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CAROLINE FISHER, MD, PhD, EDITOR-IN-CHIEF

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EDITORIAL INFORMATION

Publisher: **Daniel J. Carlat, MD**, is the founder and editor-in-chief of *The Carlat Psychiatry Report*. He is an associate clinical professor of psychiatry at Tufts University School of Medicine and has a private practice in Newburyport, MA

Editor-in-Chief: **Caroline Fisher, MD, PhD**, is the associate director of psychiatric education and training at University of Massachusetts Medical School and medical director at Pediatric Behavioral Health in West Boylston, MA

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Ken Talan, MD, is author of *Help Your Child or Teen Get Back on Track* and has a private practice in Amherst, MA

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Approach to the Child with Intellectual Disability

Caroline Fisher, MD, PhD
Associate director of psychiatry education and training
University of Massachusetts Medical School

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

I first met Christina when she was 14. She had been diagnosed with borderline personality disorder and bipolar disorder. She had blown out of four private schools in the area, not for grades but for bad behavior. She was getting into physical fights with her siblings, drinking, and smoking marijuana.

"My parents hate me," she said. In reviewing her records, I saw that she'd tried just about every medication in the pharmacy, it seemed, with almost no effect. Because I was at a loss as to what else to do, I started over with diagnosis: mood (fine), anxiety (denies), sleep (fine), social relationships (easily makes friends, struggles to keep them), family relationships (difficult), places where she is most comfortable (home), and least comfortable (school).

I asked her why school was hard, and she told me that people were always yelling at her, and that she worked really hard on her school work but no one noticed or appreciated it. I sent her for neuropsych testing for what I suspected was ADHD. I was as surprised as anyone when the testing came back. This B/C student in prestigious private schools had a full scale IQ of 80.

Christina illustrates the value of psychological testing in difficult cases. Once we had this key piece of information, the rest of her difficulties came into perspective, and we could begin to find solutions. I am likely to suspect learning disabilities when school is problematic, when kids complain that homework takes too much time, or when parents complain that homework time is a battle. "He's not motivated," or "she just doesn't try," are tip-offs.

Social kids like Christina are more likely to get missed. Children are intolerant of differences, so poor peer relations, including bullying and being bullied, may indicate a learning disability. Being great with adults or younger children but not so good with peers may also indicate trouble. Kids who won't read for pleasure may have ADHD or dyslexia. Kids who don't seem to understand you, or kids who answer a different question than you ask may be struggling with processing disorders.

In addition to neuropsychological or educational testing, it is important to screen for other issues that may be causing the appearance of a learning disability. These might include hearing loss, visual impairments, trouble at home (chaos, abuse, or drug use, for example), or trouble at school (being bullied or rejected by peers, bullied by teachers, or having inappropriate academic demands—either too much or too little).

Children with a history of a serious medical illness or a serious emotional

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Learning objectives for this issue: 1. Describe the many factors that are involved in diagnosing and treating the children with learning and developmental disabilities. 2. Explain some arguments against prescribing SSRIs to children. 3. Use the results of neuropsych and educational testing to better understand the needs of your patients with learning and developmental disabilities. 4. Understand some of the current findings in the literature regarding psychiatric treatment. This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists and other health care professionals with an interest in the diagnosis and treatment of psychiatric disorders.

Approach to the Child with Intellectual Disability

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trauma will drop off their developmental trajectories for a while because their energies have been spent coping rather than growing.

Absence seizure is another cause for apparent inattention or poor memory. If parents or teachers have reported staring spells, try hyperventilating the child in your office: Ask the child to count to 45 and to blow (hard) each time he or she says a number. An absence seizure can often be provoked this way and looks like a staring episode about 10 or 15 seconds long, often with lip smacking. More important, the child will stop counting, and will not respond to your gleefully shouting “elephants!” (Don’t say the child’s name—any child will ignore that.)

Interventions for learning disability need to focus on changing the child’s environment so that it’s working for her rather than against her. In Christina’s case, she was put in the local public school where she was given individual tutoring, extra time, and less demanding, but still mainstream, classes. She excelled, and the next time I saw her she said she loved her new school.

Family work is also crucial: Christina’s family needed to recalibrate their expectations for her, they needed to grieve their lost hopes for her, and they needed to forgive themselves for not realizing her needs before. They also needed practical knowledge about how Christina’s cognitive understanding of things translated into impulsivity and poor decision-making, and needed strategies to help her rather than chastise her. Christina needed to repair her relationships with her siblings and her parents. In addition, she needed to stop seeing herself as lazy and bad.

While there is lots of therapy work to do, medications are not of much use in learning disabilities other than ADHD. Comorbid mental illness should be treated, of course. In global cognitive impairment, symptomatic treatment of impulsivity, lack of focus, or aggression can be necessary at times.

Understanding Patients with Severe Disabilities

When working with patients with

more severe and global intellectual disabilities, the following are a few principles that have been helpful to me.

Examine the Time Course. Whether you are faced with the new evaluation of a child with intellectual disabilities or the review of someone known to you, be sure to get the actual time course of the behavior being considered. Twenty-nine days of minimal symptoms and one day of extremely frequent symptoms is not the same as thirty days of moderate symptoms. Bad mornings and good evenings usually say something about school demands, while good mornings and bad evenings may say something about the child’s ability to tolerate unstructured time. A lifetime of poor sleep may “merely” be the sequela of the structural brain differences that also cause the intellectual disability, whereas new onset of poor sleep probably indicates something else entirely.

Assess the Environment. Look for an environmental cause first. Children with intellectual disabilities generally don’t have the language facility to articulate their concerns, and they struggle with self-regulation even if they do. Therefore, behavioral symptoms quite frequently are the child’s attempt to express dislike. It is our job to figure out what they dislike and why. New staff or loss of favorite staff, new school peers or family members, even the change from summer and swimming to fall—and school—have been sources of behavioral symptoms.

Consider Medical Causes. At the same time, think of the medical causes. Aggression, compulsions, or self-injury may be signs of pain. Although I never made a proper study of it, I think the number one cause for admission to the Developmental Disabilities Unit where I was a resident was constipation. Think headache, sinuses, ears, teeth, throat, gastritis, constipation, diarrhea, appendicitis, and UTI, at least. Lactose intolerance is common and painful, too, while asthma is common and scary, particularly if the patient can’t explain what he is feeling.

Look at all of the Pieces of the Puzzle. Separate the child, the symptoms, and the jargon. Because so many of my patients with intellectual disabilities come

with staff, counts, graphs, interpretations of the graphs and so on, it’s easy to lose sight of the usual constellations of symptoms. Short episodes of apparent intense fear is still likely to be panic in a child with intellectual disabilities. Likewise, having to touch the door frame every time they pass through it still suggests OCD. However, if you only get a graph of average crying episodes, tantrum duration, or self-injury, you may never realize that what precipitated the tantrum was intense fear or being prevented from touching the doorframe.

Medication and the Child with Cognitive Impairments

If you do choose to use medication, remember that we truly do not know what we are dealing with. We know for certain that the brain of a child with developmental disabilities is different from the average child’s brain, but we don’t know how it’s different. There could be more neurotransmitter receptors or fewer, the receptors could be more sensitive or less (or not functional at all), the connections could be in the “usual” pathways, or wired completely differently.

Therefore, kids with mental retardation or autism may be more sensitive or less sensitive to medication, and there is no way of knowing ahead of time. I have patients who do well on 5 mg of fluoxetine dosed Mondays and Thursdays, and others who require 80 mg daily. Begin at a low dose and wait at least two weeks (and preferably much longer than that) between dosage changes.

An interesting study by John Rapp et al looked at behavioral sequelae of medication dose changes in a developmentally disabled population (Rapp et al, *Behav Modification* 2007;31(6):824–846). They found that irrespective of the change made—dose increases or decreases—behavior worsened the first week.

Making smaller changes over a longer time period can make for more successful tapers. Don’t let the immediate response to dose changes prevent you from tapering off medications that are no longer useful. I may take six months to taper a child off a medication, sometimes longer.

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A Commentary on “Editor’s Perspective: Do Antidepressants Work in Kids?”

Peter Parry, MBBS
 Consultant child and adolescent psychiatrist
 Flinders University, Adelaide, Australia
 Editorial board, The Carlat Child Psychiatry
 Report

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

In the September 2010 issue of *The Carlat Child Psychiatry Report*, Dr. Fisher neatly explains the meaning of Number Needed to Treat (NNT) and Number Needed to Harm (NNH), which can be a shorthand way of assessing whether to prescribe or not, and then applies this to the question of SSRI antidepressants in pediatrics. She illustrates the point that compared to other specialties, SSRIs are no worse than other commonly used medications (although there is some controversy over statins, too). However, to do so, she glosses over the rich controversy regarding SSRI use in children. I will elucidate that controversy here.

Unfortunately a key reason for a more pessimistic view is lack of trust in the published literature (Spielmans GI, Parry PI, *Bioethical Inquiry* 2010;7(1):13–29). In the January 2008 issue of the *New England Journal of Medicine*, Turner et al highlight the problem of publication bias with antidepressants (Turner et al, *N Engl J Med* 2008;358(3):252–260).

For instance, the Keller paper that Dr. Fisher refers to (Keller MB et al, *JAA-CAP* 2001;40(7):762–772), which gives paroxetine (Paxil) a NNT of six, has received strong criticism. In internal company documents (see <http://bit.ly/avtAyP>), the manufacturers of paroxetine acknowledge that data from two studies of paroxetine in adolescents (studies number 329 and 377), show no effect.

According to this document, they elected not to submit either study to regulatory bodies, but decided to publish the positive data on secondary outcome measures in study 329—the Keller study. Jureidini et al concluded, “Study 329 was negative for efficacy and positive for harm,” based on company documents that give a fuller picture of the data than the published paper (Jureidini JN et al, *Int J Risk & Safety Med* 2008;20(1–2):73–81).

Based on the previously unpublished data for study 329 (eg, “serious” events were 12% paroxetine vs 2.3% placebo, and “severe” events 27% paroxetine vs 17% placebo), the relatively high NNH rates for suicidality of up to 160 for SSRIs should be considered with some skepticism. Other SSRIs like fluoxetine (Prozac) appear less concerning in this regard than paroxetine; however another critical analysis looked at other published studies of SSRIs in the pediatric age group and came to similar concerns of overestimation of benefits and underestimation of harms (Jureidini JN et al, *BMJ* 2004;328(7444):879–883).

Although NNT and NNH are easy shorthand ways of comparing efficacy and adverse event potential, they can be misleading depending on the outcome measures. The NNT derived from the randomized controlled trials (RCTs) apply to relatively modest changes on physician recorded rating scales. Young patient self-reports in RCTs of SSRIs are few and do not reflect benefit (Jureidini, *ibid*). Therefore, NNT reflects modest improvement, whereas NNH reflects serious or potentially fatal outcomes.

In considering NNH it is worth recognizing that serotonin has many functions throughout the body and there are

other serious side effects from SSRIs in addition to suicidality. Sexual side-effects like delayed ejaculation can be problematic for adolescents’ developing sexuality. There is some evidence linking SSRIs with growth hormone suppression (Weintrob N et al, *Arch Pediatr Adolesc Med* 2002;156(7):696–701), risk of osteoporosis (Verdel BM et al, *Bone* 2010;47(3):604–609), disturbances with spermatogenesis (Tanrikut C et al, *Fert Sterility* 2010;94(3):1021–1026), and birth defects (Healy D et al, *Int J of Risk Safety Med* 2010;22(1):1–10).

Additionally there are risks of drug interactions and more benign side effects such as gastrointestinal upset and headache. A further problem that concerns me before prescribing is the risk of dependence states, which now do seem to be a factor in SSRIs (Healy D, *Med Hypotheses* 2010;74(5):764–768). There is some evidence to argue there are worryingly low NNHs for sexual dysfunction (NNH of 2 or 3), growth retardation (NNH of 2 or 3), and physical dependency states (NNH of 3 or 4) (Healy D, *J Psychopharm* 2007;21(6):668–669).

One criticism of RCTs in depression for SSRIs is that subjects often have milder major depression, dysthymia, or adjustment disorders and this may underestimate the benefit a group of those with severe major depression have from SSRIs. A recent meta-analysis of antidepressant efficacy in RCTs concludes that antidepressant efficacy “may be minimal or non-existent, on average, in patients with mild or moderate symptoms. For patients with very severe depression, the benefit of medications over placebo is substantial” (Fournier JC et al, *JAMA* 2010;303(1):47–53). It should be noted, however, that this was in regard to adults.

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Just as we can’t be certain of the effects of any given medication, we also can’t be certain of the side effects of any medication. In my experience, children with intellectual impairments are more likely to have side effects and at least as likely to be upset by them as their normal-

ly developing peers.

My patient Ernie, a traumatized boy with an IQ of about 40, was very insistent that he wanted a new medicine, but couldn’t explain why. He pointed to himself repeatedly and said, “I want a new med.” When I asked why, he would point

at himself again and say again, “I want a new med.” Finally, after asking him a lot of questions and getting the same answer, I finally got it. He wasn’t pointing to himself, he was pointing to his mouth. His antipsychotic was making him drool.



Q & A
With
the Expert

Expert Interview

Helping Our Patients With Learning Disabilities

Daniela Montalto, PhD

Clinical Assistant Professor of Child and Adolescent Psychiatry; Clinical Director, Institute for Learning and Academic Achievement, New York University



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

CCPR: Dr. Montalto, to begin, can you briefly tell us what you do at NYU?

Dr. Montalto: As the clinical director of the Institute for Learning and Academic Achievement, I evaluate children and teens for learning disabilities, developmental disabilities, and neuropsychological impairments, including ADHD. We work toward understanding the ways children learn and helping them pursue academic endeavors and overcome barriers that get in their ways.

CCPR: A large proportion of the patients of child psychiatrists undergo neuropsych or educational testing, but we don't always know exactly what information you need from us to best test the kids.

Dr. Montalto: What is really helpful is a detailed history, with documentation of things like attention difficulties in the child's history. If language and motor milestones were reached on time is also important. We also need a detailed family history, especially with information on learning disabilities, because what we know from the literature is that there is a genetic link. We want to know if the parents themselves had similar struggles, even if there was no formal diagnosis.

CCPR: And once the testing is complete, how best should child psychiatrists use the results when treating our patients?

Dr. Montalto: The results can help guide treatment goals, and further explain triggers that lead to moodiness, irritability, sadness and anxiety. When you get the results of testing from a patient, there are a few things to look out for. The most critical piece is that if it's been more than three years since the testing was completed, it needs to be updated. Early elementary school is when most kids present for testing, but it can be as early as preschool. It's around the six or seven year mark is when teachers and parents start to see red flags in basic reading, foundational skills, and math development. Another thing to look for is whether you have all the information you need. For example, say a child has results from an IQ test and some academic testing, but you sense the child's articulation is weak; you may want to get additional testing targeted at language development.

CCPR: Are there any diagnostic pitfalls when assessing kids with learning and developmental disabilities? For example, can one "disorder" actually be reflective of something else entirely?

Dr. Montalto: One big thing that both psychiatrists and psychologists see is confounds with selective mutism. We are beginning to learn that there can be some real language impediments underlying this disorder, in addition to, or rather than, just anxiety. I've developed a testing battery that doesn't require the child to verbalize responses. You also want to be sure hearing and vision tests are up to date. Another diagnostic pitfall is "absence seizures." Sometimes kids with these appear to have ADHD—since they seem not to be paying attention and staring into space—when in fact they are having seizures.

CCPR: Can you talk a little bit about the subtle learning disabilities? Like auditory processing disorder?

Dr. Montalto: With auditory processing difficulties, you have to try to get a sense of whether a child has difficulty differentiating sounds when there are other distractions around. This is hard, because kids with ADHD can look very distractible and as if they are only grasping certain words. This is why a speech and language evaluation that targets the auditory area is important. So if you are seeing some inattentiveness, especially when you are talking to the child with no distractions, he or she may not actually understand everything that you are saying. If his or her responses are a little off or you are not sure if the question was understood, you should further evaluate whether there is a speech and language impediment.

CCPR: Now contrast that, if you will, with a processing speed difficulty.

Dr. Montalto: Processing speed typically means that when the child is given a straightforward and clerical paper and pencil measure, like copying a key, that child is very slow at processing the information and getting the work done. This is usually captured with a diagnosis of learning disability not otherwise specified. It's important to note processing speed, because we know that under different circumstances where time is not a factor, these kids will do really well—it is just this slow access to information that inhibits their performance. Also look at if they are making mistakes when they do this type of task. There is a big difference between being just slow but accurate, and not getting it right.

CCPR: And what if they are not accurate?

Dr. Montalto: That can reflect some impulsivity if they are working too quickly. They could have difficulty discerning visual objects, which is a visual spatial weakness. Or it could be that they work slowly and are trying to keep up, so they are not accurate in terms of what details they pay attention to.

CCPR: You would see that sort of disorder in the coding subtest of the WISC [Wechsler Intelligence Scale for Children]?

Dr. Montalto: Yes, on the coding and the symbol search. You may also see it with some Woodcock Johnson processing tests or any timed visual scanning task.

CCPR: Are there specific learning disabilities associated with an inability to spell?

Dr. Montalto: Weaknesses in spelling, as well as reading, are rooted in two main language areas: phonological awareness and rapid word retrieval. Phonological awareness is the understanding of sounds and how they make up words. So kids who typically have difficulty with phonological awareness may also have trouble with spelling.

CCPR: Could you talk a little bit about the kids with nonverbal learning disabilities [NLD]? You know there is this sort of diagnostic conundrum. Is this Asperger's, or is this a nonverbal learning disability?

Dr. Montalto: Right. A lot of the controversy around this stems from the kids who have the social deficits characteristic of autism, but exhibit a lesser degree of language impairment. Currently, the marker that we use when trying to distinguish Aspergers from NLD is that Asperger kids tend to perseverate, and have more restrictive interests, than children with NLD. Children with a nonverbal learning weakness usually have weaknesses in math and fine motor skills as well as social difficulties. They are interested and trying to be social, but they are just off the mark a little bit, and they are not picking up on those cues effectively.

CCPR: So once we have identified that a child has a learning disability, are there ways we can help enhance functioning?

Dr. Montalto: That's a great question. What is usually helpful is to do less, more frequently. What I mean is: say junior is having trouble with math. If he can focus on just five to 10 minutes of basic math review every day, that would be all he needs. He could use flash cards or a computer program. Consistency is what's important. And you can make it fun. If a child is having language difficulties, maybe a daily game of Articulate or Scrabble might be perfect. In addition, it is important to recommend specific learning-based interventions, such as working with a trained learning specialist to develop compensatory strategies and to help remediate areas of weakness.

CCPR: What sort of parenting recommendations can we make to our patients' parents in regard to learning disabilities? We're often asked, "How much of this is behavioral?" In other words, "How much of this should I discipline and how much should I forgive?"

Dr. Montalto: This is a tough call for parents because they want to do what is best for their children, but they also really want to get that homework done! When kids aren't compliant it can be very frustrating. Children should not be punished for their learning difficulties. These kids are often really motivated, but they get frustrated easily and sometimes having their parents on their backs makes them less likely to do their work.

CCPR: So how do you suggest parents balance this?

Dr. Montalto: Much like a child with ODD, a child with a learning disability needs support for his or her efforts, such as reinforcing and shaping the small steps toward a larger goal, and using transitional reminders and warnings to help them persist with their work. A lot of children with learning disabilities benefit from a "daily report card," which is a way of highlighting goals and reinforcing the work they are doing, such as spending 10 minutes a day focusing on writing, even though they don't like it and it's really hard. It's important for parents to show kids they are paying attention to the things they are doing well and not just the things they are having trouble with.

CCPR: Do you have tips for helping parents convey the information about learning or developmental disabilities to teachers?

Dr. Montalto: If the child has a testing report, the person who did the testing should be contacted. If the teacher and school are open to it, he or she should come for a meeting with them, so everyone can talk about this child's life.

CCPR: Thank you, Dr. Montalto.

For a list of reading recommendations, visit www.thecarlatchildreport.com

Understanding Common Learning and Developmental Disabilities		
Learning Disability	Impact on Function	Appropriate School Intervention(s) (most important)
ADHD	-Problems with accuracy, organization, planning, and time and materials management -Overall learning difficulties, as child may not be available to take in information taught	-Daily report card (DRC) with three target goals -Preferential seating within teacher's "action zone" -Non-distracting breaks
NVLD (nonverbal learning disability)	-Visual spatial weaknesses -Math difficulties -Fine motor weaknesses -Poor social-peer relationships due to difficulty picking up on nonverbal or visual cues	-Social skills group or speech and language therapy in small group to build pragmatic language skills -Occupational therapy to build fine motor skills -Working with learning specialist/math tutor who can help student build skills for breaking down complex/abstract visual information (eg, maps, grids, graphs)
Slow processing speed	-Slow access to information or retrieval of facts	-Extended time during in class tests and work, and during standardized tests
Memory impairments	-Difficulty learning and subsequently recalling information (visual or verbal)	-Teach students to use visualization skills to help encode verbal details and to use verbal mediation to help break down complex visual displays -Determine student's "learning style," eg, if repetition helps—use flashcards; if she benefits from context—link information to prior experience
Auditory processing disorder	-Weaknesses in processing sounds, particularly in the face of other auditory distractions, which affects understanding of language	-Information should be presented both visually and verbally -Frequent "check ins" to ensure student has understood all directions and steps -FM amplification unit
Math disability/dyscalculia	-Difficulty with basic math fact recall, math calculation, or math reasoning (word problems) -May also have trouble with understanding time	-Weekly remediation with math tutor, daily review of math facts for short periods of time (eg, 5 to 10 minutes) -Strategies to help break down math terminology and to identify key procedures
Writing disability	-Difficulty generating ideas, building upon a main topic, or sequencing and organizing details -Difficulties can be compounded by spelling weaknesses, fine motor difficulties, and misunderstanding of grammatical rules and punctuation	-Working with teacher/learning specialist to build strategies to help brainstorm and generate an outline or map main ideas -Use of computer software such as Draftbuilder -Working with OT to build keyboarding skills
Dyslexia	-Reading decoding, fluency and/or comprehension is compromised	-Multisensory approach to learning -Language based remediation to build phonological skills and reading fluency -Previewing material to increase comprehension

The Treatment for Adolescents with Depression Study (TADS) study was well powered and had adolescents who were more severely depressed (TADS team, *Arch of Gen Psychiatry* 2007;64(10):1132–1144). This may have led to the relatively low NNT of four. However the reported benefit of fluoxetine over placebo derives from the clinical global impression (CGI) scale and the children’s depression rating scale–revised (CDRS-R) used categorically (benefit vs no benefit), rather than dimensionally (ie, how much benefit?). If the CDRS-R is used dimensionally (as it arguably should be), then fluoxetine fails to statistically differentiate itself from placebo. Apart from the issue of statistical significance, a three-point difference on a 96 point scale is not likely to be of great clinical significance. The other two arms of the TADS study compared cognitive behavioral therapy (CBT) alone with CBT plus open-label fluoxetine, and were limited by lack of a CBT plus placebo arm.

When the TADS was extended to 36

weeks, there was no differentiation in efficacy of fluoxetine from CBT (TADS team, *Arch of Gen Psychiatry* 2007;64(10):1132–1144). The TADS team concluded that combination therapy was superior on the basis of more rapid response (in first 12 weeks), and because the increased suicidality seen in fluoxetine monotherapy was not seen in combination with CBT (fluoxetine alone 14.7%, combination therapy 8.4%, CBT 6.3%). Given the other factors of concern from SSRIs, a case can be made from TADS to use CBT rather than medication in the first instance.

My first job as a consultant child and adolescent psychiatrist was in a mood disorders unit for young people, where I prescribed SSRIs and other new antidepressants to almost all. Benefit often seemed underwhelming after an initial probable placebo response, and agitation/activation reactions were not uncommon. Today I reserve SSRIs for severe OCD, phobic anxiety states not responding to CBT, and severe depression with melancholic fea-

tures like psychomotor retardation, and use them only very rarely for the typical adolescent depression that fails to improve.

However the “typical” depressed teenager seems to benefit quite well from an eclectic mix of a “behavioral activation” approach of exercise and socializing, improved sleep hygiene, diaphragmatic breathing relaxation practices, healthier diet, omega-3 supplementation, and reduced substance abuse—along with addressing school academic and bullying issues, and providing family and individual psychotherapy. Mental health services need to be structured and funded to support a holistic approach.

Editor’s Response: Dr. Parry is accurate and scholarly—however, the problems he notes are pharmaceutical industry practices, not psychopharmaceutical industry practices.

Acknowledgements: Thanks to Professor David Healy and Professor Jon Jureidini for their reading and helpful comments regarding this commentary.

Research Updates IN PSYCHIATRY

TREATMENT AS USUAL

Treatment as Usual Effective for ADHD and Anxiety Disorders

Studies of “treatment as usual” in outpatient child and adolescent psychiatry settings are hard to come by. Recent research out of Germany looked at the effectiveness of the usual treatment for four psychiatric disorders: ADHD, anxiety disorder (AD), depressive disorder (DD), and conduct disorder (CD).

In this observational study, researchers followed all new admissions at nine participating outpatient child and adolescent psychiatry practices for one year. All participating practices offered care from a variety of practitioners (eg, pediatricians and psychotherapists in addition to psychiatrists) and offered various forms of intervention, including several styles of individual and family psychotherapy, academic support, and psychopharmacology.

Information was collected by standardized telephone interviews with patients or their parents at admission into the practice, three months later, and at one year. Although interview data was available from 800 of the original 1182 patients after one year, the data used in this analysis was only from 306 patients for which parents had completed the Child Behavior Checklist (CBCL) at both admission and at the one year point.

Within the group of 306, the mean age was 8.8 years (+/- 3.3 years). Diagnostically, 94 had ADHD, 57 CD, 38 DD, 53 AD, and 64 had some other diagnosis. Fifty-eight percent had received less than eight sessions of evaluation or consultation, 42% received greater than eight sessions; with the range encompassing zero to 50 child sessions and zero to 40 parent sessions. Twenty-six percent received pharmacotherapy of some kind.

Overall 66% of patients had no clinically relevant symptoms of their illnesses after one year of treatment. Researchers

analyzed if how much time spent in therapy was a factor in improvement. They found that patients with “high dose” therapy (greater than nine sessions) showed more improvement than patients with “low dose” therapy (from one to eight sessions) for ADHD and AD, and calculated a small to moderate effect size for “dose” of therapy in these disorders. There was not a significant difference in effectiveness between the two for CD, and researchers found that among patients with DD, there was a group that responded well to low dose therapy and one that responded poorly to any amount of therapy (Bachmann M et al, *World Psychiatry* 2010;9:111–117).

CCPR’s Take: One of the difficulties of interpreting the medical literature is the problem of figuring out what works instead of just what demonstrates a statistically significant difference between groups. In this study, two thirds of patients were clearly improved after one

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CME Post-Test

As a subscriber to CCPR, you already have a username and password to log on www.TheCarlatChildReport.com. To obtain your username and password, please email CME@thecarlatreport.com or call 978-499-0583.

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

1. Research by Rapp et al found that when changing medication dosages for children with developmental disabilities, which of the following was true (Learning Objective #1)?
 - a. Behavior worsened in the first week after a dose increase only
 - b. Behavior worsened in the first week after a dose decrease only
 - c. Behavior worsened in the first week after a dose change, irrespective of the change made
 - d. There was no significant change in behavior related to dose changes
2. There is some evidence that links SSRI use to growth hormone suppression, increased risk of osteoporosis, disturbances with spermatogenesis, and birth defects (L.O. #2).
 - a. True
 - b. False
3. Because a child with an auditory processing disorder has difficulty differentiating sounds when there are other distractions around, he or she can appear to have what (L.O. #3)?
 - a. ADHD
 - b. processing speed difficulty
 - c. phonological awareness difficulty
 - d. dyscalcula
4. Dyscalcula is characterized by difficulties generating ideas and sequencing and organizing details (L.O. #3).
 - a. True
 - b. False
5. Bachmann et al found what percentage of patients in their study had no clinically relevant symptoms of their illnesses after one year of treatment as usual (L.O. #4)?
 - a. 25%
 - b. 56%
 - c. 66%
 - d. 72%

To earn CME or CE credit, you must read the articles and log on to www.TheCarlatChildReport.com to take the post-test. Please see the pre-test listed below to prepare for this month's post-test. Learning objectives are noted on page 1. You must answer at least four questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by October 14, 2011.

PLEASE NOTE: WE CAN AWARD CME CREDIT ONLY TO PAID SUBSCRIBERS

Your evaluation of this CME/CE activity (ie, this issue) will help guide future planning. Please respond to the following questions:

1. Did the content of this activity meet the stated learning objectives? L.O.#1: Yes No L.O.#2: Yes No L.O.#3: Yes No L.O.#4: Yes No
2. On a scale of 1 to 5, with 5 being the highest, how do you rank the overall quality of this educational activity? 5 4 3 2 1
3. As a result of meeting the learning objectives of this educational activity, will you be changing your practice performance in a manner that improves your patient care? Please explain. Yes No

4. Did you perceive any evidence of bias for or against any commercial products? Please explain. Yes No

5. How long did it take you to complete this CME/CE activity? ___ hour(s) ___ minutes

6. **Important for our planning:** Please state one or two topics that you would like to see addressed in future issues.

Research Updates IN PSYCHIATRY

Continued from Page 6

year, and that's good news no matter how you look at it. The question arises, though, whether that improvement had anything to do with treatment. The patients in this study were given individualized treatments depending on what the clinician felt they needed at the time of evaluation. Some kids presented to the clinician needing a little intervention, and some presented needing a lot. Furthermore, as a naturalistic study, treatment comprised a full spectrum of interventions—some evidence-based, some not; some well-performed, some not. The authors used statistical methods to overcome this as much as possible, and in doing so probably understate the findings. Despite that, there was a dose-effect of therapy, an important finding for advocating for therapy interventions for children and adolescents. Compare this also to the findings of Gledhill and Garralda, who evaluated patients ages 13 to 18 presenting with depression to their primary care physicians in a London clinic: After 6 months, more than 50% of them had not improved, and the average duration of symptoms was 13 months (Gledhill J and Garralda ME, *Soc Psychiat Epidemiol* 2010; online ahead of print). We must be doing something right! All in all, the study is helpful in allowing a natural and realistic comparison group for the carefully controlled efficacy studies generally done. However, we have to ask ourselves: if treatment-as-usual were to incorporate more evidence-based interventions, would the effect be larger?

October 2010

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