1

INTRODUCTION

- Started working in the field in 1988 – largely focused on understanding psychotic conditions
- 15 years working in residential treatment – clinician & administrator
- 20+ years in private practice - adolescents and adults
- 13 years teaching – Chicago School of Professional Psychology, PsyD program
  - Focused on C & A disorders, Pediatric Psychopharm, Evidence-based tx
- Involved with Reclaiming Youth since mid-1990s

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TOO MUCH BUT NOT ENOUGH

- Youth in distress are receiving TOO MUCH medication… but there is NOT ENOUGH evidence to support it.

- Why do we use antidepressants? How do they work?
- Despite a profound lack of evidence for the effectiveness of SSRIs, prescription rates have continued to increase. Moreover, the theory that promotes their use is solidly refuted (7.20.22):
- "Our comprehensive review of the major strands of research on serotonin shows there is **no convincing evidence** that depression is associated with, or caused by, lower serotonin concentrations or activity."

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BEING TRAUMA-INFORMED

- It feels like everyone is promoting themselves (their programs) as trauma informed.
- What does it take?

Exhibit 1. Key Ingredients for Creating a Trauma-Informed Approach to Care

Organizational	Clinical
▪ Leading and communicating about the transformation process	▪ Involving patients in the treatment process
▪ Engaging patients in organizational planning	▪ Screening for trauma
▪ Training clinical as well as non-clinical staff members	▪ Training staff in trauma-specific treatment approaches
▪ Creating a safe environment	▪ Engaging referral sources and partnering organizations
▪ Preventing secondary traumatic stress in staff	
▪ Hiring a trauma-informed workforce	

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THE SIGNS OF TRAUMA

- DSM-5-TR clinical characteristics of Trauma Exposure:
  - Negative Mood
  - Negative Thoughts
  - Suicidal ideation / behaviors
  - Unstable relationships
  - Sleep problems
  - Quick Tempered, overly reactive
  - Verbal / Physical Aggression, Destruction of Property
  - Reckless or self-injurious behaviors
  - Emotional Dysregulation
  - Dissociative symptoms such as derealization or depersonalization
  - Perceptual disturbance (the DSM-5-TR labels them pseudo-hallucinations)
  - Paranoid ideation
  - Substance abuse
  - Concentration / memory difficulties

May 2022

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TRANSLATED TO DISORDERS

- DSM-5-TR clinical characteristics of Trauma Exposure:

Negative Mood Negative Thoughts Suicidal ideation / behaviors	Mood Disorders – Depression, Persistent Depressive Disorder
Unstable relationships Sleep problems	
Quick Tempered, overly reactive Verbal / Physical Aggression, Destruction of Property Reckless or self-injurious behaviors Emotional Dysregulation	Mood Disorders – Bipolar, DMDD Impulse Control, ODD, CD
Dissociative symptoms such as derealization or depersonalization Perceptual disturbance (the DSM-5-TR labels them pseudo-hallucinations) Paranoid ideation	Psychotic or Dissociative Disorders – Schizophrenia, Brief Psychotic Disorder
Substance abuse	
Concentration / memory difficulties	NeuroDevelopmental – ADHD

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OH, BY THE WAY…

- Many of you work with clinical psychologists
- How many APA accredited Clinical Psychology Doctoral Programs ***require*** a course in Trauma?
  - A. 0 – 10%
  - B. 10 – 30%
  - C. 30 - 50%
  - D. 50 – 75%
  - E. 75 - 100%

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Trauma Curriculum	Ph.D.				Psy.D.				All Programs			
	Programs		First Year (FY) Students		Programs		First Year (FY) Students		Programs		FY Students	
	#	%	#	%	#	%	#	%	#	%	#	%
Required Course	5	3%	54	4%	4	5%	148	7%	9	4%	202	6%

STUNNING RESULTS

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'BEST PRACTICES' – SHOULD WE MEDICATE?

- We are medicating youth with more medications than 20 years ago (polypharmacy)
- As many as 300,000 youth now receive **3** or more classes of meds at the same time
- Polypharmacy prescribing continues with little, if any, replicated evidence to support the prescriptions strategies that impact thousands of young people.

- Factors increasing the growth of pediatric polypharmacy (Zito et al., 2021)
  - **Predominance of the biological model in psychiatry**
  - **Invalid assumptions on efficacy of combinations**
  - **Limited professional awareness of metabolic and neurological adverse events**
  - **Infrequent use of appropriate prescribing**

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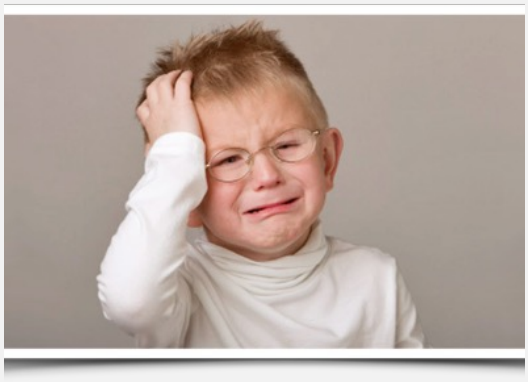
AACAP – PRACTICE GUIDELINES



- PTSD Practice Parameters recommend that SSRI antidepressants can be considered as an additional treatment…or when symptoms are severe

- How many children should inform this decision?

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THE *SUPPORTING* RESEARCH

Study	Details	Number of Children
Seedat et al., 2002 Comparison of response to selective serotonin reuptake inhibitor in children, adolescents, and adults with PTSD. J Child Adolesc Psychopharmacol.	Compared children and adults diagnosed with PTSD receiving citalopram (Celexa) in an 8 week open trial	
Yorbik O, Dikkatli S, Cansever A, Sohmen T. (2001) The efficacy of fluoxetine treatment in children and adolescents with posttraumatic stress disorder symptoms	A Turkish open trial of fluoxetine (Prozac) showed effectiveness in improving earthquake-related PTSD symptoms in participants 7 to 17 years old	
	Total	

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JAACAP GUIDELINES – PTSD (P. 424)

- "Two more recent randomized trials have evaluate the efficacy of SSRI medication for treating PTSD in children and adolescents. **The first failed to find any superiority of sertraline over placebo in 67 children with initial PTSD diagnoses**, although both groups experienced significant improvement, suggesting a strong placebo effect."
- "The second compared TF-CBT plus sertraline to TF-CBT plus placebo in 24 10 to 17 year olds with sexual abuse related PTSD symptoms. **All children significantly improved** with no group-by-time differences found except on Children's Global Assessment Scale scores.
- This study concluded that, although starting treatment with combined sertraline and TF-CBT might be beneficial for some children, it is generally preferable to begin with TF-CBT alone and add an SSRI only if the child's symptom severity or lack of response suggests a need for additional interventions."

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AACAP…*SUPPORTED STATEMENTS?*

- "Children with comorbid major depressive disorder, general anxiety disorder, obsessive-compulsive disorder, or **other disorders known to respond to an SSRI may benefit from the addition of an SSRI earlier in treatment.** More than 60% of the participants in the TF-CBT plus sertraline study had comorbid major depressive disorder, yet the **results did not indicate a clear benefit of adding sertraline with regard to improvement in PTSD or depression scores**" (AACAP, 2010).

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JAACAP GUIDELINES - PTSD

- "On the basis of the above information, there are insufficient data to support the use of SSRI medication alone (i.e., in the absence of psychotherapy) for the treatment of childhood PTSD."

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TRANSLATED TO MEDICATIONS

- DSM-5-TR clinical characteristics of Trauma Exposure:

Negative Mood Negative Thoughts Suicidal ideation / behaviors	Antidepressants Antipsychotics (e.g. Rexulti commercial)
Unstable relationships	
Sleep problems	
Quick Tempered, overly reactive Verbal / Physical Aggression, Destruction of Property Reckless or self-injurious behaviors Emotional Dysregulation	Antipsychotics "Mood Stabilizers" Antihypertesive
Dissociative symptoms such as derealization or depersonalization Perceptual disturbance (the DSM-5-TR labels them pseudo-hallucinations) Paranoid ideation	Antipsychotics
Substance abuse	
Concentration / memory difficulties	Stimulants, Antihypertensive, Antipsychotic

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THE *FUNCTION* OF MEDICATING

- If we recognize that symptoms – while not proven to be understood from a physiological / biological basis – may actually be signals to us…
  - This young person needs help
  - This young person is hurting
  - This young person is scared
  - This young person is struggling to make sense out of the world around them

Then suppressing these signs with medications is like taking the batteries out of a smoke detector.

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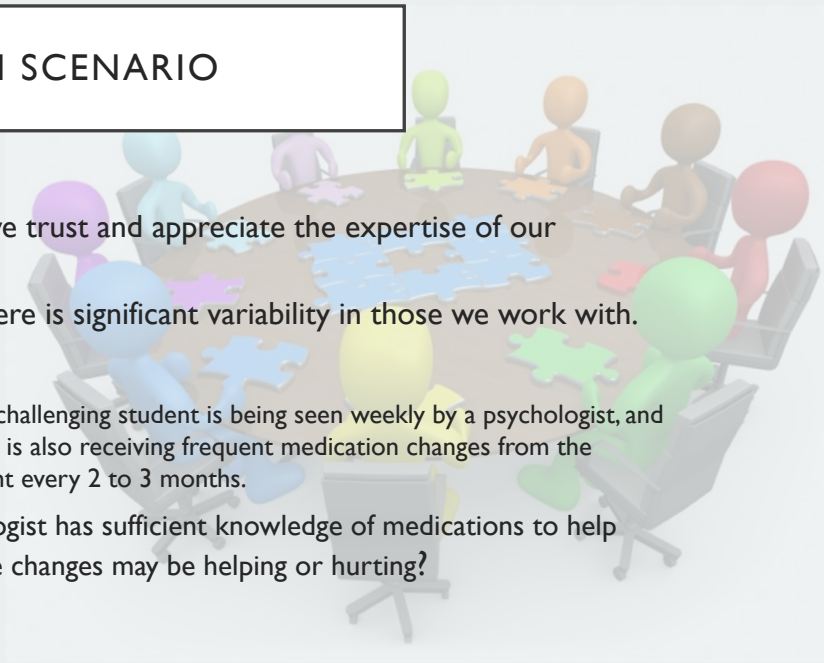
A COMMON SCENARIO



- When we are collaborating, we trust and appreciate the expertise of our colleagues.
- But we also recognize that there is significant variability in those we work with.
- Consider this…
  - You're working in a school. Your challenging student is being seen weekly by a psychologist, and you also realize that your student is also receiving frequent medication changes from the psychiatrist who sees your student every 2 to 3 months.
- Do you expect that the psychologist has sufficient knowledge of medications to help guide the process / identify if the changes may be helping or hurting?

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OH, BY THE WAY…

- How many APA accredited Clinical Psychology Doctoral Programs ***require*** a course in Psychopharmacology?
  - A. 0 – 10%
  - B. 10 – 30%
  - C. 30 - 50%
  - D. 50 – 75%
  - E. 75 - 100%

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SURPRISED?

Psychopharmacology Curriculum	Ph.D.				Psy.D.				All Programs			
	Programs		First Year (FY) Students		Programs		FY Students		Programs		FY Students	
	#	%	#	%	#	%	#	%	#	%	#	%
Required	26	15%	345	25%	40	52%	1098	55%	66	26%	1443	43%
Elective	59	33%	439	32%	15	19%	471	24%	74	29%	910	27%
Not Offered	68	38%	453	33%	8	10%	219	11%	76	30%	672	20%

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AAP - SSNRS

- 2021 American Academy of Pediatrics
- **SAFE, STABLE, NURTURING Relationships**
- "Not only do SSNRs buffer adversity and turn potentially toxic stress responses into tolerable or positive responses, but they are also the primary vehicle for building the foundational resilience skills that allow children to cope with future adversity in an adaptive, healthy manner."

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THE REPLICATION CRISIS

- "In modern times, the science of psychology is facing a crisis. It turns out that many studies in psychology—including many highly cited studies—do not replicate. In an era where news is instantaneous, the failure to replicate research raises important questions about the scientific process in general and psychology specifically."
(Feldman, 2018).

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NO REPLICATION CRISIS HERE

Table 1: A Consilience of Research on Positive Youth Development

Circle of Courage	Belonging	Mastery	Independence	Generosity
The Hierarchy of Needs Maslow, 1943	Belongingness	Esteem	Self-Actualization	Self-Transcendence
Bases of Self-Esteem Coopersmith, 1967	Significance	Competence	Power	Virtue
Positive Peer Culture Vorrath & Brendtro, 1974	Trust	Problem-Solving	Responsibility	Care and Concern
Youth Aliyah Feuerstein, 1974	Unconditional Belonging	School Success	Managing Stress	Contributing to Community
Resilience Research Benard, 2004	Social Competence	Problem Solving	Autonomy	Purpose
Resilient Brains Masten, 2014	Attachment	Mastery Motivation	Self-efficacy	Spirituality/Purpose

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RECLAIMING BEST PRACTICE

Belonging
Mastery
Generosity
Independence

Aligning your Agencies & Service Delivery with the foundation of Trauma-Informed, Strength-Based Model of Care

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QUESTIONS?

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