Current Literature in Pediatric Psychosomatics (CLiPPs)

CliPPs: Parent Religiosity and Children's Suicidality?

Svob Connie, Wickramaratne PJ, Reich L, *et al.* Association of parent and offspring religiosity with offspring suicide ideation and attempts. *JAMA Psychiatry.* 2018;75(10):1062. https://www.doi.org/10.1001/jamapsychiatry.2018.2060.

Reviewed by: Rebecca Ba'Gah, MD, PGY3, Triple Board Resident, University of Kentucky College of Medicine, and Amy L. Meadows, MD, MHS, Departments of Psychiatry and Pediatrics, University of Kentucky College of Medicine.

Background: Suicide rates among adolescents are climbing. This recently published study by Connie Svon, PhD, *et al.* adds additional factors to consider in a child's risk assessment for suicide. Although prior studies have examined religiosity in adults, finding lower rates of suicide associated with religious beliefs and practices, little is known about how the parent's religious beliefs and practices can shape the child's risk for suicide ideation and attempts.[1]

Methods: The research objective was to examine the associations of parent and offspring religiosity with suicide ideation and attempts in offspring. The study followed 3 biologically related generations (grandparents, parents, and children) for 30 years (spouses were excluded). The first generation was categorized as either high risk or low risk based on history of diagnosed Major Depressive Disorder. Participants in the study's analysis included 214 individuals in generation 3 who were assessed between age 6 and 18. Religiosity was assessed by examining religious service attendance and religious importance to participants and their parents (generations 2 and 3).

Results: Parent and child religiosity was assessed for relationships with child suicidal ideation or attempt. The child's own religiosity was inversely associated with suicidal behavior in girls but not in boys. Parental religious importance and religious service attendance of a parent was inversely associated to daughter's suicidal behavior, but only parental religious importance was inversely associated with sons' suicidal behavior.

Conclusion/Commentary: Parental belief in the importance of religion may be a more robust factor than religious attendance. Although the study does not examine the mechanism, religious importance seems to play a role in lowering suicidal behavior. Additionally, the fact that religious importance of parents may mitigate the risk of suicidal behavior in both males and females may add important information to a child and family's assessment. In certain children and families, involving spiritual or pastoral care as a part of a multidisciplinary treatment team may bolster both engagement in treatment and protective factors.

Take Away

Parental religious importance was associated with decreases in child's suicidal behavior, whereas the child's own religiosity was only associated with decreases in girls' suicidal behavior. Asking about both parent and child's beliefs can add another protective factor to safety planning for suicidal adolescents.

This article review originally appeared in the CLiPPs Edition 7.

References

1. Dervic K, Oquendo MA, Grunebaum MF, Ellis S, Burke AK, Mann J. Religious affiliation and suicide attempt. *Am J Psychiatry.* 2004;161(12):2303-2308. https://www.doi.org/10.1176/appi.ajp.161.12.2303

Additional resources related to this CLiPP:

- Landor, Antoinette, *et al.* The role of religiosity in the relationship between parents, peers, and adolescent risky sexual behavior. *Journal of Youth and Adolescence.* 2010;40(3):296–309. https://doi.org/10.1007/s10964-010-9598-2

CLiPPs: Background: Association of Adverse Childhood Experiences With Co-occurring Health Conditions in Early Childhood

Bright MA, Thompson LA. Association of adverse childhood experiences with co-occurring health conditions in early childhood. *J Dev Behav Pediatr.* 2018;39(1):37-45. https://www.doi.org/10.1097/DBP.0000000000000514

Reviewed by: Reviewer: Jake Crookall, MD, Toronto/Sick Kids Hospital

Background: Adverse Childhood Experiences (ACEs) have been repeatedly studied since originally described by Felitti *et al.*,[1] demonstrating strong associations between increasing childhood adversity and a wide array of medical and mental health conditions. Recent review articles have demonstrated associations between 4+ adverse childhood events and 23 different health conditions in adults with particularly strong associations for sexual risk-taking, mental illness, alcohol misuse (ORs 3-6), substance misuse and interpersonal and self-directed violence (ORs > 7).[2] A systematic review of pediatric physical health outcomes found associations between ACEs and developmental delay, asthma, somatic complaints, recurrent infections requiring hospitalization, and sleep disruption.[3] Another study demonstrated associations between parents' own ACE scores and their children's mental health outcomes.4 In the context of these associations, many clinicians, academics and health administrators have argued for increased efforts to prevent, detect and mitigate ACEs.

The article reviewed is the first using this methodology in children ages birth to five.

Methods: The study used a subset of subjects (age 2-5yrs, n=19,957) from the 2011-12 National Survey of Children's Health (NSCH), a retrospective parent-report phone survey representative of all noninstitutionalized children in the US, with response rate estimates between 23% and 54%.[5] The authors used univariate, bivariate and multivariable logistic regression models. Predictors were the sum number of ACEs reported since birth: divorce/separation of parents; household member with substance abuse; household member with mental illness; parent spent time in jail; witness or victim to neighborhood violence; exposure to domestic violence; parent death; discrimination because of race or ethnic group. Outcomes included if parents were ever told by a health care practitioner that their child had any of 18 health conditions, which were grouped into 3 domains of developmental, physical or mental health. Covariates analyzed included demographic factors, access and utilization of health care.

Results: Notably, only 11% of parents reported 1 ACE, 3.8% reported 2 ACEs, and 3.5% reported 3 or more ACEs. In multivariate regression, compared to those with no ACEs, having 1 ACE was associated with 1.42 increased odds of having at least one condition; this increased to OR of 1.57 with 2 ACEs and OR 3.19 with 3+ ACEs. Having 3+ ACEs was associated with 7.19 times the odds of having comorbid physical, mental and developmental conditions. Unadjusted relationship in Figure 1 of the article demonstrates the growing comorbidity of developmental, physical, and mental health conditions associated with increasing number of ACEs reported. Of children who were diagnosed with both a physical and mental condition, 71% had experienced at least one ACE and 32% had experienced 3+ ACEs.

Conclusion/Commentary: This study identified a lower prevalence of ACEs in children ages 2-5 than previously documented for children ages birth to 18, potentially reflecting less cumulative time for children to have experienced ACEs, selection bias in the sample, or parents' response bias. Most importantly, the study extends the observation that children age 2-5yrs have increased odds of physical, mental, and developmental conditions with increasing number of adverse experiences. Experiencing 3+ ACEs compared to 0 ACEs in the first 5 yrs of life is associated with an approximate 3.19 times adjusted odds of having any medical condition. Importantly, these are associations and do not necessarily reflect causal relationships given there may be confounders that were not adjusted for in this analysis and there may be elements of reverse causality,

such as children with increased medical needs leading to increased parental distress or poverty and maladaptive coping, such as substance use or intimate partner violence. High quality, prospective studies and randomized clinical trials of interventions to reduce ACEs could support evidence of causality.

Take Away

CL psychiatrists serve populations with comorbid physical, developmental, and/or mental health conditions and thus are likely to have many of their patients under age 5 experiencing multiple ACEs. This prevalence highlights the need for detailed assessment and interventions to address ACEs for young patients on medical psychiatry services.

This article review originally appeared in CLiPPs Edition 7.

References

1. Felitti VJ, Anda RF, Nordenberg D, *et al.* Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*. 1998;14(4):245-258. https://doi.org/10.1016/S0749-3797(98)00017-8
2. Hughes K, Bellis MA, Hardcastle KA, *et al.* The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *The Lancet Public Health*. 2017;2(8):E356-E366. https://doi.org/10.1016/S2468-2667(17)30118-4
3. Oh D, Jerman P, Silvério Marques S, *et al.* Systematic review of pediatric health outcomes associated with childhood adversity. *BMC Pediatrics.* 2018;18(1):83. https://doi.org/doi: 10.1186/s12887-018-1037-7.
4. Schickedanz A, Halfon N, Sastry N, Chung P. Parents' adverse childhood experiences and their children's behavioral health problems. Pediatrics. 2018;142(2). https://doi.org/10.1542/peds.2018-0023
5. Centers for Disease Control and Prevention. National Center for Health Statistics, State and Local Area Integrated Telephone Survey. 2011-2012 National Survey of Children's Health Frequently Asked Questions. April 2013. Available from URL: http://www.cdc.gov/nchs/slaits/nsch.htm.

CLiPPs: Psychotropic Medication Use in Parents of Children Diagnosed With Cancer

Salem H, Andersen EW, Dalton SO, *et al.* Psychotropic medication use in parents of children diagnosed with cancer. *Pediatrics.* 2019;143(5):e2018-2605. https://doi.org/10.1542/peds.2018-2605

Reviewed by: Roslyn Gerwin, DO, Maine Medical Center.

Background: While childhood cancer has an overall survival rate >80%, their parents may continue to struggle emotionally beyond treatment completion.[1] Objective measures to assess parental distress are limited. Emotional support is often not universally available to these families, and recent reviews have differing results on the long-term adverse psychological impact.[2,3] This study aimed to better characterize the needs of affected parents through a population-based retrospective cohort study of the incidence of psychotropic medication initiation.

Methods: Information was obtained on all antidepressant, anxiolytic, and hypnotic prescriptions since 1995 from the Danish National Prescription Registry (DNPER). Cohorts were identified for examining the incidence of psychotropic use based on the child's cancer status and independent parental risk factors. With regards to the child's cancer status, 7821 biological parents of children <20 years old diagnosed with cancer between 1998 and 2014, and who resided in Denmark were identified using the Central Population Registry (CPR), were identified. Parents with psychotropic prescriptions 1-3 years prior were excluded, resulting in 6744 parents. A comparison group of cancer-free children with matching birth years was chosen randomly in a 1:10 ratio, resulting in 65,747 parents.

For examining independent contributing parental factors, with similar exclusion criteria, 3290 parents of children with cancer were identified, however those children were <15 years old, and did not capture 16- to 19-year-olds as the above cohort.

An additional parent cohort of children with cancer, Childhood Cancer Registry (CCR) for the years 2003-2015. This allowed for gathering information between 3 main diagnostic cancer groups and whether the child survived.

Sociodemographic information for parents was obtained through the Civil Registration System (CRS) correlating to the diagnosis or index date, as well as 1 year prior.

Statistical analyses were presented as hazard ratios and conducted in Stata version 14. Parents were followed from cancer diagnosis until the first prescription, death, emigration, or June 30,2015, whichever came first.

Results: Parents of children with cancer had a 4% increased incidence of psychotropic medication prescription after 3 years. During the first year after diagnosis, there was increased rate of a first prescription across all 3 medication categories, with significant increase in the rate of anxiolytics and hypnotics use. There was no statistically significant difference according to cancer type, however relapse and death of a child did increase use of medication. Influencing sociodemographic factors included lower education, lower income, and younger parents.

Conclusion/Commentary: It may not be surprising that there is more frequent use of psychotropic medications for hypnotics and anxiolytics amongst parents of children with cancer. The study suggested stress and anxiety-related symptoms may be more prevalent in this population than depression severe enough to require use of psychotropics. Previous studies have consistently demonstrated the presence of elevated anxiety and depression, though longer-term post-traumatic stress disorder is less consistently appreciated, suggesting that the impact of psychological distress can decrease with time.

Interestingly, there does not appear to be a correlation with cancer type, and therefore treatment protocols, and use of psychotropic medication. This implies that any experience as a parent of a child with cancer can have impact. Not unexpectedly, relapse and death of a child confer increase incidence of psychotropic medication use, as well as certain factors that may limit resilience.

Limitations of this study include using prescription data as an indicator of psychological distress. Surveillance bias can not be excluded. And, prescriptions have only been registered since 1995.

This paper also frequently utilized the word “risk” to describe the rates of medication use. This review did elect to describe rate use in terms of “incidence” as “risk” could imply that parents of children with cancer seeking mental health treatment as a negative.

Take Away

Education of medical professionals regarding the emotional needs of parents whose child have cancer is essential to adequately anticipate and assess for the stress response of the whole family. This study highlights the importance of further research to develop effective parental and family interventions.

This article review originally appeared in the CLiPPs Edition 9.

References

1. Teliarova-Foucher E, Columbet M, Ries LAG et al; IICC-3 Contributors. International incidence of childhood cancer, 2001-10: a population-based registry study. *Lancet Oncol.* 2017;18(6):719-731.
2. Kearney JA, Salley CG, Muriel AC. Standards or psychosocial care for parents of children with cancer. *Pediatr Blood Cancer.* 2015;62(suppl 5):S632-83.
3. Ljungman L, Cernvall M, Gronqvist H, Ljotsson B, Ljungman G, von Essen L. Long-term positive and negative psychological late effects for parents of childhood cancer survivors: a systematic review. *PLoS One.* 2014;9(7):e103340.

CLiPPs (Current Literature in Pediatric Psychosomatics) are pertinent article reviews from the AACAP Physically Ill Child Committee for psychosomatic clinicians on a range of medical science journals and literature. CLiPPs are edited by Chase Samsel, MD, of Boston Children's Hospital and Dana-Farber Cancer Institute, Harvard Medical School, Boston, MA. All critical summaries are written by the designated reviewers. If you have any questions or are interested in writing for CLiPPs, please email **connect@jaacap.org**.