

The Challenges of Treating Developmental Trauma Disorder in a Residential Agency for Youth

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Abstract: In recent years the task of psychiatrists serving youth in residential programs has largely shifted to rendering diagnostic evaluations and prescribing medications. Children in residential facilities are often misdiagnosed and treated with high doses of multiple medications drawn from several different classes of psychopharmaceuticals. The more accurate diagnosis for many of these children, Developmental Trauma Disorder (DTD), reconceptualizes the treatment approach and leads to substantial clinical benefit. Initiating treatment through application of milieu and dynamic psychotherapy and the tapering of medication very likely will encounter the challenges of staff resistance and the modification of the residence's institutional culture.

The number of children receiving medication, the amount and number of medications used, and the number of aggressive incident reports fell dramatically over a 2-year period. Regarding mood and conduct disorders as manifestations of past trauma, rather than as biochemical imbalances, is the dominant focus of an analytically-informed treatment of DTD.

Over the past nearly 20 years, casual observation suggests that an increasing number of young patients have been admitted to residential programs with formal or presumptive diagnoses of bipolar disorder (BD), pediatric bipolar disorder (PBD), or severe mood dysregulation (SMD). According to Moreno et al. (2007), diagnoses of BD in youth increased from 1994-95 to 2002-03 by an astonishing 4,000%. This article

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represents an effort to re-frame this phenomenon. This article argues the following:

1. Expand the role of consulting psychiatrists beyond responsibility for providing prescriptions.
2. Conceptualize irritable and moody youths as likely to be responding to early, chronic and severe trauma, that is, as suffering from Developmental Trauma Disorder, as described by van der Kolk (2005), rather than to a neurochemical impairment.
3. Accept the idea that it is necessary to change institutional culture by increasing the competency and self-confidence of clinicians and child care staff if the use of medication is to be successfully reduced.

Providing consultation for a few hours per week over several decades to various nonprofit agencies serving youth convinced the author that many child and adolescent patients are frequently overmedicated. This appears to be especially true for the past 15 years and applies even more for those youth who are publicly funded. The conclusion drawn from this experience is that such children are at risk of being diagnosed with BD/PBD, often with comorbid Attention Deficit Hyperactive Disorder (ADHD), or SMD. Most often, these patients' conditions appear to meet the criteria for Developmental Trauma Disorder (DTD). DTD more adequately describes youths presenting with a range of difficulties that encompass rage reactions, problems with attachment and authority, affect and impulse dysregulation, and impairment of cognition and attention. The conception of DTD invites primary consideration of possible exposure to early, chronic, and severe trauma. While a tendency to rage must, as does all behavior, involve some biology, it may more significantly reflect a patient's reaction to adverse and inhumane treatment. If so, it would follow that youths with histories of chronic and severe trauma could benefit more from efforts to deal with their trauma rather than from the poly-pharmacologic approaches so often used for SMD and BD/PBD, with or without comorbid ADHD.

The goal here is to summarize what the author has come to believe from more than two years' experience at a children's residential center, evaluating diagnoses and providing medication treatment. The article includes illustrative narrative case reports, followed by reflections on the limitations of an exclusive biologic understanding of the disorders of the many irritable and violent youth flooding our mental health services. It further considers what else needs to be done to successfully reduce medication usage and improve treatment outcome in the youths

just described. The article then proceeds to suggest an alternative diagnostic path and a plan for evaluating diagnoses and medication programs with the use of tapering trials of medication. Finally, it presents data that correlate greatly reduced dosages of medications dispensed per day with an associated reduction in aggressive incidents reported by the staff.

AN ILLUSTRATIVE CASE

(The name is changed, but the details are not, as permission for publication has been granted by the patient and her court guardian.)

Maya was 12 years old at admission in 2006 and 14 years old at discharge. She was referred under a specially negotiated contract from a somewhat distant county, as previous approaches to her treatment over 10 years had been met by increasing behavioral dyscontrol. Costs for her care had been regarded as excessive. The desire of the county authorities was to achieve a comprehensive diagnostic evaluation with recommendations for effective treatment. A hospital report from 2002 listed her diagnosis as ADHD and added, "Other client Emotional Condition: Child has PTSD, Depression and is Bipolar." Not listed was the diagnosis of Oppositional Defiant Disorder, which had been attributed to her the same year at another facility. At various times, in and out of hospitals, she had been on aripiprazole, quetiapine, ziprasidone, topiramate, valproate, guanfacine, benztropine, diphenhydramine, and melatonin.

Maya had been evaluated in infancy for seizures. Later, she had been treated for migraines and had received speech therapy. Born to a mother who reportedly suffered from schizoaffective disorder and mental retardation, Maya was often homeless until removed from mother's care at age 2. In the next 10 years, she moved through at least 29 and perhaps as many as 50 foster and group home placements before being admitted to our agency. Many of the moves had been prompted by her aggressive behavior. A few moves had been for reasons that had little to do with her. In addition to the many losses of attachments implied by the large number of moves, her chart includes a reference to her having, "... experienced, witnessed and been confronted with events which include sexual and physical abuse to self and others." This had occurred while she was placed in homes under the protection of the court. Prior psychological testing at age 9 had concluded that she had borderline intellectual functioning, ADHD, disruptive behavior disorder NOS, and, by history, physical abuse and neglect. The evaluator added, "While [Maya's] behavior may appear, on the surface, to reflect an emotional

disturbance, it clearly does not. [Maya] has a skills deficit rather than an emotional disorder”

Psychologic assessment at our agency concluded with diagnoses of PTSD, speech impediment, headaches, seizure history, and victimization through neglect and abuse. Other stated diagnostic possibilities were mixed receptive-expressive language disorder and mild mental retardation.

Maya was in residence at the author’s facility for a little over 2 months before the author was assigned to her unit. The first months in the program were characterized by considerable acting out on her part, as indicated by the large number of aggressive incident reports that she generated (see Table 1). During an initial consultation, a speech defect was noted. She had recently been evaluated at an ear, nose, and throat clinic and was considered “tongue tied.” She was referred for a frenulectomy. Maya’s speech normalized and the request for surgical intervention was withdrawn shortly after tapering trials of her medications were begun. (Clinicians are often unaware of the detrimental impact of atypical antipsychotics on speech.) General physical examination, EEG and laboratory tests, including genetic testing, were all negative.

Even before the medications were tapered, and then in its early stages, Maya related to the author primarily by asking multiple times a day for her medications to be reduced. I would respond by talking to her about how much I wished to do that, but she first had to help both staff and me believe that she had the ability to control her behavior when on less medication. Staff resistance to tapering was determined primarily by concern over safety. Maya was large and powerfully built. Once staff became comfortable enough to agree to my tapering dosages, we praised her every step of the way. It is notable that just before her last medication (guanfacine) was to be eliminated, she asked the Unit Supervisor and me to discontinue the taper. We agreed and worked with her around her anxiety that she would not be able to contain her anger once off medication. We made no further moves to reduce the drug until she asked us to do so. Importantly, the tapering of her medications was associated with a decline in the number of Aggressive Incident Reports she generated.

While there were 18 incidents reported in her first 6 months, only 2 occurred in her last 10 months. This roughly reflects the trajectory of the tapering trials. It is likely that this improvement reflected Maya’s increased availability for therapy and the increasing enthusiasm and ability of staff to think in psychosocial and psychodynamic terms as they appreciated her improvement.

TABLE 1. Aggressive Incident Reports Involving Maya

Admission to Discharge, 3/2006-6/2007

Month	Number	Location	Type
3/06	3	Unit A	2 Self-Harm; 1 Emotionally Acting Out
4/06	3	School	1 Injury due to Restraint; 1 Physically Acting Out; 1 Assault to Staff
5/06	5	4 School; 1 Unit A	2 AWOLs; 1 Threats to Youth; 1 Physically Acting Out; 1 Assault to Youth
6/06	1	School	1 Assault to Youth
7/06	4	3 School; 2 Unit A	1 Out of Designated Area; 1 Assault to Youth; 1 complaint against Staff; 1 Injury to Staff
8/06	2	1 School; 1 Unit A	1 Threats towards Staff; 1 Assault to Youth
9/06	0		
6-Oct	1	School	1 Complaint against Staff
6-Nov	0		
6-Dec	0		
1/07	1	Unit A	1 Physically Acting Out
2/07	0		
3/07	0		
4/07	0		
5/07	0		
6/07	0		
Total incidents	20		

Maya progressively learned to control her violent behavior with less outside help. In speaking to the Unit Supervisor, she said that she had previously never acquired any coping skills because, “. . . every time I was bad, they gave me a pill. I feel like I’m in my own skin for the first time that I can remember . . . I feel like I can learn things now.” She

became able to get through a school day without incident. An excellent athlete, she rejoined the facility's basketball team from which she earlier had to withdraw due to anxiety and unreliable conduct. She began to read and put herself to sleep at night with a book. If one were not available, she would read from a dictionary to increase her vocabulary. At this writing, 15 months after discharge to a foster placement and to a public junior high school in her county of origin, she remains off medications and continues to do well. A report card showed that at the end of her first semester post-discharge she had attained a GPA of 2.2. By the end of the academic year it was 3.3 and she had received awards for attendance and for being "most athletic." She is scheduled to enter a mainstream high school after summer recess.

Although still only a proposed official diagnostic category, it appears likely that applying the diagnosis of DTD provided the most effective way of conceptualizing Maya's disorder. Multiple prior diagnoses encouraged the use of multiple medications. These resulted in unsuccessful efforts to obtain behavioral control through correction of presumed neurochemical imbalances. The medications caused numerous side effects, most significantly the distraction of both patient and treating personnel from what proved to be the more central issue, namely her history of trauma. Although Posttraumatic Stress Disorder (PTSD) helps conceptualize a focus on a history of trauma, it fails to appreciate the complexity and the severity of the disruptions of functioning that follow when trauma comes early in a child's development, when it is overwhelming and prolonged, and when it often involves caretakers who either inflict trauma or fail to provide protection from trauma. On the other hand, conceptualizing a child with the singular diagnosis of DTD, which refers specifically to the child's life history, does not primarily encourage pharmacologic interventions. Instead, it facilitates understanding, empathy, the need for safe and well-bounded attachments, and for dynamic psychotherapy in the milieu. The latter is directed towards assisting the child to develop the capacity to bind anxiety and to trust others, in gaining a vocabulary and a tolerance for affect, and in enhancing self-esteem.

As an agency psychiatrist, the author's tasks in the treatment plan were specified, as follows: "Medically assess and manage client's mood states with psychotropic medication *if deemed appropriate*. *Work in conjunction with (agency) staff to educate staff and to offer consultations and guidance*" (emphasis added). The tasks assigned to others were more complex. Those for the nonpsychiatric clinician included, first and foremost, "Provide safe and contained environment in which client is free to explore past traumatic events." Others involved encouraging Maya

TABLE 2. Core Components of Complex Trauma Intervention

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1. Safety: The installation and enhancement of internal and environmental safety.
 2. Self regulation: Enhancement of the capacity to modulate arousal and restore equilibrium following dysregulation across domains of affect, behavior, physiology, cognition (including redirection of dissociative states of consciousness), interpersonal relatedness, and self attribution.
 3. Self reflective information processing: Development of the ability to effectively engage attentional processes and executive functioning in the service of construction of self narratives, reflection on past and present experience, anticipation and planning, and decision making.
 4. Traumatic experiences integration: The transformation, incorporation, or resolution of traumatic memories, reminders and associated psychiatric sequelae into a nondebilitating, productive, and fulfilling existence through such therapeutic strategies as meaning-making, traumatic memory containment or processing, remembrance and mourning of the traumatic loss, symptom management and development of coping skills, and cultivation of present-oriented thinking and behavior.
 5. Relational engagement: The repair, restoration or creation of effective working models of attachment, and the application of these models to current interpersonal relationships, including the therapeutic alliance, with emphasis on development of such critical interpersonal skills as assertiveness, cooperation, perspective taking, boundaries and limit setting, reciprocity, social empathy, and the capacity for physical and emotional intimacy.
 6. Positive affect enhancement: The enhancement of self worth, esteem and positive self-appraisal through the cultivation of personal creativity, imagination, future orientation, achievement, competence, mastery seeking, community building, and the capacity to experience pleasure.
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Cook et al. (2005)

to find “words to express feeling states,” self-soothing skills, and to “offer (a) nonthreatening, realistic client/therapist relationship . . .”

The child care staff were expected to:

- Provide client with a consistent and safe environment in which to express self.
- Respect client’s need for personal space.
- Speak directly and clearly to client in calm voice.
- Due to nighttime fears, allow client’s bedroom door to be propped open/allow light on if necessary.
- Assist client in identifying positive behaviors.
- Coach client to use control plan when experiencing intrusive thoughts and feelings.
- Prompt client to utilize replacement behaviors. Engage and help client in making choices.
- Provide simple direct one-phrase prompts and requests.

As the patient and staff developed, these basic treatment elements, which were consistent with those suggested by Cook et al., 2005 (see Table 2), were increasingly refined.

ADDITIONAL CASE MATERIAL

(Identifying information has been changed.) It is clear, that as placing children on medication is not magic, neither is it magic to simply take them off. Nevertheless, the tapering of medications often result in a child's becoming more easily engaged in our program. As with Maya, patients who are more engaged tend to act out less. The housing units themselves become more calm. In turn, it becomes easier for staff to explore and understand the dynamics of episodes of acting out. Staff is better positioned to help the child understand and work on his or her issues, and it seems reasonable to expect still less aggressive acting out.

Another factor favoring less frequent episodes of acting out may be the increased sense of self-esteem that some children experience following reduction of medications. Bud, for example, prior to the reduction in his medications was a very difficult patient. Now in good control only on a very low dose of an atypical antipsychotic, he introduced me to his mother: "This is my doctor—he's the one who gave me a chance to be myself."

Many children improve but still show a high level of reactivity when traumatic memories and affects are triggered anew. This may happen in relation to provocative interactions with staff, peers, or families. Consider Cassie. She is an early adolescent with five lengthy prior psychiatric hospitalizations. She was admitted directly to our agency from her last hospitalization where she had required frequent seclusion for aggressive conduct. Her medications on arrival were quetiapine, carbamazepine, lithium carbonate, valproate, and guanfacine.

Following transfer to Unit A of the residential treatment center, Cassie began making progress and we believed a trial of tapering medication was indicated. Her parents were reluctant, delaying the onset of tapering. When consent was finally obtained, tapering off medications proceeded quickly and in a short time she was doing well on the unit and in our school. This improvement was considered a consequence of emphasis on structure and on appropriate, nonpunitive limit setting. Additionally, she had the benefits of being medication-free and involved in psychotherapy. As a consequence, she was quick to meet criteria for discharge to a lower level of care.

Understandably, but unfortunately, on home visits and even on the unit when visited by her parents, she exhibited roughly the same aggressive and provocative behaviors that had led to her earlier hospitalizations. The parents, who also required frequent limits, ultimately made themselves completely unavailable for family therapy and for work around transitioning Cassie into day treatment and home. We do not have follow-up data on Cassie, but it is likely that she is not doing well, that she is likely again on multiple high dose medications, and that they are no more effective now than they were before.

While the majority of patients have been considered improved after medication tapering has been completed, there are some for whom the change is minor. Dante, a large preadolescent, was transferred to us following several years at a similar residential agency in order to place the site of treatment closer to his mother. The referring agency also believed he had plateaued in their program and would not likely make further progress there. Although he has been less assaultive in this current placement, at this writing he is still quite provocative. While his multiple psychotropic medications have been discontinued, his behavior has changed minimally. Work continues in the milieu and in his psychotherapy on several issues, including the numerous traumata he had experienced. Although the results are clearly not impressive, staff are content that he is off medication because, as they say, "at least he is not any worse." They joke about my not having any pills for provocativeness.

A few patients have required tapering trials to be terminated. Some of these patients were subsequently discharged to lower levels of care with their last remaining medication a low dose atypical antipsychotic. Erin made progress throughout the tapering of all but the last psychotropic. With the elimination of the final remaining medication, an atypical antipsychotic, she became considerably more anxious. While this was not reflected in dangerous behavior, she would become frantic if she found a single insect in her room. Reassuring her was difficult. In the interest of having her more comfortable, a low dose of antipsychotic was resumed on a purely symptomatic basis. While she calmed and was able to be moved to a lower level of care with a diagnosis of DTD, it remained unclear on theoretical grounds why the small dose of an antipsychotic empirically proved to be beneficial.

Several patients who were admitted on high doses of medications were noted to show serious adverse effects. Several were so sedated that initially they could not be interviewed. Several others came with significant weight gain secondary to atypical antipsychotics. One was admitted in an agitated state and with extreme hyperactivity until his high dose of methylphenidate was discontinued. One patient receiv-

ing a very high dose of antihistamine for sedation reported a visual hallucination—a monstrous, black “daddy spider” on the ceiling.

REVIEW OF THE LITERATURE

In 1995, Wozniak, Biederman, Kiely, et al., asserted that BD in young children was often missed, due to the manner in which mania presented in youth. They stated, “. . . the predominant mood in the children meeting criteria for mania was that of severe irritability rather than euphoria . . . [and] . . . the type of irritability . . . was very severe and often associated with violence.” Such patients were described, “. . . as ‘completely wild,’ ‘explosive,’ ‘extremely aggressive,’ or ‘creating a war zone’” (p. 872). The authors also asserted that, “. . . the rate of ADHD in children with mania was 98% . . .” (p. 873). It is likely that such articles served to encouraged others to diagnose increasing numbers of poorly controlled, raging children as having PBD with comorbid ADHD. That in turn led to treatment approaches that involved psychopharmaceuticals commonly used for BD in adults and for ADHD. Thus, like Maya, the majority of children at intake to our agency have been on the multiple psychotropic medications associated with those diagnoses. The admitting records routinely document the exposure of these children to one or more atypical antipsychotics, one or more mood stabilizers, a stimulant, an antidepressant and an alpha-adrenergic agonist.

However, a Research Update Review of a decade of the literature on PBD (Pavuluri, Birmaher, & Naylor, 2005) speaks to the amount of diagnostic disagreement surrounding PBD. The authors note that, “The clinical presentation of this disorder in the preadolescent and early adolescent age groups is greatly debated . . .” (p. 846). Further, they concede that, “Because of the overlapping symptoms of BD and other psychiatric disorders, it is difficult to differentiate BD from other disorders . . .” The alternative these authors provide is a differential diagnosis that includes only ADHD, schizophrenia, pervasive developmental disorder, and substance abuse (p. 851). No reference is made to issues of trauma.

Blader and Carlson (2007) considered several phenomena which might, “account for the growth in . . . BD diagnoses to children . . .” (p. 112). They developed several hypotheses, but they concluded that the possibilities they considered were “implausible” or “unlikely to explain” the huge increase found for BD in youth. Other clinicians speak to problems with diagnosis, suggesting that diagnostic confusion could lead to inaccurate and inflated rates. In a letter to the editor in 2005, Tucker noted, “Young children who are currently labeled as having bi-

polar disorder are clearly in need of treatment. Their mood and behavioral symptoms can be extremely problematic, *but this does not mean that these nonbiphasic, nonepisodic symptoms represent bipolar disorder*" (p. 996, emphasis added). Dickstein et al. (2007) point out that the PBD diagnosis, ". . . remains the subject of much debate, centering on two issues: First, because irritability is a nonspecific symptom common to many pediatric psychiatric disorders . . ." Second, the authors speculate that perhaps PBD is, ". . . a developmental presentation of BD . . ." (p. 341), and therefore manifests different characteristics. Hopkins added to this in 2006 by pointing out that, "The current criteria for diagnosing bipolar disorder were developed for adults," but they may not be applicable for youth. Finally, Brotman et al., (2007) raise the issue of "narrow phenotype bipolar disorder" versus SMD. Carlson (2007), in an editorial response to Brotman's work, questions, "But who *are* the children with severe mood dysregulation/rages?" Speaking to the ". . . huge increases in rates for bipolar diagnoses . . ." (p. 1238), she suggests that this might be due to clinicians applying diagnostic criteria inconsistently. In addition, she points out that parents may report "rages" as "mood swings," although the latter may occur in many pediatric disorders and specifically lists, ". . . ADHD, oppositional defiant disorder, anxiety disorder, depressive disorders, and autism spectrum disorders" (p. 1140), any of which might be confused with BD/PBD. But again, no reference is made to the possibility of a child's reacting to trauma.

Each of these articles maintained a focus on biology. It is worth considering that preoccupation with neurobiology and pharmaceutical interventions precludes a more humanistic, psychosocial, and psychodynamic understanding of each child's situation. The predominant focus on a biologic etiology makes it difficult to recognize that these severely symptomatic children need comprehensive treatment programs which provide psychodynamic play therapy, talking therapies, family interventions; and, in residential settings, safe housing, milieu and group therapies, and appropriate educational and activities programs. That is, (1) that the pattern of polypharmacy is not only not required but may be counterproductive and (2) that many children diagnosed with SMD or BD/PBD may, in fact, have DTD.

MY BACKGROUND

The author's 45 years of office, agency, and hospital-based child, adolescent, and adult psychiatric practice have been persuasive in underscoring the reality of a broad spectrum of severe psychiatric disor-

ders, including ADHD, BD, and other mood disorders. But in the last 15 years, two cases have been exceptional.

Consider Mary, a 10-year-old who had been started on stimulants at age 4½. At age 5, multiple medications for BD were added. By the time of our consultation, she was receiving 16 psychoactive tablets or capsules a day, representing four classes of medications. A review of medical records revealed that, over nearly 6 years, 86 prescriptions had been written for psychiatric, neurologic, and/or behavioral reasons. Medications, due to refills, had been dispensed 103 times. The number of pills, capsules or tablets, which were dispensed at any one time, ranged from 49 (atomoxetine) to 600 (olanzapine). By the end of our extended evaluation, she was off all medications. Telephone contact 2 years following the consultation sessions revealed that she was then receiving low doses of gabapentin for nighttime sedation and fluoxetine. The antidepressant was prescribed, as one parent laughingly said, because "You know we are all crazy in this family."

The other case was that of a young adult who consulted for medication maintenance only. She was in a dynamically oriented psychotherapy provided by a young psychologist. Ten years earlier she had been given diagnoses of BD, borderline personality disorder, and alcoholism. Subsequently she had gone through multiple difficult hospitalizations. At the time of referral to me, she was receiving large doses of antimanic, antidepressant, and antipsychotic medications. In a few years, all medication was discontinued. Now, many years later, her former therapist reports that she is stable and doing well occupationally and socially. Each of the evaluations of these two patients uncovered early trauma, which had not been considered previously.

It is crucial to concede at the outset that the quantitative part of this article has a number of methodologic limitations and is properly regarded as impressionistic. The data come from a single agency. The patient population is small in size. Many, though not all, patients come from a socioeconomic underclass. Furthermore, the measure of medication usage is imprecise. The total milligrams of psychotropic medications, not otherwise specified, dispensed per day were simply compared over time.

Nonetheless, substantial reductions in medication usage did occur while, simultaneously, the number of aggressive incidents fell dramatically. Further, in the 2-year period under discussion, there were no instances in which any child on less or no medication showed signs or symptoms consistent with BD, PBD, SMD, or ADHD.

CLINICAL APPLICATION

The children cited in this study are aged 6 to 14, with the majority being inner city children funded by Medicaid. The most common admitting psychiatric diagnoses for youth admitted to this agency were Mood Disorder, NOS; BD; ADHD; PTSD; Reactive Attachment Disorder; and Enuresis. Often each had been “in the System” for years, due to the intervention by Child Protective Services in an effort to protect them from neglect, chaos, and physical and sexual abuse. Though failing in significant respects, the *DSM-IV* diagnosis that most nearly describes this type of child is “PTSD” followed by a parenthetical phrase specific to each case, such as, “with features of disorders of affect regulation, attachment, attention, activity, cognition, impulse control, and mood.” Axis IV may be used to summarize the usual histories of loss, neglect, and physical and sexual abuse. The abuse was typically severe, chronic, familial, and of very early onset. In utero drug exposure was also often reported.

In 2005, The Complex Trauma Taskforce of the National Child Traumatic Stress Network took a major step in identifying and rectifying the problems associated with this diagnosis. It proposed “Developmental Trauma Disorder” to best describe this population of children (van der Kolk, 2005). The Taskforce expressed the apparent pathology of these children:

It is also critical to understand the interrelation among multiple symptoms that are now captured by multiple, seemingly unrelated “comorbid” diagnoses that address affect dysregulation (e.g., bipolar illness), chronic distrust of authority (e.g., oppositional defiant disorder), inability to focus and concentrate (e.g., attention-deficit/hyperactivity disorder), and others. None of these diagnoses provides a comprehensive understanding of the scope of what traumatized children suffer. (p. 378)

According to the Taskforce (Cook et al., 2005), core components of complex trauma intervention involve safety, self-regulation, self-reflective information processing, traumatic experiences integration, relational engagement, and positive affect enhancement (Table 2).

The author sought to operationalize in the residential setting the treatment options recommended by the Taskforce. The intention, simply stated, was to understand each patient as comprehensively as possible. This meant seeing how each child functioned off medication, a

policy consistent with the logic found in the wonderfully titled article, "Less Is More," by Kratochvil, Varley, Cummins, and Martin (2006). In it, Andres Martin notes, "Antipsychotics are easy to start. They can be frightfully difficult to stop, especially outside the safety of inpatient sanctuaries. These same caveats are not too different for mood stabilizers." He further noted, "Through subtraction (of medications) we may at times be able to best see the patient before us" (p. 624). This approach also reflected a position taken by the Child Psychiatric Workgroup on Bipolar Disorder (Kowatch et al., 2005), which recommends that, when faced with poor clinical outcome, before changing medications, "... it is important to consider factors frequently associated with nonresponse, such as misdiagnoses, poor adherence to treatment, presence of comorbid disorders (e.g., ADHD, substance, anxiety disorders), and exposure to environmental and biological stressors" (pp. 219-220).

Not surprisingly, some staff resistance emerged. In applying this approach to Cassie, one Unit Supervisor told me emphatically that such a trial would not be tolerated. He added, rhetorically, "And where will you be when Cassie starts breaking windows and heads?"

Institutional resistance was sufficient to indicate a need to effect change in the institutional culture if tapering trials were to be implemented. I needed to reassure the staff that I would "be there," when patients began breaking things. I spent as much time on the Units as I could, interacting with both staff and children. Additionally, the understanding of patients as being biologically impaired and in need of control by chemical agents would need to shift. Other means of attempting to change behavior would need to be found. The development of the therapeutic skill levels of staff would have to precede changes in the dispensing of pills. (In writing this, I am grateful to Fleissner, 2008, for coining the phrase, "Skills not Pills.")

Developing alliances with treatment teams in the hope of gaining commitment to a different way of conceptualizing and treating children became the new goal. As much as possible, medication decisions were made on a consensual basis. Efforts were made to render the team process open, transparent, and democratic. This meant that everyone on the Unit was encouraged to voice his or her opinion. Their contributions had to be taken seriously and given equal weight in the building of a consensus.

If change were to come about, it would be based in part on a parallel process: How the children were treated would hinge on how the child-care staff was treated. Many of them came from backgrounds very similar to those of our patients. The staff needed to be encouraged to see themselves as professionals; they needed to develop an understanding and acceptance of themselves; they needed to be treated in ways

which could serve to increase their own self-esteem. They needed to see themselves not as agents of control, but as facilitators of change in children who had powerful reasons to fear and mistrust adults. Our charges could not be easily threatened “to behave,” as they had already experienced threats, deprivations, and abuse far beyond any which we could legally, ethically—or helpfully—provide.

Practically, this meant that in all but critical situations, medication changes were first proposed in team meetings. At the beginning, I invariably had to be the one who would question if it might be time to see what would happen if we tapered, on a trial basis, one of the medications a child was on. With the team process more in place, this job was no longer left exclusively to me. Others now may first raise the issue of medication reduction. Except in urgent situations, a trial would not be initiated until a consensus exists. Tapering orders were limited to one medication at a time. The taper is gradual, and the orders were written with the proviso that, if I were not available and there is reason to believe that a child is increasingly dangerous to self or others due to the reduction in medication, the Unit Supervisor may stop or reverse the tapering process. (As of writing, this has occurred only once.)

In relationship to a tapering trial, time in team meetings is spent discussing psychopharmacology in general, the desired and the side effects of specific medications, and what might be expected with either a successful or an unsuccessful outcome. One or more of us take responsibility to speak to the child about the trial. If the patient’s family is involved, it is usually the child’s clinician who informs them of the taper.

Tapering trials are embedded in the overall treatment program. It is in the team meetings where we review the child’s course of treatment, develop a comprehensive understanding as well as a diagnostic label for a child, and discuss clinical and milieu interventions that speak to the child’s strengths and weaknesses. As trauma has invariably been a prominent part of each child’s history, there is much discussion of how children tend to cope with traumatization (e.g., by dissociation; by behavioral freezing; by defensive violence), how we might avoid triggering traumatic memories and affects, and the like. The discussions are both child-specific and general in nature. In addition, the concepts of transference and countertransference are elaborated. Working in the milieu is very much like working in individual psychotherapy. Staff who remain unaware of their own feelings are very likely to act them out. Therefore, the staff is encouraged to be open about feelings stirred up by our work and to be tolerant and accepting of feelings expressed by colleagues. These feelings range from excesses of affection (e.g., in

TABLE 3. Milligrams of Psychotropic Medication Dispensed Per Day, by Class and Unit

CLASS	Friday, 10 Feb 2006		Friday, 9 Feb 2007		Friday, 8 Feb 2008	
	UNIT		UNIT		UNIT	
	A	B	A	B	A	B
α -Adrenergic agonists	0	1	0	1	0	1
Anti-depressants	30	445	125	310	0	120
Antipsychotics	1529	339	740	193	0	196
Mood stabilizers	4310	1450	3150	2775	0	1375
Stimulants	108	54	0	15	0	0
TOTAL Mgs/DAY BY UNIT	5977	2289	4015	3264	0	1692
TOTAL Mgs/DAY (% CHANGE)	8266 (0%)		7279 (- 12%)		1692 (-80%)	

the wish to adopt) and sympathy (e.g., in a reluctance to set limits) to fear, disgust, guilt, hopelessness, and rage.

The data show that Units A and B had differing rates of change (see Table 3). This can be explained by how much institutional support can be generated at any given time for different approaches to working with patients. A synergy emerged between tapering trials and other elements of the treatment program. In order to taper a child's medication successfully, one must deal with many different but related issues. These include institutional resistances to change; the need to have staff informed not only about psychopharmacology, but also about developmental, dynamic, and psychosocial concepts (again, the skills vs. pills dilemma); and the need for staff to understand more about such matters as trauma and attachment theory, all the while becoming less invested in "control." After issues of safety, the primary goal of residential care should be the creation of self-control in the patient, not control imposed from the outside. Additionally, staff at all levels can do better clinically and be more understanding and tolerant of acting out behavior of less medicated children when the treatment team is comfortable thinking about and working with transference and countertransference feelings in the milieu.

In other words, it is easier to reduce a child's medication load and help the patient remain stable and calm when the milieu itself is stable and calm. When it is not, it becomes very difficult or impossible to successfully reduce chemical sedation. For reasons beyond anyone's control, Unit A had much more stable staffing than did Unit B. This was of considerable advantage on Unit A in promoting staff development and the building of an effective, well-functioning treatment team. During

the period covered in this report, the author worked on Unit B with four different clinicians, three different Unit Supervisors, and with a complete turnover among childcare staff. This slowed team building in Unit B and is reflected in the outcomes of the patients on that Unit.

Team building and staff development occur in a variety of ways over time. These may include emphasis on personal contact, case consultation, sharing of oral and written educational material, role modeling, team meetings, and large doses of humor. If a childcare worker (CCW) complains about aggressive behavior in a patient, it will trigger an inquiry as to what might explain the problem, as illustrated below:

CCW1: We need to talk about James! He's totally out of control! He hit (CCW2) with a rod and ever since has been AWOLing all over the place, throwing rocks and everything.

Dr. L: So what's going on?

CCW1: I don't know. (Teasingly): He was doing just fine until you insisted on tapering his meds (laughter).

Dr.: Oh yeah, again it's all my fault! Exactly when did this start?

CCW1: About 2 weeks ago.

Dr.: Hmm . . . it looks like the last taper was Nov. 9—that's more like 5 weeks ago. Given the half-life of the med and its washout time, I doubt the med change is likely going to be the problem. Anything else going on?

CCW3: Oh yeah. He was supposed to go home for Thanksgiving Day, and his grandma did show up. But she had a whole bunch of kids in the back of her car. She took him out to the car to say "hi" to them, and then told him she had so much to do she could only stay 5 minutes. It was after that he hit (CCW2) and he's been wild ever since.

CLINICIAN: Well, I spoke with grandma on Tuesday, and she's under a lot of pressure. She's gotten stuck again taking care of another daughter's kids.

This interchange leads into some sharing of feelings of concern about staff safety, the overwhelmingly tragic aspects of the lives of both James and his grandmother, and the impact of racism and poverty on mental health. Discussion may then move to a review of our patient's history of neglect, followed by reflecting on triggering events, attachment issues, and the likelihood that we, as surrogate parents, are often the ones who are on the receiving end of anger that we do not deserve. We might then talk about what should be our therapeutic goals and what types of interventions might best be used to obtain them. What might be done to support grandmother, so she can better meet James's needs? How should the staff deal directly with James? (The risks and benefits of having the police take James to Juvenile Hall may need consideration.) Psychodynamic thinking would be used to help formulate interven-

TABLE 4. Patients on Psychotropics/Total Patients

Unit A	6 / 8	6 / 8	0 / 8
Unit B	7 / 8	8 / 8	6 / 8
Total	13/16	14/16	6/16

Note. Data supplied by Charles Haskins, B.F.A., L.P.T.

tions and the group would collectively plan how to implement them in a variety of ways, including in individual and group therapy and in the milieu.

DATA

The number of milligrams of psychotropic medications dispensed per day and by unit, for each time period, is shown in Table 3. Interpreting these figures, as already noted, carries statistical caveats. First, the figures reflect many medications of widely varying potency. Hence, comparing total milligrams per day is a crude measure. Second, residential children come and go and there may be meaningful individual differences. Still, over time, the populations of the units are largely homogeneous.

The data show that the total amount of milligrams of psychotropic medication per day decreased by 12% by the end of the first year this treatment approach was in effect. By the end of the second year it had fallen to 80% of baseline. Additionally, the number of children on psychotropic medication ultimately decreased over time (see Table 4). Initially, in February 2006, 13 out of 16 children were receiving psychotropics. Unit A had 6 children on psychotropic medication and Unit B had 7 children. Two years later, 6 children on Unit B were on drugs, while no psychopharmaceuticals at all were being prescribed on Unit A. It is likely that the stronger team functioning on Unit A allowed for an adequacy of psychosocial interventions such that no child on Unit A was then in need of chemical restraint.

The agency maintains weekly records of reportable incidents. Table 5 shows the number and types of Aggressive Incident Reports made for the weeks in which the amounts of psychotropic medication have been detailed. Notably, in the last week of the period under consideration, not one Aggressive Incident Report had been made on either unit.

TABLE 5. Aggressive Incident Report Comparison Data: First Week of February 2006, 2007, 2008

February 2006			February 2007			February 2008		
Type of Incident	Unit	#	Type of Incident	Unit	#	Type of Incident	Unit	#
1 Emotionally Acting Out, 4 AWOL	A	5	1 Assault to Peer, 2 Out of Designated Area	A	3	None reported	A	0
4 Physically Acting Out, 2 Emotionally Acting Out, 2 Assaults to Peers, 1 AWOL	B	9	2-Assault to Staff, 1 Assault to Youth, 1 Suicidal ideation, 1 Injury to Child due to assault, 1 Property Destruction, 1 Sexually Acting Out, 1 Physically Acting Out, 3 Emotionally Acting Out, 1 Out of Designated Area	B	12	None reported	B	0
Total Incidents		14			15			0

Note. Data provided by Nancy Oakley, M.A.

CONCLUSIONS

Residential treatment programs can serve children well by reconsidering their diagnoses and by re-evaluating medication use. This study argues from an individual clinician's experience that the overwhelming majority of children do no worse and most do considerably better entirely off or at doses of psychotropic medication significantly lower than that prescribed in the mainstream of contemporary child psychiatric care. It seems reasonable to attribute the clinical improvement of these children to diminished efforts to control thinking, affect, and behavior by pharmacologic interventions, while simultaneously increasing the amount and quality of analytically informed treatment. Success in effecting dramatic reductions in prescribed medications suggests that in mainstream child psychiatric care there is excessive overdiagnosing and overmedicating of affectively labile and rageful, aggressive children. Very likely, these children are responding to trauma and warrant the diagnosis of DTD rather BD/PBD/SMD and comorbid ADHD.

It is the author's hope that these findings will encourage others to consider alternative ways of conceptualizing children whose lives have

been marked by trauma and whose conduct is characterized by irritability, poor impulse control, anger, aggression, and problems with learning and attachment.

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