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CHILD PSYCHIATRY

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Editor-in-Chief

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Learning objectives for this issue:

1. Describe non-suicidal self injurious behavior. 2. Explain the association between suicide risk and SSRIs. 3. Explain the risk factors for suicide in young people. 4. Understand some of the current findings in the literature regarding psychiatric treatment.

The Self-Injurious Patient

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

It can sometimes be hard to distinguish normal adolescence from borderline personality disorder. Both may be characterized by unstable, tumultuous relationships, emotional dysregulation, and incomplete identity formation. Not all adolescents go through such turmoil, of course, but it is common enough that when you see a patient who has cuts on her arms, don't jump immediately to the "borderline" diagnosis. In community samples, up to 46% of adolescents report some experience with deliberate self injury, both boys and girls (Lloyd-Richardson EE, *Psychol Med* 2007;37(8):1183-1192).

When presented with a self-injuring patient, the first thing I try to find out is

what the function of the self injury is. Is it suicidal? Did the patient want to die or think he or she might die? Often the answer is "no": the patient knew full well he or she would not die, and had no desire to die.

Reasons for Self Harm

In my observation of my own patients, self harm is a way to tolerate inescapable and unbearable emotions, most often intense anxiety. When I talk with patients about their cutting episodes—what happened first, what happened next—the picture emerges of someone who is stuck in a bad situation and can't find another way to cope with the misery of it. For example, one patient cuts when she hears her parents violently arguing in another room. Unable to leave, unable to bear the emotional distress, she cuts herself as a way of coping. Another patient cuts herself when she is humiliated in front of her peers. A third

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Black Box Redux: SSRIs and Risk of Suicide

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Dr. Morris has disclosed that he has no relevant relationship or financial interest in any commercial company pertaining to this educational activity.

It has been eight years since child psychiatry first began to deal with controversy about SSRIs and their potential to prompt suicidal behavior in youth. The controversy was prevalent in the popular press from the time of the introduction of SSRIs, leading the FDA to state in 1991 that "there is no credible evidence of a causal link between the use of antidepressant drugs, including Prozac, and suicidality or violent behavior."

However, this statement applied to SSRIs in general, not to SSRI use in

children and adolescents. In April 2004, the *Lancet* published a meta-analysis of studies evaluating SSRIs versus placebo in children and adolescents. Looking at both published and previously suppressed (unpublished) studies, the authors concluded that the only antidepressant for which the potential benefits outweigh the risks was fluoxetine (Prozac) (Whittington CJ et al, *Lancet* 2004;363(9418):1341-1345). For the other antidepressants, including paroxetine (Paxil), sertraline (Zoloft), citalopram (Celexa), and venlafaxine (Effexor), analysis of unpublished data seemed to show that they were relatively ineffective for depressive symptoms in kids, and that they caused an unacceptable rate of suicidal ideation and other serious adverse events. Their bottom line was that fluox-

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The Self-Injurious Patient

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burns himself when his love interests are not interested in him.

Studies bear out this observation. Experts theorize that self harm is reinforced and therefore repeated to the extent that the behavior is effective. Studies describe four categories of self harm that are reinforcing; two intra-personal (internal) and two social. The idea is that if people try self harm and it “works,” they keep doing it.

Self harm can be supported by both positive and negative reinforcement. For those of us who are a long way from our Psychology 101 classes: “negative reinforcement” is rewarding by making an unpleasant situation stop, like taking off tight shoes, while “positive reinforcement” is rewarding by gaining something after the behavior, like getting a piece of chocolate when you turn in your compliance forms.

When self harm is negatively reinforced, it generally relieves uncomfortable emotions like anger, anxiety,

sadness, guilt, loneliness, or a feeling of numbness. Common reasons for positive reinforcement of self harm include “feeling something even if it was pain,” punishing oneself, and feeling relaxed. However, self harm also engenders feelings of shame and guilt, and can therefore lead to more self harm.

In the social world, common negative reinforcers for self harm include the desires to avoid school work and other things you don’t want to do, to avoid punishment, and to simply avoid people. Positive self harm reinforcers include making other people angry, getting your parents to notice you, feeling part of a group, and getting attention from others. In my experience, most adolescents say they self harm for several reasons at once, on average four or five. Boys are more likely to identify “to make others angry,” while girls are more likely to endorse “to punish myself” (Lloyd-Richardson op.cit).

Endogenous Opiates

Endogenous opiates—those feel-good chemicals in our bodies that mimic the feeling of a narcotic—offer a different explanation for self harm. The basic theory is that tissue damage causes a pain signal that in turn causes the release of endogenous opiates. People have varying sensitivities to the effect of opiates, which is why some people absolutely love the feeling they get when they take a Percocet, and others mostly just want to throw up. Those who experience nausea from narcotics have a different ratio, density, and location of opiate receptors, especially in the GI tract, than those who experience pleasure. In addition, endogenous opiates, specifically beta-endorphin, vary in response to stress and to affective states, especially, but not exclusively, to those induced by pain. It appears that the body releases beta-endorphin to comfort a negative mood (Stanley B et al, *J Affect Disord* 2010;124(1-2):134-140).

In self harm, it is hypothesized that the injury induces the release of endogenous opiates, which then are rewarding. Beta-endorphins are also the source of the “runner’s high” or the “hurts so good” feeling of an intense workout.

Because early childhood experiences like trauma can change both the density of opiate receptors and the levels of beta-endorphin at baseline, people who self-injure may find self harm less painful and the subsequent endorphin release more rewarding than other people do. In a study of adults with cluster B personality disorders, a lower baseline level of endogenous opiates was found in the cerebrospinal fluid in those who frequently engaged in self harm—and found it less painful—as compared with those who did not (Stanley *ibid*). In my practice, the patients who tried cutting just once almost always make a face and tell me that they didn’t do it again because “it hurt!”

The Connection to Other Disorders

So is non-suicidal self injury (NSSI) truly separate from suicidality? A study by Wilkinson et al indicates that the best predictor of suicide attempt is not previous suicide attempt but rather non-suicidal self injury (Wilkinson P et al, *Am J Psychiatry* 2011; Feb 1: online ahead of print). In fact, 70% of people who engage in non-suicidal self injury eventually attempt suicide.

Several studies have reported data that help us to predict which self-harming adolescents are more or less likely to go on to attempt suicide. Adolescents who engaged in self harm *without* suicide attempt at the time of the study had better self esteem, more reasons for living, better family and peer support, fewer and less severe symptoms of depression, more symptoms of anxiety, and were likely to be younger. Loneliness, on the other hand, is a predictor of future suicide (Brausch AM and Gutierrez PM, *J Youth Adolescence* 2010;39(3):233-242; Guertin T et al, *J Am Acad Child Adolesc Psychiatry* 2001;40(9):1062-1069).

Contrary to the belief of some, NSSI is not the same as borderline personality disorder. Adolescent inpatients who engage in NSSI may have any of several disorders; the most common are conduct disorder, oppositional defiant disorder, major depression, PTSD, and generalized anxiety disorder (Nock MK et al,

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The Self-Injurious Patient

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Psychiatry Res 2006;144(1):65–72). They may also have no disorder at all. Interestingly, while two thirds of the female patients in Nock's study also met criteria for a personality disorder, only half met criteria for borderline personality disorder. The next most frequent were avoidant personality disorder and paranoid personality disorder.

NSSI in DSM-5

Among the proposed changes to DSM-5 is making NSSI a separate diagnosis, with the criteria summarized as follows: "Five days of minor to moderate self harm (cutting, burning, or other surface tissue damage) without intent or expectation of lethal potential." It can't be nail biting or wound picking, which are apparently ubiquitous adolescent behaviors. It must be accompanied by two of the following: negative thoughts or feelings just before the event, preoccupation with the urge to self harm, frequent urges to self harm, and/or a deliberate purpose for the self harm. It must also cause distress or impaired functioning. There are two proposed NOS categories, one for subthreshold symptoms, and one for "uncertain intent." (You can read all the details at <http://bit.ly/a5X1Rz>.)

The rationale for this new diagnosis is that NSSI is currently thought of as

pathognomonic for borderline personality disorder, and it is not so in adolescents and perhaps also not in adults. It is also not clearly a suicide attempt either, as discussed above. A new diagnosis allows the phenomenon to be studied and addressed more specifically.

NSSI is strictly defined in the DSM-5, but many other behaviors may be thought of as deliberate self harm, including multiple piercings, binge drinking, self-induced vomiting, and so on. I had a patient who got together with his friends and they beat each other with sticks. Another allowed her friends to carve their names in her arm. Research shows that the number of different ways that a person engages in self harm correlates with the likelihood of suicide attempt (Nock *ibid*).

Treatment Options for Self Harm

In addition to diagnosing and treating any underlying disorder or environmental situation, the goal of therapy should be to address the various reasons that might make self harm rewarding. To that end, improving distress tolerance addresses most of the internal reasons for self harm, and improving interpersonal effectiveness addresses most of the interpersonal reasons for self harm, and as such, one can see Marsha Linehan's

particular genius in developing dialectical behavioral therapy. Cognitive behavioral therapy also has much to offer by helping adolescents stay out of the ruminative negativity that drives the sense of overwhelming distress to start with. Concretely developing alternatives to self harm, such as music, can be helpful too.

The endogenous opiate theory of self harm suggests that an opiate antagonist like naltrexone could be beneficial by interrupting the pain-reward circuit. There is some evidence to support this in autistic and developmentally disabled individuals, and in several studies, repetitive self injurious behavior has been decreased with treatment with naltrexone. (For a review of the evidence, see Symons FJ et al, *Ment Retard Dev Disabil Res Rev* 2004;10(3):193–200.) Data on individuals who are not autistic is sparse, with just a few case reports and open label studies.

NSSI is a disorder that can be both frightening and infuriating to parents, teachers, and people who work with adolescents, but ultimately it seems to be just a symptom of distress. Helping the adults who surround the patient understand and recognize the distress may be the most healing thing you can do.



Black Box Redux: SSRIs and Risk of Suicide

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etine is the only reasonably safe and effective antidepressant for young patients. This conclusion was rather controversial, with some readers accusing Whittington of everything from sloppy science to outright bias, while others were impressed with the analysis and with the difference that including unpublished studies could make.

In response to the concerns about antidepressants and suicidality, FDA researchers did a meta-analysis of 24 randomized, placebo-controlled trials of nine antidepressants throughout the 1990s, which included all data, published or unpublished. They concluded that the use of antidepressant drugs in pediatric patients is associated with a "modestly increased" risk of suicidality

(Hammad TA et al, *Arch Gen Psychiatry* 2006;63(3):332–339). Unlike Whittington et al, the FDA scientists opted not to single out any particular drugs as being safer than others, citing many possible explanations for differences in risk. Nonetheless, it was clear from the study that some medications had a lower risk ratio for suicidal ideation (citalopram (Celexa) and fluoxetine at 1.37 and 1.53 respectively), while others were much higher (eg, venlafaxine at 8.84).

The FDA's findings eventually led to a required black box warning about suicidality in children due to antidepressants in October of 2006 (the FDA had analyzed their results in 2004 but the paper took two years to go through the journal peer review process).

References for Understanding SSRIs and Suicide Risk

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Expert Interview

**Risk Factors for Suicide
Annette Beautrais, PhD**

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

CCPR: Dr. Beautrais, you have extensive experience studying suicide. Can you tell us a little about yourself and how you got interested in this subject?

Dr. Beautrais: I was working on a large research study following a birth cohort when I was invited to work as the project manager on a large psychological autopsy study of suicide. From there, I became involved in studies of cluster suicide, media reporting of suicide, means of suicide, and interventions to reduce further suicidal behavior in those who had made at least one suicide attempt. I also helped to develop suicide prevention guidelines used for media, schools, colleges, emergency departments, social workers, prison officers and other groups, and became involved in policy development.

CCPR: Tell us a little bit about how you designed that first study.

Dr. Beautrais: I suggested that, since we could not get follow-up data on those who had died by suicide, we should design the study to include a group of people who had made medically serious suicide attempts (MSSAs), and follow them to look at outcomes and trajectories after MSSAs. So we developed a three-arm case control study of completed suicides (2020 cases), MSSAs (302 cases), and control subjects (1500), the latter selected at random from the community. We included people of all ages in all three groups. The numbers in each of our subject groups were large enough that we had stand alone studies of youth and older adult suicide. We also included interviews with significant others for each subject in our suicide, MSSA, and control groups (Borges G et al, *J Clin Psychiatry* 2010;71(12):1617–1628). We followed the MSSAs for five years with personal interviews, and then we checked their hospital admission and mortality records at 10 years after their index suicide attempts.

CCPR: What are the risk factors for completed suicide?

Dr. Beautrais: In our research, and using the research of others, we have developed a model that shows risk factors for suicidal behavior ranging from micro-level genetic factors (such as family history of mood or anxiety disorders), to meso-level family influences (such as childhood abuse and adversity, parental pathology, financial stressors), to macro-level social influences (eg, unemployment rates) and global issues (eg, cyber-supported social networking), all of which can lead directly or indirectly to suicidal behavior (Borges *ibid*). An individual's vulnerability to suicide is strongly influenced by genetic susceptibility to mental health problems and, notably, to mood disorders, substance abuse, anxiety disorders and antisocial and offending behaviors. Contextual factors (means of suicide, media climate, peer suicide attempts) and life stresses are additional influences.

CCPR: So why is it that only some kids with risk factors attempt suicide and some do not?

Dr. Beautrais: According to this model, the reason that only some young people and not all of those who experience adversity or psychiatric illness attempt suicide is because there is variability in the predisposition to suicidal behavior. Both the stressors to which people are subject and their individual traits have to combine to result in suicide. Both stressors and the traits are potential targets for treatment to the extent that each can be modified.

CCPR: Are there differences in risk factors for children and adolescents compared with adults?

Dr. Beautrais: The classes of risk factors are similar in youth and in adults but have different strengths: for example, in adult suicide, childhood adversity plays a lesser role, while mental health problems play a larger role.

CCPR: How about girls compared to boys?

Dr. Beautrais: Females are generally protected from suicide, compared to males, because they tend to choose the less lethal methods to attempt suicide, such as overdose, while males choose more violent, lethal methods such as firearms, hanging, and vehicle exhaust. This difference in method choice may reflect male predisposition to anger and violence (Beautrais AL, *Emerg Med (Fremantle)* 2002;14(1):35–42.) The exception is in China, where females tend to use pesticides to overdose rather than the typical Western choice of the contents of the medicine cabinet, and since pesticides have high lethality, their suicide attempts tend to be converted to completed suicides. Overall females tend to make twice as many attempts as males, but males in western countries tend to die at three to four times the rate of females.

CCPR: What are the most likely factors that lead kids to commit suicide?

Dr. Beautrais: Childhood adversity. Those children and young adolescents most at risk of suicide tend to be those exposed to greatest childhood adversity—foster home and welfare care, parental separation or divorce, multiple changes of parental figures, high residential mobility, exposure to childhood physical and sexual abuse and neglect, bullying. Immediately precipitating events include bullying, relationship problems or breakups, or family or personal stressors.

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CCPR: We hear that issues around “coming out” and homosexuality are among the most common causes of adolescent suicide attempt. You were involved in an expert panel on suicide and suicide risk in GLBT (gay, lesbian, bisexual, and transgender) populations. Can you tell us about that?

Dr. Beautrais: Beginning with our paper in *The Archives of General Psychiatry* in 1999, we have repeatedly shown that young people who are GLBT have a five- to six-fold increased risk of suicide attempt, as well as increased risk of mental health problems with which suicide is associated (Fergusson DM et al, *Arch Gen Psychiatry* 1999;62(1):66–72). This increased risk has not been demonstrated for completed suicide. It is likely to exist but be obscured by sample size and reporting biases.

CCPR: And the increased risk is presumably because of the adversity of harassment and bullying issues?

Dr. Beautrais: Although such findings are frequently interpreted as suggesting the role of homophobic attitudes and social prejudice in provoking mental health problems in GLBT youth, it has been considered that alternative explanations are possible. These include 1) the possibility that associations are artifactual as a result of measurement and other research design problems, 2) the possibility of “reverse causality” in which young people prone to psychiatric disorder are more prone to experience homosexual attraction or contact, and 3) the possibility that lifestyle choices made by GLBT young people place them at greater risk of adverse life events and stresses that increase risks of mental health problems, independent of sexual orientation. More research is needed to explain the reported associations.

CCPR: You recently published an article about the contribution of parent pathology to suicide. Can you tell us about that?

Dr. Beautrais: I have published a number of papers linking parental psychopathology with elevated suicide risk in offspring, as have colleagues like David Brent from Pittsburgh. A large body of research suggests that *any* parental psychopathology is associated with increased risk of suicidal behavior in offspring. Independently, parental mood and anxiety disorders tend to be associated with offspring suicide ideation and plans, while parental disorders characterized by impulsive aggression (for example, antisocial personality) and anxiety/agitation (for example, panic disorder) tend to be linked with offspring progression from suicidal ideation to attempt. A dose-response relationship between parental disorders and their children’s risk of suicide ideation and attempt has been found. Parental suicide predicts persistence of offspring suicide attempts (Goodwin RD et al, *Psychiatry Res* 2004;126(2):159–165; Brent DA et al, *Acta Psychiatr Scand* 1994;89(1):52–58).

CCPR: Are there ways we clinicians can better predict or assess risk of suicide in our patients? For example, are there standardized instruments or specific questions we can ask other than, “Are you planning on killing yourself?”

Dr. Beautrais: The Columbia Scale has a series of questions to explore suicide risk, and the FDA has mandated use of this scale in research, so it will likely follow that it becomes “standardized” in clinical practice. [You can learn more about this scale at www.cssrs.columbia.edu.] Child psychiatrists need to ask patients about plans for suicide, including how many, how recently, and what kept them from following through with plans; access to means of suicide to carry out those plans, like guns, for example; and who the patient knows who has made attempts or died by suicide, and how recently.

CCPR: What community interventions are effective for preventing suicide?

Dr. Beautrais: Restricting access to means of suicide may prevent impulsive suicides (Nordentoft M, *Danish Med Bull* 2007;54(4):306–369). The U.S. Air Force has a program that combines aggressively educating commanding officers (the gatekeepers) to recognize the early signs of mental illness and refer for treatment, while at the same time equally aggressively educating service personnel to combat the stigma of mental health treatment by reframing depression, anxiety, and PTSD as natural occupational hazards. They assure soldiers that there will be no adverse career consequences to mental health treatment (Knox K et al, *Am J of Public Health* 2010;100(12):2457–2463). There is little else that has been shown to be effective, although many community programs are funded and implemented as if they were effective.

CCPR: Thank you, Dr. Beautrais.

Black Box Redux: SSRIs and Risk of Suicide

After the black box warning, rates of prescriptions for antidepressants for children decreased, although debate quickly arose about precisely when this drop occurred and whether it led to negative consequences. One study argued that the regulatory warnings (starting with FDA case reports of suicide issued in late 2003) and ensuing changes in prescribing resulted in *increases* in suicide rates in children and adolescents, citing a 14% increase in youth suicides in 2004, the

largest increase in the period from 1988 to 2004. The authors argued that an inverse relationship between prescription of SSRIs and rate of suicide in youths exists in both the U.S. and the Netherlands (Gibbons et al, *Am J Psychiatry* 2007;164(9):1356–1363). In truth, however, prescribing decreases did not occur until 2005, and data published by the CDC for 2005 actually showed a decrease in suicide rate by about 3%.

Despite the heated academic debates about suicidality, most researchers agreed

that the evidence for efficacy of antidepressants in children was, to say the least, underwhelming. Our confidence in antidepressant efficacy has improved over the past several years due to a series of studies. The first of these, the NIMH-funded Treatment for Adolescents with Depression Study (TADS), endorsed the effectiveness of fluoxetine, though suicidal adolescents were specifically excluded from that study (March JS et al, *JAMA* 2004;292(7):807–820). The Treatment

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Research Updates
IN PSYCHIATRY

TIC DISORDERS

Attention Not a Problem in Tic Disorders

Children and adolescents with tic disorders (TD) very often have comorbid psychiatric diagnoses. In fact, some research shows that up to 90% of these kids have at least one additional condition (Freeman RD et al, *Develop Med Child Neurol* 2000;42(5):436–447). All these diagnoses can make it difficult to figure out which condition is causing which symptoms.

Researchers recently set out to determine if a TD itself is the cause of the attention problems sometimes seen in these kids, versus the other way around (the ADHD causing the TD). In this German study, 96 kids between the ages of eight and 17 (mean age 12) were given a series of four tests related to various aspects of attention. The children were diagnosed with either tic disorder (21 participants), ADHD (23 participants), comorbid tic disorder and ADHD (25 participants), or were part of a control group with no psychiatric diagnoses (27 participants). None of the participants had a psychiatric disorder that has shown a great impact on neuropsych test performance or general functioning, such as conduct disorder, oppositional defiant disorder, OCD, pervasive developmental disorders, affective disorders, posttraumatic stress disorder, or psychosis. However, children with elimination disorder, specific developmental disorders, specific childhood-onset emotional disorders, and specific phobias were allowed to participate. None of the participants were taking medication at the time of the testing.

The children took four computer tests over a period of about 40 minutes to assess different aspects of attention: a sustained attention task that involved identifying specific target patterns of dots tested the “intensity” domain; a divided attention task focused on discriminating audio and visual cues tested “attention

selectivity”; a go/no go task that required a response to stimulus, and a visual set shifting task both tested the “supervisory attentional system.”

As might be expected, children with ADHD performed poorly on all tests, both in reaction time and number of errors. Children with comorbid ADHD and TD tended to perform poorly on most tasks as well. However, TD alone was found to have no negative effect on any of the attention measures. In fact, the group with TD alone outperformed all others in the set shifting task—their mean reaction time was 12% to 14% faster than that of the control group (Greimel E et al, *J Abnorm Child Psychol* 2011; online ahead of print).

CCPR’s Take: So what does this mean for our practices? First, it’s an interesting lesson in the way a young brain works, since researchers think the superior performance in the set shifting task among the TD-only group might be associated with increased prefrontal control mechanisms in these kids—the same part of their brains they use to suppress tics. Second, this suggests that any attentional problems we see in children and adolescents with comorbid ADHD and TD are most likely due to the ADHD, and we should focus our treatment on that condition.

ADHD

Restricted Diet for ADHD?

Advocates tout restricted diets for the treatment of everything from migraines to autism. Now it’s time to add ADHD to the list—and if a recent study of Belgium and the Netherlands is any indication, this one might really work.

The Impact of Nutrition on Children with ADHD (INCA) study was conducted on a group of four- to eight-year-old children to determine whether a restricted elimination diet could improve symptoms of ADHD. The trial spanned 13 weeks—broken into a baseline period, a first phase, and a second phase. One hundred children with ADHD were ini-

tially recruited into the study. Exclusion criteria included kids who were already on a restricted diet, or those taking meds or undergoing therapy for ADHD.

During the three-week baseline period, all participants were fed a normal balanced diet and assessed with a number of rating scales, including the 18-item ADHD rating scale (ARS) and the abbreviated Connors’ scale (ACS). At week four, the children were equally randomized to either a normal balanced diet (control group, n=50), or an individualized, restricted elimination diet (diet group, n=50), which included “hypoallergenic” foods such as rice, meat, vegetables, and water. At the end of this phase (5 weeks), children were again assessed with the ratings scales. Children in the diet group showed a statistically significant improvement in both ADHD scales from baseline to the end of phase one, compared to the control group, in both physician and teacher ratings.

Children from the diet group who showed improvement of at least 40% on the ARS were randomized into the final phase of the trial (32 kids), where they were individually given two consecutive, two-week food “challenges” to reintroduce foods into their diets: one with foods that they had shown little reactivity to (based on blood tests), and one with foods that they had shown sensitivity to. After each challenge these children were again assessed with the usual rating scales. Nineteen of 30 children who completed this phase showed a relapse after one or both challenges (based on rating scale scores). There was no correlation between high sensitivity food or low sensitivity foods and relapse.

CCPR’s Take: Among the kids who showed improvement after the elimination diet, reintroducing foods into their diets led to a relapse of ADHD symptoms. Blood tests indicating a presence or lack of sensitivity to certain foods did not predict whether there would be a relapse.

This suggests that perhaps, among a subgroup of children, ADHD symptoms

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CME Post-Test

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

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Below are the questions for this month's CME post test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning objectives are listed on page 1.

1. What percentage of people who engage in self harm later attempt suicide, according to Wilkinson et al (Learning Objective #1)?
 a. 5% b. 16% c. 45% d. 70%
2. In the 2004 Whittington meta-analysis, what was the only antidepressant for which the authors concluded benefits outweighed risks (LO #2)?
 a. fluoxetine (Prozac) b. paroxetine (Paxil) c. sertraline (Zoloft) d. citalopram (Celexa)
3. The conclusion of the 2006 FDA meta-analysis of suicide risk and SSRIs was that the use of antidepressant drugs in pediatric patients is associated with a "modestly increased" risk of suicidality (LO #2).
 a. True b. False
4. According to Annette Beautrais, how great is the risk of suicide attempt among GLBT youths (LO #3)?
 a. twice that of heterosexual youths b. three to four times that of heterosexual youths
 c. five to six times that of heterosexual youths d. ten times that of heterosexual youths
5. The Greimel et al study found that kids with tic disorders are more likely to perform poorly on tasks associated with focus and intensity (LO #4).
 a. True b. False

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Black Box Redux: SSRIs and Risk of Suicide

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of Adolescent Suicide Attempters (TASA) study, reported in three papers in the October 2009 issue of *JAACAP* (Vol 48, Issue 10), addressed the question of efficacy around adolescents whose depression included suicidal ideation. (To read an in depth review of these studies, see *CCPR*, September 2010.) While these studies were not strictly comparable (TADS was double blind in design, while TASA was not), TASA lent credibility to the use of SSRIs as well as a specific form of CBT in adolescents with suicidal behavior prior to treatment, and TADS pointed towards fluoxetine.

Most recently, a large randomized, controlled study, Treatment of SSRI-Resistant Depression in Adolescents (TORDIA), examined depressed adolescents who had failed treatment with an initial SSRI. In SSRI-resistant adolescent

depression, this study found that CBT plus a switch to either a different SSRI or venlafaxine (150 mg to 225 mg) showed a higher response rate (54.8%) than a medication change alone (40.5%) (Brent D et al, *JAMA* 2008;299(8):901-913). Of interest, the data from the TORDIA study replicated the FDA study finding that venlafaxine was associated with an increased risk of self harm events compared to those treated with an SSRI (Brent D et al, *Am J Psychiatry* 2009;166(4):418-426).

You may be more confused now than you were before starting this article! Is there a bottom line here? Not really, but the most recent data does something to enhance our confidence that a variety of SSRIs and SNRIs—and not just fluoxetine—can treat depression in kids. All antidepressants may or may not be equal in their risk of triggering suicidal ide-

ation—though venlafaxine may be more risky than the others.

CCPR's Verdict: Regardless of what the large scale studies show, we as clinicians deal with our patients one by one. Depression in childhood is itself the greatest risk factor for suicidal behavior; depressed children should be offered treatment in accordance with a growing base of evidence supporting CBT and antidepressant medication. All children starting on antidepressants should be monitored closely, and those who have previous self-injurious behavior should be watched particularly carefully. For another perspective on SSRIs and kids, see "A Commentary on "Editor's Perspective: Do Antidepressants Work in Kids?" in *CCPR*, October 2010.



can be alleviated by a specialized, restricted diet. A diet of not much more than chicken, rice, and water is a pretty hard sell, though, so if you want to try this method, you need to be sure to have commitment from parents and kids.



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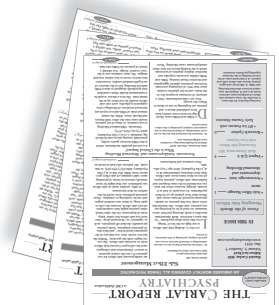
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