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Editor-in-Chief

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IN THIS ISSUE

Clinical Complexity With Children and Adolescents

Learning Objectives
After reading these articles, you should be able to:

1. Plan and execute mental health care that takes into account children living in two households and demonstrates cultural competence.
2. Describe the state of the research on genetic testing in child psychiatry.
3. Screen children and adolescents for specific impacts related to the COVID-19 pandemic.
4. Summarize some of the findings in the literature regarding psychiatric treatment for children and adolescents.

Cultural Competence: Impact on Clinical Care

Fagie Mandel Greenberg, M.Ed., CDT. Dyslexia and behavior specialist, EdMind LLC; Professor of Literacy and Special Education, Kean University, NJ.

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

Hien, your 8-year-old Vietnamese American patient with autism spectrum disorder, is referred to you for "assault" and "elopement." The school psychologist describes Hien hugging peers ("assaults") during reading ("non-preferred task"), leaving his desk ("elopement"), and coming to the teacher and leaning into her chest ("sexual misconduct"), despite IEP goals for "quiet hands and body" and "manding" (asking appropriately). The school hopes that adjusting medication will improve his compliance. Hien's parents are a

Highlights From This Issue

COVID-19 demands specific assessment so that children and adolescents can be better routed to effective care.

We are learning a lot from whole genome sequencing; however, there is currently little clinical impact either from this or from testing liver enzymes.

Working within cultural contexts, consider how psychiatric conditions present differently and adjust treatment for respectful and more effective care.

Leveraging different perspectives in divorced families can create a more nuanced and collaborative conceptualization of a child's difficulties to inform care.

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Q&A With the Expert

Pharmacogenetics: Not Quite Ready for Prime Time?
Aaron Besterman, MD

Child & adolescent psychiatrist at the Rady Children's Hospital inpatient child and adolescent unit, San Diego, CA.

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

CCPR: Welcome, Dr. Besterman. Please tell us who you are and where you work.

Dr. Besterman: I'm an adult and child & adolescent psychiatrist at the Rady Children's Hospital inpatient child and adolescent unit in San Diego, and I'm a clinical investigator at the Rady Children's Institute for Genomic Medicine studying psychiatric genetics.

CCPR: Clinicians are inundated with ads for genetic testing. We'd like to help our colleagues understand how these tests work and whether they're helpful, plus discuss a little of the underlying science. Can you start with the basics?

Dr. Besterman: Essentially, there are two types of genetic testing: diagnostic testing, which attempts to identify a specific disorder; and pharmacogenetic testing, which looks at a cluster of genes to try to understand how well an individual might respond to a medication.

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Expert Interview—Pharmacogenetics: Not Quite Ready for Prime Time?

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CCPR: Let's talk about diagnostic testing first.

Dr. Besterman: Diagnostic testing is only indicated for patients with neurodevelopmental disorders. This includes intellectual disability, a history of developmental delay, or autism spectrum disorders. The current guidelines state that we should be requesting chromosomal microarray (CMA) testing for all of these patients to detect genetic deletions (having one copy of a gene instead of the normal two copies) or duplications (having three copies instead of two). (*Editor's note:* The International Society of Psychiatric Genetics [ISPG] guidelines for genetic testing and genetic education are available at www.ispg.net/genetic-testing-statement.) In 10%–20% of patients with neurodevelopmental disorders, CMA can detect a change associated with a specific genetic syndrome. It's also recommended that both boys and girls get testing to look for Fragile X syndrome.

CCPR: Does insurance cover these tests?

Dr. Besterman: Order the CMA through your usual lab. You may need to advocate with the insurance company. If you get the CMA and if there is something of interest, refer to your genetics or dysmorphology clinic and they may order more testing. Currently, the process is a cascade approach where you get authorization from insurance for one test; then, if that comes back negative, you try to get authorization for the next; and so on. It can take a lot of time and often is not approved by insurance companies. But technology is developing rapidly, and now whole genome sequencing can detect all the known genetic changes that confer risk for neurodevelopmental disorders with one test. I'm trying to provide it to kids with neurodevelopmental disorders who are on our inpatient service.

CCPR: How does the genetic testing you suggest affect clinical care?

Dr. Besterman: In general, genetic testing doesn't significantly alter psychiatric care, and that's important for patients and families to know. But it can be useful in a number of other ways. For example, it can inform providers about the need to monitor for common comorbidities with some genetic conditions. It can also provide families with an answer for why their child has a certain condition, which can provide relief to those who've been on a diagnostic odyssey, going from specialist to specialist looking for an answer. It can also help these families connect with other families who have a child with a similar genetic condition for social and emotional support. Genetic testing also helps with reproductive counseling, if a family wants to know whether their next child could have the same condition. Lastly, genetic testing can plug families into clinical research opportunities where kids could be enrolled in research studies specifically for their genetic condition.

CCPR: What do you do when you discover a known genetic disorder such as 22q13 deletion syndrome (Phelan-McDermid syndrome), which is becoming better recognized as a cause of autism-like syndromes?

Dr. Besterman: You need to provide proper counseling. If you feel comfortable doing all of it on your own, that's fantastic. If not, there are alternatives. You can work alongside genetic specialists to make sure patients get what they need. If you order a test and it comes back positive, you could refer the patient to a medical geneticist for further counseling. Even if it comes back negative, you could refer to a geneticist if you feel the patient might benefit from more sophisticated testing. Medical geneticists are MDs. Non-MD genetic counselors are also a great resource.

CCPR: What are genetic counselors?

Dr. Besterman: Genetic counselors are medical professionals who are experts in genetic medicine and often work alongside medical geneticists. They can facilitate genetic testing, consenting for genetic testing, and counseling to accompany test results. If you live in a rural area and there aren't many genetic counselors nearby, you can find one through the National Society of Genetic Counselors (www.nsgc.org).

CCPR: There's another topic in psychiatric genetics called polygenic risk. Can you talk about that?

Dr. Besterman: Polygenic risk refers to the idea that complex medical disorders, including disorders like depression, schizophrenia, anxiety, or basically all common psychiatric diseases, are typically not caused by a single gene change. Instead, they're caused by the cumulative effect of dozens, hundreds, or thousands of tiny genetic changes: ones that we inherit from our parents

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Prescribing to Children of Divorce

Anthony Charuvastra, MD. Adjunct Assistant Professor, NYU Langone Medical Center Department of Child and Adolescent Psychiatry.

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

Each year in the US, there are about 1.04 million divorces, affecting about 800,000 children. Beyond that, 1.9 million cohabiting (and unmarried) couples break up each year, of whom 60% have children (www.census.gov/data/developers/datasets/acs-1year.html). It may not be the divorce itself that is hard on children, but how the divorce is handled (ie, amicably or not). This article will help you support divorced parents as they make treatment choices that are in the best interests of their child and the family system.

Legalities and paperwork

Before treating your patient, make sure that the parent bringing the child has the authority to consent for outpatient treatment. Ask for a copy of the custody paperwork and clarify what the legal custody arrangement is. "Physical custody" refers to the child's living arrangements, while "legal custody" refers to decision-making authority that parents have after separation or divorce. "Sole legal custody" describes a situation where the court has decided that only one parent (the custodial parent) has decision-making authority; in this case, only the custodial parent will need to sign contracts, information releases, and consent for treatment forms. By contrast, "joint legal custody" describes a situation where *either* parent can consent for medical treatment. In most states, under joint legal custody, consent is needed from only one parent, unless the court papers specifically instruct that both parents must consent for medical treatment (Benitez BR, *The Therapist,* May/Jun 2001; www.tinyurl.com/35zj77f4).

Be sure to talk about payment too. Even if only one parent has custody, you will need to establish who is paying for services, including what insurance company, if applicable. Do not assume that the custodial parent is paying for treatment since such expenses might be shared or even covered only by the non-custodial parent. Such complexities reinforce that the clinician must always make an effort to involve both parents in treatment discussions and document this effort.

Building a working relationship

How do we involve both parents in cases of separation or divorce? From the very start, try to speak with parents together. This will help you assess their ability to suppress hostilities and work collaboratively in the interests of their child. The expectation of collaboration makes parents more open to expert advice, defusing the power struggles between parents that often characterize the post-divorce landscape, and improving such things as medication compliance in both households. To make this work, it helps to review some of the common problems inherent in family and parental interactions so that you can adjust your approach.

Emotions impacting treatment

Guilt or anger may cause parents to disengage from co-parenting or, alternatively, to become intensely involved in the process. They may perceive routine and necessary psychiatric treatment as proof of their inadequacy. With ADHD, for example, parents may resist accepting the diagnosis and go to heroic lengths such as changing schools several times or hiring help to supervise the child. These reactions can also undermine treatment plans, ranging from the subtle (forgetting to give their child medicine) to the overt (explicitly telling their child that they "don't believe in ADHD"). Alternatively, one parent may blame the child's difficulties on the other parent. You may also experience direct hostility from parents.

Some tips for addressing these challenges include:

1. Reframe disagreements as opportunities to help patients. There is an advantage to having multiple points of view at the table. Welcome these differences by using them to better define shared values and determine what is important—eg, homework, friends, time with each parent, sibling relationships, etc.

2. Establish agreed-upon systems. Try to set out a clear and reasonable plan for such things as tracking medication dosing, sleep hygiene, homework completion, or other target symptoms or goal areas. A neutral, calm tone can help you establish a trusting relationship with both parents.

3. Provide a holding environment. A calm, concerned expert can depoliticize a child's suffering. Use plain, neutral education to inform a skeptical parent about the evidence base for treatment. Think with parents about their child's strengths and how to build on those, as well as the child's challenges and ideas that might help address them.

4. Take the long view. Help parents understand that the best plans are arrived at by trying things out, seeing how they work, staying in contact, and changing course if needed. This requires regularly scheduled appointments, not simply ad hoc follow-up visits. Using this reflective stance, parents can brainstorm together with you, try

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Four Principles for Helping Children in Separated or Divorced Families
1. Clarify custodial rights before starting the assessment. Stay up to date on your state's laws.
2. Cultivate an expectation of collaboration from the start. Actively seek all points of view to find shared values and goals.
3. Get objective data from both households whenever possible (eg, medication logs, sleep logs, etc).
4. Take the long view. Employ a calm, reflective, iterative approach to support effective treatment and build parental confidence and collaboration over time.

Expert Interview—Pharmacogenetics: Not Quite Ready for Prime Time?

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and ones that arise anew during development as part of the impact of the environment and experience on genetic expression and activity (epigenetics). Researchers compare large groups of individuals with a given disease to groups of individuals without that disease and look for genetic differences between the groups. Instead of looking at each genetic difference individually, you look at a cumulative polygenic risk score.

CCPR: How do we use that risk score clinically?

Dr. Besterman: With our current research, polygenic risk scores are not good enough to predict with clinical certainty whether someone will have one of these psychiatric disorders. Still, the goal is not to use these risk scores in isolation, but to combine them with other risk factors, such as environmental risk factors, to improve our prediction of onset of disease.

CCPR: OK, we've spent some time unpacking diagnostic testing. What about pharmacogenetic testing?

Dr. Besterman: Pharmacogenetic testing looks at genes involved in drug metabolism. There's an international organization, the Clinical Pharmacogenetics Implementation Consortium (CPIC), that puts out guidelines for pharmacogenetic testing (www.cpicpgx.org). Right now, the recommendations in psychiatry include three genes. The first is CYP2D6, which metabolizes many antidepressants, antipsychotics, and atomoxetine; the second is CYP2C19, which metabolizes citalopram, escitalopram, and sertraline. Testing for these genes can predict how fast or slow a person will metabolize these medications. It doesn't tell us how well they will respond to them. The third gene you might check is HLA-B; a particular variant of this gene is often present in people of Asian descent and predisposes a person to carbamazepine hypersensitivity. If a person has this gene variant, their risk of developing Stevens-Johnson syndrome is greatly elevated. So, this is definitely indicated for Asian patients who are being started on carbamazepine.

"Genetic testing can provide relief to those who've been on a diagnostic odyssey, going from specialist to specialist looking for an answer. It can also help these families connect with other families who have a child with a similar genetic condition for social and emotional support."

Aaron Besterman, MD

CCPR: The advertised tests cover a broader set of genes. Is there a scientific basis for their approach?

Dr. Besterman: There are a lot of direct-to-consumer commercial companies, especially in pharmacogenetics, where the patient and the doctor receive this report that puts medications in green, yellow, and red boxes. But how the companies come to those conclusions is not well understood. If you compare the recommendations between companies, they're often very inconsistent. This information can be misleading and potentially even cause harm.

CCPR: I saw two patients recently whose families insisted on getting a genetic test to see what medication their child should have. In both cases I told them I didn't think the test would tell us anything, and it would be expensive and might even suggest things that aren't helpful. One family hasn't done it yet, maybe because of the cost. I had already started the other patient, a teen, on fluoxetine because that's what the clinical data supported. The kid had a great response to the fluoxetine, but the test report said it was in the red box and therefore recommended against using it.

Dr. Besterman: Yes, that's one of the risks: not using medications that could potentially be helpful, or stopping medications that are already helpful, because the families don't understand what it means for the medication to be in a red box.

CCPR: Patients say, "My relative got a test that showed them why their medication didn't work. Now they're on a different medicine and they're doing great. I want the test, too." What should we say to them?

Dr. Besterman: I say, "Every person is unique, and we need to assess you individually." Try to understand their goals, then decide whether pharmacogenetic testing is helpful for that patient. Emphasize that testing can only really help us decide whether an individual should be on higher or lower doses than average of certain medications—it doesn't tell us anything about whether a patient is going to respond overall to a medication. Sometimes they're still interested in getting tested, and I go along with that. It can be helpful for patients when they're particularly anxious about medication side effects and want some objective data. But it's really important to not make decisions just on the pharmacogenetic data; instead, use the data together with other information to make a decision based on your best clinical judgment.

CCPR: How about MTHFR and COMT? There's a lot of marketing, especially for L-methylfolate and primary care doctors getting a test from 23 and Me to look at COMT.

Dr. Besterman: A decade ago, during the candidate gene era of psychiatric genetics, we didn't have much information about the genetic architecture of psychiatric disease, and researchers would guess which genes might be related to psychiatric illness based on neurobiology. The evidence supporting their role in either risk for genetic disorders or drug response in psychiatric treatment is still limited, and ordering genetic tests for MTHFR and COMT is not particularly helpful for our psychiatric patients. That's not to say that those genes have absolutely no role in the neurobiology of psychiatric illness, but there is insufficient evidence to say testing for changes in those genes will alter our care in any way.

CCPR: You mentioned that the test results from different companies might be inconsistent.

Dr. Besterman: There was a study a few years ago by Bousman and colleagues. He took patient

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Expert Interview—Pharmacogenetics: Not Quite Ready for Prime Time?

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samples and sent them to different direct-to-consumer laboratories and got their medication recommendations. There was a lot of inconsistency between the companies, not only in the specific genotypes, but also in the metabolic phenotypes—meaning whether they thought a given patient was a poor, intermediate, or rapid metabolizer. And the medications that they were putting into green, yellow, and red boxes were also very different (Bousman CA et al, *Pharmacogenet Genomics* 2017;27(11):387–393). There needs to be standardization in the field. In fact, the FDA started sending cease-and-desist letters to some of these companies last year. The field is undergoing some evolution, and that's probably a healthy thing.

CCPR: Do you have any quick guidelines that we might use?

Dr. Besterman: Absolutely. Visit the ISPG website at www.ispg.net. They have helpful educational resources.

CCPR: Is it possible to pack all of this into a bottom-line message for our colleagues?

Dr. Besterman: Learn more about genetics, including the hopes but also the current limitations. It is a growing area of medicine and is going to permeate all fields, including psychiatry, more and more with time. There are many resources out there. I've co-written some reviews regarding what psychiatrists need to know about genetics that are freely available on PubMed (www.ncbi.nlm.nih.gov/pmc/articles/PMC5371713). In addition to the ISPG, there's also the National Neuroscience Curriculum Initiative or NNCI (www.nncionline.org), which is an incredible education resource with many online modules that take you step by step through easily digestible scenarios, including genetics.

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

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Cultural Competence: Impact on Clinical Care

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soft-spoken couple who tell you that he causes no trouble at home. They encourage Hien to come to them with any worries and are alarmed over his difficulties at school. You are concerned that the school has misinterpreted Hien's anxiety as misbehavior and schedule a call, resisting the pressure to try to solve this with more medication.

Our assumptions about children shape diagnosis and treatment; we may interpret a given behavior entirely differently based on the setting in which it occurs. We want to avoid inadvertent participation in a treatment plan that fails to bridge cultural differences and thus is ultimately unhelpful. This article builds on our recent interview with Dr. Andres Pumariega about cultural issues in child and adolescent psychiatry (*CCPR,* July/Aug/Sep 2020) to improve your awareness of how culture impacts assessment and treatment.

Cultural differences in communication

Communication styles vary from culture to culture, impacting how we interpret a person's meaning and intent. For example, Western European culture uses intentional eye contact to convey care and presence, yet in Japan and Southeast Asia, sustained eye contact connotes aggression. Silence also is perceived differently in various cultures. In China, silence connotes agreement and acceptance; in many aboriginal cultures, sustained introspective silence is the norm before responding to a question; and in North America and the UK, silence between people implies distance or disinterest. Facial cues also vary between cultures. It can be difficult to read subtle facial cues in patients from cultures that tend to avoid facial expressions of negative emotions, as is common in Japan (Huang Y et al, *Psychiatry Clin Neurosci* 2001;55(5):479–483). In addition, individuals from Native American and some European cultures may perceive direct questioning as rude. In our case example, Hien's behavior of "flocking" to peers and adults is communicating anxiety in a manner consistent with his family's culture.

One month later, you learn that Hien has been moved to a new school for children with conduct problems. After several restraint episodes, his behavior is "much improved"; however, there is a report that older peers have gotten Hien to "talk funny Asian" for them. When you speak to him, Hien is quieter than during the previous appointment. His affect is flat and he is less responsive. You worry that Hien's compliance comes from a sense of helplessness. You tell Hien's parents that you are concerned Hien is too compliant, which might make him vulnerable to being mistreated by his peers, and that you wish to work together to see if there are other possible approaches to care. They reply, "Yes, of course; we will do whatever you say so that Hien will be a good boy." Two weeks later, you receive an online review about yourself that states, "The doctor said that he didn't want our child to behave."

Adjusting your assessment style

Despite our best efforts to offer respectful care, any of us might misstep. For instance, collaborative therapeutic relationships can confuse clients from hierarchical cultures who expect explicit direction, something common among Latino communities. Similarly, clients from cultures with an emphasis on humility, such as Asian and Native American cultures, may benefit from being asked to think about their strengths in terms of the perspectives of others.

Be aware that mental health is more stigmatized in some populations, and this can have a significant impact on the patient. Families may distrust mental health providers, may view problems in terms of being good or bad, or may disregard them entirely. For example, a Western patient with anxiety

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or depression might experience psychological distress, but a patient from a Filipino culture with anxiety or depression might experience and interpret that distress solely as physical symptoms. Some families will avoid treatment; others may decline medication, particularly in favor of culturally congruent remedies or practices.

Research supports open, therapeutic environments for diverse clients (Asnaani A and Hofmann SG, *J Clin Psychol* 2012;68(2):187–197). Within your working relationship with both patients and families, you may evoke a range of responses: compliant deference, egalitarian partnership, or even outright fear or hostility. Here are some ways to guide your assessment:

1. Remain non-judgmental. We all have preexisting ideas about cultural groups different from our own, and these assumptions can cause patients to feel misrepresented or marginalized. Treat those assumptions as hypotheses. If you assume many patients from a certain culture will somaticize, remember that an individual patient from that culture might not.

2. Don't play the expert. You may be tempted to demonstrate your knowledge of your patient's culture, leading patients and families to feel prejudged. Instead, it is better to acknowledge your limitations. For example, you might say, "I know about learning problems, and I also know you are the expert in how you and your family think about learning."

3. Get input and stay humble. Ask patients, "Help me understand how you think these problems happened." Inquire how they usually like to work with doctors and other professionals. Listen for and ask about how they communicate at home. The Cultural Formulation Interview (APA, 2015) is a useful tool for identifying client cultural identity, cultural explanations of mental illness, cultural factors, and cultural communication (APA allows this supplemental tool to be reproduced for clinical and research purposes; see www.tinyurl.com/19sdrkr7).

4. Be aware of developmental enculturation. Teens will often request mental health care as they become enculturated into the dominant Western culture, even if their parents and families do not share or support this view. Mediate this topic, allowing all parties to voice their opinions. You could say, "It seems that there are different ideas about what is happening at school—let's list them all so we can think about them together."

Adjusting treatment

During your next family appointment with Hien and his parents, you try an authoritative tack, mirroring the parents' language about being "good" and recommending placement in a small, emotionally supportive school now that Hien's behavior is "better."

Once you have a better understanding of how your patient culturally experiences the world, you can shape a better care plan. Here are some strategies for adjusting care to your patient's cultural context:

1. Employ a communication style that fits with the family's needs. For example, with some families you may need to take a more authoritative stance; others might call for being more egalitarian and collaborative; and still others might necessitate cultivating the role of humble service.

2. Frame your treatment plan from your patient's perspective. Some families may not be comfortable with discussing emotions during a therapy session. Some may prefer a more indirect approach like meeting regularly with the child's teacher. Similarly, some families find hospitalization extremely stigmatizing and may do better if their children receive intensive outpatient care. You may also want to obtain permission to talk with important figures, perhaps a patriarch or matriarch, about medications and other treatments.

3. Seek empirical data on treatment adaptations identified for various cultures. The U.S. Department of Health & Human Services' Office of Minority Health sponsors a helpful website called Think Cultural Health (www.thinkculturalhealth.hhs.gov/about). It contains an online library with resources on integrating cultural competence into therapeutic practice. See also *CCPR* Summer 2020 for examples, such as CBT for depression in teens modified for Puerto Rican culture and brief strategic family therapy developed for Latino families in the Miami area.

4. Keep learning from your families. With every family, you will become more effective over time as you learn more about how the patient and family members express themselves, how they interpret others, and what the family's ongoing expectations are of the child, the school, and you. Use that information to inform your approach and problem solving. A helpful PDF called "Understanding the Families You Work With: Reflective Questions to Uncover Cultural Differences" is available at www.tinyurl.com/dosveu2u.

Six months later, Hien is thriving on no medication. However, he is having trouble with the boisterous recess environment where there is no organized play. You learn that at home there is a structured schedule of activities much like what Hien's parents had as children. You work with the school to offer optional semi-structured facilitated playground activities. A few days later, you read a new online review that says, "This doctor is very wise."

CCPR VERDICT: Autism itself has a culture of care, and yet, like for all conditions, cultural aspects can create an entirely new clinical picture. Through information and tools, we can adjust care to better meet the needs of our patients and their families in their cultural context.

Q&A With the Expert

Treating Pandemic-Associated Trauma in Children and Adolescents

Alan Steinberg, PhD and Naser Ahmadi, MD, PhD

Dr. Steinberg is Associate Director of the National Center for Child Traumatic Stress at UCLA.
Dr. Ahmadi is Assistant Professor of Psychiatry at UCLA.

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

CCPR: Tell us about your backgrounds.

Dr. Steinberg: I'm the Associate Director of the National Center for Child Traumatic Stress at UCLA.

Dr. Ahmadi: I'm Assistant Professor of Psychiatry at UCLA and Director of Family Trauma Distress at Olive View, and Dr. Steinberg and I worked together with colleagues to develop our UCLA Brief COVID-19 Screen for Child/Adolescent PTSD.

CCPR: What is the National Center for Child Traumatic Stress? What's its purpose?

Dr. Steinberg: The problem of child traumatic stress in the US is enormous: sexual abuse, physical abuse, neglect, domestic violence, and mixtures of complex trauma histories—including kids who are exposed to natural and manmade disasters, catastrophic school violence, community violence, exploitation, trafficking, traumatic bereavement, and so on. That's the reason for the National Child Traumatic Stress Network Initiative: to make all systems that provide care and services to children and families more trauma informed, to ask about trauma histories and PTSD, and to help these kids receive needed assessments and evidence-based interventions.

CCPR: What are some of the symptoms of pandemic-associated trauma in children? And how do you assess for these symptoms?

Dr. Ahmadi: In our current pandemic, the trauma is often related to losses and traumatic events even when the child is unlikely to have COVID. Many youths have traumatic experiences related to COVID, like having someone close to you die from COVID—a family member, schoolmate, or teacher—or having a parent working in an environment where they're exposed to the illness or where there's been a quarantine in the family. Our new screening instrument can help clinicians assess these concerns more specifically for better treatment planning. (*Editor's note:* The UCLA Brief COVID-19 Screen for Child/Adolescent PTSD is available at no cost in both English and Spanish for use by professionals across a range of child-serving systems, including behavioral health, primary care, pediatrics, schools, child welfare, juvenile justice, and residential care. See www.tinyurl.com/uv4qu5gr.)

CCPR: Is there research specifically on the effects of COVID on mental health?

Dr. Steinberg: We know from global reports of the pandemic that many adults and children have traumatic and stress symptoms due to COVID. When you assess kids who suffer from trauma, you usually expect maybe 10% or 20% to have PTSD. In April 2020, we saw an influx of adults and children coming with much more dysregulation, and we found 20%–40% of these people had PTSD related to the pandemic, which was kind of a shock to us. This is really important because the current standard of care for trauma screening is very limited in scope.

CCPR: How do you treat children with pandemic-related PTSD?

Dr. Ahmadi: In addition to usual trauma-informed care—such as helping kids get back to familiar routines, supporting structure and new routines when that's not possible, and supporting parents and other caregivers so they can be present and supportive and reassuring to kids—we have used two techniques that show a lot of promise. One is called "reminder-focused positive psychiatry" (RFPP) and the other is called "trauma-focused cognitive behavioral therapy" (TFCBT). RFPP is focused on helping patients identify and manage reminders of trauma that trigger symptoms, including consciously shifting attention away from those reminders to more positive feelings, thoughts, goals, and choices. TFCBT is the adaptation of usual cognitive behavioral therapy to traumatic events. It places a focus on the traumatic event itself and on symptom relief by shifting how the patient thinks about the event, eg, how much the patient blames themselves and how that impacts their mood and other symptoms. Both are easy-to-learn approaches for clinicians who have an interest in doing this in the office.

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"Reminder-focused positive psychiatry (RFPP) helps patients identify and manage reminders of trauma that trigger symptoms, including consciously shifting attention away from those reminders to more positive feelings, thoughts, goals, and choices. These behavioral modules focus on self-compassion, treatment engagement, distress tolerance, and safety planning skills."

Alan Steinberg, PhD and
Naser Ahmadi, MD, PhD

Expert Interview—Treating Pandemic-Associated Trauma in Children and Adolescents

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CCPR: How do you deal with children who come into the emergency room with suicidality?

Dr. Ahmadi: It depends on how severe the symptoms are. In our emergency care unit, we sometimes need to transfer the child with PTSD and suicidality to an inpatient unit for further stabilization. On the other hand, even when children present with suicidal ideation, we can sometimes come up with a good suicide prevention plan that allows them to go home. We've actually published a study on suicide prevention (Ahmadi N et al, *J Am Acad Child Adolesc Psychiatry* 2020;59(10):S251–S252). The technique is derived from RFPP, and we call it RFPP-S (reminder-focused positive psychiatry and suicide prevention intervention).

CCPR: Can you tell us more about RFPP-S?

Dr. Ahmadi: RFPP-S is a brief, 2-day program that typically occurs while the child is in the emergency room. It consists of two 10-minute-long therapy sessions per day. These are behavioral modules focused on self-compassion, treatment engagement, increased ability to manage trauma reminders, distress tolerance, and safety planning skills. Adolescents with PTSD and suicidal ideation receive 10 minutes of RFPP-S modules twice a day for 2 consecutive days. There is also one 10-minute RFPP-S parent psychoeducation module. We used the Columbia-Suicide Severity Rating Scale (C-SSRS) as our outcome variable and found that the scores dropped from an average of 3.5–4.5 at baseline to 1.5–2.5 on the second day. This was followed by discharging from the emergency room and post-discharge outpatient management (Ahmadi N, *J Am Acad Child Psy* 2019;58(10):S269; see "Positive Skills in RFPP-S" table below).

CCPR: What did the research show?

Dr. Ahmadi: Our study was a retrospective nested matched case-control study of 50 children with PTSD and suicidality who received RFPP-S and 150 children with PTSD and suicidality who did not receive RFPP-S during their 2-day psychiatric ER treatment visit. We found that the technique was significantly more effective than treatment as usual. There was a 55% reduction in PTSD symptoms vs only 10% in usual treatment, and there were clinically meaningful reductions in suicidality scores in 80% of those in the treatment group vs only 15% in usual treatment. The 1-month readmissions for suicidality for those getting RFPP-S was 0 compared to 205 (some patients had multiple readmissions).

Positive Skills in Reminder-Focused Positive Psychiatry and Suicide Prevention Intervention (RFPP-S)

Module	Therapeutic Messaging/Techniques
Self-Compassion	Accept yourself, including your suffering, thoughts, and feelings. Notice that each of your unwanted thoughts is just one of many ways to think about your situation.
Treatment Engagement	Your passionate and purposeful interactions with others can improve your positive feelings and interpersonal relationships.
Managing Trauma Reminders	Label traumatic reminders with silly names. Call out the silly name when reminded of the trauma, followed by gratitude and self-compassion.
Distress Tolerance	Think about a time in your life when something bad happened and practice distress tolerance skills.
Safety Planning Skills	When you think of death or suicide, tell your parents "I am sad; make me happy." They are aware of your triggers and will work with you through self-compassion, gratitude, and engagement exercises for 30 minutes or more until this wave of emotion crests and subsides.
Parent Psychoeducation	Parents should practice handling trauma reminders with their child, using techniques of self-compassion, gratitude, resilience, and engagement exercises.

CCPR: Thanks again for your time, gentlemen.

Editor's note: Training in TFCBT is available at a nominal cost at www.NCTSN.org. Dr. Ahmadi plans to develop more training programs for RFPP-S in the near term.

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Prescribing to Children of Divorce

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ideas, and see what works and what doesn't. This process supports the development of each parent's sense of confidence in their care of the child, building a more collaborative environment for treatment.

5. If parents cannot or will not be present in the same meeting, schedule regular time with each parent separately to gather information, talk about treatment planning, and negotiate workable treatment plans. This will double your time on the case, and it underlines the importance of your role in supporting the child through a difficult life circumstance.

CCPR VERDICT: In divorce, the usual complexities of clinical practice are amplified. Children of divorce do better when parents co-parent in a collaborative manner. Faced with parents who are often suffering and don't like each other, the clinician can be a trusted, neutral figure who elicits the best from each parent and reminds them that they can find common ground in working together to support their child.

Research Updates IN PSYCHIATRY

OCD

Long-Term Treatment Response in Pediatric OCD

REVIEW OF: Melin K et al, *J Am Acad Child Adolesc Psychiatry* 2020;59(2):244–253

OCD affects 1%–4% of children and adolescents and can be chronically debilitating in 40%–60% of cases.

The well-known Pediatric OCD Treatment Study (POTS) published in 2004 showed that CBT and sertraline had comparable benefits over 12 weeks of treatment; however, it left us with questions about whether we should continue CBT or recommend pharmacotherapy for youth who do not respond to CBT in 12–16 sessions. Also, given the chronic course of OCD in many patients, questions persist about how treatment options compare in the long run. The current study tried to find answers to the latter.

The Nordic Long-term OCD Treatment Study (NordLOTS) enrolled 269 children and adolescents (ages 7–17 years) with OCD from clinics across Sweden, Norway, and Denmark. Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) scores were used as inclusion criteria (> 15) and to deem subjects as responders (0–15), non-responders (16–40), or in remission (0–10).

All participants were treated with 14 weeks of manualized exposure-based CBT. Non-responders to weekly CBT (n = 64) were randomized to continued CBT (n = 28) for 10 more sessions or switched to sertraline (n = 26) titrated at 25–200 mg over 16 weeks. Subjects were followed periodically for 3 years.

After 3 years, 73% (n = 196) of kids were in remission with 24% scoring 0 on the CY-BOCS. Another 17% (n = 46) had mild symptoms (CY-BOCS 11–15). Those who responded well to initial CBT (65%, n = 177) continued to do well with minimal additional intervention.

Non-responders to initial CBT had significantly more severe OCD at baseline (CY-BOCS 26.4 vs 23.8, $p < 0.001$) but showed comparable improvement at 2-year follow-up (CY-BOCS 9.6 vs 5.6, $p < 0.001$) and caught up with responders at 3-year follow-up (CY-BOCS 5.0 for both). Surprisingly, non-responders to initial CBT did equally well with continued CBT vs a switch to sertraline.

Only 27% of the participants had a chronic course in this study (17% mild and 10% moderate to severe), perhaps due to early initiation of quality treatment (average 1.2 years after onset of symptoms).

CCPR'S TAKE

Quality manualized exposure-based CBT remains an excellent approach for pediatric OCD, but some kids need continued treatment for adequate response. In contrast to adult studies showing that CBT benefits may endure better than medication treatment once treatment ends (Ponniah K et al, *J Obsessive Compuls Relat Disord* 2013;2(2):207–218), this study shows that in kids, SSRIs are just as effective for those who don't benefit from or cannot access CBT. Either treatment works better when started earlier and coupled with ongoing monitoring. With good treatment, long-term prognosis for pediatric OCD is excellent.

—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.

EATING DISORDERS

New Canadian Eating Disorders Guidelines

REVIEW OF: Couturier J et al, *J Eating Disorders* 2020;8:4

Good guidelines can optimize clinical practice. The APA last published eating disorder guidelines in 2012. In 2020, a group of Canadian psychiatrists published new practice guidelines for eating disorder treatment. Let's take a look.

This systematic and comprehensive literature review screened thousands of abstracts to find several dozen articles and prioritized randomized controlled trials (RCTs). The diverse 24-member research team included parents and patient representatives and looked at various psychotherapies: family-based cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), medications (primarily atypical antipsychotics and SSRIs), and site of treatment.

Of the studies reviewed, many suffered from significant potential bias and many showed no significant effect of treatment. But there was some strong research. For example, one study compared CBT with psychodynamic therapy for 81 girls with anorexia nervosa. The two treatments were comparable, each yielding remission rates of about 33% after an average of 37 weeks of treatment.

After synthesizing all the study results, the researchers arrived at two main recommendations: First, family-based treatment is clearly effective for both anorexia nervosa and bulimia nervosa, and second, less restrictive treatment environments (eg, family-based or day treatment) are more effective than lengthy hospitalizations. The following five modalities were also recommended, but with less confidence: multifamily therapy, CBT, adolescent-focused psychotherapy, yoga, and olanzapine or aripiprazole with anorexia nervosa "if monitored carefully."

Why weren't SSRIs recommended? After all, the 2012 APA guidelines found grade A evidence for numerous antidepressants in bulimia nervosa (36 RCTs) and binge eating disorder (26 RCTs) with adults. The answer is that these Canadian researchers excluded studies with subjects over age 18, eliminating the great majority of medication RCTs in eating disorders.

CCPR'S TAKE

Don't rely on medications to be game changers for children and adolescents with eating disorders. This exhaustive review of the literature on child and adolescent eating disorder treatment guides us to favor evidence-based psychotherapies in the least restrictive environments (*Editor's note:* To review the guidelines for eating disorders, see the Couturier et al study at www.tinyurl.com/3whtlsxa).

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

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Research Updates
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SLEEP

Melatonin for Sleep-Onset Insomnia

REVIEW OF: Wei S et al, *Sleep Medicine* 2020;68:1–8

Sleep-onset insomnia, characterized by difficulty falling asleep and daytime fatigue, is a common problem among youth. While sleep hygiene is the first step, families often have trouble implementing such measures, which include regular wake-up times, daily exercise, shutting down screens in the evening, and reserving the bed just for sleep. At *CCPR,* we advise caution before using marketed sleep medication (*Editor's note:* For a full discussion, see Carlat's 2018 *Child Medication Fact Book for Psychiatric Practice*). One potentially safer option is melatonin. But is exogenous use of this hormone effective? Is it safe? This meta-analysis looked at the safety and efficacy of melatonin in randomized placebo-controlled studies.

The authors of the meta-analysis examined 550 studies and found that only seven met their criteria for methodology. In these studies, a total of 387 youth with sleep-onset insomnia were enrolled in placebo-controlled trials. Most subjects were children (94.6%), with a mean age of 9 years. All studies used immediate-release melatonin tablets at doses of 1–6 mg/day for 1–4 weeks.

Melatonin was often effective in very low doses. Sleep onset time, the primary outcome for efficacy, generally came over a half hour earlier with use of melatonin compared to placebo. Total sleep time was increased by about 20 minutes.

Side effects included fatigue, headache, gastrointestinal upset, and depressed mood. Specific percentages of these were not reported; however, symptoms were mild to moderate, with little difference in dropout rates between melatonin and placebo. One patient developed generalized seizures 4 months after using melatonin, and there were mixed reports of both more and fewer seizures in the studies that were not included in the meta-analysis. The authors note possible concerns in long-term use of melatonin, with particular concerns about reproductive function and the course of epilepsy.

CCPR'S TAKE

This study suggests a modest clinical utility for short-term use of melatonin in children and adolescents struggling with sleep-onset insomnia, perhaps starting at 1 mg. Although generally safe, melatonin may lower the seizure threshold and should be used with caution in patients with seizure disorders. As a note, melatonin tends to work better given 90–120 minutes before desired sleep onset, and good sleep hygiene always comes first.

—Lauren Cashion, MD. Dr. Cashion has disclosed no relevant financial or other interests in any commercial companies pertaining to this educational activity.

LANDMARK STUDY

The MTA Turns 21: Implications for ADHD Treatment

REVIEW OF: The MTA Cooperative Group, *Arch Gen Psychiatry* 1999;56(12):1073–1086

The Multimodal Treatment Study of Children with ADHD (MTA) published its first and most important results 21 years ago, answering fundamental questions about the roles for medicine and behavioral treatment in childhood ADHD.

Funded by NIMH, the study enrolled 579 children (ages 7–9.9 years) with combined-type ADHD for 14 months of treatment. Investigators randomly assigned children into four groups. Control arm kids ("community care") saw their pediatrician for medication. Medication arm kids had monthly 30-minute visits with a psychopharmacologist. These prescribers methodically titrated patients to an optimal dose of immediate-release methylphenidate, prescribed 3 times daily, and could switch to another medicine if needed. The behavioral management arm received multiple interventions: Kids attended an 8-week, 9 hour/day therapeutic summer day camp; a treating clinician delivered about 30 hours of parent training and 10 hours of school consultation; and kids had 60 days of in-school coaching by a dedicated paraprofessional. The combined group got the best of both worlds—medication and behavioral treatments. The study measured outcomes with multiple observers using standard rating scales.

The groundbreaking result was that for the core symptoms of ADHD, medication management was equivalent to combined treatment, and it was superior to behavioral therapy alone. For ADHD-adjacent outcomes (aggression/oppositionality, internalizing symptoms, social skills, parent-child relations, and academics), medication and behavioral treatment were equivalent. Compared to the control group, combined treatment looked stronger than either modality alone for these functional domains.

Many of us were surprised that beyond expert medication treatment, elaborate behavioral treatments added little to the treatment of core ADHD symptoms. For all domains affected by ADHD, medication was necessary to get the best outcome. Compared to medication management, control kids receiving medicine were taking it less often (3 doses/day vs 2.3 doses/day) and in lower doses (31–38 mg vs 23 mg). Follow-up reports on these cohorts have found that after the interventions ended, medication was used less intensively and systematically over time. Concomitantly, differences between the treatment groups dissipated. However, there is accumulating evidence from other studies that ongoing stimulant treatment for ADHD is effective and is associated with long-term academic gains and reductions in criminality (Lichtenstein P et al, *N Engl J Med* 2012;367(21):2006–2014; Jangmo A et al, *J Am Acad Child Adolesc Psychiatry* 2019;58(4):423–432).

CCPR'S TAKE

This landmark study supported adequate dosing and the development of extended-release treatments. Since this study, we have learned that behavioral treatments and coaching offer added effect, although cost can be a limiting factor. For all patients, the abiding lesson is the importance of sustaining ongoing, expert-delivered psychopharmacological care for patients with ADHD across childhood and into adulthood.

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

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1. What is a helpful strategy when creating a culturally competent treatment plan for a patient who is from a non-Western cultural background (LO #1)?
   - [ ] a. Seek empirical data on treatment adaptations identified for the patient's culture
   - [ ] b. Present a treatment plan that has benefited most patients from a Western culture
   - [ ] c. Communicate with the patient and their family the same way you'd communicate with a patient from a Western culture
   - [ ] d. State in neutral and clear terms that your treatment plan is supported by scientific research

2. According to Dr. Besterman, what can be concluded from pharmacogenetic tests of the CYP2D6 and CYP2C19 genes (LO #2)?
   - [ ] a. The tests can show the need to monitor for common comorbidities with some psychiatric disorders
   - [ ] b. The tests can reveal a patient's likelihood of responding to a certain pharmacotherapy
   - [ ] c. The results can be used to predict a patient's rate of metabolism of certain medications; however, this does not generally impact routine careful prescribing
   - [ ] d. The results can be used to predict a patient's likelihood of remission with certain medications

3. In a 2020 systematic and comprehensive literature review, what was concluded about eating disorder treatments for children and adolescents (LO #4)?
   - [ ] a. Family-based treatment is effective for anorexia nervosa, but not bulimia nervosa
   - [ ] b. CBT yielded remission rates of about 22% in girls with anorexia nervosa
   - [ ] c. Less restrictive treatment environments are more effective than lengthy hospitalizations
   - [ ] d. Both CBT and psychodynamic therapy yielded remission rates of 49% in girls with anorexia nervosa

4. In a 2019 study of children who presented to the ER for PTSD and suicidality treatment, how did the RFPP-S group compare to the treatment as usual (TAU) group (LO #3)?
   - [ ] a. The RFPP-S group had significantly reduced suicidality scores and hospital readmissions, but did not significantly differ from TAU in PTSD symptoms
   - [ ] b. The RFPP-S group had an equal reduction in suicidality scores compared to TAU
   - [ ] c. TAU was significantly more effective than RFPP-S
   - [ ] d. RFPP-S significantly reduced PTSD symptoms and readmissions for suicidality, and yielded clinically meaningful reductions in suicidality scores vs TAU

5. Tomorrow, you will meet a new patient and their parents. You lack general exposure to their cultural background, but you would like to have a culturally competent assessment and relationship with them. Which of the following would be the least effective way of accomplishing this (LO #1)?
   - [ ] a. Remaining non-judgmental by treating your assumptions as hypotheses
   - [ ] b. Asking them how they work best with providers, and how they believe certain problems emerged
   - [ ] c. Researching and demonstrating knowledge about their culture
   - [ ] d. Being aware that the patient and their parents might have different beliefs and views about mental health

6. A parent with sole physical custody has full decision-making authority and is the only parent needed to sign off on psychiatric-related paperwork (LO #1).
   - [ ] a. True
   - [ ] b. False

7. In a 2020 study involving children and adolescents with OCD, which statement about the non-responders to initial exposure-based CBT is supported by evidence (LO #4)?
   - [ ] a. The non-responders showed comparable improvement to the responders at 1-year follow-up
   - [ ] b. The severity of the non-responders' OCD was equal to that of the responders at baseline
   - [ ] c. The non-responders showed improvement at 3-year follow-up, but their improvement was significantly less than the responders
   - [ ] d. The non-responders randomized to either continue CBT or switch to sertraline did equally well

8. According to Dr. Steinberg, the COVID-19 pandemic has had what effect on the rates of emotional dysregulation and PTSD in children and adults (LO #3)?
   - [ ] a. Rates of emotional dysregulation have increased in children and adults, but rates of PTSD have only increased in children
   - [ ] b. Rates of emotional dysregulation and PTSD have increased in children and adults
   - [ ] c. Rates of PTSD have increased in children and adults, but rates of emotional dysregulation have only decreased in adults
   - [ ] d. Rates of PTSD have only increased in adults, while rates of emotional dysregulation have only increased in children

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Clinical Complexity With Children and Adolescents
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Autism in Children and Adolescents
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Note From the Editor-in-Chief

In this first issue of 2021, we dig deeper into current and chronic areas of clinical complexity. Genetic testing can find identifiable disorders, offering relief to families searching for answers and perhaps guiding future treatment. Despite the hype, though, pharmacogenetics has limitations; we need to know what it can and cannot tell us. In the age of COVID-19, we must assess for pandemic-related impacts on children and adolescents. We cover UCLA's COVID-19 PTSD screen and expert intervention to address suicidality.

Don't be pressured to medicate your way out of cultural problems. We offer a respectful how-to approach to help families caught between cultures. How can we help families that are separated or divorced? Read about the legalities, the dynamics, and a collaborative approach to good mental health care despite inevitable differences between parents in these situations. Also in this issue, we cover best practices with melatonin, eating disorders, OCD, and a classic ADHD study.

As always, don't hesitate to get in touch—we want to hear from you.

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