

# Childhood Traumatic Grief Must Be Addressed

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BOSTON — The assumption that toddlers and preschoolers are not emotionally affected by traumatic grief in the same way as older children and adults is not only wrong, it's dangerous, according to Chandra Ghosh Ippen, Ph.D.

Unaddressed traumatic grief in a very young child can manifest as vague but persistent and stress that threaten the

child's core sense of safety and security, setting the stage for later behavioral problems and mental illness, Dr. Ippen said in a symposium at the annual meeting of the American Academy of Child and Adolescent Psychiatry.

Defined as a condition in which a child has lost a loved one under sudden or frightening circumstances that negatively affect the child's ability to negotiate the normal grieving process, childhood traumatic grief overlaps with, but is distinct from, uncomplicated bereavement in chil-

“In these kids,” she said, “the physical reaction is immediately evident when the loved one's name is brought up or the topic of the circumstances of the loss is introduced.”

Although efforts to accurately define and measure childhood traumatic grief are just emerging, effective intervention is possible. Within the CTRP, for example, Dr. Ippen and her colleagues have found child-parent psychotherapy (CPP) to be an effective tool.

An attachment-based intervention, CPP

incorporates psychodynamic, relationship, and cognitive-behavioral principles for infants, toddlers, and preschool children who have experienced trauma. The treatment, which is delivered by a psychotherapist and typically lasts from 6 months to 1 year, is based on the premise that trauma-related problems in young children should be addressed within the context of the child's primary attachment relationships.

“In young children, their attachment system is the main organizer of emotional and behavioral responses, so the goal is to promote safety and growth in that relationship,” Dr. Ippen said. Doing so, she added, “will affect their entire developmental trajectory.”

Through free play with the parent and child, and the therapeutic use of developmental guidance and information, CPP targets and strengthens the caregiver-child relationship. The ultimate goal is the restoration of the child's sense of safety and trust in adult caretakers.

In a study published in 2005, CTRP in-

vestigators demonstrated the efficacy of child-parent psychotherapy in a randomized controlled trial of young trauma-exposed children. Dr. Ippen, along with lead author Alicia Lieberman, Ph.D., director of CTRP, and Patricia Van Horn, Ph.D., associate director, compared the impact of CPP with that of usual care in 75 children aged 3-5 years who had witnessed domestic violence (J. Am. Acad. Child Adolesc. Psychiatry 2005;44:1241-8).

The study population was not made up of children who had lost a parent or a loved one to death, but the trauma symptoms were similar, Dr. Ippen noted.

After treatment, the CPP children showed significantly greater reductions in total behavior problems and traumatic stress symptoms, compared with the usual care group. Additionally, CPP caregivers showed significantly greater reductions in avoidant symptoms.

In a 6-month follow-up study, the investigators observed that the improvements in both children's behavior and maternal symptoms continued after treatment had ended (J. Am. Acad. Child Adolesc. Psychiatry 2006;45:913-8).

“These findings suggest promise for childhood traumatic grief as well, where the goals are the same: to establish a safe and consistent environment and behavior, and to build empathetic relationships,” Dr. Ippen said.

“It's important to remember that where you have a child with trauma, you will generally have a caregiver with trauma.”

Therefore, using a relational approach simultaneously helps caregivers and children cope with their situations, she said. Also, promoting growth in the caregiver-child relationship “supports the healthy development of the child long after the intervention ends.”

## LEXAPRO® (escitalopram oxalate) TABLETS/ORAL SOLUTION

(3% and <1%); Anorgasmia (2% and <1%); \*Events reported by at least 2% of patients treated with Lexapro are reported, except for the following events which had an incidence on placebo: Lexapro: headache, upper respiratory tract infection, back pain, pharyngitis, inflamed injury, anxiety, anxiety. \*Primarily ejaculatory delay. †Denominator used was for males only (N=225 Lexapro; N=188 placebo). ‡Denominator used was for females only (N=490 Lexapro; N=404 placebo). **Generalized Anxiety Disorder Table 3** enumerates the incidence, rounded to the nearest percent of treatment-emergent adverse events that occurred among 429 GAD patients who received Lexapro 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients. The most commonly observed adverse events in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were nausea, ejaculation disorder (primarily ejaculatory delay), insomnia, fatigue, decreased libido, and anorgasmia (see TABLE 3). **TABLE 3. Treatment-Emergent Adverse Events: Incidence in Placebo-Controlled Clinical Trials for Generalized Anxiety Disorder (Lexapro (N=429) and Placebo (N=427)).**

**Autonomic Nervous System Disorders:** Dry Mouth (9% and 5%); Sweating Increased (4% and 1%); **Central & Peripheral Nervous System Disorders:** Headache (24% and 17%); Paresthesia (2% and 1%); **Gastrointestinal Disorders:** Nausea (18% and 8%); Diarrhea (8% and 6%); Constipation (5% and 4%); Indigestion (3% and 2%); Vomiting (3% and 1%); Abdominal Pain (2% and 1%); Flatulence (2% and 1%); Toothache (2% and 0%); **General:** Fatigue (8% and 2%); Influenza-like symptoms (5% and 4%); **Musculoskeletal:** Neck/Shoulder Pain (3% and 1%); **Psychiatric Disorders:** Somnolence (13% and 7%); Insomnia (12% and 6%); Libido Decreased (7% and 2%); Dreaming Abnormal (3% and 2%); Appetite Decreased (3% and 1%); Lethargy (3% and 1%); Yawning (2% and 1%); **Urogenital:** Ejaculation Disorder<sup>1,2</sup> (14% and 2%); Anorgasmia<sup>3</sup> (6% and <1%); Menstrual Disorder (2% and 1%); \*Events reported by at least 2% of patients treated with Lexapro are reported, except for the following events which had an incidence on placebo: Lexapro: inflamed injury, dizziness, back pain, upper respiratory tract infection, rhinitis, pharyngitis. †Primarily ejaculatory delay. ‡Denominator used was for males only (N=182 Lexapro; N=195 placebo). †Denominator used was for females only (N=247 Lexapro; N=232 placebo). **Dose Dependency of Adverse Events** The potential dose dependency of common adverse events (defined as an incidence rate of ≥5% in either the 10 mg or 20 mg Lexapro groups) was examined on the basis of the combined incidence of adverse events in two fixed-dose trials. The overall incidence rates of adverse events in 10 mg Lexapro-treated patients (66%) was similar to that of the placebo-treated patients (61%), while the incidence rate in 20 mg Lexapro-treated patients was greater (86%). **Table 4** shows common adverse events that occurred in the 20 mg/day Lexapro group with an incidence that was approximately twice that of the 10 mg/day Lexapro group and approximately twice that of the placebo group. **TABLE 4. Incidence of Common Adverse Events\* in Patients with Major Depressive Disorder Receiving Placebo (N=311), 10 mg/day Lexapro (N=310), 20 mg/day Lexapro (N=252); Insomnia (4%, 7%, 14%); Diarrhea (5%, 6%, 14%); Dry Mouth (2%, 4%, 9%); Somnolence (1%, 4%, 9%); Dizziness (2%, 4%, 7%); Sweating increased (<1%, 3%, 8%); Constipation (1%, 3%, 6%); Fatigue (2%, 2%, 6%); Indigestion (1%, 2%, 6%); Adverse events with an incidence rate of at least 5% in either the Lexapro groups and with an incidence rate in the 20 mg/day Lexapro group that was approximately twice that of the 10 mg/day Lexapro group and the placebo group. **Male and Female Sexual Dysfunction with SSRIs** Although changes in sexual desire, sexual performance, and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that SSRIs can cause such untoward sexual experiences. Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance, and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experiences and performance cited in product labeling are likely to underestimate their actual incidence. **Table 5** shows the incidence rates of sexual side effects in patients with major depressive disorder and GAD in placebo-controlled trials. **TABLE 5. Incidence of Sexual Side Effects in Placebo-Controlled Clinical Trials (in Males Only: Lexapro (N=407) and Placebo (N=383)); Ejaculation Disorder (primarily ejaculatory delay) (12% and 1%); Libido Decreased (6% and 2%); Impotence (2% and <1%). (in Females Only: Lexapro (N=73) and Placebo (N=56)); Libido Decreased (3% and 1%); Anorgasmia (3% and <1%)** There are no adequately designed studies examining sexual dysfunction with escitalopram treatment. Priapism has been reported with all SSRIs. While it is difficult to know the precise risk of sexual dysfunction associated with the use of SSRIs, physicians should routinely inquire about such possible side effects. **Vital Sign Changes** Lexapro and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, and diastolic blood pressure) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses did not reveal any clinically important changes in vital signs associated with Lexapro treatment. In addition, a comparison of supine and standing vital sign measures in subjects receiving Lexapro indicated that Lexapro treatment is not associated with orthostatic changes. **Weight Changes** Patients treated with Lexapro in controlled trials did not differ from placebo-treated patients with regard to clinically important change in body weight. **Laboratory Changes** Lexapro and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables, and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Lexapro treatment. **ECG Changes** Electrocardiograms from Lexapro (N=625), racemic citalopram (N=351), and placebo (N=527) groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed (1) a decrease in heart rate of 2.2 bpm for Lexapro and 2.7 bpm for racemic citalopram, compared to an increase of 0.3 bpm for placebo and (2) an increase in QTc interval of 0.9 msec for Lexapro and 0.7 msec for racemic citalopram, compared to 0.5 msec for placebo. Neither Lexapro nor racemic citalopram were associated with the development of clinically significant ECG abnormalities. **Other Events Observed During the Premarketing Evaluation of Lexapro** Following is a list of WHO terms that reflect treatment-emergent adverse events, as defined in the introduction to the **ADVERSE REACTIONS** section, reported by the 1429 patients treated with Lexapro for periods of up to one year in double-blind or open-label clinical trials during its premarketing evaluation. All reported events are included except those already listed in **Tables 2 & 3**, those occurring in only one patient, event terms that are so general as to be uninformative, and those that are unlikely to be drug related. It is important to emphasize that, although the events reported occurred during treatment with Lexapro, they were not necessarily caused by it. Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring on one or more occasions in at least 1/100 patients; infrequent adverse events are those occurring in less than 1/100 patients but at least 1/1000 patients. **Cardiovascular:** Frequent: palpitation, hypertension, infrequent: bradycardia, tachycardia, ECG abnormal, flushing, varicose vein. **Central and Peripheral Nervous System Disorders - Frequent:** light-headed feeling, migraine. **Infrequent:** tremor, vertigo, restless legs, staking, twitching, dysequilibrium, tics, carpal tunnel syndrome, muscle contractions involuntary, sluggishness, coordination abnormal, faintness, hyperreflexia, muscular tone increased. **Gastrointestinal Disorders - Frequent:** heartburn, abdominal cramp, gastroenteritis. **Infrequent:** gastroesophageal reflux, bloating, abdominal discomfort, dyspepsia, increased stool frequency, belching, gastritis, hemorrhoids, gagging, polyposis gastric, swallowing difficult. **General - Frequent:** allergy, pain in limb, fever, hot flashes, chest pain. **Infrequent:** edema of extremities, chills, lightness of chest, leg pain, asthenia, syncope, malaise, anaphylaxis, fall. **Hemic and Lymphatic Disorders - Frequent:** bruise, anemia, nosebleed, hematoma, lymphadenopathy cervical. **Metabolic and Nutritional Disorders - Frequent:** increased weight. **Infrequent:** decreased weight, hyperglycemia, thirst, bilirubin increased, hepatic enzymes increased, gout, hypercholesterolemia. **Musculoskeletal System Disorders - Frequent:** arthralgia, myalgia. **Infrequent:** jaw stiffness, muscle cramp, muscle stiffness, arthritis, muscle weakness, back discomfort, arthropathy, jaw pain, joint stiffness. **Psychiatric Disorders - Frequent:** appetite increased, lethargy, irritability, concentration impaired. **Infrequent:** jitteriness, panic reaction, agitation, apathy, forgetfulness, depression aggravated, nervousness, restlessness aggravated, suicide attempt, amnesia, anxiety attack, bruxism, carbohydrate craving, confusion, depersonalization, disorientation, emotional lability, feeling unreal, tremulousness nervous, crying abnormal, depression, excitability, auditory hallucination, suicidal tendency. **Reproductive Disorders/Female† - Frequent:** menstrual cramps, menstrual disorder. **Infrequent:** menorrhagia, breast neoplasm, pelvic inflammation, premenstrual syndrome, spotting between menses. \*% based on female subjects only. **N= 905 Respiratory System Disorders - Frequent:** bronchitis, sinus congestion, coughing, nasal congestion, sinus headache. **Infrequent:** asthma, breath shortness, laryngitis, pneumonia, tracheitis. **Skin and Appendages Disorders - Frequent:** rash. **Infrequent:** pruritus, acne, alopecia, eczema, dermatitis, dry skin, folliculitis, lipoma, furunculosis, dry lips, skin nodules. **Special Senses - Frequent:** vision blurred, tinnitus. **Infrequent:** taste alteration, earache, conjunctivitis, vision abnormal, dry eyes, eye irritation, visual disturbance, eye infection, pupile dilated, metallic taste. **Urinary System Disorders - Frequent:** urinary frequency, urinary tract infection. **Infrequent:** urinary urgency, kidney stone, dysuria, blood in urine. **Events Reported Subsequent to the Marketing of Escitalopram** - Although no causal relationship to escitalopram treatment has been found, the following adverse events have been reported to have occurred in patients and to be temporally associated with escitalopram treatment during post marketing experience and were not observed during the premarketing evaluation of escitalopram: abnormal gait, acute renal failure, aggression, akathisia, allergic reaction, anger, angoedema, atrial fibrillation, choreoathetosis, delirium, delusion, diplopia, dysarthria, dyskinesia, dystonia, ecchymosis, erythema multiforme, extrapyramidal disorders, fulminant hepatitis, hepatic failure, hypoesthesia, hypocalcemia, hypokalemia, INR increased, gastrointestinal hemorrhage, glaucoma, grand mal seizures (or convulsions), hemolytic anemia, hepatic necrosis, hepatitis, hypotension, leucopenia, myocardial infarction, myoclonus, neuroleptic malignant syndrome, nightmare, nystagmus, orthostatic hypotension, pancreatitis, paranoia, photosensitivity reaction, priapism, prothrombin decreased, prothrombin time prolonged, pulmonary embolism, QT prolongation, rhabdomyolysis, seizures, serotonin syndrome, SIADH, spontaneous abortion, Stevens Johnson Syndrome, tardive dyskinesia, thrombocytopenia, thrombosis, torsade de pointes, toxic epidermal necrolysis, ventricular arrhythmia, ventricular tachycardia and visual hallucinations.**

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## Child-parent psychotherapy can be an effective intervention for helping infants, toddlers, and preschool children who have experienced trauma.

“Children with traumatic grief get ‘stuck’ on the traumatic way their loved one died,” she said, so that efforts to remember happy, positive times with their loved one evoke only thoughts of how the person died. As a result, these children are, in effect, retraumatized each time they think or talk about their loved one, which impedes the normal course of a healthy grieving process—specifically the ability to reminisce about and preserve positive memories of the person who died and to reinvest in new relationships, she said.

“In very young children, the impact of the traumatic loss of a parent or caregiver is most evident through what they do versus what they say—how they interact, their body language,” said Dr. Ippen, clinical research coordinator of the Child Trauma Research Project (CTRP) at the University of California, San Francisco.

# Conduct Problems Tied to Mothers' Drinking

BY MARY ANN MOON  
Contributing Writer

Prenatal alcohol exposure appears to cause later conduct problems in childhood, reported Dr. Brian M. D'Onofrio of Indiana University, Bloomington, and his associates.

In contrast, the later attention and impulsivity problems seen in children who were exposed to alcohol in utero appear to be caused by other factors correlated with maternal drinking rather than to the alcohol exposure itself, the researchers said.

Dr. D'Onofrio and his associates used data collected in a large longitudinal study of adolescents and young adults to examine the relationship between drinking in young women and behavior in their offspring. The survey, funded by the U.S. Bureau of Labor Statistics, covered a racially diverse sample of more than 6,000 subjects who were assessed annually from 1979 through 1994 and then biannually since then (Arch. Gen. Psychiatry 2007;64:1296-304).

Dr. D'Onofrio and his associates analyzed data on a subsample of 4,912 young

female subjects who had at least one child aged 4-11 years by the 2004 assessment. The women had furnished information on their substance use both before they had become pregnant and during their pregnancies. They then reported on their children's conduct problems and attention/impulsivity problems using the Behavior Problem Index.

Prenatal exposure strongly correlated with conduct problems, and children with exposure to higher levels of alcohol had more such problems than those exposed to less alcohol. Compared with children who were not exposed to alcohol in utero, those who were exposed to alcohol every day had an increase of 0.35 standard deviations in conduct problems.

This link persisted after the data were adjusted to account for potentially confounding factors such as prenatal exposure to nicotine and other drugs, maternal

traits, and genetic and environmental factors. It also persisted in comparisons with siblings and cousins, and in a number of statistical models.

“The results of all models are consistent with a causal association between prenatal alcohol exposure and offspring conduct problems,” the investigators said.

In contrast, prenatal alcohol exposure did not appear to be causally related to attention/impulsivity problems, although these problems were highly prevalent in exposed children. It is likely that some other factor related to maternal drinking explains this association, they added.

This large-scale study complements but does not replace more focused studies that can more accurately assess the particular mental health problems in children who were exposed to alcohol prenatally, Dr. D'Onofrio and his associates noted.

The survey covered a racially diverse sample of more than 6,000 subjects assessed annually from 1979 through 1994 and biannually since then.