Psychopharmacology for Child Advocates, Clinicians, and School Counselors

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I'll Address…

- Maturational and developmental issues regarding response to medication in youth
- Mental disorders that typically emerge during childhood and adolescence – depression, bipolar disorder, anxiety, ADHD
- Medications used to manage these disorders
- What symptoms to look for and how to differentiate one disorder from another

Special Aspects of Child Psychopharmacology

- In the U.S., any psychiatric medication prescribed for adults can be prescribed for children
- Safety studies for psychiatric medication use in youth were not mandated until 1998.
- Medications are being prescribed to children for symptoms that are within the spectrum of normal behavior, particularly preschoolers
- Many medications are rapidly metabolized by children. Toxic effects vs. therapeutic effects?

Assessing Children and Adolescents

- When possible, observe the child in multiple settings. Children may behave differently in social situations – compared to their actions in school or at home
- Assessment is a team effort. Input from teachers, coaches, other school officials is important to confirm observations
- Conduct interviews with the affected child and at least one parent. Responsible parents or primary caretakers are our de-facto specialists
- Do a thorough review of the child's medical history, particularly when the behavior is violating others or is outside accepted social norms
- Obtain a thorough family history of psychiatric disorders. Understanding family genetics can be a major ally

Mood Disorders in Children

Depression – The Big Picture

Symptoms of Pediatric Depression:

- Persistent mood disturbance that is a change from prior functioning
- Diurnal variation in mood
- Lack of energy, motivation or enthusiasm
- Changes in sleep or eating patterns
- Irritability, agitation, unwarranted crying
- Pervasive anhedonia
- Sad or morbid play that concentrates on harming themselves or others

Manifestations of Depression in Children

- Demoralization
- Physiological

Demoralization Issues

- I see many, many kids meeting diagnostic criteria for major depression, but largely their disturbed mood and unhappiness are related to challenging life circumstances: bad schools, family chaos, poor peer relationships, poverty, etc.
- They appear more dispirited and disheartened than clinically depressed from a physiological perspective.
- So, how do we sort whether a child meeting general criteria for depression is demoralized or clinically depressed?
- Demoralized kids want to feel better, but life is getting in the way; clinically depressed kids require pharmacological help
- The number of kids suffering from clinical depression is small compared to those who are demoralized.
- I've found that demoralized children don't necessarily have poor esteem and image issues, but all children with poor esteem and low image are demoralized.

Case Example: Demoralization

During the past two months, 11 year old Kyle has appeared distracted, agitated and irritable throughout the school day. His grades have fallen off somewhat, but he's in no danger of failing. He interacts with other students and school personnel and is engaged, confident and assertive in class and recreational activities, but seems demoralized. When you approach him regarding your observations and ask him what's been going on, he responds, "my dad lost his job and he and my mom are fighting all the time." "It makes me mad and unhappy to hear them fighting and I want it to stop, but I don't know what to do."

What To Look For

Notice first that Kyle is willing to express his concerns about how difficult the situation between his mom and dad has become for him. This is a huge step when it comes to making progress. Also important is that Kyle is coming to school every day and is engaged. His grades have fallen off somewhat, but this is likely a by-product of the frustration he's feeling, which in turn is affecting his concentration and desire to apply himself.

How To Proceed

Demoralized youth will better respond to time-honored problem-solving techniques, so take medication off the table for now. Kyle seems willing to talk, so ask him for some more details about the situation and what really bothers him about the discord between his mother and father. Then use Kyle's confidence and assertiveness as strengths to help him confront his parents about what's happening and how it makes him feel. Assist him with developing a script he can try out – "mom and dad, it upsets me when you constantly fight and I wish you would stop, please don't do it in front of me." Then role play the script with him to determine his competence at delivering his message. Also, mindfulness techniques work well with demoralized kids, and if need be, notifying Kyle's parents may be warranted. If professional help outside of school is pursued, parents should be encouraged to seek a professional who routinely works with or specializes in treating mood disorders in children.

Physiological

- A clearly defined episode onset that includes a change from prior functioning is present:
  - Psychomotor slowing
  - Attention and concentration problems (clear onset to others in the child's life)
  - Usual onset age: 15-18
  - If I see an unhappy 6 or 7 year old, I'm going first to demoralization or anxiety
- Diurnal variation in mood – which is a worse mood in the morning, but improving throughout the day. Involves "phase shifting" and often sleep deprivation
- Pervasive anhedonia - important
- Medical conditions (asthma); Drugs: (substance abuse, steroid inhalers

Treatment

- Medication
- Counseling (Cognitive-behavioral, (Mindfulness)
- Diet
- Exercise

Demoralization: What Works

- Psychotherapy is the treatment of choice, any of the models already mentioned can be quite effective.
- Work from the position that the child is NOT damaged by utilizing sound problem-solving techniques.
- Direct efforts toward building on the child's strengths instead of shoring up weaknesses.
- If teens are aware that their low mood is related to their life circumstances, a med trial may demoralize them further.
- "I'm having it tough and all I get is this stupid pill."

Physical Depressions

- Medication IS the mainstay of treatment for melancholic, vegetative, depressed manifestations
- Important: Don't separate the depression help from treatment for the medical disorders, because they are comingled
- Psychotherapy, diet, exercise serve as adjuncts to care

Most Frequently Prescribed Antidepressants

- Prozac – FDA approved for kids 8 and older
- Zoloft
- Paxil
- Celexa
- Lexapro – FDA approved for kids 12 and older
- Effexor
- Wellbutrin

Antidepressant Use

What to expect:

- Increased energy, feeling “brighter,” less “phase shifting,” improved ability to experience pleasure

What they won’t do:

- Change behavior
- Teach children how to cope
- Make them happy
- Take troubles away
- None of these are physiological

Bipolar Disorder

Bipolar Disorder Facts

- Historically referred to as manic-depressive illness
- Cyclic pattern of mood, behavior and thought processes alternating between mania and depression
- Investigated in children as young as age five

- **Mania is characterized by:**
  - Racing thoughts
  - Pressured speech
  - Grandiosity
  - Distractibility
  - Insomnia
  - Decreased need for sleep
  - Flight of ideas
  - Increase in goal-directed activity
  - Increase in risk-taking behavior

Depression is characterized by:

- Low energy
- Sleeping too much
- Increased Appetite

Children with BPD

Look for:

- Bipolar kids tend to be mean
- Perpetrate harm on peers; show no remorse
- Often speak in highly sexualized language
- Willing to take unreasonable risks
- Decreased need for sleep which doesn't interfere with task completion.

Assessing a Child for Bipolar: The 3 Best Questions to Get Started

1. Has there been a time when you can remember having lots of energy for getting things done, where you needed little sleep, and people noticed this and thought you were acting strange or different?

2. Has there been a time when you felt sad and down and isolated yourself, and people noticed that you were absent?

3. Is there anyone in your family as far back as you can remember who has been treated for what I just asked you?

Case Example: Mania and Depression

Leo is a bright, energetic 9-year-old who tends to act in a dominating way toward peers and even authority figures. He likes to be in charge and take over a situation regardless of the setting or circumstance. His overbearing nature and attitude stirs anger in those around him. He can be mean-spirited and aggressive to the point of starting fights and perpetrating harm on peers, expressing no remorse afterwards. Leo is also quite imaginative and curious, making him prone to speaking in highly sexualized language directly in front of you. But in a perplexing twist, you notice periods where he acts withdrawn, falls asleep in class and does not want to talk to anyone or do any of the activities he usually enjoys.

What to Look For

Leo is showing symptoms of mania and depression. Instead of grandiosity, Leo is exhibiting bullying-type behavior and aggressiveness which is off-putting to other students and faculty. He is mean to others leading to fights and disruption and is not sorry for his actions. Although such behavior may be symptomatic of a conduct problem, Leo is not truant, has not encountered problems with the law, and is not into destroying property or perpetrating serious harm indicative of cruelty. He does however have a fertile imagination which is stimulating his curiosity toward sexual matters. But he also is prone to demonstrate symptoms which are the polar opposite of those just discussed when he shuts down, isolates himself and becomes withdrawn.

How to Proceed

Leo is typical of classic bipolar disorder. He exhibits manic symptoms which periodically switch to depression. All responsible parties interacting with Leo should be made aware of his mood and actions. Treatment should be coordinated with true bipolar symptoms in mind, as Leo demonstrates both ends of the bipolar spectrum. Because bipolar is a brain-based mental disorder, he may very well require medication to truly “stabilize” him because he switches from mania to depression and vice versa. And when a medication regimen has taken shape, adding behavioral treatment would be a major plus to support and provide back-up for the drug treatment.

Treatment

- Bipolar illness is a brain-based illness
- Most common treatment is pharmacological intervention
- Psychotherapy as an adjunct to care

Medications for Bipolar Disorder

- Lithium
- Depakote

Lithium

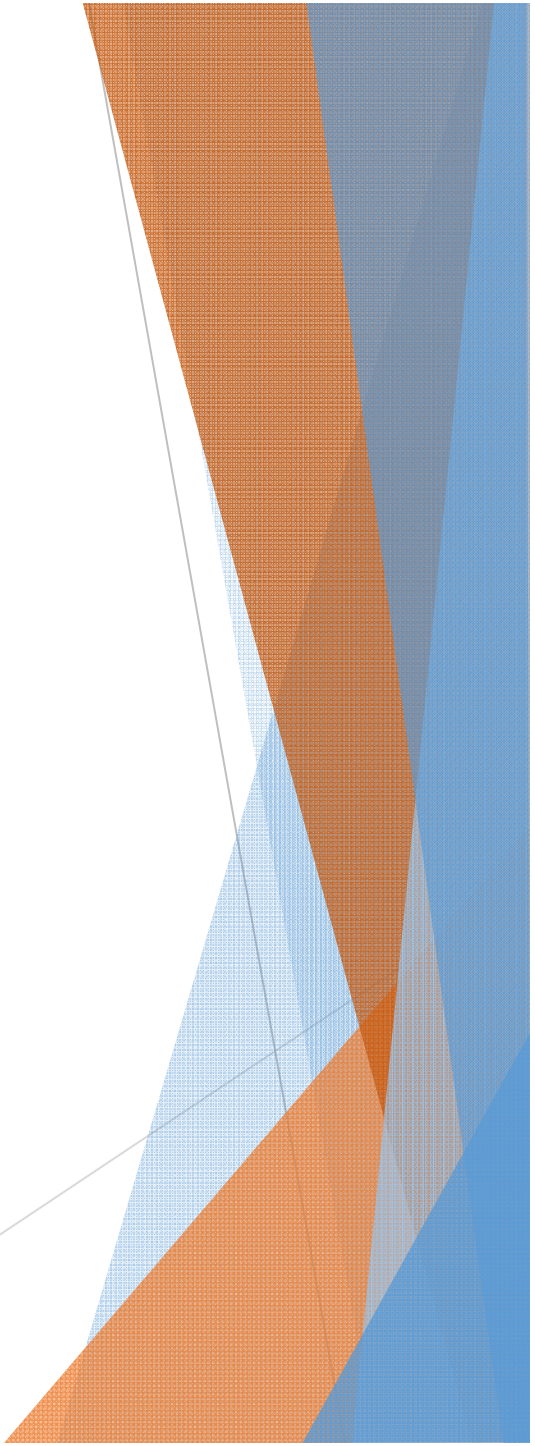
- Treats acute mania
- Produces “normalizing” effect by smoothing out manic highs and depressive lows
- Most effective single agent for bipolar disorder
- Used to treat aggression or self-injury in children and adolescents with conduct disorder, autism and intellectual disability
- FDA approved in children at least 12 years of age

Depakote

- Effective for mania, but not as effective as lithium
- Treats seizures
- Treats rage reactions and extreme mood instability
- Lithium/Depakote combination optimal in mania prevention
- Side effects: birth defects; PCOS

Bipolar Disorder in Youth

- Enormously controversial
- There was an epidemic of bipolar diagnosing in youth over the last several years
- Many diagnoses are now made by PCPs with little expertise in psychiatry, less time with each child, and intolerant of unruly behavior
- Children are often shuffled from one clinician to another



Other Issues

- Many kids getting the diagnosis today have temper outbursts and irritability; classic swings between mania and depression are being largely ignored
- The boundaries of pediatric BPD have pushed far into unfamiliar territory
- Because of its fad status, the DSM-5 created a new diagnosis – Disruptive Mood Dysregulation Disorder to create a less harmful diagnosis for kids who shouldn't have even been diagnosed in the first place

Anxiety Disorders in Children and Adolescents

Generalized Anxiety

- Chronic low-level anxiety
- Resolved worries are quickly replaced with new ones, consuming excessive amounts of time
- These are children who: worry all the time; worry about what they worry about; worry if they're not worrying
- Common in children and adolescents, not just adults

Understanding GAD

- We're all often very competent at handling real, identifiable problems…because
- An unambiguous problem invites an unambiguous solution
- So, a clear plan of action settles the anxious mind
- Worriers have trouble distinguishing what is a problem from what might be a problem

Take Action by…

- Sorting out what is real and what can be controlled
- Turning worry into a combination of planning and thought-stopping by printing out the biggest, reddest STOP sign from Google images
- Medication: Will numb symptoms only, not extinguish them; provide short-term relief from worry by reducing the “excitability” factor
- The benzodiazepine Klonopin is the best option
- Again, if at all possible, avoid such medication use in youth

Obsessive-Compulsive Disorder… I Get Lots of Questions

"My 12-year-old son is adamant about toilet tissue being placed on the roller so that the tissue dispenses from the top of the roll, not the bottom. When other family place it on the roller in reverse, he becomes irritated and immediately changes it back. Does this mean he has OCD?"

Obsessive-Compulsive Disorder

- We all have eccentricities, oddities, habits
- The full-time companion
- A disorder of excessive carefulness accompanied by an exaggeration of possible danger
- Persistent thoughts and compulsions accompanied by shame and guilt
- Often incapacitating
- Emerges in late childhood, prevalent in children and adolescents
- If untreated, symptoms remain remarkable throughout life

What Else To Look For

- Writing a sentence or phrase, erasing it or lining through it, and then writing the same thing again
- Slow to complete tests and other exercises
- Checking work repeatedly before actually turning it in
- Becoming upset when rules aren't followed by other kids, as on the playground
- Being precise, meticulous, demonstrates a need for near perfect order; fastidious about appearance; need for symmetry
- Examining backpacks and gym bags for needed items repeatedly, particularly when leaving school for the day

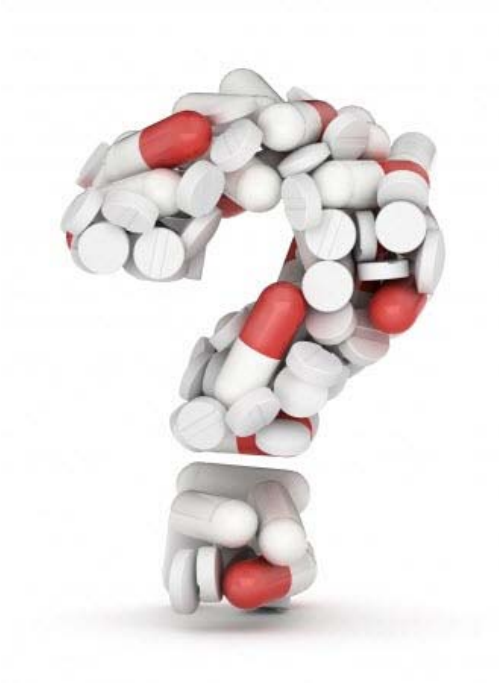
Best Practices for Managing OCD

- Use of logic results in abject failure
- Expose and prevent; expose and prevent – THIS IS HOW AFFECTED CHILDREN GET BETTER
- Example: A child with an excessive "checking" type of OCD
- Visual and audio confirmation
- For those who stick with E&P and practice regularly – 85% improve
- Serotonin antidepressants such as Prozac may be helpful but often impede progress. As such, I don't consider them treatment mainstays

Medicating Children for Anxiety

Medicating Anxiety

- Medication management studies are virtually non-existent and inconclusive
- Mood stabilizer, antipsychotic use on the rise for the treatment of violent outbursts, severe aggression, tantrums, destructive behavior



Antihistamines

- Reduce anxiety through their sedative effects and are used to treat children with insomnia
- Not habit-forming
- Can produce “hangover” effect
- Benadryl used for more than 40 years to treat anxious children

ADHD

- CDC: Nearly one in five high school age boys in the U.S. and 11% of school-age children have received a diagnosis of ADHD
- 53% rise in diagnosis in those ages 4-17 in this past decade
- Some diagnosticians are hastily viewing any complaints of inattention as ADHD and are diagnosing it haphazardly
- Slipshod diagnosis accompanied by stimulant prescribing will have kids using these drugs as mental steroids
- Increases in diagnosis = more pills = an increased risk for abuse and drug diversion
- Parents are pressuring doctors for pills, instead of challenging and questioning this diagnosis

What to Look For

Consider the possibility of ADHD if:

- It is obvious that in multiple milieus (school, play, home) it seems impossible for the child to sit and focus without becoming easily distracted and inattentive within a few minutes
- The child has much difficulty following directions and playing by the rules – for example, when "quiet time" is required
- The child is being shunned and is being treated like an outcast by teachers, peers and even family members because he or she is so difficult to be around

What to Look For

- The child has never done well academically and is consistently failing
- The child is often placed in “time-outs” or in some type of “punish hall”
- The child is not responding to multiple attempts at redirection

ADHD Medications

The 5 Ps

The Pills:

- Ritalin; Focalin; Adderall

The Pump:

- Concerta

The Pellets:

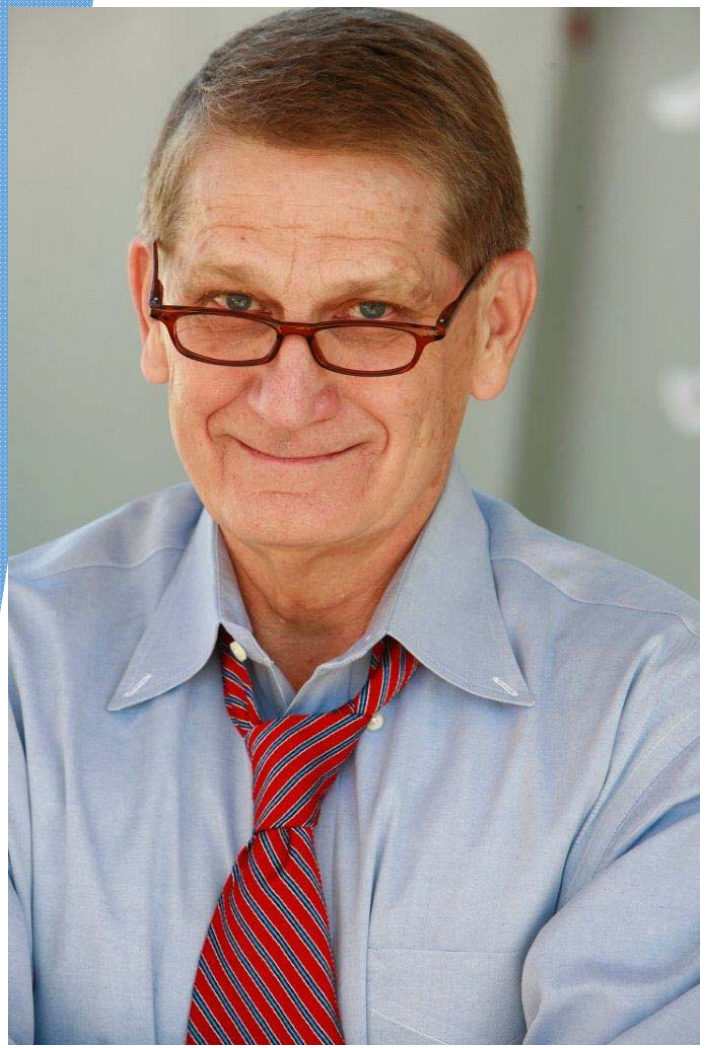
- Ritalin LA; Focalin XR; Adderall XR

The Patch:

- Daytrana

The Pro-Drug

- Vyvanse



Thanks for Attending!

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