

# Atypical Antipsychotics in Youth: Use Caution

BY DIANA MAHONEY  
New England Bureau

BERLIN — When prescribing atypical antipsychotic drugs to children with major psychiatric disorders, physicians “can’t be guided by scientific data alone because there are just not enough from properly conducted trials,” Stanley Kutcher, M.D., advised.

Clinicians need to proceed with caution and “consider the symptoms, adverse effects, function, and evidence associated with each of the drugs relative to the symptoms they’re being used to treat,” he said at the 16th World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions.

The literature on atypical antipsychotics in pediatric patients is limited. With the exception of a small number of controlled studies, “most of the published data come from anecdotal case reports and small open-label trials,” said Dr. Kutcher of Dalhousie University, Halifax, N.S.

“You can’t determine the efficacy and tolerability of any medication from open-label studies or case series, regardless of the number of participants, and while there have been some acute, controlled studies, data from these cannot be extrapolated to the long term. There can be a loss of efficacy over time, and there can be problems with side effects that don’t show up in the first few months of treatment, but emerge later,” he explained.

What little evidence does exist—most-

ly from adult studies—suggests that the atypical, or second-generation, antipsychotics are at least as effective as first-generation compounds and have a lower incidence of extrapyramidal symptoms such as dystonia, parkinsonism, and akathisia. Anecdotally, the atypical drugs have been linked to favorable outcomes in children with psychotic disorders, which in turn has evoked interest in their use for other psychiatric conditions, including bipolar disorder, autism-spectrum disorders, aggression and disruptive behavior disorders, and tic disorders, Dr. Kutcher noted.

A review of the literature on the use of atypical antipsychotics showed 2 double-blind randomized control trials, 22 open-label studies, 10 retrospective investigations, and 14 published reviews. “Basically, it looks like there are more people reviewing what’s out there than writing anything new,” Dr. Kutcher joked. And even the two randomized control trials looked only at short-term results (6 and 8 weeks) and examined the effects of very different dosages, making it impossible to extract definitive guidelines, he said.

The dearth of scientifically based treatment guidelines has many pediatric and adolescent psychiatrists walking a tightrope without a net. “The incentive to use the newer antipsychotics is there because of their efficacy in reducing acute psychiatric symptoms, but caution must be exercised, particularly in the face of the false security brought on by a quick, dramatic response,” he said.

Physicians must be aware that the drugs described as atypical antipsychotics—clozapine (Clozaril), risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), ziprasidone (Geodon), and aripiprazole (Abilify)—are not interchangeable. Each has a unique pharmacologic profile and may be associated with a range of different adverse events that can drive treatment decisions. “For

example, some drugs may be more likely than others to induce akathisia. To those not aware of this, the effect can be misinterpreted as an increase in psychosis, leading clinicians to increase the medication dose when it should be decreased,” Dr. Kutcher noted.

Careful consideration of the drugs’ actions and side effects can help mitigate potential problems, Dr. Kutcher said. ■

## Dosing Recommendations for Atypicals

Dosage determination is critical when prescribing atypical antipsychotics to children. Current dosage recommendations have been extrapolated from adult studies, typically relying on body weight and proportionately reducing an adult dosage. This approach is problematic, though, because the different pharmacokinetics in children and adolescents could make the resulting plasma concentration either subtherapeutic or toxic, Dr. Kutcher said.

To minimize the risk of adverse events and maximize the potential for therapeutic effect, children and adolescents should always be started on the lowest possible dose with any of the antipsychotic agents. Gradual increases should be guided by clinical response. Because there are also insufficient data to support hard and fast recommenda-

tions for medication duration, these decisions must be guided by clinical instinct as well.

Toward that end, Dr. Kutcher made the following recommendations:

- ▶ When a minimal therapeutic dose is established, maintain the pediatric patient on this dose for 1 year, carefully monitoring the patient for changes and potential adverse events.
- ▶ After 1 year of stable treatment, partner with the patient and parents to discuss medication withdrawal.
- ▶ Choose the correct time to make a change. Any changes should not be implemented during a critical or stressful period in the child’s life.
- ▶ Devise a slow discontinuation schedule, monitoring the child carefully for symptoms.
- ▶ If symptoms recur, return to the therapeutic dose of the medication.

# School-Based Intervention Helps Aggressive Kids Cope

BY DIANA MAHONEY  
New England Bureau

BERLIN — School-based preventive interventions can positively affect children’s antisocial behavior at the time of transition to middle school, and the gains can be maintained for at least a year after the intervention ends.

Elementary school children identified by their peers and teachers as aggressive have been shown to be at risk for later delinquency and substance use, according to John Lochman, Ph.D., professor and Saxon Chair of Clinical Psychology at the University of Alabama, Tuscaloosa.

Exposing these moderate- to high-risk preadolescents to specific social-cognitive coping techniques in the classroom—while also engaging parents in the preventive intervention—can mitigate the potential for their developing conduct disorders during adolescence, Dr. Lochman reported at the 16th World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions.

Dr. Lochman and his colleagues evaluated the effects of a school-based aggression-intervention program on two samples of teacher-rated aggressive preadolescent children at the time of transition from elementary to middle school. The Coping Power program is based on an empirical model of risk factors for substance use. It addresses high-risk children’s

deficits in social competence, self-regulation, school bonding, and positive parental involvement.

The first sample included 183 fourth- and fifth-grade boys from 11 elementary schools, and the second sample comprised 245 fifth-grade boys and girls from 17 elementary schools. The children in both samples were randomly assigned to one of three groups: the Coping Power child component, the full Coping Power program with a combined parent and child component, or a control group.

In the second sample, some classrooms were also randomly assigned to a universal intervention through which the teachers received special training to help foster Coping Power skills in all students within the class.

The child component of the Coping Power program included 33 1-hour group sessions (4-6 boys per group) in an after-school setting over a 15-month period.

The sessions, which were led by a family-school program specialist and a school guidance counselor, focused on behavioral and personal goal setting; awareness of feelings and their associated physiologic arousal; the use of coping self-statements, distraction techniques, and relax-

ation methods; the development of organizational and study skills, perspective-taking strategies, and social problem-solving skills; attribution retraining; and dealing with peer pressure and neighborhood-based problems.

During the same 15-month period, the parental component of the program included 16 group sessions, with four to six parents/couples per group. The program content was derived from social learning

theory-based training programs and included skills for identifying both prosocial and disruptive behavioral targets in their children, rewarding appropriate child behaviors, giving effective instructions, establishing age-appropriate

rules and expectations, applying effective consequences to negative child behavior, and establishing ongoing communication through weekly family meetings. Parents also learned to be supportive of the Coping Power skills their children were attaining, and they were introduced to stress management techniques to help them remain calm during difficult interactions with their children.

One year after the end of the intervention period, children in both samples who participated in the Coping Power program

had lower rates of self-reported delinquent behavior. Children in the first group had lower parent-rated substance use, and children in the second group had lower self-reported substance use. Both intervention conditions (child-only and combined child and parent) produced positive effects on the children’s social competence and self-regulation and the parents’ parenting skills, Dr. Lochman reported. “The intervention effects were most apparent for the full Coping Power, with parent and child components,” he said.

The intervention was also associated with teacher-rated behavioral improvements in school during the follow-up year—effects that appeared to be primarily influenced by the child component of the program, Dr. Lochman said. The follow-up measures also indicated that the universal intervention directly affected child substance use ratings and enhanced the Coping Power effects on delinquency. This finding suggests that providing teachers with the appropriate cognitive-behavioral techniques can have an effect on student aggression and antisocial behaviors.

The current study is the first to show that the effects of the intervention are maintained 1 year after the end of the program, and that an intervention that includes a combined parent and child component produces a greater improvement than does the Coping Power child component alone, Dr. Lochman noted. ■

**The results suggest that providing teachers with the appropriate cognitive-behavioral techniques can affect student aggression and antisocial behaviors.**