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**Editor-in-Chief**

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#### Learning Objectives

After reading these articles, you should be able to:

1. Describe best practices for treating children and adolescents who have experienced trauma.
2. Clarify the role of qualified interpreters in communicating with patients and families.
3. Engage children, adolescents, and their families using appropriate cultural and gender-specific language.
4. Summarize some of the current findings in the literature regarding psychiatric treatment for children and adolescents.

## Principles of Trauma Informed Care

Rehan Aziz, MD, Associate Professor of Psychiatry and Neurology, Rutgers Robert Wood Johnson Medical School.

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

**T**rauma is common and takes on many forms: abuse, neglect, disaster, displacement, and illness. According to the CDC, at least 1 in 7 children have experienced child abuse or neglect in the past year and, depending on the source, about 1 in 3 to 4 girls and 1 in 5 to 13 boys will experience childhood sexual abuse ([www.cdc.gov/violenceprevention/childabuseandneglect](http://www.cdc.gov/violenceprevention/childabuseandneglect); [www.preventchildabuse.org](http://www.preventchildabuse.org)). In mental health settings, the prevalence of trauma is even greater. Added to the already high frequency of baseline trauma, there is a significant likelihood that any psychiatric patient has a trauma history. Clinicians,

### Highlights From This Issue

Humility and persistent learning are the keystones for respectful care in approaching culture diversity.

Empathic support for transgender and gender-diverse patients is a necessity for managing suicide risk in this population.

Learn how to use interpreters effectively in the course of patient care.

Integrate the principles of trauma informed care into your everyday practice.

then, should approach all patients with this presumption.

Further, the recent COVID-19 pandemic has created fear, displacement,

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Q & A  
With  
the Expert

## Communicating With Patients About Gender

Alex Keuroghlian, MD, MPH

Director, National LGBT Health Education Center at The Fenway Institute; Director, Massachusetts General Hospital Department of Psychiatry Gender Identity Program; Associate Professor, Harvard Medical School

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

### CCPR: Welcome, Dr. Keuroghlian. Please tell us what you do.

**Dr. Keuroghlian:** At The Fenway Institute, I see transgender and gender-diverse (TGD)\* patients in the behavioral health department. We also conduct education, training, technical assistance, and implementation with health systems and programs nationwide. I also direct the Gender Identity Program in the Massachusetts General Hospital Department of Psychiatry. At Harvard Medical School, I help incorporate gender and sexual minority content into all courses and clerkships.

**\*Ed note:** For those unfamiliar with the concept of TGD, it is “an umbrella term used to describe anyone whose gender identity or expression is different from that which was assigned at birth or is expected of them by society.” Dr. Keuroghlian’s advocacy occurs alongside concerns about everything from the natural course of play preferences to long-term side effects of hormone treatment. We welcome comments on this complex topic that engenders research, treatment, and policy.



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Expert Interview—Communicating With Patients About Gender

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**CCPR: Tell us about your research.**

**Dr. Keuroghlian:** We study best practices in caring for TGD patients. Our research found that gender identity conversion efforts are associated with an increase in suicide attempts among TGD people. Exposure to these efforts before age 10 is associated with more than 4 times increased odds of attempting suicide throughout one's lifetime (Turban JL et al, *JAMA Psychiatry* 2019;77(1):1-9). Another recent study shows that access to medication for suppression of puberty among TGD people who desire it is associated with significantly lower odds of lifetime suicidal ideation (Turban JL et al, *Pediatrics* 2020;145(2):e20191725).

**CCPR: There are policy debates about these therapies.**

**Dr. Keuroghlian:** Yes, there is a national movement to ban these conversion therapies related to gender identity and sexual orientation. Massachusetts, Colorado, and Utah passed bans in 2019. We estimate that there are almost 200,000 TGD people in the US who have been exposed to these conversion efforts (Turban JL et al, *Am J Public Health* 2019;109(10):1452-1454). In the fall of 2019, the American Medical Association passed a resolution in favor of a federal ban on conversion.

**CCPR: I understand that some states are limiting doctors' ability to help minors transition to a different gender.**

**Dr. Keuroghlian:** Yes, recent efforts in 15 states would make it criminal to provide what we call "gender-affirming medical care" for minors, or would result in physicians losing their medical license, or would result in parents being reported for child abuse

because they sought such care. There is a lot of confusion among clinicians and the general public. These treatments are considered evidence based and have been incorporated into the AACAP Practice Parameters since at least 2012.

**CCPR: What is our role in this as clinicians?**

**Dr. Keuroghlian:** All TGD people—children, adolescents, and even adults—need to be psychosocially affirmed in their gender identity. Children as young as 3 or 4 can have a clear sense of what their gender identity is. In those cases, the best practice is to follow the child's lead in terms of their gender identification, pronouns, name they choose to go by, and gender expression with regard to clothing.

**CCPR: So we need to ask about it.**

**Dr. Keuroghlian:** All health care practices ought to have at least screening questions related to gender identity. Sometimes a parent or guardian may come in with questions about their young child's gender expression, and in other instances important conversations may start with a clinician asking the child: "Some kids feel like a girl; some kids feel like a boy; some kids feel like something else. What do you feel like? There's no right or wrong answer." Then you could say, "Should I call you she, he, they, or something else?" The child may or may not have a clear answer, and if they don't, that's fine. You're not going to do any damage by asking. It's a perfectly healthy thing for them to think about.

**CCPR: What about parents?**

**Dr. Keuroghlian:** Clinicians can ask parents if they have any thoughts or observations related to the child's gender identity or gender expression. You can say: "I have this conversation with all parents to ensure you have the tools to fully support your child in their gender identity and gender expression." This framing makes it clear that the best practice in terms of parenting and medical care is a gender-affirming approach.

**CCPR: When do you consider medical treatment?**

**"Ask parents if they have any thoughts or observations related to the child's gender identity or gender expression. Say: 'I have this conversation with all parents to ensure you have the tools to fully support your child in their gender identity and gender expression.' This framing makes it clear that the best practice in terms of parenting and medical care is a gender-affirming approach."**

Alex Keuroghlian, MD, MPH

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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.

## Using an Interpreter in Psychiatric Practice

Jess Levy, MD. Child and adolescent psychiatrist, Cleveland Clinic Foundation, OH.

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

According to US census data, 21.9% of the US population speaks a language other than English at home: chiefly Spanish, followed by Chinese (Center for Immigration Studies; [www.tinyurl.com/s5e8s9q](http://www.tinyurl.com/s5e8s9q)). Language barriers impair a child's ability to receive appropriate, timely psychiatric treatment. Given these facts, as clinicians, we often need interpreters in our practices.

Interpreters provide meaning-for-meaning delivery of oral communication. This is different from translators, who provide word-for-word delivery of written communication. Accessing and appropriately utilizing interpreters can be difficult. Interpreters can cost as much as \$150 per hour for in-person services or \$3.50 per minute for video services (Jacobs B et al, *Ann Fam Med* 2018;16(1):70–76), and there are administrative and legal requirements to follow as well. Fortunately, clinicians can take steps to mitigate barriers and serve families.

### Complying with requirements

Providing interpreter services is important for good care and legally required. Section 1557 of the Affordable Care Act (ACA) codified guidelines that healthcare providers must follow to avoid patient discrimination. Every clinic with 15 or more employees must post a statement offering interpretation services in the 15 most common languages seen in the facility. This applies to practices who submit claims to Medicare, Medicaid, and CHIP (Jacobs B et al, 2018). Covered practices must provide accurate and timely, confidential language assistance programs free to patients and staffed by qualified interpreters.

Who is a “qualified interpreter”? According to the ACA's requirements, an interpreter must:

- Adhere to a code of ethics, including patient confidentiality
- Be proficient in English and at least one other spoken language
- Be able to accurately and impartially interpret using any

necessary specialized vocabulary and phraseology (CyraCom Language Solutions; [www.tinyurl.com/y9z7rcad](http://www.tinyurl.com/y9z7rcad))

Section 1557 does not mandate a particular certification or credentialing process. However, the best practice would be to utilize interpreters who have undergone formal training, testing, and certification.

The “qualified interpreter” requirement has important ramifications. Unless there is an emergency and time is of the essence, do not use family or friends to interpret, even when this seems convenient. In particular, do not use bilingual children as interpreters. Patients (and families) may decline interpreter services and want to use an adult family member or friend. However, we strongly recommend counseling families against this option. If you do use a layperson, have a low threshold for bringing in a professional interpreter if you feel that the designated individual cannot accurately interpret. If a layperson's interpretation results in a medical error, the clinician will be held liable.

The ACA also discourages using bilingual physicians or coworkers. Unless a bilingual staff member or clinician meets the above description of a qualified interpreter, they should not interpret for patients. Even if they are qualified, they should only do so if language interpretation is part of their defined job duties.

Finally, despite progress in computer-assisted translation tools such as Google Translate, these technologies should never be used as a replacement for a qualified interpreter except in dire emergencies. One recent study of translated patient instructions found that 2% of the sentences that were translated from English to Spanish using Google Translate contained potentially harmful errors when back-translated using an interpreter (Khoong EC et al, *JAMA Intern Med* 2019;179(4):580–582).

### Understanding interpreter options and controlling costs

Telephonic or video interpreter services are great options for clinicians who have

smaller practices or have few patients who are not proficient in English. Both options have pros and cons. Telephonic interpreter services have a low equipment cost, are easy to use, and offer access to a wider variety of languages than video services. However, this option may not work for patients or families who are hard of hearing, and the interpreter cannot rely on visual cues—which are especially important in pediatric mental health. Video interpreter services preserve those visual cues, but carry a higher technology overhead and must meet certain quality standards (see [www.telehealth.hhs.gov](http://www.telehealth.hhs.gov)), though these standards have been relaxed with the coronavirus pandemic. Staff also need to know how to use the technology and troubleshoot common problems.

Costs of in-person or telephonic interpreters range from about \$1.50 to \$2.50 per minute or up to \$150 per hour. Because of the plethora of services and varying quality, we cannot offer names of specific companies. Check with your local hospital or other big clinics as well as attorneys to find good referrals, and vet them yourself too. State Medicaid and CHIP programs sometimes directly reimburse providers. Check your state's programs to see if such reimbursement exists. Also, CPT codes, such as T1013 or the interactive complexity add-on code, might help.

### Working with interpreters

Professional interpreters are trained in relaying the meaning of your message to the patient and vice versa. You will often be working with an interpreter on sensitive issues (eg, abuse, suicide, or psychosis). Consider talking with the interpreter ahead of time and afterward to ensure accurate communication. Interpreters can often help you understand cultural aspects and help recognize if something is unusual or “off” about the patient's presentation. Encourage the interpreter to access their own emotional supports should this become an issue in the course of their work. When seeing patients with an interpreter, allow 50%–100% longer times. Speak to the patient, not the interpreter. Have family members

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## Using an Interpreter in Psychiatric Practice Continued from page 3

speak one at a time. Do not conduct private conversations in English in front of patients or families, and do not ask the interpreter not to interpret something. For more information, see the “Tips for Using Interpreters” box.

### Counseling families about interpreters

Some families are hesitant to use interpreter services. They may feel their English is adequate enough, underestimate the density of medical jargon, or fail to realize that subtleties of language can impact medical decision making. Some families worry about burdening the health care system, incurring extra costs, or giving up confidentiality. Explore their hesitation and provide reassurance. Emphasize that an interpreter helps you listen better. Inform patients that interpreter services cost them nothing, and that interpreters maintain confidentiality. You may also wish to keep an interpreter available

during the appointment but agree to only use the interpreter if there is something that needs to be clarified. If a patient or family continues to decline interpreter services, then consider terminating care—though consult your legal team before doing so.

**CCPR VERDICT:** Medical errors due to language barriers are considerably more costly than interpreter expenses. Find professional interpreters who can talk about medical and emotional concepts with children and teens. Put policies in place for their use, and avoid using family, friends, and especially children as interpreters. Using interpreters may seem daunting and costly. However, such service is essential for good patient care, prevents discrimination, and in most cases is legally mandated.

### Tips for Using Interpreters

- Clinicians must provide free, timely, and accurate language assistance from a qualified interpreter—not only is this good patient care, it’s the law.
- Telephonic interpreters may be more accessible, cost less, and have more language options; video interpreter services may be more effective in conveying information.
- Learn how to access interpreter services, including the technical aspects.
- Do not use family (especially children) as interpreters or rely on computer-assisted translation tools such as Google Translate. Bilingual staff and clinicians should only interpret if they are specifically trained to do so and if it is part of their job duties.
- Your state may offer funding and reimbursement support to offset the costs of interpreter services.
- Budget more time for appointments when using interpreters, including time to talk with the interpreter before and after the actual clinical interaction.

## Expert Interview—Communicating With Patients About Gender Continued from page 2

**Dr. Keuroghlian:** Once kids hit Tanner Stage II, there’s the possibility of pubertal suppression with gonadotropin hormone-releasing agonists. We found access to these medications is associated with significantly decreased odds of suicidal ideation. The prevalence of lifetime suicide attempts among TGD people in the US is as much as over 40%, which is alarmingly high (2015 US Transgender Survey; [www.ustranssurvey.org](http://www.ustranssurvey.org)). Whether or not youth want or are able to access medical intervention, it’s important to have genuine affirmation at home, at school, and in the surrounding community.

### CCPR: What about “rapid-onset gender dysphoria”?

**Dr. Keuroghlian:** There was a recent study where the researchers asked parents about their children’s gender identity or dysphoria but did not actually ask the children, giving the impression that youth are identifying as TGD only because they’ve heard the idea from peers—a social contagion hypothesis. The overwhelming majority of TGD adolescents continue to identify that way into adulthood. We published research on youth no longer identifying as TGD and subsequently identifying as cisgender. As far as we can tell, this is very rare, and the couple of youth I have met in this group do not regret having identified as TGD. They do not regret starting on gender-affirming hormone therapy, either, and they describe this as an important component of their gender journey (Turban JL and Keuroghlian AS, *J Am Acad Child Adolesc Psychiatry* 2018;57(7):451–453; Turban JL et al, *JAMA Pediatr* 2018;172(10):903–904). Most youth we see who discontinue hormone therapy do so involuntarily, because they can no longer access treatment or do so safely.

### CCPR: Does hormone therapy have risks?

**Dr. Keuroghlian:** From a medical standpoint, gender-affirming hormone therapy is considered low risk. There may be some fat redistribution, some hair changes, some vocal changes, but you weigh that against a 40% lifetime risk of attempting suicide.

### CCPR: Can you comment on gender fluidity in the autism community?

**Dr. Keuroghlian:** The truth is, our field understands very little about this, so people have floated different hypotheses without much supporting evidence. More rigorous studies are needed (Thrower E et al, *J Autism Dev Disord* 2020;50(3):695–706). One hypothesis is that people on the autism spectrum are less preoccupied with social cues and what people think of them, so there is speculation about whether these folks may have more uninhibited expression and exploration of the natural gender diversity that exists among all humans. There are other speculative hypotheses, including one about an inflammatory basis for both autism and gender diversity, related to the reported 4:1 prevalence of autism between boys and girls. The key point is that a gender-affirming clinical approach remains the best practice.

### CCPR: How does autism affect our clinical approach?

**Dr. Keuroghlian:** Take care eliciting the patient’s history of gender identity development and

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present experience to better understand their lived experience. Some of the ways in which clinicians may assume patients will explain their gender identity during the informed consent process may not be the case for all people on the autism spectrum.

**CCPR: About 30 years ago, people were doing MRI studies looking at gender identity and brain structure. Has that research evolved, for instance with fMRI studies?**

**Dr. Keuroghlian:** Those studies were often underpowered and had other methodological flaws, so the jury is out on neurobiological correlates of gender diversity. We need more rigorous studies. That said, scientific research may be unlikely to persuade folks to be more inclusive and gender affirming, so while those are intellectually interesting questions, those studies are not going to address the urgent health needs of TGD people today.

**CCPR: What about parents whose beliefs about gender do not fit their child's experience?**

**Dr. Keuroghlian:** That's the most crucial challenge clinicians face when working with TGD minors. We put incredible energy into family systems work and support groups for parents and guardians of gender-diverse youth. If a child or adolescent is gender diverse and seeking gender-affirming medical care, they can only access it with consent of all legal guardians in the picture. I think this is true in all 50 states. If one parent won't consent, that youth won't receive gender-affirming medical care despite the extremely high risk of a suicide attempt.

**CCPR: So what do you tell parents?**

**Dr. Keuroghlian:** We emphasize that evidence shows TGD children who have strongly supportive families are likely to have mental health outcomes comparable to their cisgender peers, and that they thrive socially, academically, and otherwise in a manner comparable to their peers (Simons L et al, *J Adolesc Health* 2013;53(6):791–793). So strong family support is an incredibly foundational determinant of psychosocial health for TGD people. In our study that came out in January 2020, we showed that even if you control for family support, there is still a difference between being able to access pubertal suppression medication versus an inability to access it (Turban JL et al, *Pediatrics* [in press]).

**CCPR: Do you talk about the risks?**

**Dr. Keuroghlian:** Yes. We tell parents and guardians that their child is at high risk unless affirmed in their gender identity, and that pubertal suppression medication and gender-affirming hormone therapy are low-risk treatments for TGD youth. One approach is to network parents and guardians of TGD youth with folks who seem similar to them and have come around to accepting and affirming their TGD child.

**CCPR: How effective is this approach?**

**Dr. Keuroghlian:** We've seen parents and guardians reluctantly attend support groups with other folks who seemed reasonable to them, go out to dinner with them after the group, and eventually transform and come around to being strong advocates for their kids. If a parent or guardian is showing up with their child and taking the child's gender identity seriously enough to be in the office with you, you're ahead of the game. That's a wonderful opportunity to model gendering the child appropriately, deliver some family education, and refer the parent or guardian to appropriate resources.

**CCPR: What can you tell us about the social impact of stigma?**

**Dr. Keuroghlian:** Gender minority stress and stigma are related to health inequities among TGD youth. TGD people, from early childhood to older adulthood, experience discrimination, victimization, microaggressions, and all too often frank violence at a much higher prevalence than the general population. For some youth, this may adversely impact coping skills and lead them to believe that it's never going to get better and that nobody can be trusted.

**CCPR: Can you say more about stigma's internal effects on a person?**

**Dr. Keuroghlian:** In the minority stress model, external stigma-related stress can contribute to internal stigma-related stress, such as internalized transphobia, expecting rejection because you're so used to it, and identity concealment. Minority stress can be associated with higher prevalence of depressive disorders, anxiety disorders, post-traumatic stress disorder, and substance use disorders as a coping mechanism. Per the minority stress model, stigma is associated with decreased self-care, decreased engagement in health care, and down the road a much higher prevalence of various physical health problems.

**CCPR: What can we do about this in daily practice?**

**Dr. Keuroghlian:** We can develop basic skills related to sensitive and effective communication with TGD youth, which means asking every child in your practice for the name they go by and their pronouns, and honoring these. Make sure every colleague and employee in your practice knows to reflect that self-determined language back for the youth you serve. And understand that you want to affirm a child's gender identity, rather than trying to align it with the sex they were assigned at birth.

**CCPR: What other resources can we access?**

**Dr. Keuroghlian:** Identify local resources socially for TGD youth and clinical referrals for primary pediatric care. It's not necessarily the pediatric endocrinologists who prescribe pubertal suppressants or gender-affirming hormone therapy. Increasingly, primary care practices do it. And engage families in the critical family systems therapy work that needs to happen, because strong family support is a critical determinant of health for these kids. Our National LGBT Health Education Center at [www.lgbthealtheducation.org](http://www.lgbthealtheducation.org) has free webinars and over 80 best practice briefs, including several on caring for TGD youth and on mental health. We have recorded talks from our national Advancing Excellence in Transgender Health conference and offer continuing education credits for these materials. People are welcome to reach out to us with any clinical questions.

**CCPR: Thank you for your time, Dr. Keuroghlian.**

## Principles of Trauma Informed Care

Continued from page 1

economic disaster, and loss, potentially leading to an explosive increase in trauma. Worsening the situation, mental health care services have been impeded by the cessation of in-person visits, potential lack of online access for some patients, and decrease in actual service availability. Minority patients, already at higher risk for traumatic histories owing largely to social and systemic inequities, are suffering far more than others. Patients may also have concerns about discussing sensitive information virtually. All of these factors have increased our patients' vulnerability during this time. The concept of trauma informed care (TIC) offers a framework for understanding and addressing the needs of patients. It promotes developing a culture of safety, empowerment, and healing. This article will offer an overview of TIC and discuss ways to integrate it into your practice.

### Impact of trauma

Trauma creates problems. It produces toxic, chronic stress. This causes sympathetic nervous system activation, resulting in a wide range of physical and psychological symptoms. In childhood, exposure to violence increases the risk of injury, future violence, substance use, STDs, delayed brain development, and lower educational attainment. In adulthood, those with childhood exposures have a significantly higher risk for alcohol, tobacco, and drug use disorders; depression; and suicide attempts. Physically, they have greater chances of developing severe obesity, ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. These findings from the classic studies by Felitti have given way to an entire field focused on adverse childhood experiences, or ACEs (Felitti VJ et al, *Am J Prev Med* 1998;14(4):245–258).

More recent research has defined a wide range of trauma-related problems, including depression, anxiety, post-traumatic stress disorder, and epigenetic changes. These epigenetic changes in genomic activity place the person and their descendants at a higher level of internal arousal and can shorten telomeres, the protective caps at the ends of chromosomes. The result is a lower threshold for reactivity and higher rates

of chronic diseases such as obesity, hypertension, and adult-onset diabetes.

### Resist re-traumatization

Unfortunately, patients can become unintentionally re-traumatized in health care, which may cause them to develop anxiety about treatment, avoid medical care altogether, or mistrust clinical settings. In particular, when a child or teen is subjected to rigid behavioral approaches that fail to begin with empathic efforts to understand their perspective, the patient may become more upset, receiving negative labels such as “oppositional” or “assaultive” rather than helpful care. One example of how this can happen is by using restraints on a child who's been sexually abused. Another is placing a child who's been neglected or abandoned in a seclusion room. In office settings, patients may become re-traumatized when they:

- Don't feel safe and secure
- Feel unseen/unheard
- Feel they don't have any control
- Think that treatment is not collaborative
- Have to continually repeat their story
- Believe their trust has been violated ([www.tinyurl.com/v3fp3pg](http://www.tinyurl.com/v3fp3pg))
- Have no chance to provide feedback

Diagnoses that are symptom based and neglect a trauma history can also be problematic. Treatment may focus exclusively on pharmacotherapy and/or CBT rather than a more appropriate family therapy, trauma-informed psychotherapy,

or child protection role. Research in the field of pediatric bipolar disorder and disruptive mood dysregulation disorder (Parry, 2012) and other diagnostic categories such as ADHD has mostly been based on symptom rating scales. However, these scales miss the role of trauma or fail to consider the adaptive function of symptoms arising from a trauma context, such as fight/flight/freeze/appease reactions that manifest as oppositionality, anxiety, avoidance, dissociation, inattention, and manic-defense excitability.

### Principles of TIC

Employing TIC can reduce the negative impact of assessment and treatment for children and teens who have suffered traumatic experiences. Principles of TIC include:

1. **Safety**—Everyone works to ensure the patient's physical and emotional security.
2. **Choice**—Patients are supported in making choices regarding their care. Self-advocacy skills are developed.
3. **Collaboration**—Clinicians and patients partner to share power and decision making.
4. **Trustworthiness**—Decision making is transparent. Patients are respected and professional boundaries are followed.
5. **Empowerment**—The patient's strengths are recognized and built upon, along with the belief that they can recover from trauma. It's also important to create a culture that allows patients to feel validated and supported (SAMHSA, *Concept of Trauma and Guidance for a Trauma-Informed Approach*, 2014; HHS Pub. No. 14-4884).

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### Tips for Talking: Trauma Informed Care

| Principle       | Example   |
|-----------------|---|
| Safety          | “We want this to be a safe space. Please let me know if you feel uncomfortable at any time, so we can address it right away.”                       |
| Choice          | “Help me understand what you think about medication, therapy, and other treatment choices.” “If you need to end now, that's OK. We can talk later.” |
| Collaboration   | “Let's come up with a plan we can all agree on.”  |
| Trustworthiness | “I will give you my honest opinion, and we should talk about what stays private and what information should be shared.”                             |
| Empowerment     | “It sounds hard, everything you've been through. But people do get better. It'll take work on both our parts.”                                      |



**Cultural Issues in Child and Adolescent Psychiatry**  
**Andres Pumariega, MD**



*Professor and Chief, Division of Child and Adolescent Psychiatry, Department of Psychiatry, University of Florida, Gainesville, FL*

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

**CCPR: Welcome, Dr. Pumariega. Please tell us about your work.**

**Dr. Pumariega:** I have been examining the impact of culture on mental health my entire career. My early work involved clinical practice, literature review, and my own studies to operationalize culturally competent services, leading to the Cultural Competence Standards for Four Racial Ethnic Populations out of the Centers for Mental Health Services in 1999. More recently, my group authored the practice parameter for cultural competence out of the American Academy of Child and Adolescent Psychiatry ([www.tinyurl.com/t3uwza4](http://www.tinyurl.com/t3uwza4); Pumariega AJ et al, *J Am Acad Child Adolesc Psychiatry* 2013;52(10):1101–1115).

**CCPR: Can you outline from your perspective as Chief of Child Psychiatry at University of Florida, Gainesville, the deficits in our knowledge of respectful care in culture and identity?**

**Dr. Pumariega:** Today’s workforce is diverse, with many from immigrant families or underserved minority groups. They’ve been through that process of acculturation. But they don’t connect their personal experience and professional practice. Their experiences are so personal that they have a hard time talking about them.

**CCPR: How does your own experience come into this?**

**Dr. Pumariega:** I was born in Cuba and immigrated at 9 years old. My acculturation process had two stages, growing up in the ethnic enclave of Miami and then after medical school when I left Miami. I saw different populations, learning from patients, families, and their communities. Two things are important: First, humility—not seeing your perspective on values and beliefs as the only one, and not only accepting but also learning from the perspectives of people around you. The second thing is that you need to learn enough about the background of your patients—the population they came from and their personal experience. From here, you make adaptations to care to engage people who are different than you, translating interventions within the context that makes sense to your patients.

**CCPR: Can you give us an example?**

**Dr. Pumariega:** A simple example is separation and individuation. We have 30-year-olds living in their parents’ basement due to socioeconomic change. But in many cultures, the idea of a totally separate individual identity doesn’t even compute. It is a collective identity. In South Asian families, living under their parents’ roof or nearby in their 40s and 50s has been the norm. Immigration has imposed a lot of change to traditional cultures—you now have kids living in the US experiencing physical distance and sometimes emotional distance. Is marriage arranged or something you pursue yourself? Are relationships approved by the family? (Rothe E and Pumariega AJ. *Immigration, Cultural Identity, and Mental Health*. New York: Oxford Press; 2020)

**CCPR: I see that with Middle Eastern populations. Is there a set of general themes we want clinicians to pay attention to?**

**Dr. Pumariega:** Look at cultural norms around emotional expression. In some cultures, emotional expressiveness is very muted. Other cultures are intense, bordering on the high emotional expressiveness side, and perceived erroneously as psychopathology (Pumariega AJ et al, 2013). A classic example of this was the crash of a plane in Long Island that was headed to the Dominican Republic, shortly after 9/11. The scene at the airport in Santo Domingo was pandemonium, with multiple instances of dissociation, but all within culturally normal expressions of grief, close to ataques de nervios (a culture-bound syndrome seen among Caribbean Hispanics and Puerto Ricans, Dominicans, and Cubans). It’s the most emotionally intense scene you ever witnessed. Other people might just put on black, have quiet tearfulness and sadness, but not be so voluble.

**CCPR: Right, we do not want to over-pathologize culturally typical emotional expressions and contribute to the mistrust of health care providers by minority populations. This reminds me of my Indonesian colleague whose emotional expression is very subtle, and contrasts with my very vocal Hungarian family members.**

**Dr. Pumariega:** You need to know the normative emotional expression of someone’s cultural background as well as the stressors they’re dealing with, including immigration, acculturation, and the trauma of those transitions. Also, learn the strengths they bring, such as unique positive cultural values that reinforce resilience, normative defenses, and coping skills like humor or intellectualization. Have some familiarity and be able to identify those in people you serve.

**CCPR: What about the stigma of mental illness?**

**Dr. Pumariega:** US culture suffers from stigma around mental illness—our biopsychosocial model is not the norm. However, in some cultures, mental illness has a spiritual element or an interpersonal and spiritual element, like ascribing it to somebody putting a hex on the affected person. Or in some cases, mental illness is so shameful that you certainly wouldn’t share it with family or with people close to you, or even wouldn’t be able to marry as a result. In many minority communities in the US, it’s something that people are guarded about. For example, African Americans have been oppressed for centuries and don’t want the added burden of mental illness. It leads to double discrimination (Pumariega AJ et al, 2013).

Continued on page 8

**CCPR:** We have Latino families told to be structured in how they interact with their autistic kids, but that isn't how they relate to their kids. And we've got families from Japan who politely cancel services after people visit their home and leave their shoes on, which is a serious cultural taboo.

**Dr. Pumariega:** Exactly. We have to adapt our methods.

**CCPR:** How can clinicians organize their approach to culture?

**Dr. Pumariega:** I see two levels of learning that are important. First, read up on the typical presentations of mental illness, traditions, and normative expressions for that group. You won't know everything, but due diligence is important. Use reading materials, colleagues or friends, and cultural consultants—fellow professionals or somebody in the community that you trust. A helpful reference is a textbook titled *Ethnicity and Family Therapy*, Third Edition (McGoldrick M, Giordano J, and Garcia-Preto N, eds. New York: Guilford Press; 1996). Second, remember that cultures are not stereotypes—each person lives their culture differently, so listen for that in the clinical encounter. Ask how they experience key aspects of the culture that may bear on the interpretation and expression of the clinical problem.

**Ed note:** *In San Diego, we are doing research on using promotoras, cultural brokers who are trusted community members with experience in the treating system, to bridge the connection between patient/family and provider, foster trust, and provide bidirectional understanding.*

**CCPR:** So would it be appropriate to say something like, “So, my understanding is that families from where you come from tend to make decisions together, rather than expecting individuals to make their own decisions. Is that how it works in your family?”

**Dr. Pumariega:** Yes, either in the family they grew up with or in their current family now. There's a wonderful book from the 1970s by a former president of the American Psychiatric Association, John Spiegel, called *Transactions*. He looked at the impact of premature assimilation on European immigrants. Spiegel pointed out how this made for conflict in marital and work relationships when value systems clashed between couples from different backgrounds, though they had submerged their identities of origin. It includes beautiful case examples, all about diversity for folks of European origin (Spiegel J. *Transactions: The Interplay Between Individual, Family, and Society*. Science House; 1983).

**CCPR:** We have microcultures in San Diego, including a surfer beach community, an inland community that is agricultural, and several others. And then there's the wide variety of infant rearing practices—some where parents avoid looking at their infants, others where children are carried on the backs of their parents for about 18 months.

**Dr. Pumariega:** Modes of interaction have a history in the rate of survival of infants for different populations, and so it has shaped infant-parent interaction. Parents from populations who had high historic infant mortality rates have traditionally avoided making the emotional investment for fear of painful loss.

**CCPR:** What does the research in this area look like?

**Dr. Pumariega:** There are randomized controlled trials of culturally adapted interventions for particular populations, and a number that relate to language and communication of emotions. There's also a new line of neurobiological research, looking at neural representations of theory of mind that relate to culture. One study looked at Chinese college students in China, Chinese American college students, and then Chinese students who came to the US and stayed on and assimilated here. They looked at how the brain lit up when students thought about themselves and their mothers. The Western-raised, multigenerational Chinese American students lit up one area for themselves and a different one for their mother. The Chinese students in China had only one area of the brain that lit up when they thought of themselves or of their mother. When those Chinese students come over to the US and assimilate, it becomes like the pattern of those raised in the US (Pumariega AJ and Joshi SV, *Child Adolesc Psychiatr Clin N Am* 2010;19(4):661–680).

**CCPR:** Can you give me an example of a culturally adapted intervention that might come up in everyday practice?

**Dr. Pumariega:** Psychologists in Puerto Rico adapted a CBT manual for depression for youth. This is the same manualized therapy, with fidelity to what the original intervention is supposed to do, but they used more interpersonal concepts and conceptualized more of the examples within family interactions or peer interactions. And they changed idiomatic expressions, even using folk sayings that were different. Instead of “You can please some of the people some of the time, but you can't please all of the people all of the time,” the Puerto Ricans say “I'm not a hundred-dollar bill,” which means “I can't make everybody happy.” And the coping skills they teach fit the culture. For example, they emphasize humor over intellectualization.

**CCPR:** Do you have any other examples of interventions?

**Dr. Pumariega:** Yes, brief strategic family therapy (BSFT), which is a NIDA-supported, evidence-based intervention for adolescent substance use. It was developed at University of Miami to work with Latino kids on parent-child acculturation differences, such as when traditional parents are in conflict with their kids who are learning the language, customs, and peer culture. Kids want independence from their parents, who are then reacting to this, so the focus of family therapy is the

Continued on page 9

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**“One way for clinicians to organize their approach to culture is to read up on the typical presentations of mental illness, traditions, and normative expressions for that group. Also, remember that cultures are not stereotypes—each person lives their culture differently, so listen for that in the clinical encounter.”**

Andres Pumariega, MD

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## Expert Interview—Cultural Issues in Child and Adolescent Psychiatry

Continued from page 8

generational cultural divide and bridging both ways. BSFT is supposed to be culturally specific but is very translatable; it also works with African American kids and Caucasian kids (Santisteban D et al, *J Comm Psych* 1997;25:453–471).

**CCPR: That's really interesting.**

**Dr. Pumariega:** Another example involves yoga-based meditation therapies. That's about as traditional as you get, as the literature in Sanskrit goes back a couple of thousand years.

**CCPR: We have a backlash among some families worried that yoga is connected with a foreign, alien religion.**

**Dr. Pumariega:** Right. They see yoga subverting what they've taught their kids, the values that their culture or religion teaches. Sometimes you have to not only adapt the approach, but also bridge the explanatory model of how the therapy works back to their belief system.

**CCPR: This thinking generalizes to other situations. Some people don't accept psychosis treatment, or they don't believe in Western medicine—or gender transition.**

**Dr. Pumariega:** Many traditional cultures don't deal with gay, lesbian, or transgender identities very well and have incredible bias and stigma, which sometimes leads to incredible alienation between youth and their families in the midst of acculturation. That takes so much more bridging work—minority LGBT kids have some of the highest risk for suicide because of that disconnection (Hatzenbuehler ML et al, *Pediatr Clin North Am* 2016;63(6):985–997).

**CCPR: What about native peoples?**

**Dr. Pumariega:** Be open to using traditional healing methods. This is not incompatible with pharmacotherapy, and there are psychological interventions that utilize native rituals for native youth. Many Indian Health Service psychiatric units have ceremony rooms. Pedro Ruiz, former president of the American Psychiatric Association, the World Psychiatric Association, and many others, started out practicing in New York City. He recognized that many Latino patients were being siphoned off from his partial hospital program by folk healers meeting in church basements practicing Santería rituals (Afro-Cuban or Afro-Caribbean religion). Pedro visited the healers and invited them to collaborate with him on cross-referral, with mutual participation in their respective programs, asking for their support with medication—combining forces.

**CCPR: Any final thoughts?**

**Dr. Pumariega:** Culture matters in mental health. It's not mysterious. If we stay humble, check our biases, learn about the culture and some adaptations in how we talk to the patient and relate to their belief system, we can be particularly effective.

**CCPR: Thank you for your time, Dr. Pumariega.**



## Principles of Trauma Informed Care

Continued from page 6

### Asking about trauma

Pay attention to the setting—is the child comfortable? Helping the child to be regulated is key to connecting adequately and then communicating effectively to get a history about difficult moments. If possible, it is important to minimize the number of interviews, as asking the child over and over about their experiences can be traumatizing for the child (and the interviewer) and lead to the child simply giving rote recitations, which may be less accurate. Where appropriate, have parents help soothe the child. Although you need to obtain a lot of information—the who, what, where, when, and how—try to avoid interrogating the child. Instead of question formats, try calm, gentle statements: reflecting your need for help vs commanding the child to provide information. When the child seems uncomfortable, back off and talk about other things for a bit. Be careful to neither lead the child nor allow yourself or a parent to answer for the child.

When employing the TIC framework, don't press patients to describe

their history in emotionally exhausting detail. While technique modifications may be needed in the age of online therapy, younger children often find it easier to express aspects of their trauma histories through play, and a consulting room with adequate play space and materials such as doll houses and sand trays with figurines can allow for enactment and catharsis of attachment trauma experiences. The clinician can gently interpret, narrate, or inquire about the child's play, and the child may then verbalize their experiences and feelings. Sometimes, using paper-and-pencil instruments or self-report tools for screening and assessment is less threatening and allows patients to pace themselves in relating their story. Talk about how you'll use the findings to plan treatment. Discuss any immediate action necessary, like arranging for personal support, referring to community agencies, or proceeding straight to the active phase of care. Solicit feedback and comments from the patient. At the end of the session, make sure the patient is safe before

leaving (SAMHSA, *Trauma-Informed Care in Behavioral Health Services*, 2014; HHS Pub. No. 13-4801).

### What do we tell parents and families?

We recommend reinforcing your treatment goals to family members using a statement like this: "Your child needs to feel safe in order for us to treat her effectively. We need to recognize that her symptoms may be at least partly due to the difficult situation she's experienced. Control and trust were taken away from her, and it's important we work together to help her build back her trust and sense of control."

**CCPR VERDICT:** The impact of trauma is ubiquitous in everyday clinical practice and is often hiding beneath the surface.

Our practice needs to reflect this reality. Using TIC avoids re-traumatization and helps to provide security and safety for patients, while keeping them engaged in treatment. TIC should be a part of every clinical encounter.

Research Updates  
IN PSYCHIATRY

AUTISM

**Does Prozac Treat Repetitive and Stereotypical Behaviors in Children With Autism?**

**REVIEW OF:** Reddihough DS et al, *JAMA* 2019;322(16):1561–1569

Restrictive, repetitive, and stereotypical behaviors in children and adolescents with autism spectrum disorder (ASD) are a common concern, and there are no FDA-approved medications for their treatment. We know that fluoxetine is effective in the treatment of obsessive-compulsive disorder in children and adolescents (Geller DA et al, *Am J Psychiatry* 2003;160(11):1919–1928), and even though our best understanding is that this phenomenon is different from OCD, it is nevertheless common for clinicians to try to treat symptoms that seem similar. Given that, would fluoxetine help these OCD-like symptoms in ASD patients? This study focused on this question.

The authors used a randomized, placebo-controlled design and enrolled children and adolescents with a history of ASD and a score of more than 5 on the CYBOCS-PDD scale (Children’s YBOCS modified for PDD). Seventy-five participants aged 7.5 to 18 years received fluoxetine, while 71 age-matched patients received placebo. The dose of fluoxetine was titrated over 3 weeks to a maximum of 20–30 mg (depending on weight) and continued for a total of 16 weeks. Dosage was kept on the lower side to avoid behavioral activation in this vulnerable population. Over 40% of participants in both groups experienced adverse effects, but more patients dropped out in the fluoxetine group than the placebo one (41% vs 30%).

While some individuals seemed to benefit, due to the high variability of the group outcomes, neither fluoxetine nor placebo led to significant symptom reduction, with no additional clarity when factors such as gender and baseline CYBOCS-PDD scores were controlled. No differences were noted in secondary outcomes either (eg, CGI scores).

**CCPR’S TAKE**

Based on this fairly small study, we have no research to be confident that low dosages of fluoxetine will reliably treat perseveration in ASD. Fluoxetine and other SSRIs have a similarly unproven role in treating anxiety and depression in autism, which—as is often the case in ASD—leaves us guessing, trying, and watching for side effects such as behavioral activation.

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

SUICIDE

**Update: Is Watching 13 Reasons Why Bad for Teens?**

**REVIEW OF:** Bridge JA et al, *J Am Acad Child Adolesc Psychiatry* 2020;59(2):236–243

Netflix’s *13 Reasons Why* (13RW) continues to generate controversy that it may do more harm than good amid the backdrop of an already increasing teen suicide rate, and CCPR has been watching the unfolding research (see Mar/Apr 2019 and Sept/Oct 2019 issues). Last time, we reported an increased suicide rate in 10- to 19-year-old females during the 3 months following the show’s 2017 premiere (Niederkrötenhaler T et al, *JAMA Psychiatry* 2019;76(9):933–940). Let’s look at a second, similarly designed study.

Investigators examined CDC-collected suicide and homicide data before and after the show’s release in April 2017. Data were assessed across 5 years (2013–2017) and these age groups: 10–17 years, 18–29 years, and 30–64 years.

Among the show’s target audience (ages 10–17), suicide counts were 28.9% higher than expected in the first month following the series premiere. No excess suicide mortality was found in other age groups or in the control outcome, homicide counts. Overall, there were an additional 195 suicide deaths among 10- to 17-year-olds in the 9 months following the premiere. Suicides beyond expected rates were higher in boys than in girls. (Of note, season 1 depicts a male

adolescent character making a serious suicide attempt.) Further, the authors used data showing suicide completion; adolescent girls are 3 times more likely to attempt suicide than boys, but boys are 4 times more likely to complete suicide.

We now have two epidemiological studies that found associations between the release of 13RW and increased youth suicides: one finding a higher rate in girls, the other finding a higher rate in boys. Each study supports potential suicide contagion by media, at least for season 1, based on timing and age specificity. Netflix has since taken measures to try to reduce risk such as adding content warnings, removing the season 1 suicide scene, and publishing an online toolkit for clinicians, parents, youth, educators, and media professionals ([www.13reasonswhytoolkit.org](http://www.13reasonswhytoolkit.org)). The toolkit summarizes research outcomes from 13RW, counsels that at-risk youth should not watch the series, and cautions against teen binge-watching. It also recommends that if teens watch the show, they should do so with a parent or trusted adult and engage in discussions around viewing risk and how to recognize and seek help for negative reactions, if they occur. This is crucial given the recent release of the series’ fourth and final season.

**CCPR’S TAKE**

Based on growing research, it seems apparent that 13RW is problematic for at-risk youths. As mental health providers, we need to be aware of this association and provide psychoeducation to youth and families. Our role includes urging parental engagement and advocating for treatment for at-risk youth, while admonishing the media to value life over profits. Criticism from mental health providers about the show’s content and associated risk led to Netflix’s changes, demonstrating the impact of our collective voices. This situation warrants continued surveillance on suicide rates in association with viewing the series, particularly as the final season was just released in June 2020.

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

## CME Post-Test

To earn CME or CE credit, log on to [www.TheCarlatReport.com](http://www.TheCarlatReport.com) to take the post-test. You will be given 2 attempts to pass the test. You must answer 75% of the questions correctly to earn credit. Tests must be completed within a year from each issue's publication date.

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1. To ensure the physical and emotional security of children and teens who have been exposed to trauma, principles of trauma informed care (TIC) include: (LO #1)
 

|   |  |
|---|--|
| <input type="checkbox"/> a. Empowerment and safety  | <input type="checkbox"/> c. Diagnosis and collaboration    |
| <input type="checkbox"/> b. Choice and goal setting | <input type="checkbox"/> d. Trustworthiness and boundaries |
2. Computer-assisted translation technologies are accurate tools that can be used interchangeably in place of qualified interpreters. (LO #2)
 

|                                  |                                   |
|----------------------------------|-----------------------------------|
| <input type="checkbox"/> a. True | <input type="checkbox"/> b. False |
|----------------------------------|-----------------------------------|
3. According to Dr. Keuroghlian, what is the relationship between gender identity conversion efforts before age 10 and attempted suicides in transgender and gender-diverse people? (LO #3)
 

|   |
|---|
| <input type="checkbox"/> a. No relationship between gender identity conversion efforts before age 10 and attempted suicides |
| <input type="checkbox"/> b. More than twice the odds of attempting suicide between ages 10 and 15                           |
| <input type="checkbox"/> c. More than 4 times increased odds of attempting suicide throughout one's lifetime                |
| <input type="checkbox"/> d. More than 8 times increased odds of attempting suicide throughout one's lifetime                |
4. In a 2019 study, what effect did fluoxetine have on OCD-like symptoms in patients with autism spectrum disorder (ASD)? (LO #4)
 

|   |
|---|
| <input type="checkbox"/> a. Slight symptom reduction but 20% increased agitation in patients taking low-dose fluoxetine       |
| <input type="checkbox"/> b. Significant symptom reduction but 75% increased agitation in patients taking high-dose fluoxetine |
| <input type="checkbox"/> c. Slight symptom reduction and improved CGI scores in patients taking fluoxetine                    |
| <input type="checkbox"/> d. No significant symptom reduction in patients taking low-dose fluoxetine                           |
5. Exposure to violence in childhood increases the risk of \_\_\_\_\_ (LO #1).
 

|   |   |
|---|---|
| <input type="checkbox"/> a. Substance use and obsessive-compulsive disorder | <input type="checkbox"/> c. Attention deficit disorder and substance use  |
| <input type="checkbox"/> b. Future violence and attention deficit disorder  | <input type="checkbox"/> d. Delayed brain development and future violence |
6. In order to comply with the Affordable Care Act, a "qualified interpreter" must meet the following language requirements: (LO #2)
 

|   |   |
|---|---|
| <input type="checkbox"/> a. Fluency in English and one other language | <input type="checkbox"/> c. Proficiency in English and at least one other spoken language |
| <input type="checkbox"/> b. Proficiency in any two spoken languages   | <input type="checkbox"/> d. English fluency and a master's degree in one other language   |
7. Which of the following statements is true about parents/legal guardians and transgender and gender-diverse children? (LO #3)
 

|   |
|---|
| <input type="checkbox"/> a. Gender-diverse youth can access gender-affirming medical care without the consent of a legal guardian                                       |
| <input type="checkbox"/> b. Parents/legal guardians are more likely to emphasize the high risks of gender-affirming hormone therapy when discussing it with their child |
| <input type="checkbox"/> c. Children with gender dysphoria who have supportive parents/legal guardians are more likely to identify as cisgender as older teens          |
| <input type="checkbox"/> d. Transgender and gender-diverse children with supportive families are more likely to thrive socially and academically                        |
8. Using language with your patient such as, "As you continue to talk through this and work on your plan, you will be taking the steps to get better." reflects which principle of trauma informed care? (LO #1)
 

|                                    |  |                                    |   |
|------------------------------------|--|------------------------------------|---|
| <input type="checkbox"/> a. Choice | <input type="checkbox"/> b. Transparency | <input type="checkbox"/> c. Safety | <input type="checkbox"/> d. Empowerment |
|------------------------------------|--|------------------------------------|---|
9. A limitation in a 2019 study on fluoxetine for children and adolescents with ASD included which of the following? (LO #4)
 

|  |
|--|
| <input type="checkbox"/> a. There was a high dropout rate in the fluoxetine group compared to the placebo group  |
| <input type="checkbox"/> b. Some of the sample group participants had comorbid diagnoses                         |
| <input type="checkbox"/> c. High-dose fluoxetine in sample group could have contributed to behavioral activation |
| <input type="checkbox"/> d. The study excluded adolescents between ages 15 and 18                                |
10. What percentage of the US population speaks a language other than English at home? (LO #2)
 

|                                   |                                     |                                     |                                     |
|-----------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> a. 5%–9% | <input type="checkbox"/> b. 10%–15% | <input type="checkbox"/> c. 18%–23% | <input type="checkbox"/> d. 24%–29% |
|-----------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
11. Suicide counts were 28.9% higher than expected in the first month following the series premiere of the Netflix show *13 Reasons Why* in April 2017. Which recommendation was advised in a corresponding online toolkit to address suicide risk? (LO #4)
 

|   |
|---|
| <input type="checkbox"/> a. Teens should binge-watch all four seasons to put the series in context  |
| <input type="checkbox"/> b. At-risk youth should not watch the series                               |
| <input type="checkbox"/> c. At-risk teen boys should avoid the fourth season, released in June 2020 |
| <input type="checkbox"/> d. At-risk boys and girls ages 10–17 should avoid the first season         |
12. Children may become re-traumatized if they have experienced past neglect and are left alone in a treatment setting, or if they must continually repeat their traumatic event or story. (LO #1)
 

|                                  |                                   |
|----------------------------------|-----------------------------------|
| <input type="checkbox"/> a. True | <input type="checkbox"/> b. False |
|----------------------------------|-----------------------------------|

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**Identity & Culture in  
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## Note From the Editor-in-Chief

As we head back into our homes in the midst of bungled reopenings and anguished protests, we at CCPR are striving to more consciously address social determinants and inequities. In this long-planned issue on culture, we talk about approaches to understanding cultural diversity in our everyday practice, the risks and care related to our transgender and gender-diverse patients, trauma informed care, and the wise use of interpreters. We also have research updates on the vagaries of SSRIs in autistic perseveration, and an update on suicide risk with *13 Reasons Why*. We hear the calls for better equity, and we are working to incorporate into our articles an analysis of how our work reflects efforts to improve access to good care for all of our families. Listen to our podcasts, and please give us feedback.



Regards,  
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