

# THE CARLAT REPORT

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**Editor-in-Chief**

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### IN THIS ISSUE

#### Mood Disorders in Children and Adolescents

Our Role In Community Disasters	— 1
Expert Q&A	— 1
Martha J. Ignaszewski, MD Glen Spielmans, PhD Duty to Warn? Debating Antidepressant Suicidality	
What Do We Do About Dyslexia?	— 3
Tables:	
• The Eight Psychological First Aid (PFA) Core Actions	— 6
• Video Gaming Assessment Checklist	— 8
Expert Q&A	— 7
Joseph B. Dilley, PhD Managing Video Gaming in Children and Teens	
Research Updates:	— 9
• Oral Contraceptive Users and Depressive Symptoms	
• Vitamin D for ADHD?	
• Which Medications Have the Lowest Risk of Side Effects?	
CME Test	— 11
Note From the Editor-in-Chief	— 12

#### Learning Objectives

After reading these articles, you should be able to:

1. Identify ways for clinicians to talk with youth patients and families about the risks of suicidality related to antidepressant treatment.
2. Discuss steps that clinicians can take to positively impact individuals and their communities in response to disasters.
3. Evaluate the effect of factors such as video gaming and dyslexia on mood dysregulation in children and adolescents.
4. Summarize some of the findings in the literature regarding addiction treatment.

## Our Role in Community Disasters

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.

**A** wildfire has broken out near your clinic and is racing through a local neighborhood. Evacuations are underway and thousands are crowding the roads. Reports of several deaths follow shortly and the local Red Cross needs assistance. You want to help out. But how?

School shootings, storms and fires, pandemic, civil unrest—we are faced with unprecedented community suffering outside of what we usually encounter in our practices. This article covers potential roles for assisting your community.

#### How communities respond to trauma

Whole communities can be subject to acute, chronic, and cumulative trauma.

#### Highlights From This Issue

Despite the downplaying of suicidality with antidepressants, it is a real if uncommon risk and must be included in informed consent with families.

With the current pandemic and natural disasters on the forefront, we guide you through ways to help when disasters strike.

Dr. Dilley helps us unpack the practical dynamics to consider when addressing video gaming problems.

Clinicians need to know how to guide treatment to ensure that underlying dyslexia is addressed.

Similar to individuals, communities have distinct risk factors and protective factors, including economic opportunities,

Continued on page 5

Q&A  
With  
the Expert

## Duty to Warn? Debating Antidepressant Suicidality Martha J. Ignaszewski, MD Glen Spielmans, PhD

Martha J. Ignaszewski, MD, fellow, University of California, San Francisco. Glen Spielmans, PhD, Professor of Psychology, Metropolitan State University, St. Paul, MN

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

**CCPR:** We are here with Dr. Ignaszewski and Dr. Spielmans to review the latest on emergent suicidality in children and adolescents during antidepressant treatment. Dr. Spielmans, please give us the context of this issue and how your recent article fits in (Spielmans GI, Spence-Sing T, and Parry P, *Front Psychiatry* 2020;11:18).

**Dr. Spielmans:** In 2004, the FDA required a black box warning for antidepressants, which said that antidepressants lead to a higher risk of suicidality than placebo among children and adolescents. The warning was updated in 2006 to include young adult patients (up to age 24). Shortly after that, some researchers reported that this warning had a bad outcome—namely, that it resulted in fewer antidepressant prescriptions

Continued on page 2



## Expert Interview—Duty to Warn? Debating Antidepressant Suicidality

Continued from page 1

for kids and adolescents and increasing suicide rates in youth. This became accepted wisdom. But in our paper, we reviewed the research and concluded that the original black box warning should not be merely dismissed.

### **CCPR: Can you describe your paper's methodology and what you found?**

**Dr. Spielmans:** Yes, we did a selective literature review of papers from 1990 to 2018. We found a large increase in the number of antidepressants prescribed from the 1990s up to 2004. After the black box warning in the US in 2004, this decreased slightly for a while, but returned to the previous rates by 2009 and has continued to rise. Meanwhile, the US suicide rate in teens has been rising over the past decade. We also found that at the time of the US warning in 2004, the prescribing rate plummeted in the UK but there was no increase in suicides. For some reason, less antidepressant prescribing was related to somewhat higher rates of suicide in the US, but not in the UK.

### **CCPR: What do you think accounts for the difference in the two countries?**

**Dr. Spielmans:** When we looked at the US research, we concluded that some research cherry-picked certain years. For example, a very influential paper in

2007 by Robert Gibbons and his team looked at one particular year (2003–2004), and reported that there was a decrease in antidepressant prescriptions and an increase in suicides during that time frame (Gibbons RD et al, *Am J Psychiatry* 2007;164(9):1356–1363). But every year there will be fluctuations or blips in the data: more or fewer suicides, more or fewer antidepressant prescriptions. Therefore, accurately studying these trends requires a time series of several years of data.

### **CCPR: What other problems with the research did you identify?**

**Dr. Spielmans:** Another paper from the Gibbons team analyzed the clinical trials of Prozac (fluoxetine) and claimed that these studies showed no increase in suicide risk due to this antidepressant. But the measure of suicide risk used one item from the Children's Depression Rating Scale (CDRS) (Gibbons RD et al, *Arch Gen Psychiatry* 2012;69(6):580–587). The FDA and even GlaxoSmithKline say that's not a good measure of suicide risk (<https://pubmed.ncbi.nlm.nih.gov/16553530>; [www.tinyurl.com/yx8hjcsk](http://www.tinyurl.com/yx8hjcsk)). Another SSRI, Paxil (paroxetine), has in fact been associated with increased risk—several papers have reported higher rates of suicidality, with one study showing 3.4% vs placebo at 0.9%.

### **CCPR: What about kids with severe depression? Do they benefit more from antidepressants?**

**Dr. Spielmans:** That's an important distinction. In the US, antidepressant prescriptions were reduced among kids with milder depression, but not among severely depressed kids (<https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700089>), so we don't know if decreased use of antidepressants leads to increased suicidality in this population.

### **CCPR: The data you just described were from 10 or more years ago. What have we seen since then?**

**Dr. Spielmans:** Over the time period 2004–2016, self-reported rates of suicide attempts and self-reported rates of antidepressant prescription among adolescents in the US were highly correlated ( $r = 0.83$ ; [www.tinyurl.com/yyqpeuwg](http://www.tinyurl.com/yyqpeuwg)). However, I think it's unwise to draw conclusions based on those data. There are all sorts of variables that influence suicide, like unemployment and drug use (by the kids or by their parents). Parental military deployments can influence suicide rates too. The best way to examine whether antidepressants cause suicide in some cases is to look at controlled trials rather than time-series observational studies. That said, a time series that looks at trends over many years is more valuable than one that uses a short time period.

**“When I am talking to patients and families, I try to differentiate normal sadness from pathological depression by focusing on functional impairment. I look for a major departure from what their life has been like, their activities and their overall developmental trajectory, perhaps no longer going to school. Medication can be indicated in these situations to get things back on track.”**

Martha J. Ignaszewski, MD

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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.

Continued on page 4

## What Do We Do About Dyslexia?

*Fagie Mandel, M.Ed. Adjunct Professor, Kean University Graduate School of Education. IDA certified Structured Literacy and Dyslexia Specialist, NJ.*

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

**J**ack, age 9, is referred by his pediatrician for depression. He says that reading is “really hard” and that the kids in class make fun of him. When Jack submits drawings at school, they are quite detailed but the captions are difficult to read because the spelling is so poor. Jack’s teachers and parents feel that he just needs to work harder. However, Jack states that when he thinks about school—whether in person or virtual—he becomes sick to his stomach and is overcome with feelings of desperation. Jack’s father had similar difficulties that still persist, and his mother’s history is notable for use of SSRIs during her pregnancy with Jack.

Dyslexia is a specific type of learning and reading disability of neurological origin. According to the Yale Center for Dyslexia and Creativity, one in five people in the US have dyslexia, with presentations from mild to extreme ([www.dyslexia.yale.edu](http://www.dyslexia.yale.edu)). Dyslexia is highly heritable (50%–70%) and affects about 5%–10% of children (Hendren RL et al, *Front Psychiatry* 2018;9:101). Although it may present with otherwise strong cognitive function, dyslexia often co-occurs with ADHD, conduct disorders, anxiety disorders, and depressive disorders (Hendren et al, 2018). The DSM-5 does not provide specific criteria for diagnosing dyslexia. In this article, we help you understand what dyslexia is and give you tips for how to help children in your practice with this learning disorder.

### What is dyslexia?

Most people with dyslexia have phonological awareness problems or rapid naming deficit, found on psychoeducational or neuropsychological testing. Phonological awareness problems make it hard to sound out words when reading or spelling. Rapid naming deficit refers to difficulty responding quickly with information even when the person knows it—the “tip of my tongue” experience. People with this type of dyslexia will know the name of an object but not

be able to call it up fast enough to keep up in conversation. Rapid naming deficit also interferes with how smoothly the person can read (reading fluency), which also impairs reading comprehension. The combination of both phonological and rapid naming deficit is called a dual deficit.

### Treating dyslexia

Dyslexia is the most common reason for reading and spelling problems in school-aged children. The gold standard treatment for dyslexia is *structured literacy*. These programs teach phonics skills, which are spelling and reading rules that avoid rote memorization. For example, in the words angel and angle, instead of memorizing which word has the soft G sound and which has the hard G sound, a structured literacy program teaches that the letter G makes the sound /j/ when followed by an E, but that it makes the sound /g/ when followed by a consonant. Programs that promote memorization of whole words have been shown to be ineffective (Shaywitz SE. *Overcoming Dyslexia: A New and Complete Science-Based Program for Reading Problems at Any Level*. New York: A.A. Knopf; 2012). (For more information on reading programs, see *CCPR* Jan/Feb/Mar 2020.)

In addition to structured literacy, research supports addressing the core deficits of dyslexia through phonological awareness activities, including games that involve rhyming, syllable tracking, and counting sounds such as in-rhythm games (Shaywitz, 2012). The IDA website ([www.dyslexiaida.org](http://www.dyslexiaida.org)) is a good place to start when referring patients for dyslexia treatment; it lists practitioners in each state along with the services they provide.

### Working with families

Dyslexia can be confusing to family members because children with dyslexia are often intelligent, articulate, and talented, yet their reading and writing performance does not match their other skills. This paradox is sometimes difficult for the child to reconcile. They are often told, “Try harder,” “Stop being lazy,” or, “If you only cared as much about reading as you do about your other interests, you would be fine.” Therefore, it is important for parents to recognize that children want to do well and are trying their best. Parents should be encouraged to

create positive literacy environments—for example, allowing the child to pick a book that is of high interest even if it might be below their grade level, then reading it together and talking about the content.

You can be a powerful advocate for your patients. Document the condition and help families seek 504 accommodations or Individualized Education Plan (IEP) services at school. Federal IDEA legislation and most states have laws that support children with dyslexia ([www.tinyurl.com/y2gzacpl](http://www.tinyurl.com/y2gzacpl)). Schools can provide children with research-based reading instruction in phonics. Text-to-speech technology can also be provided when working independently so that the child does not fall behind in comprehension and content knowledge. Also be mindful of situations that can elicit shame. Parents should insist that teachers only call on their child to read aloud or write in front of the class after checking with the child privately. Finally, encourage parents to advocate for their child to have opportunities to showcase strengths, both in and out of the classroom, that reinforce what they feel like they’re good at to build confidence and self-esteem.

*You recommend that Jack’s parents advocate for a structured literacy program at school and that they take time to encourage Jack and read books with him that he finds fun and interesting. You hold off on medication with the caveat that if these measures are ineffective, you will revisit the issue down the line. Three months later, Jack is back in the office and appears a lot happier. The structured literacy program and parental attention have helped him make substantive progress. You will see him in another three months to check in.*

**CCPR VERDICT:** Reading difficulties are common and occur across all levels of intelligence and talent. Poor reading and writing experiences often result in depressive symptoms and low self-esteem. If we focus only on comorbid symptoms without looking through the lens of dyslexia, we miss the root of the problem. Families should be encouraged to create nurturing reading environments and to seek a structured literacy phonics program.

**CCPR:** Dr. Ignaszewski, your paper looked at a decade of data and found no increased suicidality with antidepressant treatment (Ignaszewski MJ and Waslick BD, *J Child Adolesc Psychopharmacol* 2018;28(10):668–675).

**Dr. Ignaszewski:** Our paper initially was conceived as providing an update on the effectiveness of new antidepressants for treatment of pediatric depression over the last decade. As we were going through the papers, we noticed that there was a shift in methodological assessment for treatment-emergent suicide. Namely, newer research was systematically utilizing the Columbia-Suicide Severity Rating Scale (C-SSRS) to assess both baseline and treatment-emergent suicidal ideation, as opposed to the CDRS or self-report, which were used in past studies. The more recent data, which used a more sophisticated measure of suicidality, indicated that there was no increased risk of suicidality in the active medication arms versus placebo.

**CCPR:** But there's a twist here. You found no association between antidepressant use and suicidality, but Dr. Spielmans did find an association. How can you explain these apparently different findings?

**Dr. Ignaszewski:** Glen was able to drill down deeper into the data and uncover suicidal events that were not apparent in our analysis. He and his team identified that some of the data were incorrect or misattributed to placebo.

**CCPR:** As a clinician, would you be reducing the dosage right away if a patient becomes suicidal?

**Dr. Ignaszewski:** Not necessarily. Context is crucial, and this is something that I review with primary care and pediatricians all the time. Suicidal ideation travels with other symptoms of depression, such as worsening functioning, sadder mood or irritability, progressive anhedonia, and not wanting to spend time with friends or on enjoyed activities. Firstly, we want to assess whether these symptoms are also present, which would stratify our approach and we might continue or increase the medication rather than decreasing the dose or stopping it. Secondly, in any scenario, we would want to provide more frequent check-ins for the patient and family, and thirdly we'd work on safety planning. We help the child and family learn how to manage those thoughts and feelings, maintain safety and seek additional support, rather than reflexively changing medication dosage.

**CCPR:** In the absence of a clear answer to this important question, what should we be telling patients and their parents?

**Dr. Spielmans:** We need to let patients and their parents know that if suicidality emerges, it could be drug induced. If suicidality is automatically attributed to depression getting worse, then prescribers might increase doses or augment treatment in some other way. But if suicidality is viewed as possibly medication related, prescribers might take more thoughtful approaches, such as consideration of dose reduction, emphasizing psychotherapeutic approaches, and scheduling more frequent check-ins.

**CCPR:** What language do you use during the informed consent process at the beginning?

**Dr. Ignaszewski:** I talk about the advantages and risks to medication. Any medication—even Tylenol or Advil—carries risks. As I'm talking about the black box warning with patients and their families, I have already assessed for suicidal ideation and come up with a treatment plan to answer questions such as "Who's going to be the contact?" "How will we identify it?" and "What will we do in that situation?" We also talk about the risks of untreated depression, including self-esteem, relationships, and academic performance, which can easily be overlooked in the anxiety of suicidality. Ultimately, I am working with the patient and family in front of me while being mindful of the research—the potential benefits often outweigh the risks.

**CCPR:** Dr. Spielmans, what are your thoughts?

**Dr. Spielmans:** For anxiety, you can make a good case that SSRIs can be beneficial. With depression, it gets trickier. It's more effective than a placebo, but usually by a pretty small amount.

**Dr. Ignaszewski:** Right. We are talking about more severe depression. Over-pathologizing normal sadness confuses research findings because these research subjects have high placebo response rates, so we might see very limited separation from active treatments. So when I am talking to patients and families, I try to differentiate normal sadness from pathological depression by focusing on functional impairment. I look for a major departure from what their life has been like, their activities and their overall developmental trajectory, perhaps no longer going to school. Medication can be indicated in these situations to get things back on track.

**Dr. Spielmans:** I agree that impairment can be a gauge as to who needs treatment. In terms of studying the risks of untreated depression, you'd need a group of children and adolescents with depression whose families do not want treatment but are willing to participate in a study. Even for adults, the research on untreated depression is sparse, especially in the long term. I think it's dicey to guess at the risk of suicides among children and adolescents with untreated depression. Not all youth who die by suicide are suffering from underlying depression, and many children/adolescents who die by suicide have multiple mental health struggles, so it's hard to necessarily say that untreated depression by itself was the cause of suicide.

**CCPR:** So how do we make sense of the research we see in professional journals?

**“We need to let patients and their parents know that if SI emerges, it could be drug induced. If it's automatically attributed to depression getting worse, then prescribers might increase doses or augment treatment in some other way. If suicidality is viewed as possibly medication related, prescribers might take more thoughtful approaches, such as consideration of dose reduction, emphasizing psychotherapeutic approaches, and scheduling more frequent check-ins.”**

Glen Spielmans, PhD

## Expert Interview—Duty to Warn? Debating Antidepressant Suicidality

Continued from page 4

**Dr. Ignaszewski:** The responsibility is on us as clinicians to read every article through a critical lens. We have to remember that there is a lot we don't know, a lot of complexity, and many confounding variables. Raw data are usually not provided, and regardless it's not realistic to be looking at raw data for every study. Randomized controlled trials give us the most information about cause and effect, but when we're thinking about take-home messages, then meta-analyses and consensus statements based on a review of the literature can be really helpful. And we need to consider a body of research. We should not make huge, sweeping changes to our practices based on single articles, but it's also vital for all of us to be lifelong learners.

**CCPR: Dr. Spielmans, how do you do that deep dive into the data?**

**Dr. Spielmans:** My research dissects studies. In this case, one escitalopram trial attributed two suicidal events to placebo, but—and you had to read the article carefully to see this—both events happened after the people had stopped taking placebo and had started taking escitalopram in the community (<https://pubmed.ncbi.nlm.nih.gov/24041408>). It's hard, potentially impossible, to casually read an article and pick up on those things without doing a deeper dive into the numbers. I've also read a lot of internal drug company documents, and when a clinical trial is written up, it is written with marketing in mind first, science second. It wasn't until lawsuits were filed and internal documents were released that it became clear there were suicide-related events that were not reported in journal articles (<https://pubmed.ncbi.nlm.nih.gov/12835239>; <https://pubmed.ncbi.nlm.nih.gov/18792536>). We're told to practice evidence-based medicine, but if the evidence itself is not accurate, that's a problem.

**Dr. Ignaszewski:** I'm so thankful for this discussion and Glen's paper because it was so eye opening for me. As providers, we need to be more aware of these practices and go further to teach trainees about this. We need non-industry funded studies by national health organizations and others to get the data for making our decisions, and to reduce reporting with clear conflicts of interest.

**CCPR: Thank you both for your time.**



## Our Role in Community Disasters

Continued from page 1

leadership, and community attitudes. The 6-phase framework below tracks the emotional response of communities to disasters (Zunin LM and Myers D. Phases of disaster. In DeWolfe DJ, *Training Manual for Mental Health and Human Service Workers in Major Disasters*. Washington, DC: US Government Printing Office; 2000):

- Phase 1: Pre-disaster (warnings and threats)
- Phase 2: Impact (acute, intense fear)
- Phase 3: Heroic (adrenaline-induced rescue activity)
- Phase 4: Honeymoon (community cohesion, optimism)
- Phase 5: Disillusionment (discouragement, abandonment, exhaustion)
- Phase 6: Reconstruction (adjusting to a new normal, recovery)

This framework can help you predict the needs of the community. For example, in response to diminishing COVID-19 numbers, a community in the honeymoon phase might hastily push for resuming schooling without safeguards in place, while a community in the disillusionment phase of the pandemic may see a surge in depression, anxiety, and substance use among its residents.

### Leveraging social capital

Social capital is a construct that quantifies the cohesiveness of a community to enable collective action (Flores EC et al, *Soc Psychiatry Psychiatr Epidemiol* 2018;53(2):107–119). It is defined by shared norms, values, trust, and reciprocity. Communities with high social capital tend to be more vibrant and more socially connected.

The current pandemic highlights how social capital can help a community recover. Research suggests that communities with higher social capital are initially hit with more COVID-19 cases. However, these more cohesive communities have more ability to make voluntary changes and curtail the spread of disease. A European study found that an increase of 1 standard deviation in social capital resulted in up to a 32% reduction in COVID-19 cases (Bartscher AK et al. *Social Capital and the Spread of COVID-19: Insights From European Countries*. Bonn, Germany: IZA; 2020).

As clinicians, keep this concept in mind and look for ways to support the building and maintenance of social capital in your community. Start by looking at your clinic or practice. For example, work with families to brainstorm ways

they can create and nurture social connections using telehealth technology during times when in-person interactions and group events are not safe.

### Expanding our roles: Volunteer for deployment

*You call your local Red Cross (1-800-RED CROSS; [www.redcross.org/volunteer/become-a-volunteer.html](http://www.redcross.org/volunteer/become-a-volunteer.html)) and within 10 days you are credentialed. You are assigned to a shelter where you meet Julia, a 12-year-old girl with no problematic history whose older brother died when they fled the fires. Julia seems to be coping, going through the motions of daily life at the shelter. A social worker assigned to the family helps them obtain short-term housing. You reassure Julia, give guidance to her parents about responses to stress, and offer a free office appointment in six weeks.*

You do not need a degree in public health to help a community through a disaster. There are many ways you can help within your scope of practice. While not comprehensive, here's a list of service/assignment types that may be a good fit for you:

Continued on page 6

## Our Role in Community Disasters

Continued from page 5

1. Offer free office hours for children impacted by disasters. This might be the simplest way to help out. Contact referral sources such as the Red Cross to let them know that you are available ([www.redcross.org/volunteer/volunteer-opportunities/disaster-volunteer.html](http://www.redcross.org/volunteer/volunteer-opportunities/disaster-volunteer.html)).
2. Provide care at shelters. Shelters are in need of clinicians to work with staff and other professionals to assess and treat displaced children and families.
3. Advise disaster workers on supportive care. Coach first responders and other frontline personnel about how to best help children and families, emphasizing developmental differences in response to disasters.
4. Provide supportive listening. Have in-person or virtual conversations with everyone from community leaders to first responders; offer referrals for definitive care when indicated.
5. Assist with media work. As clinicians, we can have a positive impact on civil calm and self-care. Training is critical, however, as missteps with such things as patient confidentiality or community advice can amplify problems. The American Academy of Child and Adolescent Psychiatry (AACAP) offers a media training course for disaster and trauma as part of their annual meetings ([www.AACAP.org](http://www.AACAP.org)).

If you're considering deployment, whether a brief stint or extended time away from your practice, keep in mind the following:

- Never self-deploy. Showing up on your own to a disaster zone creates confusion and hinders the response process. Instead, volunteer through organizations such as the Red Cross. The American Medical Association has a listing of volunteer needs related to COVID-19 ([www.tinyurl.com/yxlgza7x](http://www.tinyurl.com/yxlgza7x)).

- Be the psychiatrist, not the primary care clinician. Federal and state laws protect volunteer health providers from medical liability, but the standard of care still applies. For instance, if you treat someone for hypertension "because it's faster than waiting for the general internist," you will be held to the usual community standard in doing so.
- Take care of your own health. Do not try to operate on little sleep, stay hydrated, and do not skip meals (Ng AT, *Psychiatric Times* 2010;27:11). Don't become a casualty; follow direction of first responders in regard to safety.

### Expanding our roles: Supporting the community from home

Not everyone can leave their practice behind and deploy themselves when a disaster happens. But there are a number of things almost any clinician can do that are very helpful.

#### Support other clinicians or responders who are volunteering

Offer backup coverage for psychiatrists who are deployed. Volunteer time for organizations that provide disaster recovery assistance—for example, you could provide an hour of pro bono care every week. Start with your local professional society (AACAP, APA chapter, or county medical society).

#### Assist your community with disaster preparedness

As respected members of the community, we have much to offer through civic engagement. Many communities have disaster response teams—check with your local government. Consider completing a Community Emergency Response Team (CERT) training program. This free course teaches laypeople how to assist first responders in a disaster ([www.ready.gov/cert](http://www.ready.gov/cert)).

#### Be a pediatric mental health liaison

When communicating with schools, colleagues, and others in your clinical practice, offer talks, interviews, or podcasts to educators, parents, first responders, and health providers about the biological, psychological, and social impacts of crisis on youth. AACAP provides training opportunities and resources for families ([www.tinyurl.com/y8nmqs66](http://www.tinyurl.com/y8nmqs66)). You can also enroll in the National Child Traumatic Stress Network (NCTSN) Psychological First Aid (PFA) course. It's quick and inexpensive, and you will learn how to assist survivors and the relief community. See the table below for core actions in PFA ([www.nctsn.org](http://www.nctsn.org)).



Our unique expertise affords us meaningful opportunities to help our communities during crises. First and foremost, though, we must take care of our patients while taking care of ourselves.

The Eight Psychological First Aid (PFA) Core Actions	
Contact and Engagement	To respond to contacts initiated by survivors, or to initiate contacts in a non-intrusive, compassionate, and helpful manner.
Safety and Comfort	To enhance immediate and ongoing safety, and provide physical and emotional comfort.
Stabilization (if needed)	To calm and orient emotionally overwhelmed or disoriented survivors.
Information Gathering on Current Needs and Concerns	To identify immediate needs and concerns, gather additional information, and tailor PFA interventions.
Practical Assistance	To offer practical help to survivors in addressing immediate needs and concerns.
Connection With Social Supports	To help establish brief or ongoing contacts with primary support persons and other sources of support, including family members, friends, and community resources.
Information on Coping	To provide information about stress reactions and coping to reduce distress and promote adaptive functioning.
Linkage With Collaborative Services	To link survivors with available services needed at the time or in the future.

Source: [www.tinyurl.com/yjgerd4d](http://www.tinyurl.com/yjgerd4d)



**Managing Video Gaming in Children and Teens**  
**Joseph B. Dilley, PhD**



*Psychologist in Pasadena, CA; author of The Game Is Playing Your Kid: How to Unplug and Reconnect in the Digital Age (Minneapolis: Bascom Hill; 2015).*

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

**CCPR:** We are here to talk about managing video gaming in children and adolescents, which is a ubiquitous habit that might be even more pronounced given that we're in the middle of a pandemic. Dr. Dilley, can you start with the relationship between mood disorders and gaming?

**Dr. Dilley:** There is a complex relationship between mood disorders and gaming, with mediating factors. Sometimes kids retreat into games because they're already depressed. They're not necessarily becoming depressed because of gaming. But if kids spend too much time gaming, play really violent content, or do it to escape the responsibilities of the real world, the probability of depression is higher. King et al list everything from genetics, personality, upbringing, and specific electronic exposures as part of the WHO-recognized hazardous gaming disorder (King DL, *JAMA Psychiatry* 2020;77(8):869-870).

**CCPR:** And unchecked video gaming in the presence of depression can impede all other treatment efforts and prolong the dysfunction.

**Dr. Dilley:** That unchecked part is dangerous, like unchecked financial spending or unchecked drinking.

**CCPR:** Tell us about the impact of violent content in video games.

**Dr. Dilley:** In the famous Bobo doll experiment of the 1960s by Albert Bandura, preschoolers became aggressive after watching a video of a Bobo doll getting knocked down. Although those early studies show that we emulate what we see, video gaming studies do not show a meaningful association between gaming and aggressive behavior. We need to be careful not to automatically blame gaming when kids act out. In fact, the quality of social interactions during gaming can be protective. When kids are gaming heavily in an environment that they experience as socially supportive, in games where they collaborate as a team, that can mitigate symptoms of depression. This mitigation is in contrast with cyberbullying on social media.

**CCPR:** Really interesting. What about people staying up late and sleep problems?

**Dr. Dilley:** Blue light inhibits the release of melatonin, a natural sleep agent. That comes from Matthew Walker's seminal book *Why We Sleep* (New York: Scribner; 2017). Other studies show total sleep time decreases as a function of exposure to screen time, particularly gaming. In part, that's because of increased sleep onset latency. The time it takes to fall asleep after gaming increases, and we end up with less total sleep time. Plus, screen time alters REM sleep and slow-wave sleep. Participants in research studies self-report higher rates of fatigue, and they perform less well on verbal memory and sustained attention tasks as a function of both poor sleep quality and lower sleep time (Peracchia S and Curcio G, *Sleep Sci* 2018;11(4):302-314).

**CCPR:** The American Academy of Pediatrics recommends 2 hours a day of screen time. But that's obviously been especially difficult recently, since kids have been stuck at home and school's been online with the pandemic.

**Dr. Dilley:** Right. And if a child is spending 3 or more hours a day gaming, the cognitive benefits that can come from gaming—like cognitive flexibility, attention, visual-spatial perception, and reasoning—disappear or at least diminish. Look at how the child behaves, thinks, and performs after various kinds and lengths of screen time. Also look at motive. Are they retreating into the screen to get away from reality? Or are they taking a break like we all need?

**CCPR:** How can we assess the extent of the problem more fully?

**Dr. Dilley:** Involve collateral informants and do conjoint and family consultations and sessions. Kids (and adults) tend to under-report their own screen use. Apps that track weekly screen time can also be useful. I like to ask parents that "miracle" question: "If you woke up tomorrow and you were confident there was no problem, particularly with screen use, how would you know?" The parent might reply: "His behavior would be different, his grades would be higher, his level of engagement and willingness to come to the dinner table would increase."

**CCPR:** Do you have any magic words to open the conversation with kids, so that they'll be more willing to participate in a discussion that they think is fair?

**Dr. Dilley:** It might go something like: "Help me understand from your perspective. What's it like when Mom comes into your room to check on what you're doing?" The kid might say, "Oh, it's like she doesn't trust me, and then she goes and tells Dad, and he gets all upset and he starts yelling." And you can empathize: "Wow, that sounds really

**"Set fair limits and offer credit for shutting down the game early. Pressing the OFF button actually gets the child more of what they're looking for, instead of the previous dynamic where ignoring Mom and Dad got the child more screen time."**

Joseph B. Dilley, PhD

Continued on page 8

## Expert Interview—Managing Video Gaming in Children and Teens

Continued from page 7

unpleasant,” and so on. Now they’re viewing you as an ally, at least in terms of being able to be heard. It doesn’t mean you’re agreeing with them that they should be able to game all night, but now you’re a validator of their emotional reality. As I am working with kids, I’ll tell them, “Show your parents how much privacy you can handle. Show them what kinds of games leave you in a good mood and what kinds don’t.” I encourage parents to steer clear of “can’t” and “should.” Instead of “You can’t,” it becomes, “You can as soon as you’re ready,” or, “What do you think I need to see to get off your case?”

**CCPR: Are there other symptoms that we should be looking for in terms of a dysfunction surrounding gaming?**

**Dr. Dilley:** Video gaming addiction looks an awful lot like other types of addiction. Also look at content/context. Keep in mind that YouTube keeps people watching by algorithmically bringing up the next perfect video to keep them engaged. You want the child to be in control, not the device. You might use a quick checklist to help in your assessment (see box at right).

**CCPR: How do we support families with practical strategies?**

**Dr. Dilley:** It takes a series of conversations in which parents set fair limits and offer credit for shutting down the game early. This strategy paradoxically gets the child more of what they’re looking for by pressing the OFF button, instead of the previous dynamic where ignoring Mom and Dad got the child more screen time. What we ultimately want is kids enjoying themselves and feeling like, “I use screens; they don’t use me.” It sounds idealistic, but it’s attainable, and we need to communicate to parents that managing excessive screen time isn’t so different from managing other temptations.

**CCPR: In your book, you talk about key behavioral pathways that we can use with families. Can you share an example?**

**Dr. Dilley:** Sure. A lot of parents will say: “I yelled at him and he still didn’t get off the game.” In this situation, the gaming is more fun than the yelling is noxious, so the intervention doesn’t work. It’s better to reward getting off the game and charge interest for overuse. If the child games past their allowed time, they get less screen time tomorrow. But if the child turns it off early, they get more time to play the next day—say, if they turn the game off one minute early, they get two minutes more time tomorrow. It’s a no-brainer. There’s no yelling, and the child is getting to decide what they do. It’s like the thought process that will happen when the child has a credit card someday: “I can overspend it, but then I’ll owe the amount plus the penalty plus the interest. Hm. I think I’ll just stay within my credit limit.” It’s an experiential learning scenario. And there’s a response cost that’s more effective than traditional punishments like lectures, yelling, hopefully not spanking. Those kinds of punishments, if they’re effective at all, only work for the short term. Also, if the kid can get you to stop yelling or lecturing, then they experience relief, although that is a weaker effect.

**CCPR: Kids can be sensitive about this topic. How do you break the ice to talk with the child about changing their gaming habits?**

**Dr. Dilley:** I appeal to their desire for independence and privacy, their own self-monitoring capacities, their desire for accomplishment and meaning. I might say: “Wouldn’t it be great if you got to decide how much time you spent gaming and what kind of content you were engaged with?” This is akin to, “Wouldn’t it be great if you had your own car? Your own apartment? Your own scholarship?” and so on. So, they say yes, and we get their buy-in. Then I ask: “What do you think your parents would need to see in order to extend those privileges to you?” The child might respond: “Well, I’d probably need to get my grades up.” Then I can ask whether that seems like an attainable goal: “OK, you think that’s possible?” And they might say, “Well, I work so hard at it, but I keep running into...” Then we get into candid discussions and find some solutions together. When they do better, parents can step back, and we get a new cycle going where Johnny’s performance at home and at school self-perpetuates in a positive direction.

**CCPR: Even with this strategizing, it can be hard for kids when you actually try to make these changes. Can you talk about the internal reward that kids get when they are gaming?**

**Dr. Dilley:** Yes. There’s a dopamine drip that gets activated and becomes more of a surge. So it makes sense that there are tolerance and withdrawal effects, the same kinds of things we see in other dependencies. This can prevent parents from sticking with a new paradigm of enforcement, because they see this extremely high resistance and they go, “Ugh! It was easier when I just gave in and let him keep playing!” I tell parents: “That burst of resistance and defiance is because your intervention is working! They’re having to try harder to get you to cave, and your job is to ride that out so that they develop a new habit.”

**CCPR: What other research do we need to be doing on this?**

**Dr. Dilley:** We need more longitudinal data on the relationship of mood disorders and gaming over time. We also need to parse out the effects further regarding screen time of all types. I ran into some research indicating that girls, even with a social network, can still have decreased self-esteem from gaming, even in a social context, possibly due to the exchange of more negative affect (Carras MC et al, *Comput Human Behav* 2017;68:472–479). This is consistent with the significantly higher rate of cyberbullying that goes on among females (Seldin M and Yanez C. *Student Reports* ——— Continued on page 9

### Video Gaming Assessment Checklist

How much is the child gaming?
Does it take away from jobs, academic responsibilities, or socialization with family?
How much control does the child have over their use? Can they stop?
Is it perseverative and highly prioritized, or does the child have a range of activities and interests?
Is it the only thing the child is talking about at the dinner table and on car rides?
How long has it been going on? Is there withdrawal when it’s time to stop gaming?
Has the child lost interest in doing anything else? Are they skipping basic needs like nutrition, sleep, and hygiene?
Is the child lying about their use?

Source: Dilley JB. The Game Is Playing Your Kid: How to Unplug and Reconnect in the Digital Age. *Bascom Hill*; 2015.



Expert Interview—Managing Video Gaming in Children and Teens

Continued from page 8

of *Bullying: Results From the 2017 School Crime Supplement to the National Crime Victimization Survey*. US Department of Education; 2019). Not all screen time is equal, and not all gaming is bad. Gaming can promote improvement in executive function and in perceptual and spatial function. Some of the research indicates growth in the right hippocampus and plasticity, as evidenced by increased density in gray matter. Are there any other benefits to gaming, and if so, what kind of games confer those benefits?

**CCPR:** Speaking of benefits, there's been a lot of hype recently about a prescription game that's FDA approved to treat ADHD. Do you have any thoughts on that?

**Dr. Dilley:** Brain training games help students get better at brain training games. The question is, what is the generalizability of this impact on executive function? Does it translate into the school scenario, or does it just help someone get better at the game? Are we seeing improvements that translate into real life? What does Johnny's mom say? What does his teacher say?

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



## Research Updates IN PSYCHIATRY

### DEPRESSION

#### *Oral Contraceptive Users and Depressive Symptoms*

**REVIEW OF:** de Wit AE et al, *JAMA Psychiatry* 2019;77(1):52–59

Since the dawn of their widespread use in the 1960s, we've worried about the impact of oral contraceptives (OCP) on mood. But the research to date has been inconsistent, with studies reporting negative, positive, or no effects on mood. Heterogeneity in study population and design may underlie these discrepancies. This new study uses a longitudinal design to provide some very useful data on the connection between OCP and various depressive symptoms.

The study used data from the Dutch population survey TRAILS (Tracking Adolescents' Individual Lives Survey), which included 1,010 females aged 16–25 years who had 1–4 assessments of OCP use and depressive symptoms. The researchers used the affective problems scale of the Youth and Adult Self-Report to measure depressive symptoms. Follow-up assessments were conducted at ages 16, 19, 22, and 25 years.

In young women (aged 19, 22, and 25 years), there was no difference in depressive symptoms between OCP users and non-users. But adolescent OCP users (aged 16 years) reported nearly twice as much crying, over 1.5

times more hypersomnia, and about 1.5 times more eating problems compared to non-users even after adjustment for age, ethnicity (Dutch vs non-Dutch), and socioeconomic status. The association between depressive symptoms and adolescent OCP users was weaker, but still present, after adjustment for virginity, acne, menstrual-related pain, stressful event exposure, and depressive symptom scores before OCP use.

This study was notable for its prospective design, 9-year follow-up across multiple time points, and use of a validated questionnaire for depressive symptomatology. Still, we don't know what indications were cited for these patients (birth control, menstrual irregularities, acne, etc), nor which OCPs were used (eg, progesterone vs mixed progesterone-estrogen). Also, we don't know if these findings generalize to a non-Dutch population.

#### **CCPR'S TAKE**

We would not merely avoid OCP to reduce depression risk. The strength and mediators of the association between OCP use and depressive symptoms in adolescents remain unclear. OCP use might also be a marker for sexual behavior associated with other psychosocial concerns. OCPs help with dysmenorrhea, premenstrual syndrome, and prevention of unintended pregnancies, and the authors note that OCP use is safer than pregnancy and postpartum depression. Moreover, SSRIs may be

helpful or may exacerbate pre- and perimenstrual mood problems. It's a complicated topic—with each patient we will learn something new.

—*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.

### SUPPLEMENTS

#### *Vitamin D for ADHD?*

**REVIEW OF:** Gan J et al, *J Child Adolesc Psychopharmacol* 2019;29(9):670–687

Many children do not respond to or tolerate standard pharmacotherapy, which drives continued interest in supplements for many conditions, including ADHD. Vitamin D plays a role in healthy brain development, and vitamin D deficiency causes neurotransmitter alterations in pathways underlying ADHD pathogenesis. But is there a link between ADHD and lower vitamin D levels? These researchers conducted a systematic review and meta-analysis to assess the strength of evidence to date.

The study looked at four randomized controlled trials (n = 256) studying vitamin D supplementation for ADHD (1,000 international units [IU] daily–50,000 IUs weekly) vs placebo as adjunctive to methylphenidate for children (5–18 years). Trial durations lasted

Continued on page 10

## Research Updates

Continued from page 9

6–12 weeks. The researchers assessed ADHD symptom severity level based on a variety of parent-only rating scales as the primary outcome. The secondary outcomes were adverse effects of supplementation and vitamin D status afterwards.

Adjunctive vitamin D supplementation yielded a small but statistically significant improvement in ADHD total score and inattention, hyperactivity, and behavior subscales. Scores for oppositional behaviors were unchanged except in a subgroup analysis of high-dose vitamin D supplementation (> 2,000 IUs daily). Notably, one study found that children with baseline vitamin D deficiency or insufficiency were more likely to respond to adjunctive vitamin D supplementation. Only one trial reported on adverse events, which were mild and similar between groups. Not surprisingly, vitamin D supplementation increased vitamin D levels and also increased the ratio of patients with sufficient vitamin D levels.

This paper used excellent methodological procedures for conducting systematic reviews and meta-analyses. Unfortunately, the RCTs were of very low to low quality. Randomization procedures were not clear, the total population was less than 400, and statistical methods varied. All of these trials were carried out in the Middle East, but children’s ethnicities were not reported, so generalizability is unclear.

### CCPR’S TAKE

Vitamin D supplementation is a relatively low-risk and low-cost intervention with general health benefits. We recommend you consider trying it both in children with vitamin D deficiency and in combination with standard ADHD treatment. It’s unclear whether similar results would extend to non-methylphenidate stimulants. More research is needed using higher-quality evidence that

examines whether vitamin D dose, administration frequency, and baseline status influences outcomes. Do take care to avoid mega-doses, though, as this can disrupt calcium metabolism. See “Recommended Vitamin D Doses” table below.

—Kristen Gardner, PharmD.

Recommended Vitamin D Doses		
Age (yrs)	Daily Requirement (IU)	Upper-Level Daily Intake (IU)
0–1	400	1,000
1–9	400	2,000
11–18	400	4,000

Source: EFSA and ESPGHAN (<https://academic.oup.com/jcem/article/99/4/1132/2537181>)

## MEDICATION

### Which Medications Have the Lowest Risk of Side Effects?

**REVIEW OF:** Solmi M et al, *World Psychiatry* 2020;19(2):214–232

Adverse effects are important considerations when choosing psychotropic medications, especially in children and adolescents. This study pooled available research to compare the safety profiles of various psychotropics used in the pediatric population. The authors screened thousands of studies of psychotropics for 78 possible adverse effects. The combined sample of these studies included roughly 337,000 children and adolescents: 120,000 on antidepressants, 66,000 on antipsychotics, 148,000 on ADHD meds, and 1,600 on mood stabilizers.

Among antidepressants, escitalopram and fluoxetine fared best, while venlafaxine was the worst owing to anorexia, abdominal pain, hypertension, and suicidality. Sertraline also performed poorly due to gastrointestinal issues, insomnia, and weight gain.

Among antipsychotics, lurasidone was found to be the least problematic, with asenapine in second place. Olanzapine was the most problematic with a host of side effects including sedation, metabolic syndrome, and extrapyramidal side effects, with aripiprazole in second-last place.

Turning to ADHD medications, methylphenidate stood out to be the safest, although it came out only slightly ahead of lisdexamfetamine, while atomoxetine was the worst of the lot due to gastrointestinal issues and weight loss. Surprisingly, guanfacine also had significant issues such as reports of abdominal pain, sedation, and (notably) QT prolongation. Finally, among the mood stabilizers, lithium was the most well tolerated, while sodium valproate trailed the pack with significant adverse effects like weight gain, sedation, and cytopenia.

A quick tally of the safest available agents favors escitalopram and fluoxetine for depression, lurasidone for schizophrenia, methylphenidate for ADHD, and lithium for bipolar disorder.

### CCPR’S TAKE

This study yielded some surprises and is worth a close read. While venlafaxine’s higher side effect profile was expected, we had not imagined sertraline to do so much worse than escitalopram and fluoxetine. Furthermore, we had, perhaps incorrectly, considered guanfacine and atomoxetine mild “starter” medications, even placebo-like, but here the stimulants stood out for their advantages in both safety and efficacy. Lastly, lithium and lurasidone deserve more consideration, despite having a narrow therapeutic range and insurance issues respectively.

—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.



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- The emergence of suicidal ideation during antidepressant use has been a controversial topic. One reason that the research may have been misleading is because: (LO #1)
  - a. The time course of the data was limited to 1 year in some studies, concealing the problem
  - b. Raw data is routinely made available to the lead authors of the papers, allowing critical review
  - c. Suicidal episodes have never been found to be misclassified as part of the placebo group
  - d. Lawsuits have been unsuccessful to date in uncovering data management in drug studies
- Within the 6-phase framework of the emotional response of communities to disasters, which phase reflects community cohesion and optimism? (LO #2)
  - a. Phase 2: Impact
  - b. Phase 3: Heroic
  - c. Phase 4: Honeymoon
  - d. Phase 6: Reconstruction
- According to Dr. Dilley, which of the following is true about screen time and sleep? (LO #3)
  - a. Sleep time decreases as a function of screen time exposure to smartphones, but not necessarily gaming exposure
  - b. Screen time exposure overall decreases sleep time but doesn't affect sleep quality in youths
  - c. Screen time exposure overall affects sleep quality but doesn't affect sleep time in youths
  - d. Sleep time decreases with exposure to screen time, particularly gaming
- In a 2019 study investigating vitamin D usage in children with ADHD, vitamin D was administered as an adjunct to which ADHD agent(s)? (LO #4)
  - a. Atomoxetine
  - b. Dextroamphetamine and amphetamine salts
  - c. Lisdexamfetamine
  - d. Methylphenidate
- During 2004–2016, self-reported rates of suicide attempts and antidepressant prescriptions among adolescents in the US were highly correlated. According to Dr. Spielman, the benefit of this time-series observational study was that it took into account other variables that influence suicide, such as unemployment, drug use, and parental military deployments. (LO #1)
  - a. True
  - b. False
- Social capital reflects the cohesiveness of a community to enable collective action. According to research, what is the relationship between social capital and the COVID-19 pandemic? (LO #2)
  - a. Communities with lower social capital have the lowest rates of community COVID-19 spread overall
  - b. Communities with lower social capital have higher initial rates of COVID-19 cases followed by a reduction in spread
  - c. Communities with higher social capital have lower initial rates of COVID-19 cases followed by a sharp escalation
  - d. Communities with higher social capital have higher initial rates of COVID-19 cases followed by a reduction in spread
- The recommended first-line treatment for helping children with dyslexia is: (LO #3)
  - a. Speech therapy during schooltime
  - b. Reading programs that promote memorization of whole words
  - c. Activities with an emphasis on speech such as drama or debate
  - d. Participation in structured literacy programs
- In a 2019 study, how did depressive symptoms in adolescent girls using oral contraceptives (OCP) compare to non-users? (LO #4)
  - a. There were no significant differences in depressive symptoms between OCP and non-OCP groups
  - b. OCP users had significantly higher depressive symptoms than non-users with progesterone vs mixed progesterone-estrogen OCP use
  - c. OCP users reported nearly twice as much crying but no difference in hypersomnia or eating problems compared to OCP non-users
  - d. OCP users reported more crying, hypersomnia, and eating problems compared to OCP non-users
- According to a 2018 study, what percentage of children have dyslexia? (LO #3)
  - a. Under 3%
  - b. 5%–10%
  - c. 10%–15%
  - d. Over 15%
- In a 2019 study, how did administration of adjunct vitamin D compare to placebo in children being treated for ADHD? (LO #4)
  - a. The vitamin D group had small improvements in inattention, hyperactivity, and behavior
  - b. The vitamin D group had severe adverse effects compared to the placebo group
  - c. The vitamin D group had less oppositional behavior when taking greater than 1,000 international units daily
  - d. The vitamin D group had similar rates of inattention compared to the placebo group
- Clinicians who volunteer mental health assistance in US disaster situations need to provide proof of additional liability coverage before deployment. (LO #2)
  - a. True
  - b. False
- In a 2019 study investigating depressive symptoms associated with oral contraceptive (OCP) usage, there was no difference in depressive symptoms between OCP users versus non-users of what ages? (LO #4)
  - a. 19, 22, and 25 years
  - b. 26, 27, and 28 years
  - c. 29, 31, and 33 years
  - d. 33, 34, and 35 years

# THE CARLAT REPORT CHILD PSYCHIATRY

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## Note From the Editor-in-Chief

With a surging pandemic and cultural turmoil, we are all working as best we can. At Carlat, we are striving to give you what you need to keep going. Every clinician needs to prepare for disasters, even if that is mainly knowing how to support your own patients when disaster strikes. And every clinician, it turns out, needs to know how to talk with patients and families about the possibility of treatment-emergent suicidality with antidepressants.

We had quite a conversation with Dr. Ignaszewski and Dr. Spielmans about why informed consent for antidepressants requires this “duty to warn.” Dr. Dilley walks us through strategies to manage video gaming, and we discuss dyslexia so that you know what it is and what to do about it.

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