CBT alone, and the combination of sertraline and CBT. The study showed we have three efficacious treatments that all separated from placebo. The one caveat is that the medication arm was the only blinded arm—it's difficult to blind CBT—so to help, independent evaluators were utilized who did not know which research treatment was assigned to the child or family.

CCPR: Was there any difference among the treatment arms?

Dr. Rynn: Those patients who received combined medication treatment with the CBT had the greatest improvement. Some experts in the field have interpreted this to say that you should begin with combined treatment.

CCPR: Do you think combined treatment is the way to go every time, if possible?

Dr. Rynn: In my experience, some families come in and say doing talk therapy is not right for them. Or the child says, "I'm not ready for that, but my anxiety is really problematic. I need something I can just take that will help me." And so, it is a reasonable choice to start with medication, depending on the clinical context of what is happening for the child. Other families are not comfortable with medication as the first step and want to try CBT. And still other families are dealing with severe symptoms, and for them the combination is the best approach.

Continued on page 4

Expert Interview

Continued from page 3

CCPR: Is the choice that straightforward?

Dr. Rynn: There are a lot of nuances in regard to the family and presentation of symptoms that come into the clinical decision-making.

CCPR: Let's talk specifics with treatment as usual. In what circumstances do you recommend starting with both medication and therapy together?

Dr. Rynn: In those cases, I look at what's going on in the child's life: Is he not going to school at all? Having terrible sleep problems? There might be weight loss and a concern about comorbid depressive symptoms. Is she having thoughts that life's not worth living? I educate the family, explaining that it can take 6–8 weeks to see improvement with CBT and, given the severity of symptoms, strongly recommending that we start with the medication and the CBT together. In the CAMS study, we start seeing a difference in medication in about 4 weeks. CBT response onset is later. For a child with moderate to severe symptoms, it is important to educate the parents and the child about all the treatment options. However, just to be clear, CBT does have efficacy with treating moderate to severe levels of anxiety symptoms, although the child and family need to be able to fully engage in the treatment and access a professional trained to provide it.

CCPR: What about side effects of medication? Any thoughts on that?

Dr. Rynn: The CAMS trial was such a large sampling that it gave us an opportunity to look at safety issues. Evaluating the adverse events across the different treatment arms, there is a suggestion that we need to be more cautious in the 12-and-under set as they might experience some activation, more irritability, and/or sleep difficulties. It's something to be considered and monitored. I think what's important is to give parents the information so that they, along with the child, can make decisions about where they want to take their next steps for treatment.

CCPR: Let's talk about CBT. How effective do you think it is?

Dr. Rynn: That was an important finding in the CAMS study: CBT is a therapy you can use with a child who has moderate to severe anxiety. It just depends on what the other additional symptoms are in terms of risk issues. If the child is able to engage in the treatment, CBT can be quite beneficial.

CCPR: How does OCD fit into this?

Dr. Rynn: When I talk about anxiety disorders, I'm referring to generalized anxiety disorders, social anxiety disorder, separation anxiety disorder, etc. With the DSM-5, OCD has been placed under a different category, which is interesting. That is informed more by thinking about the neurocircuitry, and that's important, but in terms of available treatment for OCD and this triad of anxiety disorders, it can be comorbid in children and adolescents. So my first few steps of treatment apply both for OCD and the other childhood anxiety disorders.

CCPR: For OCD, beyond going higher on the SSRIs, I think a lot of us would try another SSRI. We'll go high on the doses; maybe we'll add a neuroleptic. Do you have your own general algorithm for therapy and for medications?

Dr. Rynn: I start treatment with SSRIs or CBT exposure and response prevention as the first two kinds of treatment. John March and his group led an important study called the Pediatric OCD Treatment Study (POTS) (March J et al, *JAMA* 2004;292(16):1969–1976). It actually showed a similar pattern of differentiation from placebo with medication alone, CBT, and the combination of medication and CBT, with all doing really well. Combination treatment had an advantage over the others; however, when you look at excellent responder status—those who really, really did well—you see that CBT alone achieved that along with combination, but not medication. Medication with excellent responder status didn't differentiate from the placebo.

CCPR: What about the family? How do they fit into the process?

Dr. Rynn: It's so important to get a comprehensive evaluation, including family history of anxiety and other difficulties, as well as family dynamics and stressors, attachment issues, and possible maltreatment, so that the parents and child can understand what the issues are. There can be a decrease in symptoms just based on that, educating parents and helping them change some of their responses and some of the other things that they're doing.

CCPR: Can you talk more about that?

Dr. Rynn: Parents care for their children, and they of course mean well. They want to decrease their child's distress, but sometimes they're doing things that continue to enable the anxiety. They might be inadvertently making things worse by allowing the child to continue to avoid the things that are causing anxiety. Parents may just need more guidance. We need a more systematic way of getting that information out for children and families, and I'm very excited about another arm of the federal funding option: It's called PCORI, the Patient-Centered Outcomes Research Institute. They recently had requests for applications about treatments for children with anxiety disorders and to examine more closely the evidence-based treatments that we have in the real-world setting. There have been several announcements, and there will be studies funded on this. So that, I think, will help the field.

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

Editor's note: Access to good CBT is another issue. There are online CBT programs for OCD and anxiety disorders that have been shown to be helpful for adults, although often people do not follow through and use them enough to be of benefit. The literature is limited about the efficacy of online CBT treatment for children and adolescents.

“Talk to parents about the literature. We know a lot about outcomes if you elect to use a medication vs CBT vs a combination of these treatments. I want the parents and children to feel empowered to consider their treatment options.”

Moira Rynn, MD

Wilderness Therapy: Dangerous Waste of Money or an Effective Therapeutic Intervention?

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

Wilderness therapy programs, aka “outdoor behavioral health programs,” purport to offer structured outdoor experiences for adolescents or adults that lead to psychological shifts and better functioning. Programs vary in length from a few days to months, although 30–90 days is common. The outdoor experiences include camping, canoeing, hiking, rock climbing, and sailing. While engaging in these activities, participants receive formal and experiential therapy from trained professionals.

In most programs, attendees may continue to take any medications they’re already on, and there is a prescribing consultant who may change dosing or medications if needed; however, the emphasis is more on the program elements and not medication management or adjustment. Think summer camp with a therapy twist: Attendees might first talk about cognitive distortions, then address their own on a 300-foot zipline, or practice mindfulness while walking up a mountain and being surrounded by nature.

Various wilderness programs have a “typical” participant profile that they do best with, and treatment often centers around that profile rather than specific mental illnesses. Families generally pay out of pocket, with fees running from a few thousand dollars to more than \$30,000. “The outdoor experience is a way to engage people who wouldn’t necessarily want to engage in treatment otherwise,” says Dr. Michael Gass, director of the University of New Hampshire Outdoor Behavioral Healthcare Center, a research consortium. The center’s website, with links to safety data, such as use of restraint, injury and illness, and outcomes, can be found at <https://www.obhcenter.org>.

How is this therapy supposed to help?

The theory of change for wilderness programs is a complex model in which living in nature provides three advantages: separateness from “real life”; inherent challenge and danger; and a sense of peace. Removed from their usual relationships, participants have both the need and the

flexibility to create new relationships. They bond quickly and closely with other participants and therapists, sharing intimate details, free from the self-enforcing patterns and interactions of their usual lives. You can’t argue with your mom if your mom isn’t there to argue with.

While on an adventure, the stigma of treatment is alleviated, and it feels more natural to talk about issues. The challenge of nature allows everyone to focus on how each person helps or hinders themselves and the group, and people develop a sense of self-efficacy as they learn to work within the outdoor context. Finally, the peaceful beauty provides a space free of distractions in which participants can think about their lives and priorities.

It remains unclear how one decides whether a particular patient might benefit from wilderness therapy, and once a patient returns from a program, the known duration of any benefit afterward is similarly unclear.

Are wilderness camps effective?

Does outdoor behavioral therapy work? One meta-analysis found an effect size of 0.8 (large) using improvement on the Youth Outcome Questionnaire, measuring intrapersonal distress, somatic distress, interpersonal relationships, social problems, and problematic behaviors, as well as critical items like hallucinations and suicidal ideation; however, this questionnaire does not identify specific diagnoses (Gillis HL et al, *Child & Youth Care Forum* 2016;45(6):851–863). By contrast, wrap-around programs, a more limited version of assertive community treatment where providers collaborate in an organized manner, were found to have an effect size of 0.33 (small) on the same measure.

In a fairly exhaustive meta-analysis of wilderness activity therapy, researchers found an overall effect size of 0.47 (moderate) across multiple outcomes, with a smaller effect size for younger children and a larger effect size for older teens and adults; in comparison, they found little or no effect across non-wilderness-based alternative programs and the control group receiving no treatment (Bowen DJ and Neill JT, *The Open Psychology Journal* 2013;6(1):28–53). However, both wilderness and wraparound programs are

difficult interventions for meta-analyses because of inconsistencies across programs and studies.

How dangerous are these programs?

Since 2002, when her 15-year-old daughter died while participating in a wilderness program, Cynthia Harvey has been an outspoken critic of the industry. She and other parents have created a website called Alliance for the Safe, Therapeutic and Appropriate Use of Residential Treatment (ASTART) to warn families about their experiences, citing congressional testimony and reports of teens who have died in the custody of private-pay wilderness and residential treatment programs (<http://astartforteens.org>).

Deaths have resulted from two main types of causes: staff not recognizing acute medical situations such as dehydration and therefore failing to intervene; and face-down or other dangerous restraints. These are the same preventable problems that plague residential treatment, public and private schools, acute inpatient units, and state hospitals. Such outcomes generally result from poorly trained and poorly supervised staff.

In contrast, Dr. Gass cites the voluntary accreditation standards that many programs adhere to, ensuring both appropriate staff training and professional credentialing in mental health treatment as well as outdoor safety and wilderness first aid. “[Wilderness programs] used to be dangerous,” he says, “but now they’re no more dangerous than staying home.”

Are wilderness or private residential treatment programs worse? The answer lies in failure of regulation. While publicly sponsored and conventional insurance-based residential programs are regulated and inspected, private programs often are not, allowing some unethical providers to exploit a desperate population. Deceptive websites drive worried parents into “selecting” wilderness programs from a single provider. Programs may limit costs by using poorly trained or unqualified staff, and they may use practices that are not rigorously evidence-based or that are abusive.

One example of a practice used in some camps is the “tough love” approach, long disproven but still promoted. In this approach, kids are subjected to very rigid

Continued on page 7

Research Updates
IN PSYCHIATRY

ANXIETY

How Effective Are Medications for Pediatric Anxiety?

REVIEW OF: Strawn JR et al, *J Am Acad Child Adolesc Psychiatry* 2018;57(4):235–244.e2

Antidepressants are part of the first-line treatment for severe childhood anxiety disorders when removal of stressors and psychotherapy are not enough, but are all antidepressants created equal in this situation? A recent meta-analysis shows that antidepressants have a moderate effect size of 0.56 for treating anxiety disorders in children (see *CCPR*, Jan/Feb 2018), but do we have the data to further break that down? Another meta-analysis was recently performed that can further guide us in tailoring our medication choices for pediatric anxiety disorders.

In this meta-analysis, the authors pooled data from 9 randomized placebo-controlled trials that compared either an SSRI or an SNRI to placebo for the treatment of social, generalized, and/or separation anxiety disorders. Total sample size was 1,805 children ages 5–17 years, with 53% male. All studies were done in outpatient clinics and had a mix of federal and industry funding sources. The follow-up periods varied from 8 to 16 weeks, with a median of 10 weeks. Four SSRIs (fluoxetine, fluvoxamine, paroxetine, and sertraline) and three SNRIs (atomoxetine, venlafaxine, and duloxetine) were used in the studies. The primary outcomes were the time it took to see improvement, how treatment response differed between SSRIs and SNRIs, and differences in low-dose vs high-dose SSRIs. Rating scales, most commonly the Pediatric Anxiety Rating Scale (PARS), were administered every 2 weeks.

Overall, children improved quickly compared to placebo, with a statistically significant difference in the rating scales by week 2 ($p = 0.005$) and a clinically significant difference seen by week 6 ($p = 0.001$). SSRIs outperformed SNRIs over the entire treatment course, with a statistically significant difference emerging by week 2 ($p = 0.021$), but both classes of medications resulted in significant

improvement compared to placebo by week 2. For the high-dose vs low-dose SSRI comparison, high-dose was considered > 1.5 fluoxetine equivalents (> 49.5 mg) per day. High-dose SSRI treatment resulted in earlier improvement (week 2), while low-dose resulted in later improvement (week 6). However, over time, there was no significant difference ($p = 0.638$), but the variance was greater for the low-dose group ($p < 0.001$).

This meta-analysis found that, overall, SSRIs resulted in greater improvement in childhood anxiety disorders than SNRIs, and that high-dose SSRIs led to earlier improvement. The authors postulate that the differences may be due to an underdeveloped noradrenergic system in children compared to the serotonergic system, or due to anxiety disorders themselves being caused by more dysfunction in the serotonergic system.

CCPR'S TAKE

When making medication decisions, the more information we have, the better. This study confirms that both SSRIs and SNRIs are effective in treating pediatric anxiety disorders. And, all other things being equal, SSRIs may give better results. Unless you have a reason to avoid SSRIs, using them as the first-line medication choice makes sense. High-dose SSRIs may give faster results but may come at a cost of increased side effects. Always be on the lookout for activation (which is generally more common with SSRIs than SNRIs) and other side effects.

—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.

Editor's note: Generally speaking, a moderate effect size tells you that, if you pick randomly from the treated group vs the control group, you have a better than 50% chance that the person responded.

SUICIDE

Suicide Rates in College Students

REVIEW OF: Mortier P, *J Am Acad Child Adolesc Psychiatry* 2018;57(4):263–273

Adolescence is a time of high risk for suicidal thoughts and behaviors (STB), and rates are rising. In those ages 15–29, suicide is the second leading cause of death globally (http://www.who.int/mental_health/prevention/suicide/suicideprevent/en). A recent article published some interesting survey data, giving us a clearer picture of how common STB is and what some of the causes are.

Full-time, freshman college students at 19 colleges in 8 countries were surveyed. The response rate was 45.5%, and the final sample included 13,984 responses (54% female; mean age 19). Approximately one-third of all respondents reported STB at some point during their lifetime. The median age of onset of STB was 14, with 75% of cases starting before age 16. More than half of those with ideation at some point in their life transitioned to a suicide plan, and a quarter of planners attempted suicide. The strongest correlate for STB and transition from ideation to attempts was non-heterosexual orientation, yet it was notable that students who identified as heterosexual but with same-sex attraction also had a significantly elevated risk of transitioning from suicidal ideation to development of a plan.

CCPR'S TAKE

Suicidal ideation and behavior are distressingly common among first-year college students worldwide. Those with non-heterosexual orientation may be at particularly high risk. This study tells us to double down on screening our own patients and pressing for more screening efforts. In addition, prevention initiatives and gatekeeper training are effective in decreasing suicidality and increasing help-seeking. Where resources are limited, campus outreach could specifically target high-risk first-year students.

—Jessica Goren, PharmD, BCPP. Dr. Goren has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Editor's note: For resources on screening and intervention for suicide, see: <https://suicidepreventionlifeline.org> or <http://www.sprc.org>.

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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- According to Dr. Londono Tobon, school refusal affects ____ of child psychiatric patients. (LO #1)
 a. Under 3% b. 5%–8% c. 10%–12% d. Over 15%
- Your 13-year-old patient has been diagnosed with generalized anxiety disorder and is showing moderate to severe symptoms, including weight loss. According to Dr. Rynn, given the severity of the symptoms, what would be a first-line recommendation for treatment? (LO #2)
 a. Starting CBT with introduction of medication if no improvement after 1 month
 b. Starting CBT with introduction of medication if no improvement after 3 months
 c. Starting medication with introduction of CBT if no improvement after 2 months
 d. Starting a combination of both medication and CBT
- Pharmacologic treatment studies for school refusal and anxiety in children and adolescents indicate that escitalopram is superior to other medications. (LO #1)
 a. True b. False
- According to a 2018 study, _____ resulted in earlier improvement (week 2) in childhood anxiety disorders. (LO #3)
 a. Low-dose SNRIs b. High-dose SNRIs c. Low-dose SSRIs d. High-dose SSRIs
- A 2018 study on suicidal thoughts and behavior indicated that more than 50% of freshman college students who reported suicidal ideation at some point then transitioned to a suicide plan, with 25% of the planners attempting suicide. (LO #3)
 a. True b. False

Wilderness Therapy: Dangerous Waste of Money or an Effective Therapeutic Intervention?

Continued from page 5

rules with significant and escalating consequences for breaking them. Tough love appeals to families who are frustrated with difficult adolescent behavior and mistakenly believe it can be stopped with sufficient punishment. However, this tactic is known to be detrimental, and it has spawned several programs that have been investigated or shut down for “consequences” that amounted to child abuse. With poor regulation, particularly in programs outside the US, horror stories abound, including teens being starved, beaten, and forced into dog crates for misbehavior. Parents and providers are right to be worried and need to do their research carefully.

What do we tell parents?

Here's a brief four-point checklist we can share with parents who are considering wilderness therapy for their child:

- Keep expectations realistic. Wilderness therapy may improve overall functioning, but it is no cure for mental illnesses, nor will it help a parent-child relational problem. Some teens don't like the setting, even if the program itself is well-run and nurturing. If the teen hates dirt

and cold and is terrified of wild animals, consider something else.

- Ensure the family can afford the therapy. Many families overextend themselves, thinking it will be a magic bullet.
- Be sure the program is well-researched. Deceptive websites and high-pressure sales tactics abound, so families might want to use an independent consultant who has visited each program, receives no incentive for placement from the programs themselves, and has reports from families and participants about their experiences with recommended programs. These consultants can be found through professional associations like the Independent Educational Consultant Association (<https://iecaonline.com>) or the Independent Therapeutic Consultant Association (<https://therapeuticconsulting.org>).
- Be certain the program uses evidence-based therapeutic approaches. Staff should be qualified in wilderness first aid as well as the therapeutic approach

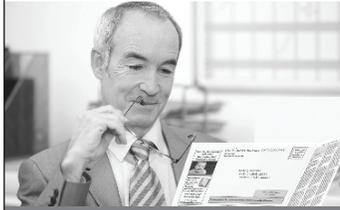
used in the program, and programs should be able to give you a list of staff and their qualifications, as well as a clear philosophy and programming schedule. Expectations regarding family communications should be clear. Many quality programs have a recordkeeping system that allows families to track their child's activities and progress using an electronic portal. The Association for Experiential Education (<https://www.aee.org/standards2>) offers voluntary accreditation with explicit standards for maintaining safe and effective programs. Many programs also participate in ongoing research on outcomes and safety.

**CCPR
VERDICT:**

Good wilderness therapy programs may engage participants productively, although the criteria for who will benefit most and the expected outcomes are unclear. However, bad programs are out there, so families should do their research, understand what they are getting, and know whether they can afford the cost.

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

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

Note From the Editor-in-Chief

For our 2019 issue on anxiety, we spoke with Dr. Moira Rynn at Duke about the concept of anxiety as a pervasive symptom that cuts across diagnostic categories. We are focused on anxiety as a target symptom that happens every day, but what are the data for medication treatment? We have an update on what works. Speaking of everyday anxiety, by this time in the year we are all dealing with kids refusing to go to school—Drs. Amelia Londono Tobon and Wendy Silverman at Yale help us think through this problem. Also, we review the new research on suicidality in college students, which helps us know more about what to look for. Finally, we grapple with a reader's question about wilderness programs. Can we vet them? Should we be recommending them? Hope you like it!

PS: Heard about the article citing increased mortality with high-dose antipsychotics in kids and teens? At *CCPR*, we take a breath and think it through—we plan on issuing a rational response next issue. Until then, look at our new *Child Medication Fact Book for Psychiatric Practice* with practical principles for safe treatment.

Regards, Josh Feder, MD, jfeder@thecarlatreport.com



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