PSYCHOPHARMACOLOGY

Psychopharmacology and Mood Disorders

CLINICAL APPLICATION

PRESENTERS:

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MODULE 4

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Downloadable Tools

To access the downloadable tools, go to: Psychopharmacology's Resources and Tools

1. Mental Health Screening and Assessment Tools for Primary Care
2. SCARED Screening Tool
3. Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS)
4. Self Awareness and Monitoring Teaching and Increasing Flexibility
5. Behavioral Activation Model
6. Article_ABA and Mood Disorders
7. Article summary - ABA and Psychological and Emotional Disorders
8. Article Summary_Irritability
9. Activity Ideas Chart Mood Disorders
10. Activity Rating Chart Mood Disorders
11. Weekly Activity Schedule Mood Disorders
12. CDI2-6-2-21
13. MASC2-6-2-21

Subject Matter Expert

Deborah P. Coehlo, PhD, C-PNP, PMHS, CFLE

Founder and Director
Juniper Pediatrics

Dr. Debbie Coehlo is a certified Pediatric Nurse Practitioner and Pediatric Mental Health Specialist with a Doctoral Degree in Family Sciences and Human Development. She is the Founder and Director of Juniper Pediatrics, a clinic modeled after John F Kennedy's multidisciplinary system of care. Using a holistic, integrated care model, Juniper provides counseling, medication management and family therapy for children with ASD, ADHD and other childhood mental health disorders.

Dr. Coehlo completed her Master's in Nursing with a specialty in parent- child nursing. She spent 10 years working at the Child Development Center at the University of Washington in the Genetics Clinic and Multidisciplinary Clinic. In 1999, she complete her Doctorate degree in Human Development and Family Studies.

She continues to teach at the undergraduate and graduate level and had pursued research in the area of social networking, transitioning to out of home care for families, and child development.

Dr. Coehlo is a co- editor for the 4th and 5th edition of Family Health Nursing (F.A. Dais, 2010/2013) and has published several journal articles in the areas of families choosing residential care, families in transition, family health nursing, and care of children with special health care needs.

Panelist

Manya C. Ralkowski, EdS, BCBA, LBA, IBA

Instructional Leadership – Curriculum Specialist
Board Certified Behavior Analyst
Licensed Behavior Analyst
International Behavior Analyst

Ms. Manya Ralkowski has been practicing in the field of applied behavior analysis for over 25 years. Her training began under direct education and training from consultants from the Lovaas Clinic in Los Angeles while completing her bachelor of arts in Communication Disorders with endorsements in special education and psychology at Western Washington University. Ms. Ralkowski continued her education and training with a master's degree in Education from Lesley University and a graduate certificate in Applied Behavior Analysis from the University of Washington while working as an assistant teacher on the Project DATA grant at the Haring Center-Professional Training Unit. She also possesses a doctorate degree in Instructional Leadership.

Her extensive educational and clinical background has afforded her many opportunities to build programs where there were none. Ms. Ralkowski has brought many programs and change to the PNW as a Design Team member for Seattle Public Schools creating the first STEM school for the district, a district consultant creating and replicating inclusion programs across the region, and most recently a Clinical Director, starting up a school and home-based ABA program serving 10+ districts and over 20 communities regionally.

Since 1994, Ms. Ralkowski has been creating and designing ABA programs and educational services from San Diego up the coast and into BC, Canada. She has been trained in many ABA based methodologies including PRT, DTT, NET, Verbal Behavior, Precision Teaching, PECS, and naturalistic ABA. She brings together disciplines such as ABA, special education, speech pathology, psychology, and remedial reading instruction for a comprehensive program for each student, each family, each teacher, and each school to create stronger and more inclusive communities.

Learner Objectives

1. Apply knowledge from Module 4: Mood Disorders to specific case studies, focusing on assessment, diagnosis, development of treatment plan and interventions, and outcomes.

2. Explore and discuss the most effective and evidence-based behavior and counseling strategies seen when treating individuals with comorbid ASD and anxiety, selective mutism, and depression with anxiety.

3. Explore and discuss possible psychotropic medications considered in the treatment of mood disorders in children.

4. Review the use of standardized screening tools in the diagnosis and monitoring of depression and anxiety
in specific case studies.

Assessment: Medical Diagnosis

- **Interview with parents**
- **History of symptoms**
  - Environmental factors
  - Risk factors
    - Genetics/ Prenatal/ Natal
- **Physical Examination/Labs**
- **Screening Tools (see chart)**
- **Developmental and Behavioral Assessment**
  - Conners' Comprehensive Behavioral Rating Scale for children ages 8-18 years
  - Observation of mood and behavior across settings
    - Report from teachers, other relatives
    - Family drawings
- **Cognitive Testing**
- **Functional Testing**
  - Academic
  - Social
  - Environmental
  - Health

The Story of Raphael

- Raphael was first diagnosed with ASD- moderate (Level 2) at the age of 7 years. Throughout his childhood, he struggled with severe generalized anxiety and OCD, with target symptoms of excessive fear of people, germs, asymmetry, and failure. When he was 15 years of age, his anxiety significantly interfered with his function, leading to:

  - Functional Assessment
  - Beginning of DBT Therapy, focusing on self awareness, mood regulation skills, fear tolerance, and flexibility in thinking.

- Through years of therapy, he shifted from being unable to function in social groups due to his rigid adherence to obsessive and compulsive behavior and thoughts, and excessive fear over routine experiences to being able to participate in social relationships and maintain employment.

- Medication considerations:
- Behavioral considerations:

Generalized Anxiety Disorder (DSM 5)

PREVALENCE	TARGET SYMPTOMS	DIAGNOSIS	TREATMENT

▪ .9% in adolescents
▪ More common in females (2:1)
▪ Median age of onset is 30 years [Note. Differentiation between GAD and an anxious temperament is important]
▪ Children and adolescents tend to worry more about performance, whereas adults worry about family and health
	▪ Excessive worry about several different events or activities more days than not for at least 6 months
	▪ Difficulty controlling the worry
	▪ One of the following:
	  ▪ Feeling restless
	  ▪ Being tired during the day
	  ▪ Difficulty concentrating
	  ▪ Irritable
	  ▪ Muscle tension
	  ▪ Sleep disturbance
	▪ Interfere with function
	▪ Not better explained by other medical or psychological conditions
		▪ History
		▪ Family history
		▪ Observation
		▪ Evaluation for co-morbidities
		▪ Most commonly diagnosed in adults, but symptoms start in childhood
		▪ Comorbid with other forms of anxiety
		▪ Assess for anxious temperament
			▪ Individual CBT counseling for 3-6 months most effective
			▪ Counseling and medication are not more effective than counseling alone
			▪ SSRIs and SNRIs show modest improvement
			▪ Tends to be chronic with episodic flare-ups

Obsessive Compulsive Disorders (DSM 5)

PREVALENCE	TARGET SYMPTOMS	DIAGNOSIS	TREATMENT

▪ 1.2% of individuals; 25% diagnosed by 14 years of age (25% of males are diagnosed by age 10 years)
▪ More common in females
▪ 40% reach remission with treatment
	▪ Recurrent and persistent thoughts, urges, or images that are intrusive and unwanted and cause anxiety or distress
	▪ Inability to ignore thoughts
	▪ Repetitive behaviors that the individual feels driven to perform and reduce anxiety or dread:
	  ▪ Hand washing
	  ▪ Checking
	  ▪ Counting
	  ▪ Cleaning
	▪ Behaviors are time-consuming
	▪ Interfere with function
	▪ Not better explained by other medical or psychological conditions
	▪ Related: Eating disorders, body dysmorphic disorder, trichotillomania, hoarding
		▪ History
		▪ Family history
		▪ Observation
		▪ Evaluation for co-morbidities
		▪ Most commonly diagnosed in adults, but symptoms start in childhood
		▪ Comorbid with other forms of anxiety
		▪ MASC/ Connor's CBRS
			▪ Individual CBT counseling for 3-6 months most effective
			▪ Counseling and medication are not more effective than counseling alone
			▪ SSRIs and SNRIs show modest improvement
			▪ Tends to be chronic with episodic flare-ups
			▪ **Note**. As many as half of untreated OCD attempt suicide

Raphael's Treatment Plan

Mood Disorders

Assessment	Diagnosis	Interventions	Medications	Comments
▪ Family history ▪ Health History ▪ Social History ▪ Individual interview ▪ Observation	▪ ASD- Level 2 ▪ GAD ▪ OCD	▪ DBT ▪ Exposure therapy	▪ 375 mg of divalproex sodium (Depakote) in the morning and in the evening ▪ 50 mg of fluoxetine in the morning ▪ Vitamin D in the morning ▪ 1 mg of Risperdal, morning and night.	▪ Interventions included ▪ Self Awareness and Monitoring Teaching and Increasing Flexibility

The Story of Amber

- Amber was 5 years old when her parents brought her for an evaluation due to her refusing to talk since starting kindergarten. She would only whisper to her mother but refused to talk to anyone else. They had tried counseling one other time, but the counselor refused to continue as Amber refused to talk. Amber's development was normal up until kindergarten. Parents denied any traumatic events. They noted she slept with her parents. She also had a younger sister (age 14 months).

- Treatment: Exposure therapy with high valued motivator (potato chips).

- Medication considerations:

- Behavioral considerations:

Pediatrics Volume 144, Number 4; October 2019

Selective Mutism (DSM 5)

PREVALENCE	TARGET SYMPTOMS	DIAGNOSIS	TREATMENT
▪ .3-1% of children ▪ More common in young children	▪ Consistent failure to speak in specific situations ▪ Interferes with function ▪ Symptoms last at least one month ▪ Refusal to speak is not associated with a physical problem or developmental delay ▪ Does not occur because of Autism or Schizophrenia	▪ History ▪ Family history ▪ Observation ▪ Evaluation for co-morbidities ▪ Most commonly diagnosed in children aged 3-6 years; can occur in adulthood ▪ Comorbid with anxiety	▪ Individual and family/ parenting counseling ▪ Individual CBT counseling or exposure counseling for 3-6 months most effective ▪ Counseling and medication are more effective than either alone ▪ SSRIs were most effective (Sertraline, Fluoxetine, and Citalopram)

Amber's Treatment Plan

Mood Disorders

Assessment	Diagnosis	Interventions	Medications	Comments
▪ Family history ▪ Health History ▪ Social History ▪ Individual interview ▪ Observation	▪ Selective Mutism	▪ CBT ▪ Exposure therapy ▪ Family/Parenting Counseling ▪ Collaboration with the school	▪ None- consider SSRI if no improvement after one month.	▪ Interventions included intensive counseling daily and included parents and teachers to assure all were on board and success was transferred across settings. Use of a highly desired motivator helped. Treatment of younger children is far more successful than adolescents or adults.

The Child Mind Institute. (2021). A parents' guide: How to help a child with selective mutism. https://childmind.org/guide/parents-guide-to-sm/

Tips for Encouraging Talking in SM

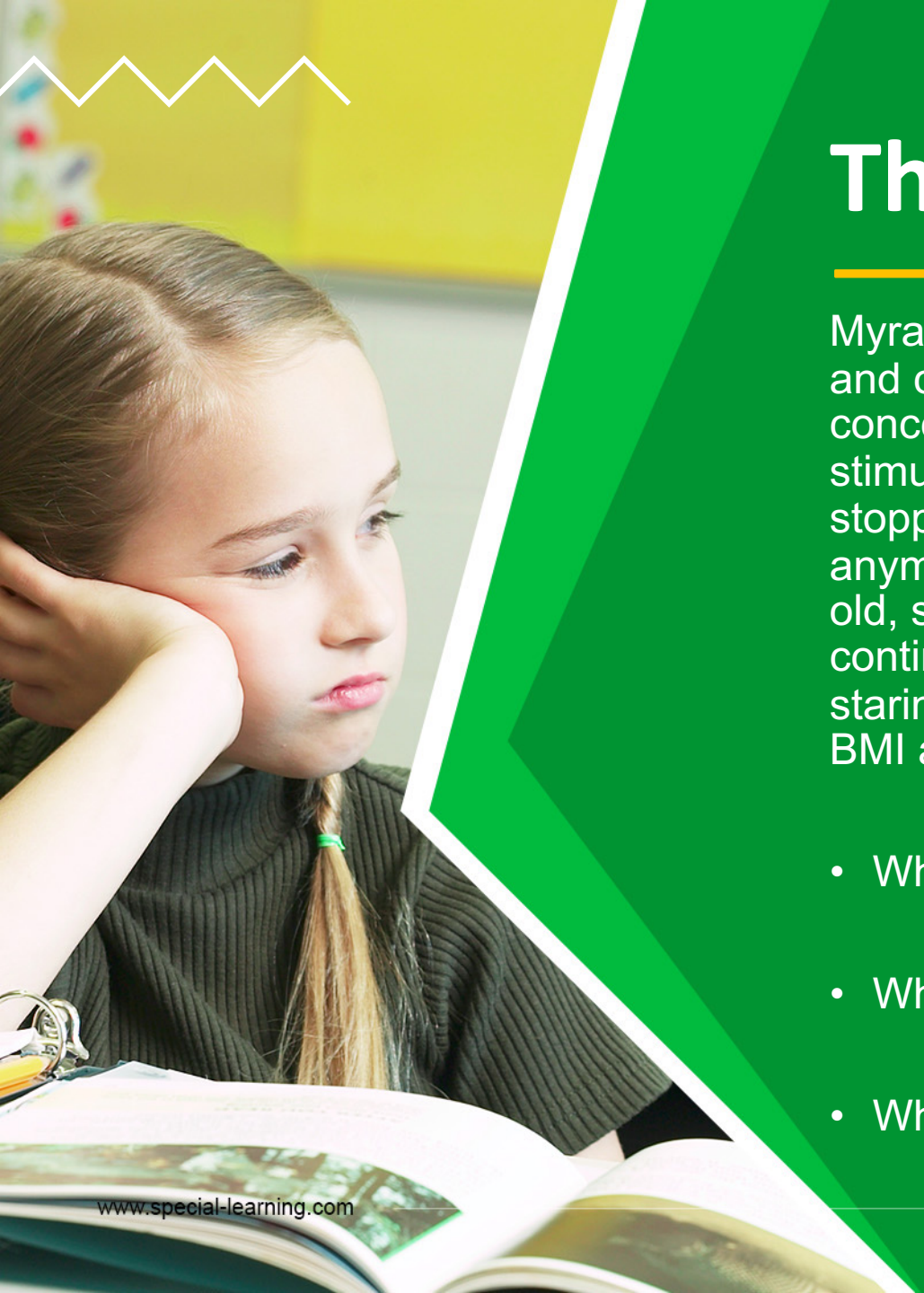
- Wait 5 seconds: We often don't give kids enough time to respond. Waiting five seconds without repeating the question or letting anyone answer for a child is a good rule of thumb. It also helps kids learn to tolerate their anxiety.

- Use labeled praise: Instead of just saying "Great job!" be specific: "Great job telling us you want juice!" This way kids know exactly what they're being praised for, and they feel motivated to keep doing it.

- Rephrase your question: Instead of asking questions that can be answered with a yes or no — or, more often, nodding or shaking her head — ask a question that is more likely to prompt a verbal response. Try giving her choices ("Would you like a puppy sticker or a star sticker?") or asking more open-ended questions ("What should we play next?").

- Practice echoing: Repeat or paraphrase what the child is saying. This is reinforcing and lets her know that she's been heard and understood.

- Reduce anxiety- SM is an anxiety disorder with an exaggerated fear of talking.



The Story of Myra

Myra was first evaluated at 7 years of age due to academic failure, and concerns from the teacher that she had poor attention and concentration and a possible learning disability. She was tried on stimulant medication at that time (Methylphenidate ER), but this was stopped due to increased anxiety. Her parents decided not to try anymore medications at that time. By the time Myra was 14 years old, she was refusing to go to school due to severe anxiety and continued academic failure. She stated she thought everyone was staring at her, thought she was fat and ugly (she was at a healthy BMI and attractive), and thought everyone knew she was stupid.

- What would you do?
- What screening tools might help with the diagnosis?
- What medications would you consider?

Summary of Screening Tools by Diagnosis

Diagnosis	Screening Tools	Age Approved	Comments
Anxiety	Multidimensional **Anxiety** Scale for Children Second Edition™ (**MASC** 2™) SCARED	8-19 years 8-18 years	Screens for GAD, OCD, social anxiety, performance anxiety, phobias, separation anxiety, panic disorder; Parent and Child Forms Screens for panic disorder, separation anxiety, GAD & school phobia
Depression	Children's Depression Inventory Patient Health Questionnaire for Adolescents Beck's Depression Inventory	7-17 years 12-18 years 15 years+	Scoring provides graph with t-scores; Parent and Child forms Quick (<10 min) screening tool Quick (<15 min) screening tool
OCD Disorders	Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS) Children's Obsessive-Compulsive Impact Scale (COIS)	6-17 years 6-17 years	Semi-structured interview- takes >30 min Rapid screen; focuses on impact rather than diagnosis; Parent and Child forms
Mood Disorders	Conner's Comprehensive Rating Scales (CBRS)	8-18 years	Separates different diagnoses; assessment tool takes >60 min

Screening Results

Copies of CDI and MASC here:

- CDI2-6-2-21
  - CDI2 6-2-21_Page 1
  - CDI2 6-2-21_Page 2
  - CDI2 6-2-21_Page 3
- MASC2-6-2-21
  - MASC2 6-2-21_Page 1
  - MASC2 6-2-21_Page 2
  - MASC2 6-2-21_Page 3
  - MASC2 6-2-21_Page 4

SUMMARY OF MEDICATION OPTIONS FOR MOOD DISORDERS

- **Selective serotonin re-uptake inhibitors (SSRIs): Depression and Anxiety**
  - This group of antidepressants increase serotonin in the synapse.
  - SSRIs decrease repetitive behaviors; decrease anxiety, irritability, tantrums, and aggressive behavior; and improve mood.
  - Examples: Fluoxetine, Sertraline, Citalopram, Escitalopram
- **Selective neuroepinephrine re-uptake inhibitors (SNRIs): Depression and Anxiety**
  - This group of antidepressants increase serotonin in the synapse and regulate the norepinephrine system.
  - SSRIs decrease repetitive thoughts and behaviors; decrease anxiety, irritability, tantrums, and aggressive behavior; and improve mood.
  - Examples: Venlafaxine, Duloxetine
- **Psychoactive or anti-psychotic medications: Depression, Mood disorders, Bipolar I**
  - These types of medications help with mood regulation and decrease aggression and self harm.
  - These medications can also decrease hyperactivity and reduce repetitive behaviors. They regulate weight in eating disorders.
  - Examples: Risperidone, Aripiprazole
- **Anti-anxiety medications: Anxiety (these medications are rarely used in children)**
  - This group of medications can help relieve anxiety and panic disorders, and symptoms of obsessive-compulsive symptoms.
  - Examples: Buspirone
- **Anticonvulsants: Mood disorders, Bipolar I, Bipolar II**
  - These medications can regulate mood in mood disorders.
  - Examples: Lamotrigine, Topiramate

Source: https://www.nichd.nih.gov/health/

Categories of Medications Used to Treat Mental Health Conditions in Childhood

Mood Disorders

Medications	Concurrent Diagnosis	Age Range	Dose Range	Comments
Anti-epileptics (Lamotrigine, Topiramate, Valproic Acid)	Mood Disorders	3 years	Variable	Lamotrigine must be titrated slowly, watch for skin rash. Valproic Acid controversial.
Bupropion (Wellbutrin)	Depression	12 years	50 to 300 mg	Comes in sustained and extended release. Watch for seizure threshold.
Atypical Antipsychotics: Risperidone, Aripiprazole, Olanzapine, Lurasidone, Quetiapine, Ziprasidone	Mood disorder, aggressive behavior	6 years	Variable	Regular labs to monitor for metabolic syndrome, watch for weight gain, tics.
SSRI and SNRI (Fluoxetine, Sertraline, Escitalopram, Venlafaxine, etc.)	Depression, anxiety, OCD and related disorders	6-12 years	Variable	No measurable effects in clinical trials.

Myra's Treatment Plan

Mood Disorders

Assessment	Diagnosis	Interventions	Medications	Comments
▪ Family history ▪ Health History ▪ Social History ▪ Individual interview ▪ Observation ▪ CDI ▪ MASC	▪ Mood Disorder: Anxiety and depression ▪ ADHD	▪ CBT ▪ Exposure therapy ▪ Family Counseling	▪ Vilazodone (Viibryd) titrated to 20 mg ▪ Aripiprazole 5 mg ▪ Omega 3 1200 mg ▪ Vitamin D 4000 IU	▪ Interventions included ▪ Previous medications tried included Fluoxetine, Sertraline, and Bupropion for depression and anxiety. Methylphenidate ER, Adderall ER, and Vyvanse for ADHD (all increased anxiety). ▪ Behavioral Activation Model

Durgam, S., Chen, C., Migliore, R., Prakash, C., Edwards, J., & Findling, R. L. (2018). A Phase 3, Double-Blind, Randomized, Placebo-Controlled Study of Vilazodone in Adolescents with Major Depressive Disorder. Paediatric drugs, 20(4), 353–363. https://doi.org/10.1007/s40272-018-0290-4

Reference Summaries

- ../Desktop/Article Summary - webinar mood disorders - irritability.docx
- ../Desktop/Article summary - ABA and psychological and emotional disorders.docx

Summary

- Treatment of mood disorders includes a careful diagnosis of mood, possible comorbid conditions, and function.
- Treatment often includes a combination of counseling and behavioral techniques with medication
- Screening and assessment tools can assist in the diagnosis and monitoring of the treatment plan but are often not standardized for diverse groups of children.
- Off label use of medications can be beneficial but must be evidence-based.
- QUESTIONS???

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The Child Mind Institute. (2021). A parents' guide: How to help a child with selective mutism. https://childmind.org/guide/parents-guide-to-sm/

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Other Webinars in this Series

- Overview of Psychopharmacology and Childhood Disorders (Recorded)
- Psychopharmacology and ADHD: April 14, 2021 (Recorded)
- Psychopharmacology and Autism: May 12, 2021 (Recorded)
- Psychopharmacology and Mood Disorders: June 9, 2021
- Psychopharmacology and Evidence-Based Practices: July 14, 2021
- Ethics of Medication: August 11, 2021
- Psychopharmacology: Diagnosis and Assessment: September 8, 2021