CTC's "Ask the Psychiatrist"

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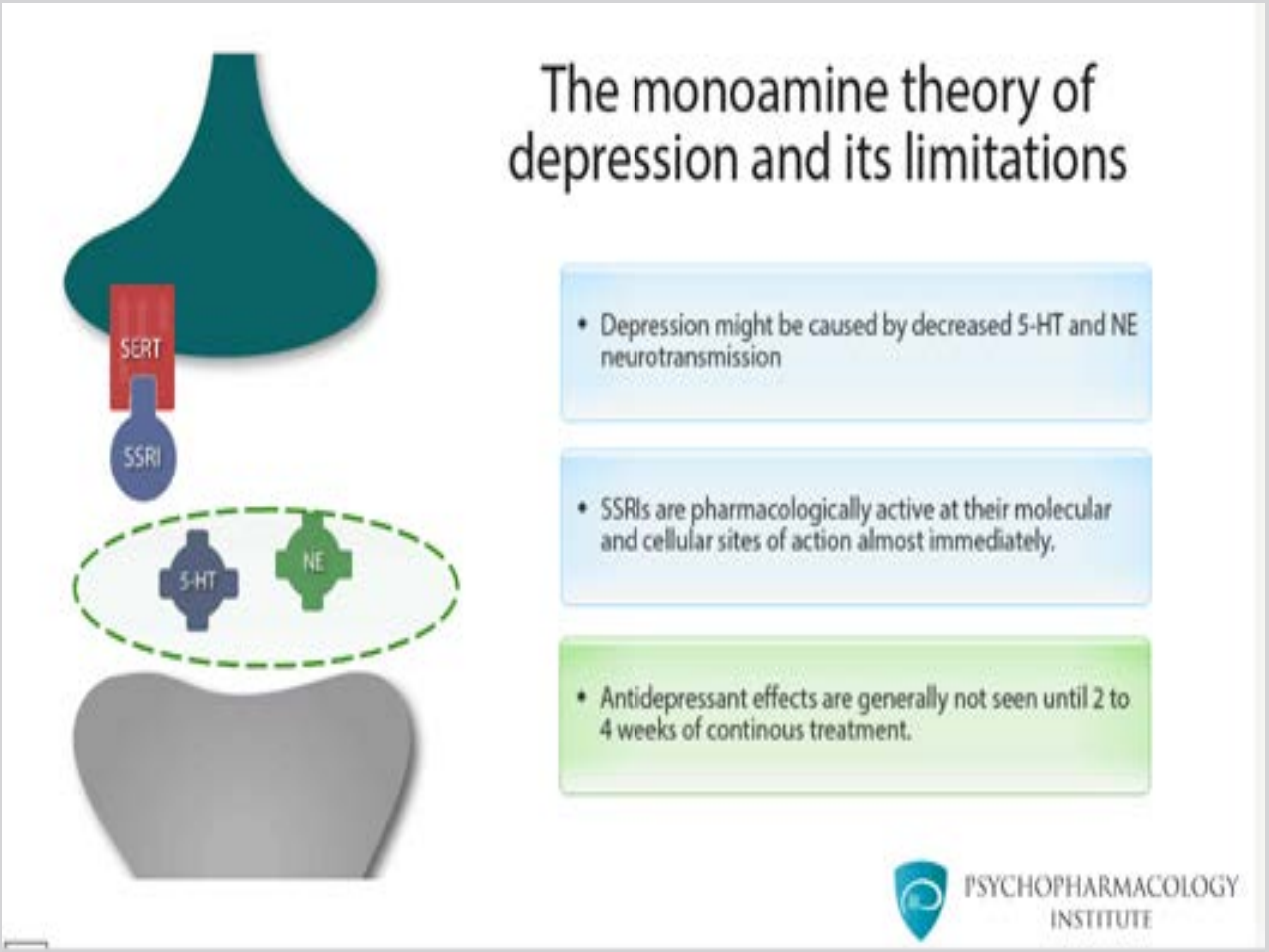
PCHC Primary Care Psychiatrist
January 9, 2020

Goals for Today

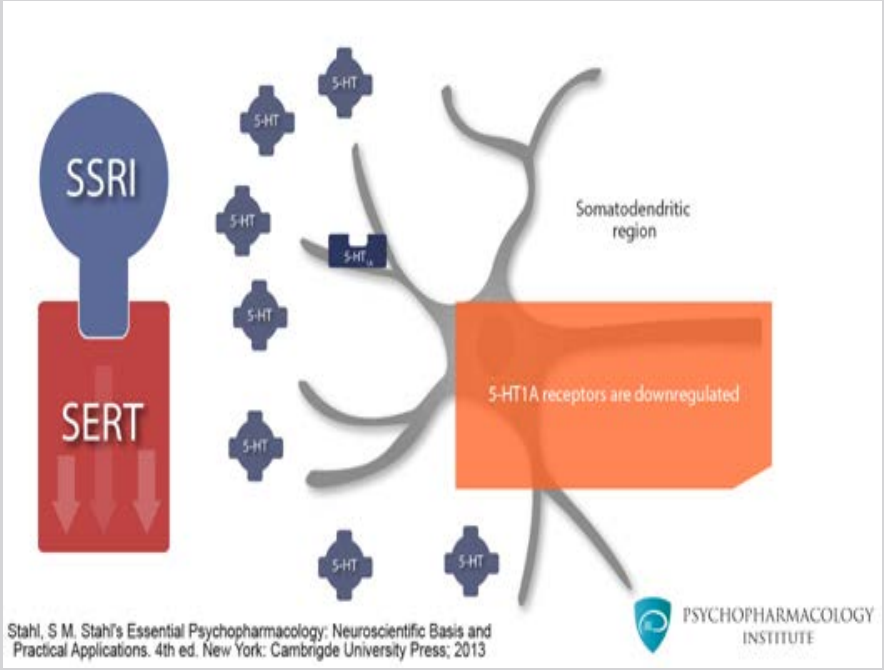
- Be most helpful to you!
- Answer questions sent to me directly (imbedded into the lecture)
- Review treatment options for common pediatric behavioral health concerns
  - Stimulants ADHD
  - SSRI for Anxiety/Depression
- Review front-line PCP psychotherapy type interventions for behavioral concerns
- Field ANY additional questions

How do I explain to patients and parents how SSRIs work?

Mono-amine Theory

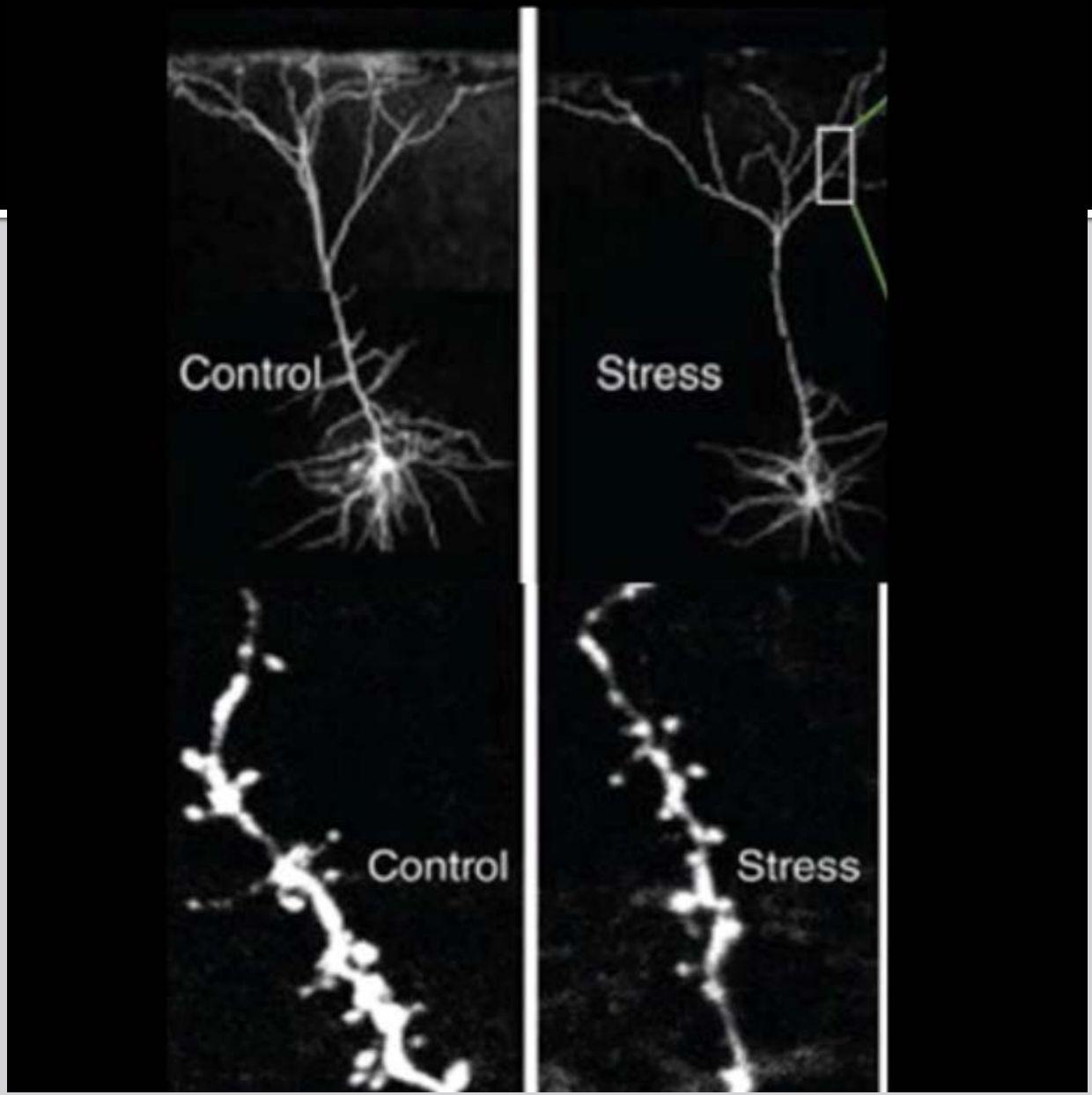


Making Mono-Amine Theory Work?

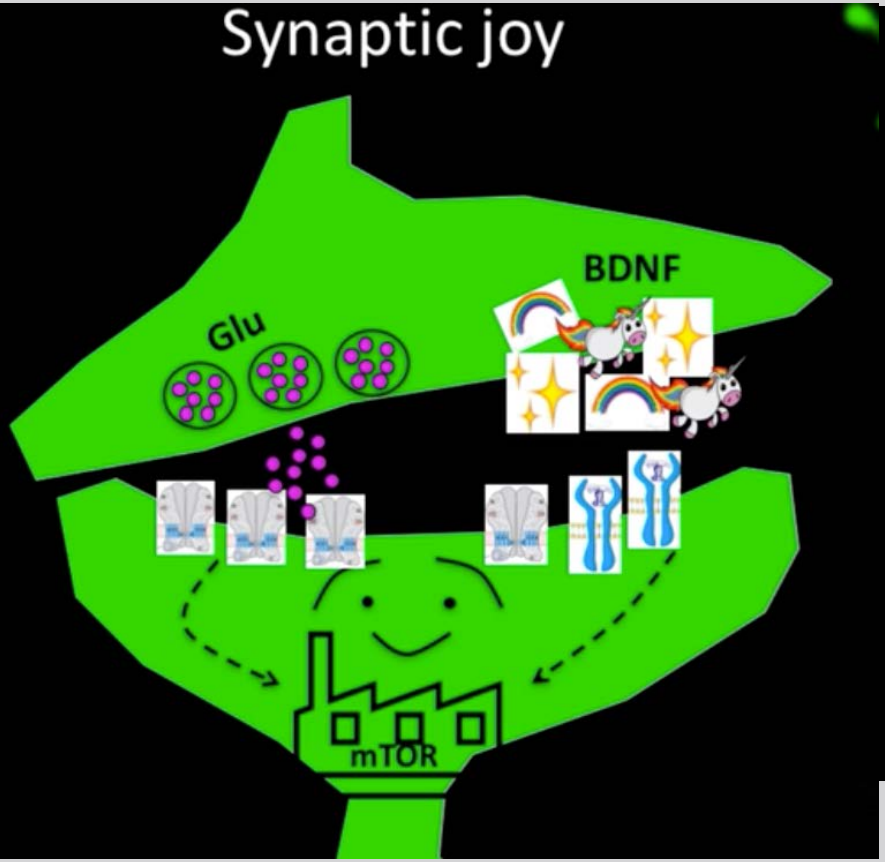


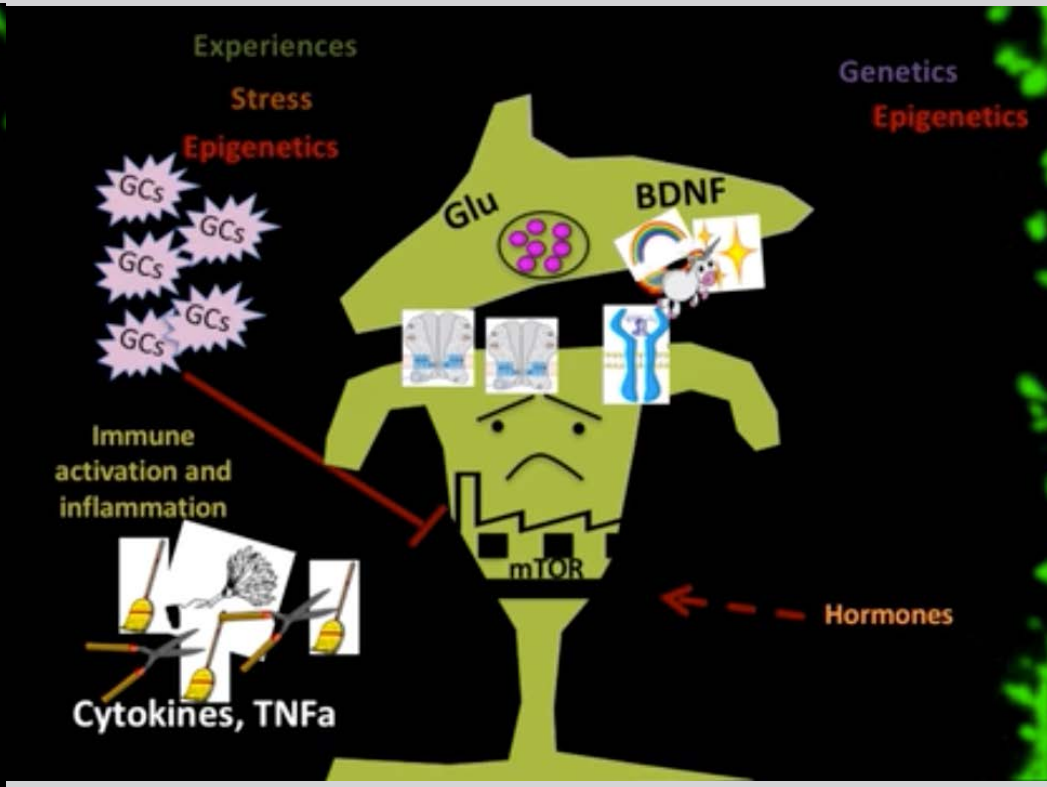
Stahl, S M. Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical Applications. 4th ed. New York: Cambrigde University Press; 2013

- As a response to serotonin stimulation, the serotonergic neuron **reduces the number of 5HT1A** receptors, this phenomenon is known as downregulation.
- Since downregulation is mediated by genomic mechanisms, the **reduction of 5HT1A receptors is not immediate**, this occurs in weeks.
- In summary, inhibition of serotonin reuptake increases serotonin concentration, which causes a downregulation of 5HT1A receptors. After the number of 5HT1A receptors is reduced, the neuron is disinhibited to release more serotonin in the synaptic space.

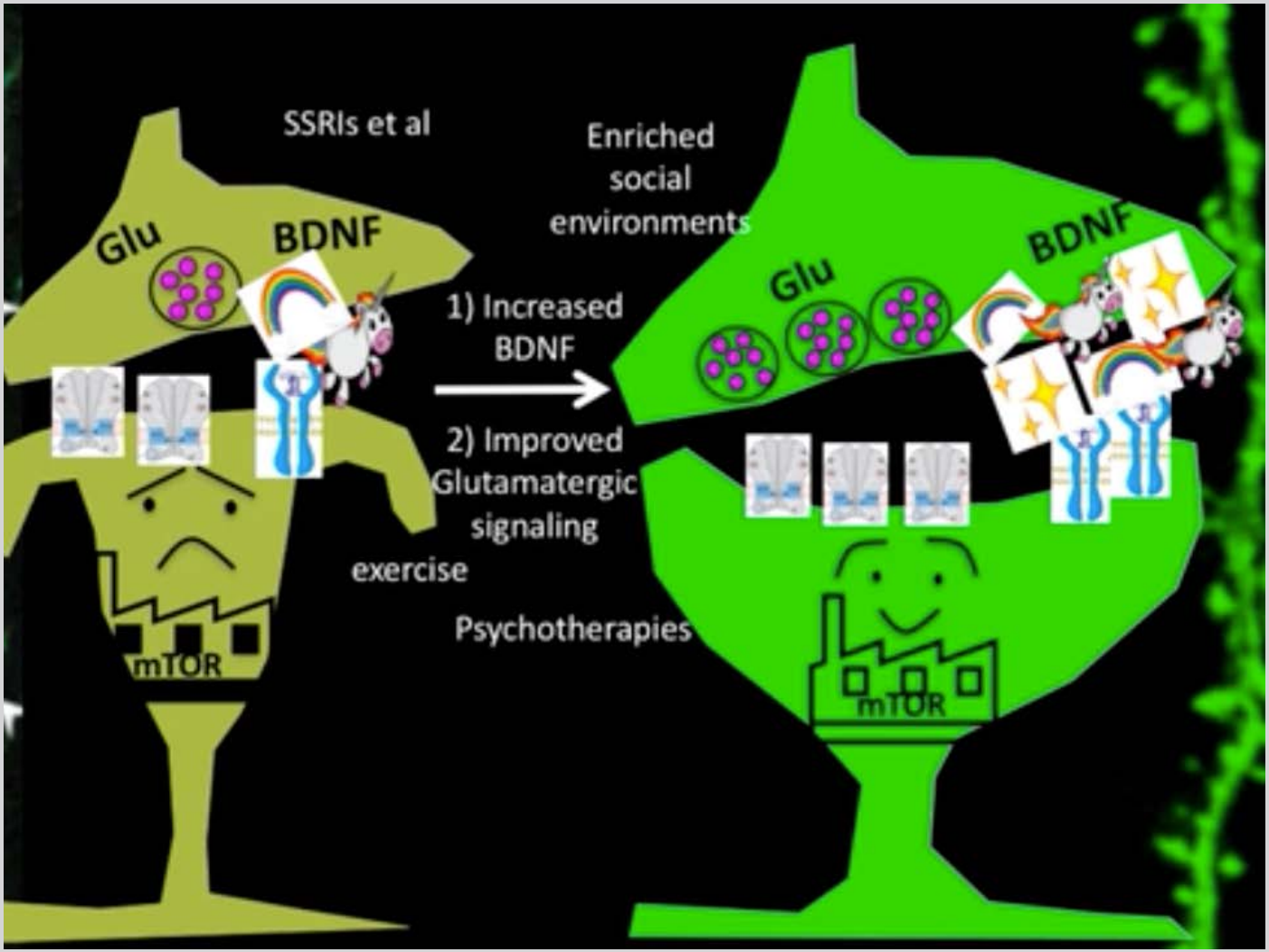

Control
Stress
Control
Stress

Maybe It's About Synaptic Health…





Rethinking the Serotonin Hypothesis



Rethinking the Serotonin Hypothesis

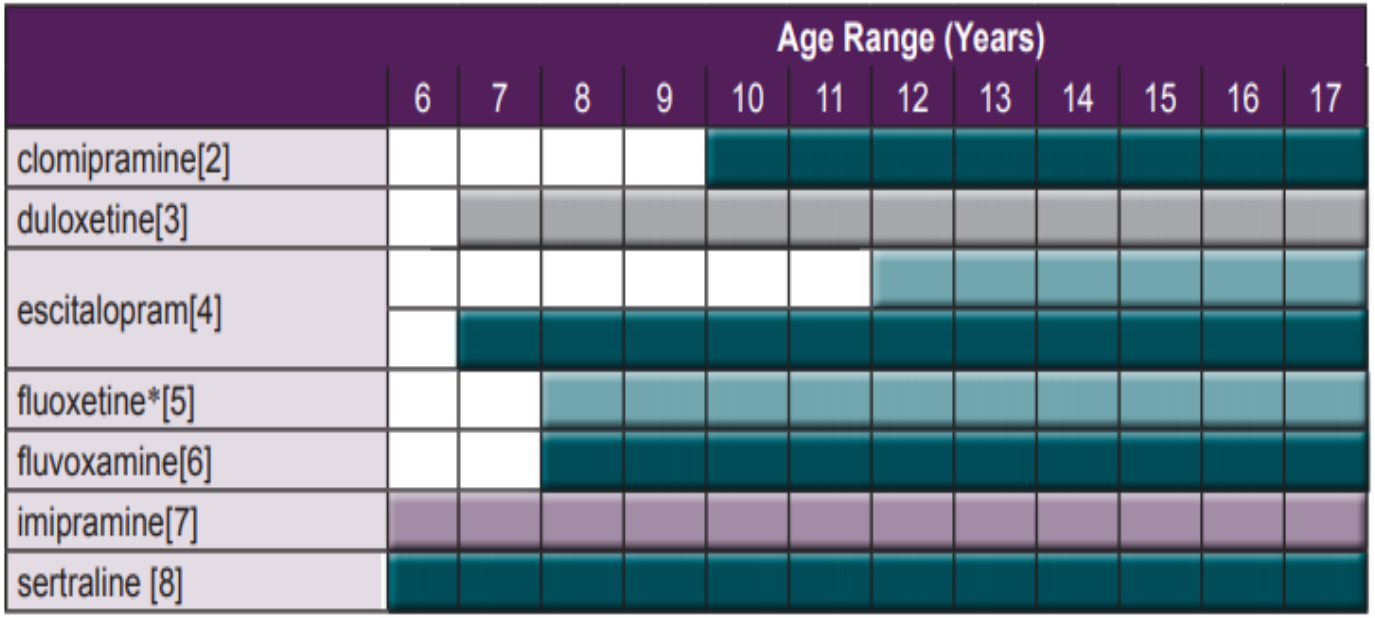
- http://www.nncionline.org/course/this-stuff-is-really-cool-july-2017/?course_type=content&course_page=2

I read only fluoxetine and escitalopram work in adolescent depression…

Is this true in practice?

FDA Approval

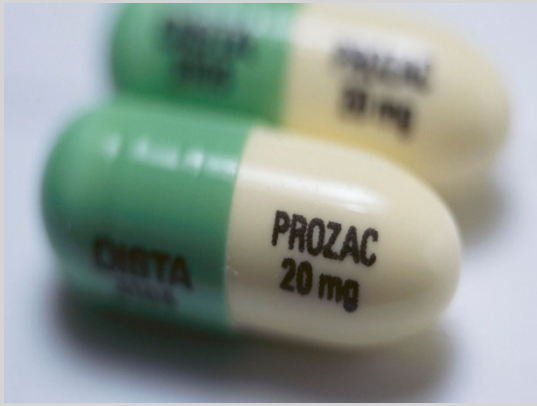
Figure 1. FDA-Approved Pediatric Age Ranges and Indications for Antidepressant Medications



* Fluoxetine is FDA approved for the treatment of MDD in pediatric patients up to 18 years old.

Fluoxetine (Prozac)

- Take-Home Points…
  - Best studied and first FDA approved SSRI in pediatric patients
  - FDA approved med for depression (also approved for OCD) in children (also approved for adolescents)
  - Long half-life so missed doses here and there aren't a problem
  - Comes in liquid & pills
- Dosing:
  - Start 5-10 mg, FDA max 60 mg
  - Increase in increments of 10-20 mg
  - Can go up to 80 mg (OCD)



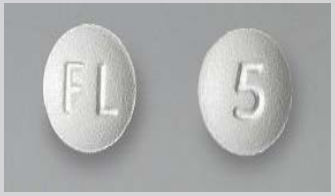
Sertraline (Zoloft)

- Take-Home Points…
  - Very frequently used and effective in pediatric patients for depression and anxiety disorders
  - Only FDA approved in kids for OCD
  - Comes in liquid & pills

- Dosing
  - Start 12.5-25mg, FDA max 200 mg
  - Increase in increments of 12.5-25 mg
  - Can go up to 300 mg (OCD)

Escitalopram (Lexapro)

- Take-Home Points…
  - Used regularly in treatment of anxiety/depression
  - FDA approved for depression treatment in adolescents (not children)
  - Recent Lancet Review (Adults) noted it may be one of best benefit, least SE
- Dosing
  - Start 2.5-5 mg, FDA max 20 mg
  - Increase in increments of 2.5-5 mg
  - Can go up to 30 mg (OCD)



What if a patient "fails" SSRI trials?

"Trial" = 6-8 weeks of adequate dose of SSRI

1. Did it fail?
   - Assess adherence!
   - Check with collateral
   - Compare screens

2. Reassess indication
   - Moderate-Severe, Depressive or Anxiety Disorder

3. Get help
   - Ensure patient connected with therapy, place patient on waitlists, consult or collaborate

4. Try alternative SSRI or SNRI

What if I want to switch?

Dose equivalency is *roughly* as follows:

Fluoxetine (in mg/day)	Sertraline (in mg/day)	Escitalopram (in mg/day)
5-10	12.5-25	2.5
20	50	5
30	75	7.5
40	100	10
50	150	15
60	200	20
70	250	25
80	300	30

Which Kids Should Get SSRI?

Indications (Paired with therapies)

- **Depression**: Cognitive Behavioral Therapy (CBT) or Interpersonal Therapy (IPT) are approved for depression
- **Anxiety**: (Separation anxiety disorder, social phobia, panic disorder, generalized anxiety disorder) CBT is the most well-studied and effective therapy for anxiety disorders
- **Obsessive compulsive disorder (OCD)**: A specific form of CBT, called Exposure with Response Prevention (E/RP) therapy is the gold standard therapy for this disorder and should be tried before or in conjunction with meds for kids with OCD
- **"Somatoform" kids** – Chronic irritable bowel sxs, chronic headaches…If you dig you'll probably find depression, anxiety, or both in these kids
- *The younger the patient, the more I push for an appropriate trial of therapy first.

What about PTSD?

General treatment components in children

- Initial stages:
  - Establishing rapport with the child and caregiver(s)
  - Providing a rationale for treatment.

1st line: Trauma-focused cognitive-behavioral treatment (CBT) to resolve PTSD

- Teaching stress management techniques
- Relaxation techniques
- Cognitive coping techniques
- Direct exploration/discussion of the traumatic experience
- Exploring and correcting inaccuate attributions

Pharmacotherapy

NICE
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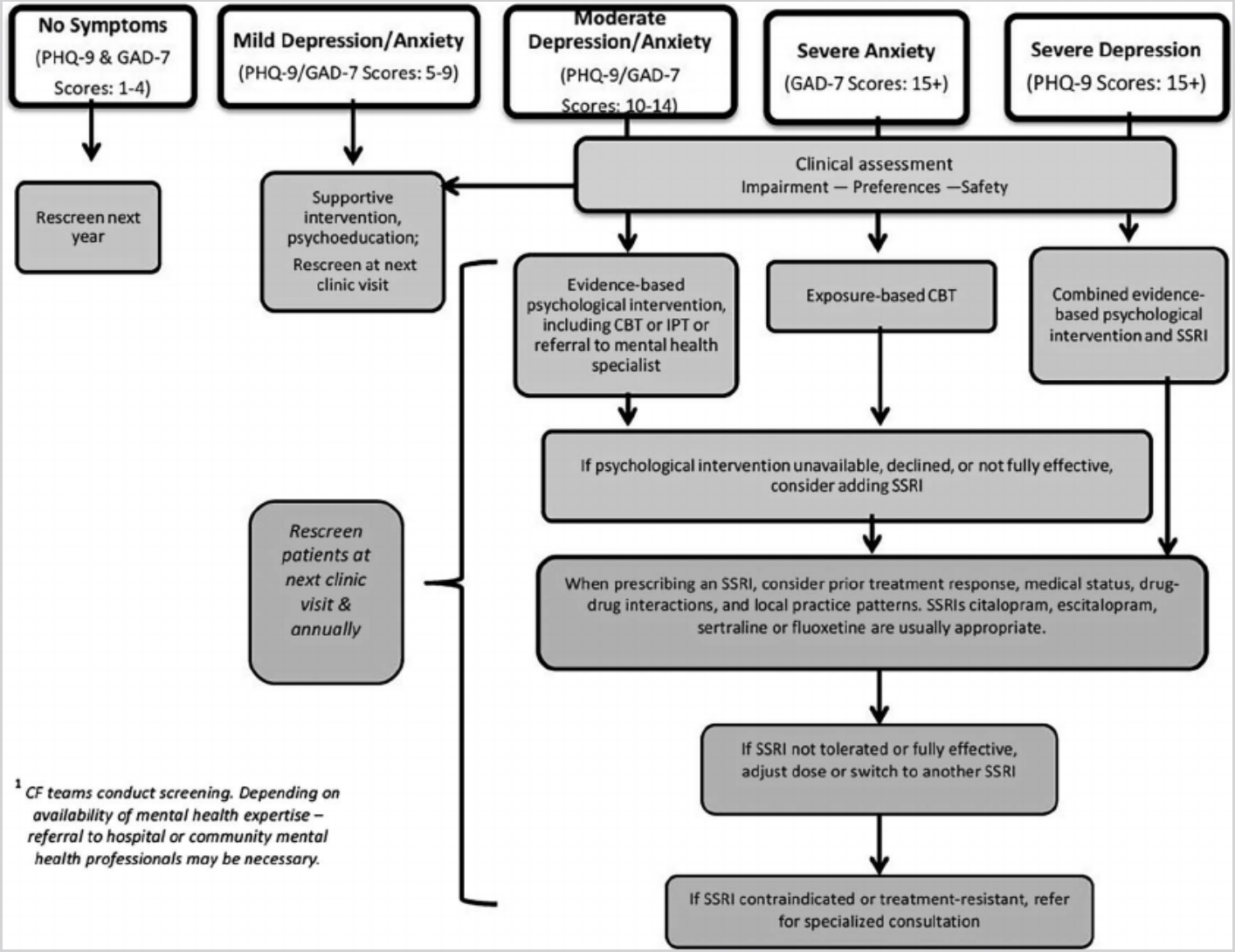
SSRIs, which have been found to reduce PTSD symptoms in adults with the disorder, **do not appear to be efficacious in children with PTSD**. No differences in PTSD symptom reduction were seen between patients randomly assigned to receive an SSRI compared with placebo in multiple randomized trials

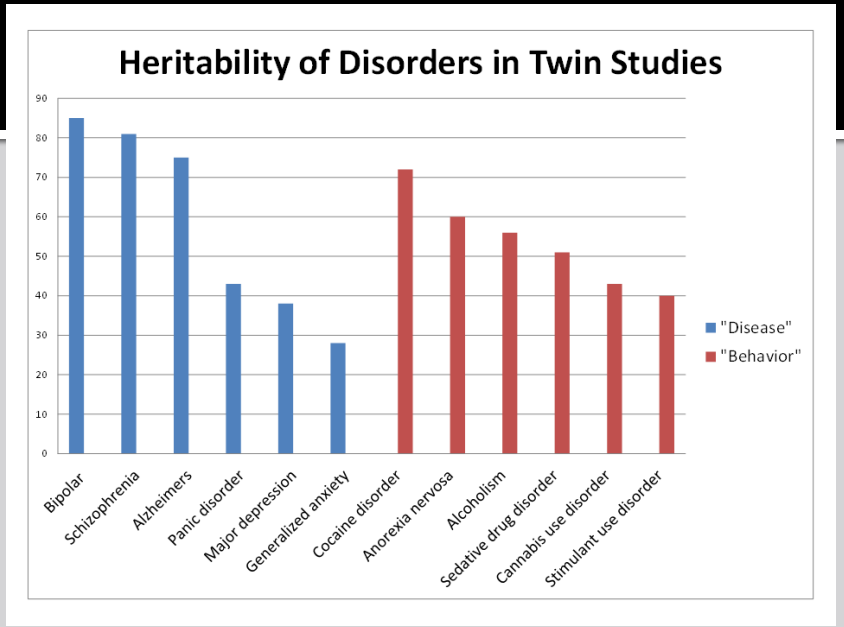
Summarized PCP plan for SSRI…



Any pearls for convincing parents SSRI are okay?

Pearls

- Clarify indication
- Emphasize medical model
  - Genes + Environment NOT personal failing
  - Helps support use of lifestyle/therapy
- Today is not forever
  - Not addictive, we can always stop
  - In 6 months we will reassess and consider trial off
- Rapport build and personal touch



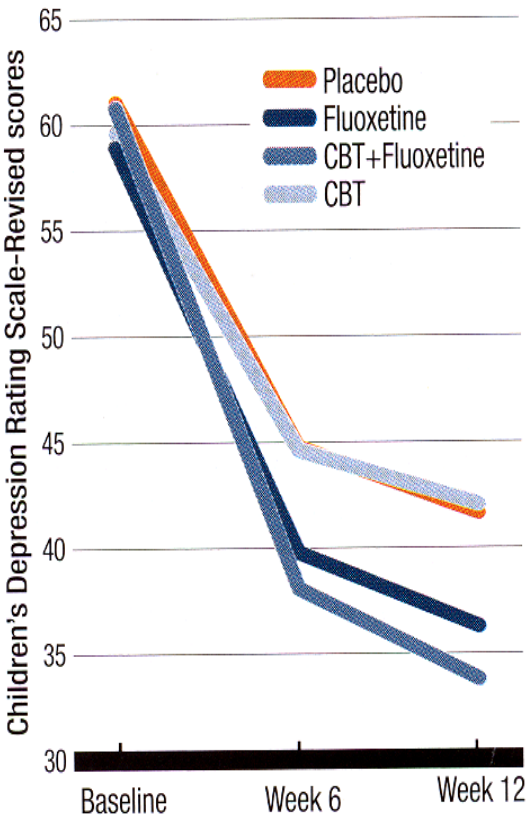
Disease or trait	Heritability
Eye color	> 99%
Type 1 diabetes	88%
Schizophrenia	81%
Alzheimer's disease	79%
Height	70-87% (m), 68-85% (v)
Obesity	65-84% (m), 64-79% (w)
Rheumatoid arthritis	53-65%
Panic disorder	43%
Depression	37%
Colorectal cancer	35%
Anxiety disorder	32%
Breast cancer	27%

MDD

NNT = 4-10

Depression in Teens: Treatments Compared

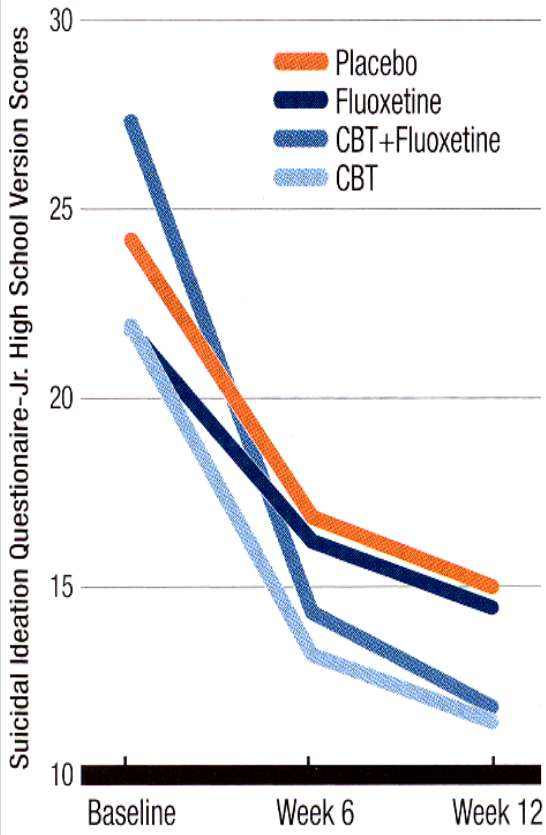
The combination of fluoxetine and CBT offered the most benefit in reducing patients' depression scores.



Source: National Institute of Mental Health's Treatment of Adolescent Depression Study (TADS)

Suicidal Ideation in Teens: Treatments Compared

Suicidal ideation improved over time in all four groups.



Source: National Institute of Mental Health's Treatment of Adolescent Depression Study (TADS)

Anxiety and OCD

- SSRIs and SNRIs, as a class, are considered effective for pediatric anxiety disorders
- A meta-analysis of 16 randomized trials on published between 1992 and 2008 found a number of SSRI and SNRI medications – fluoxetine, sertraline, fluvoxamine and venlafaxine – to be **superior to placebo in the treatment of pediatric anxiety**

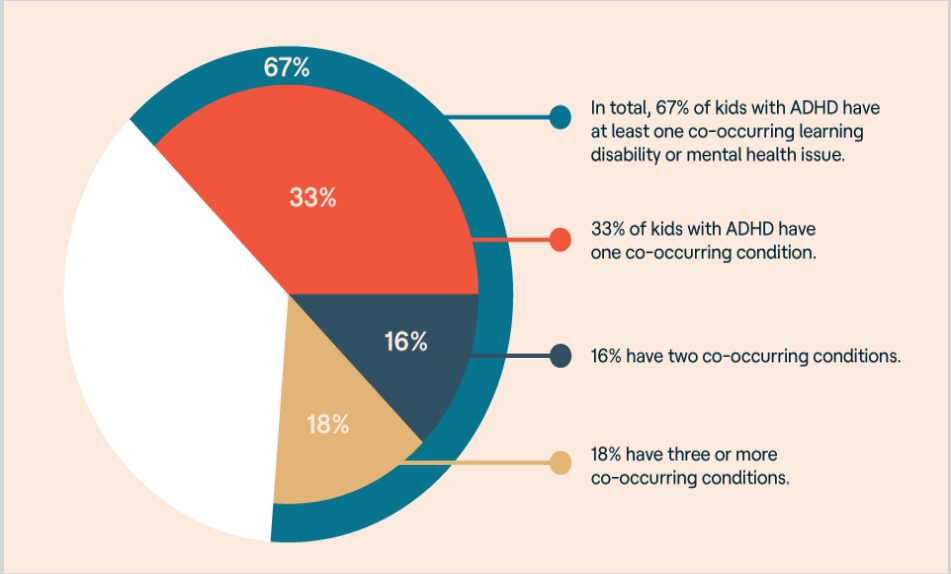
NNT = 6 for OCD 3 for Anxiety

Best practice for treating 7-12 year olds for co-morbid ADHD and Anxiety?

Co-morbidity is the Rule in ADHD

- Look at whole Vanderbilt
- Add in SCAREDs
- Stimulants remain first line for ADHD + co-morbid (except bipolar, maybe)
- Stimulants before 2nd med
- Treat co-morbidity…
  - LD: Support with 504/IEP
  - ODD: Parent training
  - Depression: Therapy +/- SSRI
  - Anxiety: Therapy +/- SSRI

Table 2. Rates of Comorbidity With ADHD	
Conduct disorder/oppositional defiant disorder	30% to 50%[25]
Depression	29% to 45%[25]
Bipolar disorder	10% to 30%[23]
Anxiety	25%[10]
Learning disability (math, reading, writing)	25% to 45%[26]
Tic disorder	20% to 30%[10]
Obsessive compulsive disorder	10%[10]



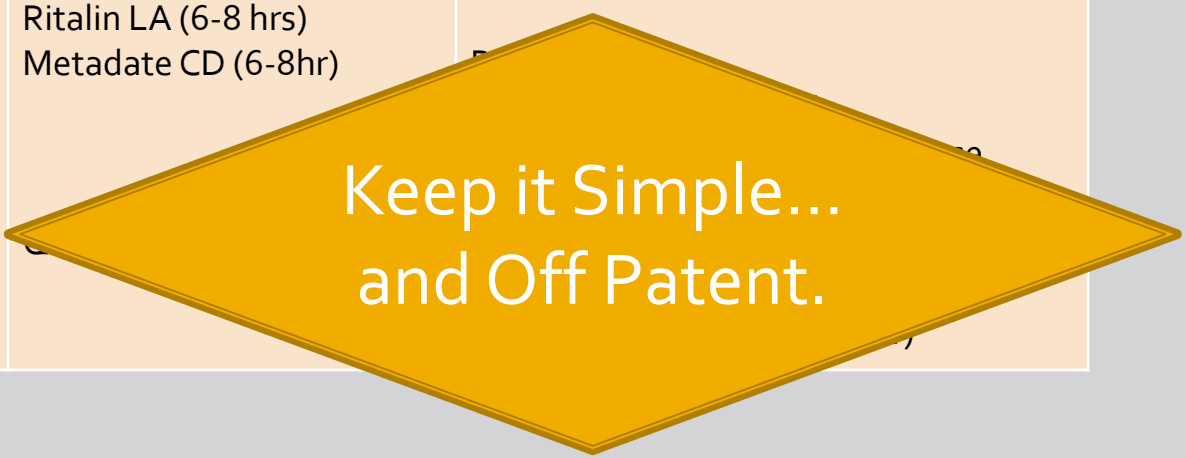
So we are going to try a stimulant…

OVERARCHING PRINCIPLES

- Weight/age does not predict dose.
- Start low and go slow.
- Treat to best effect without side effect.

Methylphenidate Products

Short Duration(3-5 hrs)	Medium Duration(5-8)	Long Duration(10-12+hrs)
Ritalin (Methylphenidate IR) • 30 minutes until effect, 90 minute peak concentration, ½ life of 3 hours via Extrahepatic metabolism Methylin (Solution) Methylin (Chewable) Focalin (Dexmethylphenidate IR)(5-6 hr)	Ritalin SR (3-8hr) Metadate ER (3-8hr) Methylin ER (3-8hr) Focalin XR (5-7 hr) Ritalin LA (6-8 hrs) Metadate CD (6-8hr)	Concerta



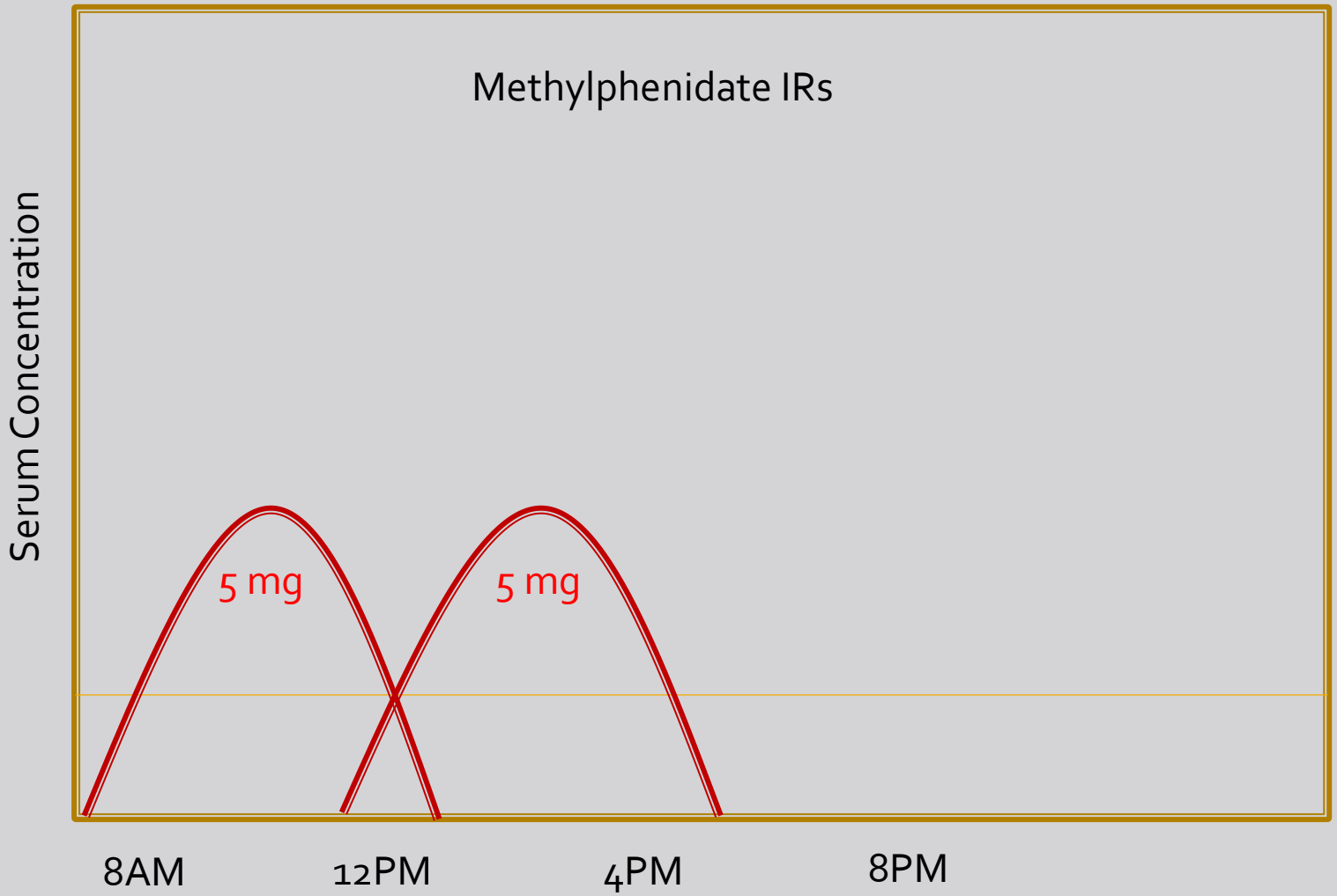
Note: Methylphenidate is a mixed(d,L enantiomer), DEXmethylphenidate is d enantiomer only

- d enantiomer is more active pharmacologically, so lower dose needed if not a mixed preparation
- i.e. Focalin doses will be 50% lower than Ritalin doses with same effect

CASE 1

- Moe Vesalot
- 11yo boy with new diagnosis of ADHD
- Primary symptoms impulsivity, inattention, distractibility.
- His transition to middle school was hard…
- Sx present both at school and home
- Family history of ADHD
- Never on medications prior

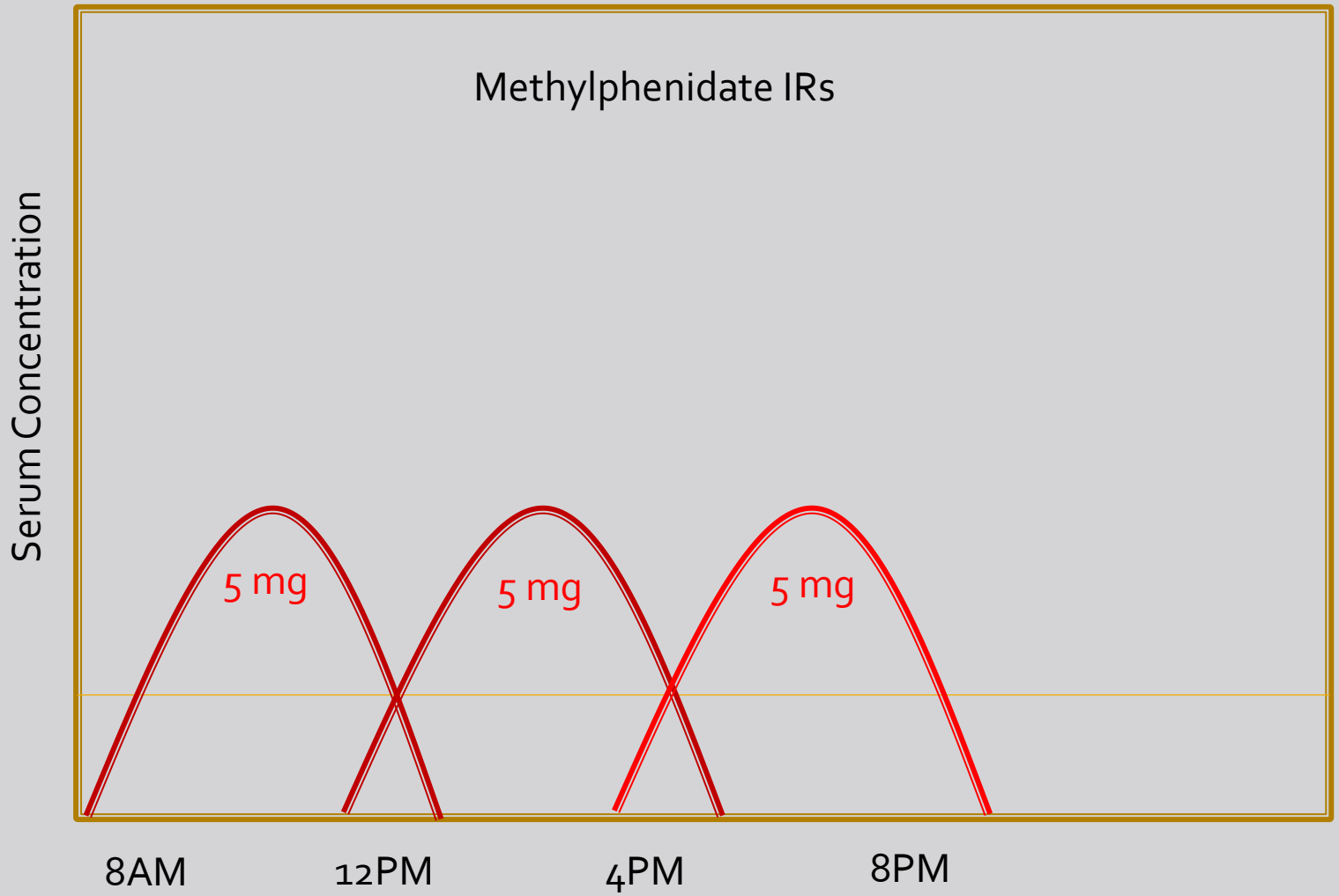
Time to Practice



CASE 1…

- Seems to be helping!
- BUT…Afternoon issues…

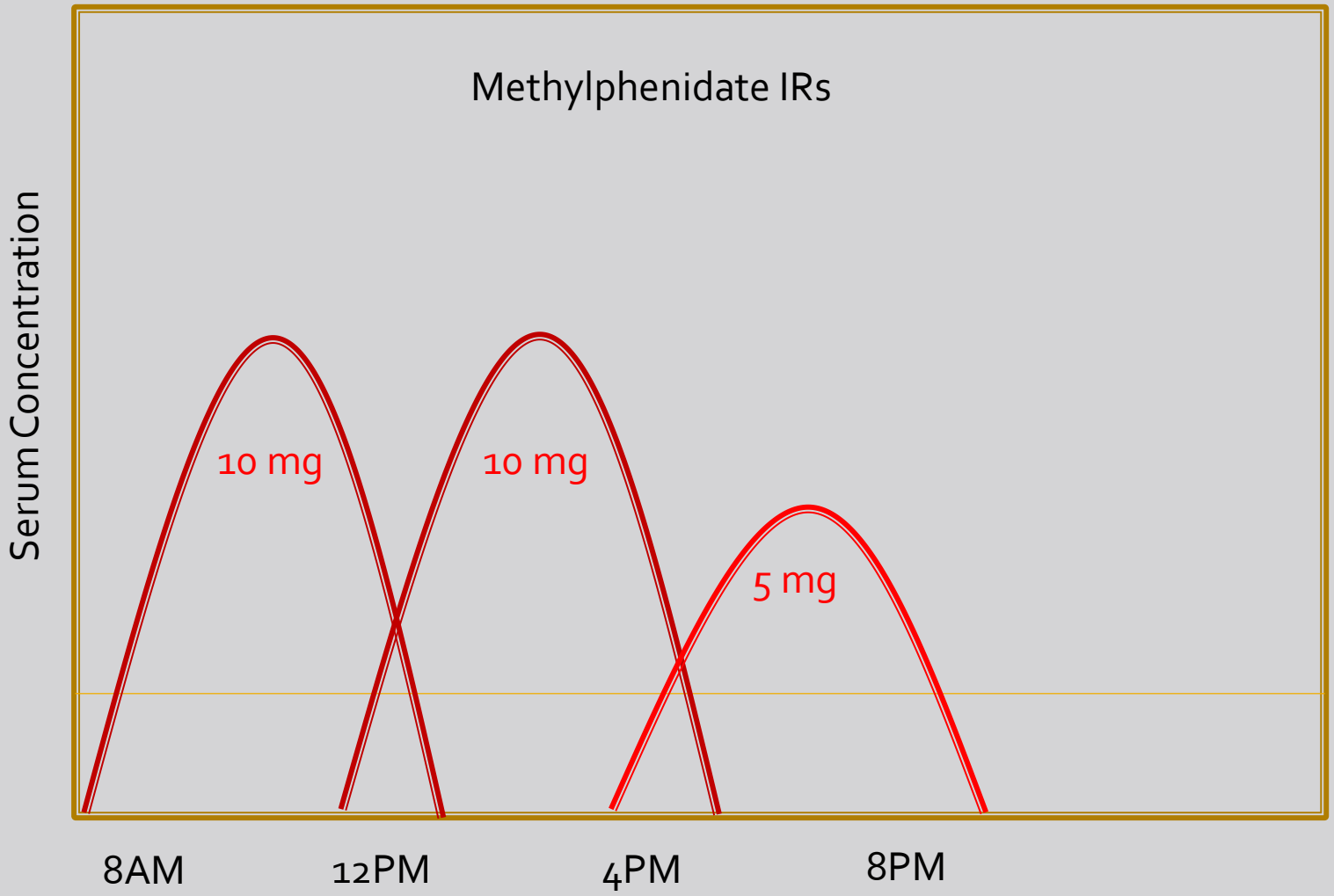
Time to Practice



CASE 1…

- Parents and patient are happy until…
- School starts back up (had been on summer break)
- Still getting called to principals once a week, grades improved but not "what I can do"

Time to Practice



CASE 1…

- Feeling really good… Nice job!
- BUT…now he doesn't want to go to the nurse
- "I forget sometimes" or "I don't like leaving lunch" or "It's weird to be the kid who leaves gym"

Which Long Acting?

Medium Duration(5-8)	Long Duration(10-12+hrs)
Ritalin SR (3-8hr) Metadate ER (3-8hr) Methylin ER (3-8hr) Focalin XR (5-7hr) Ritalin LA (6-8 hrs) Metadate CD (6-8hr) Quillichew ER (8hr)	Concerta Daytrana • TransdermaL • Higher rates of adverse effects, oral preferred Quillivant XR (12hr)-liquid suspension Aptensio XR (12 hr) Contempla XR-ODT(10-12hr)

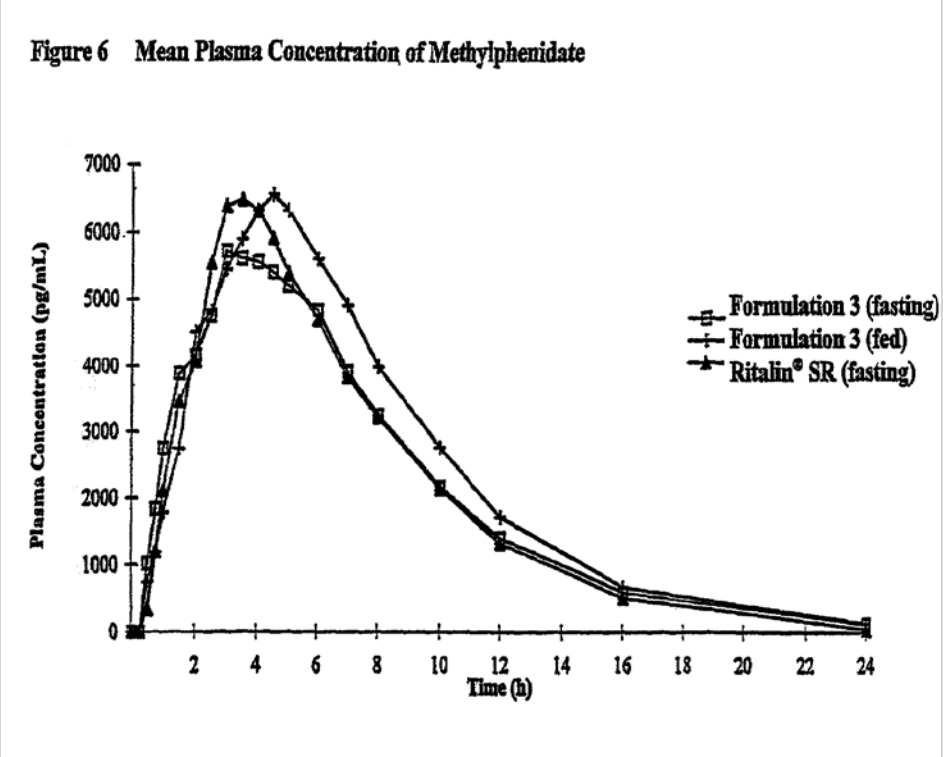
- Medications included in Neighborhood's formulary:
  - Methylphenidate (Ritalin, Metadate CD)
  - Dexmethylphenidate (Focalin)
  - Dextroamphetamine (Dexadrine)
  - Amphetamine salts (Adderall, Adderall XR)
  - Extended release guanfacine (Intuniv*)

- **The following medications to treat ADHD are not included in the Neighborhood formulary and require a prior authorization**:**
  - Methylphenidate (Concerta*, Daytrana*)
  - Atomoxetine (Straterra*)
  - Extended release clonidine (Kapvay*)

(*Prior Authorization required for all lines of business)

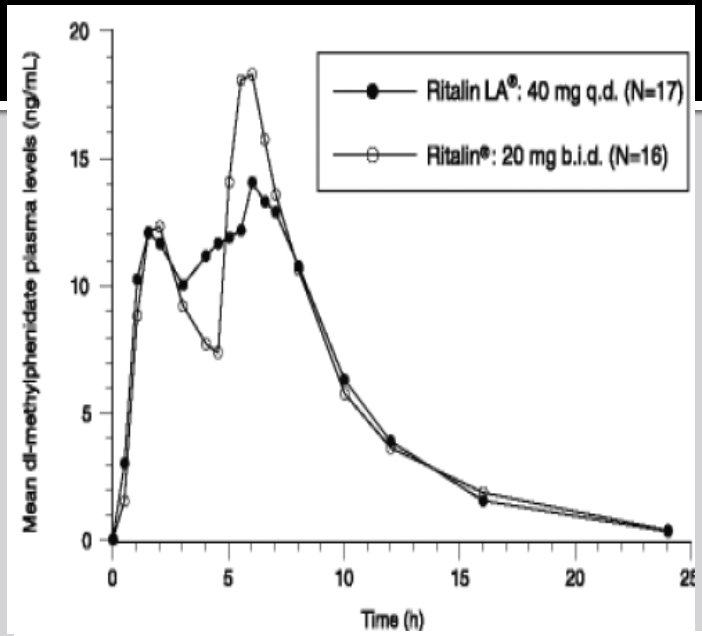
Long Acting Delivery Mechanisms "Single Pulse":

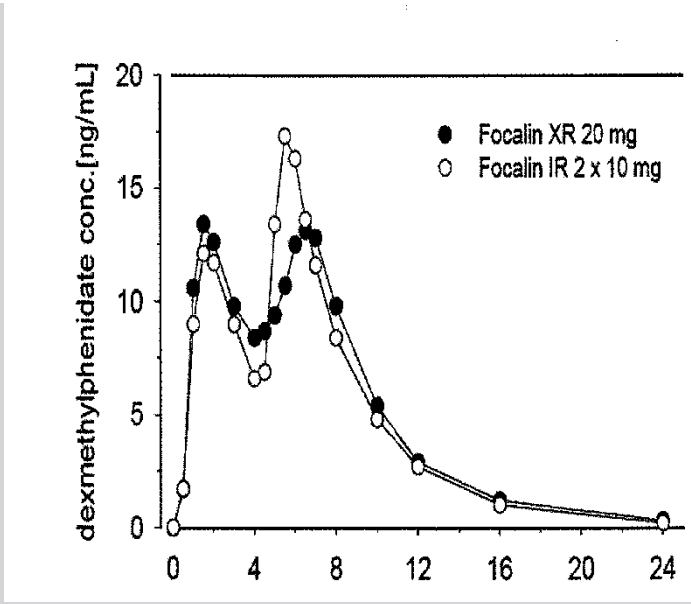
- **Ritalin SR, Metadate ER, Methylin ER**
- Wax matrix preparation
- SLOWer onset of action
- Lower serum concentrations
- Likely less effective than newer mechanisms
- May require twice daily dosing, or additional IR dose in AM



Long Acting Delivery Mechanisms "Dual Pulse": SODAS

- SODAS-Spheroidal Oral Drug Absorption System
  - Mixture of IR(Immediate Release) : DR(Delayed release)
  - 50:50, **Ritalin LA, Focalin XR**
  - 30:70, **Metadate CD**
- Lower second peak concentration
- Higher interpeak minimum concentration
- Less peak to peak fluctuation
- Mimics twice daily dosing of Ritalin IR





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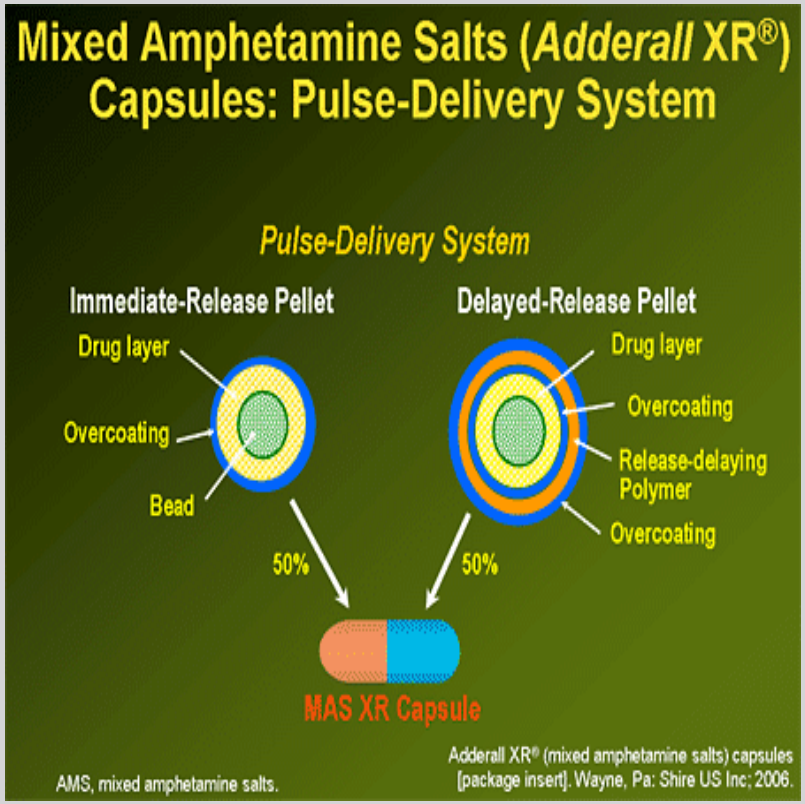
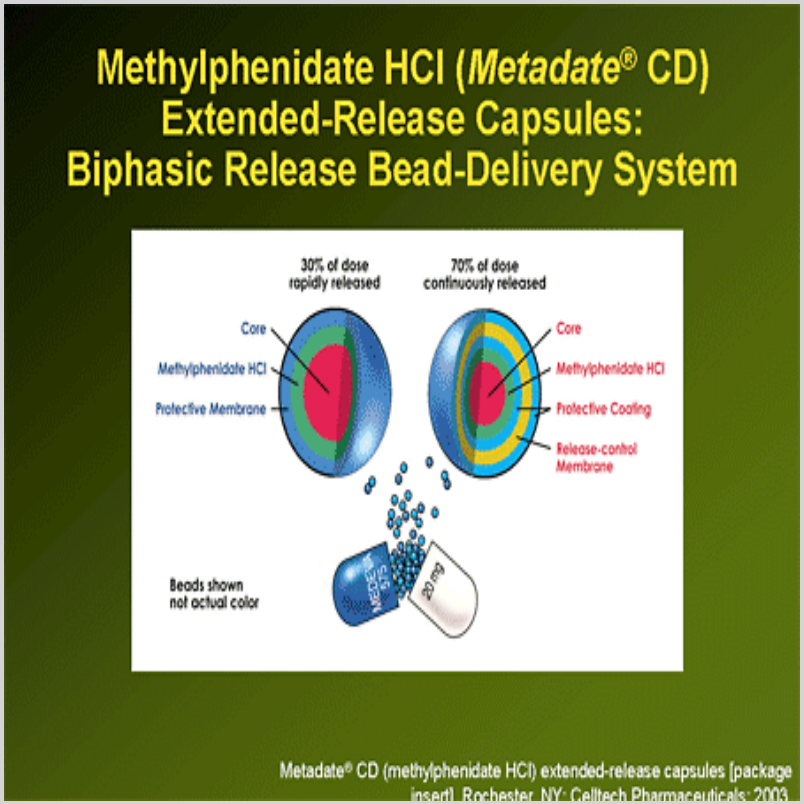
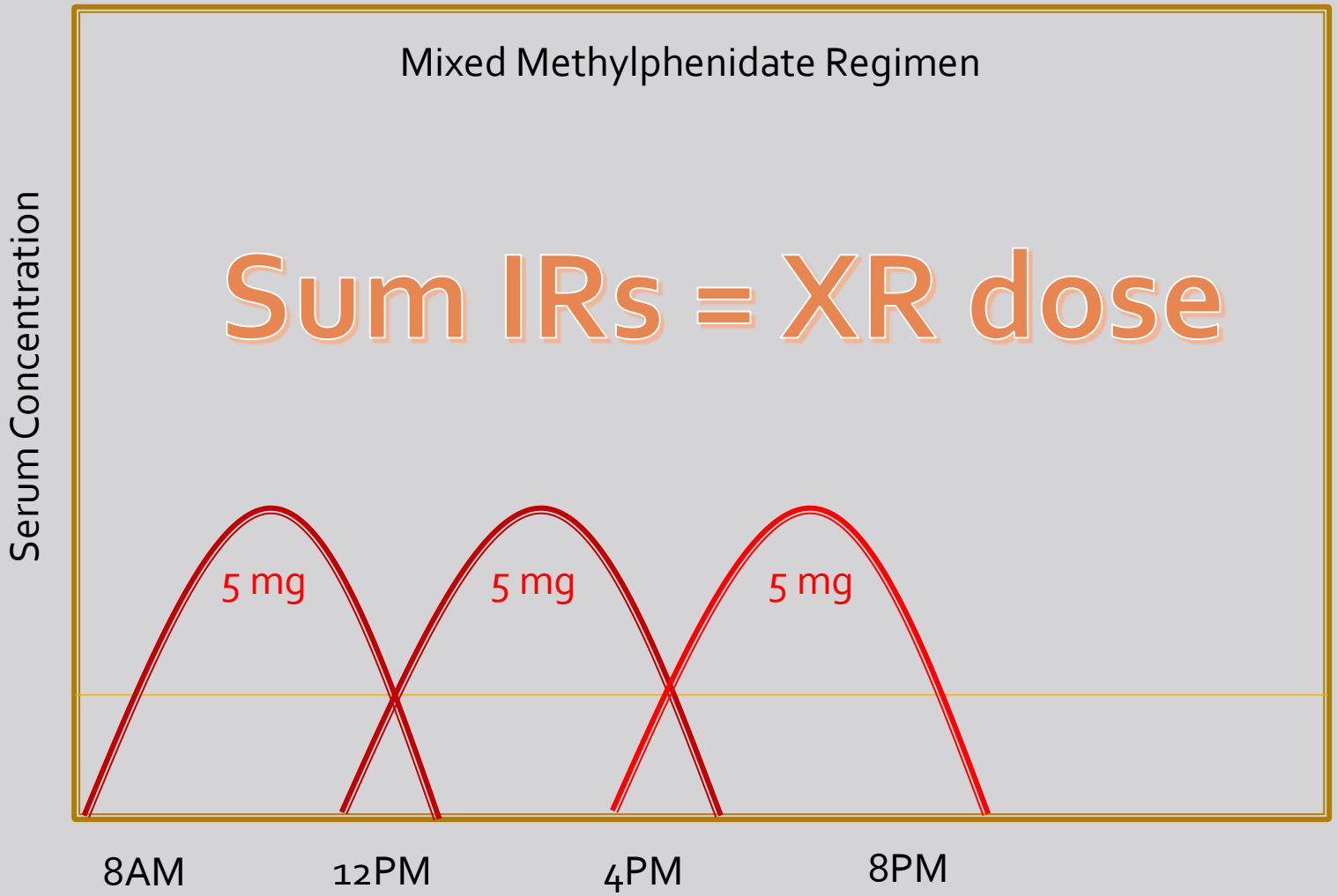




Time to Practice



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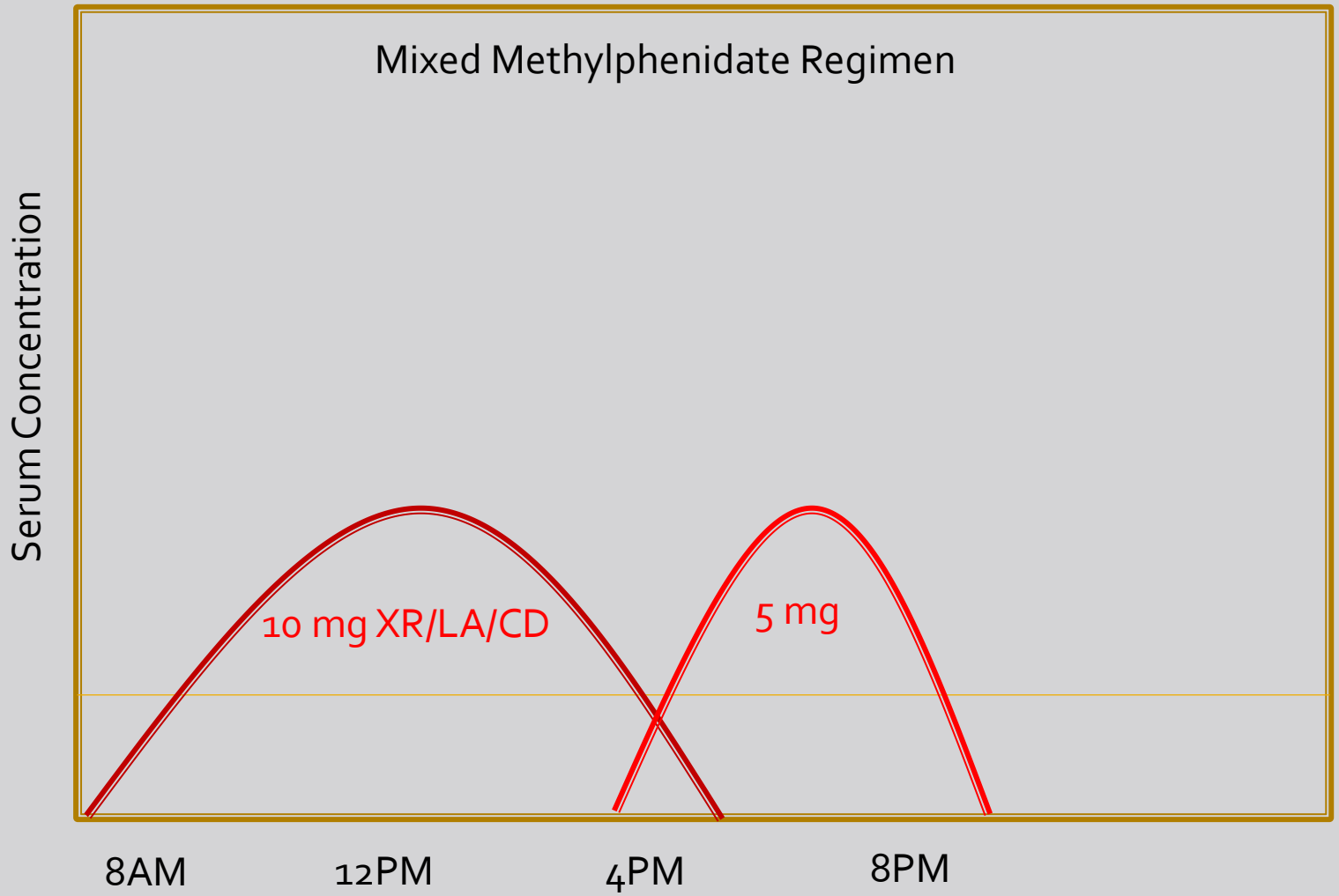

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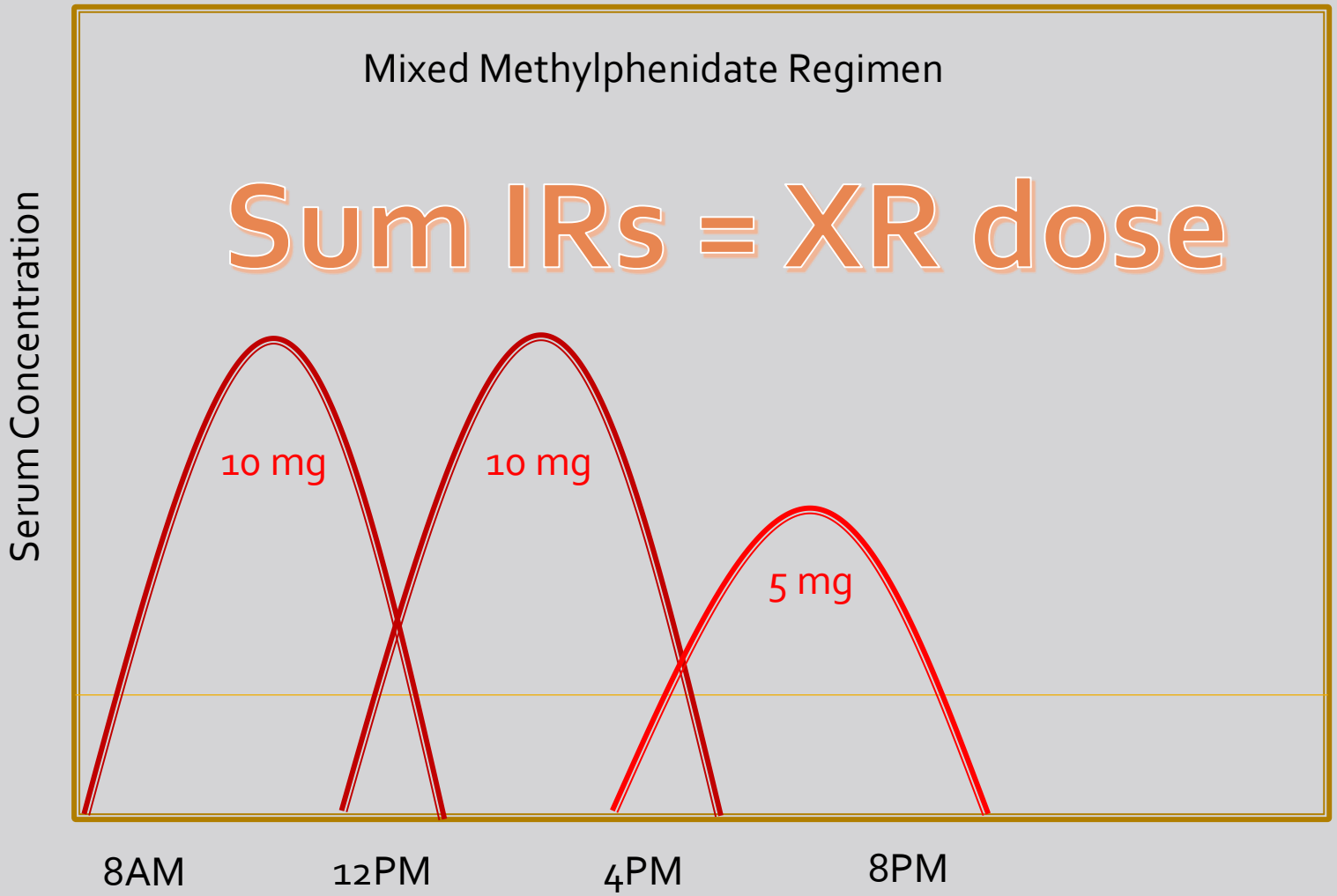

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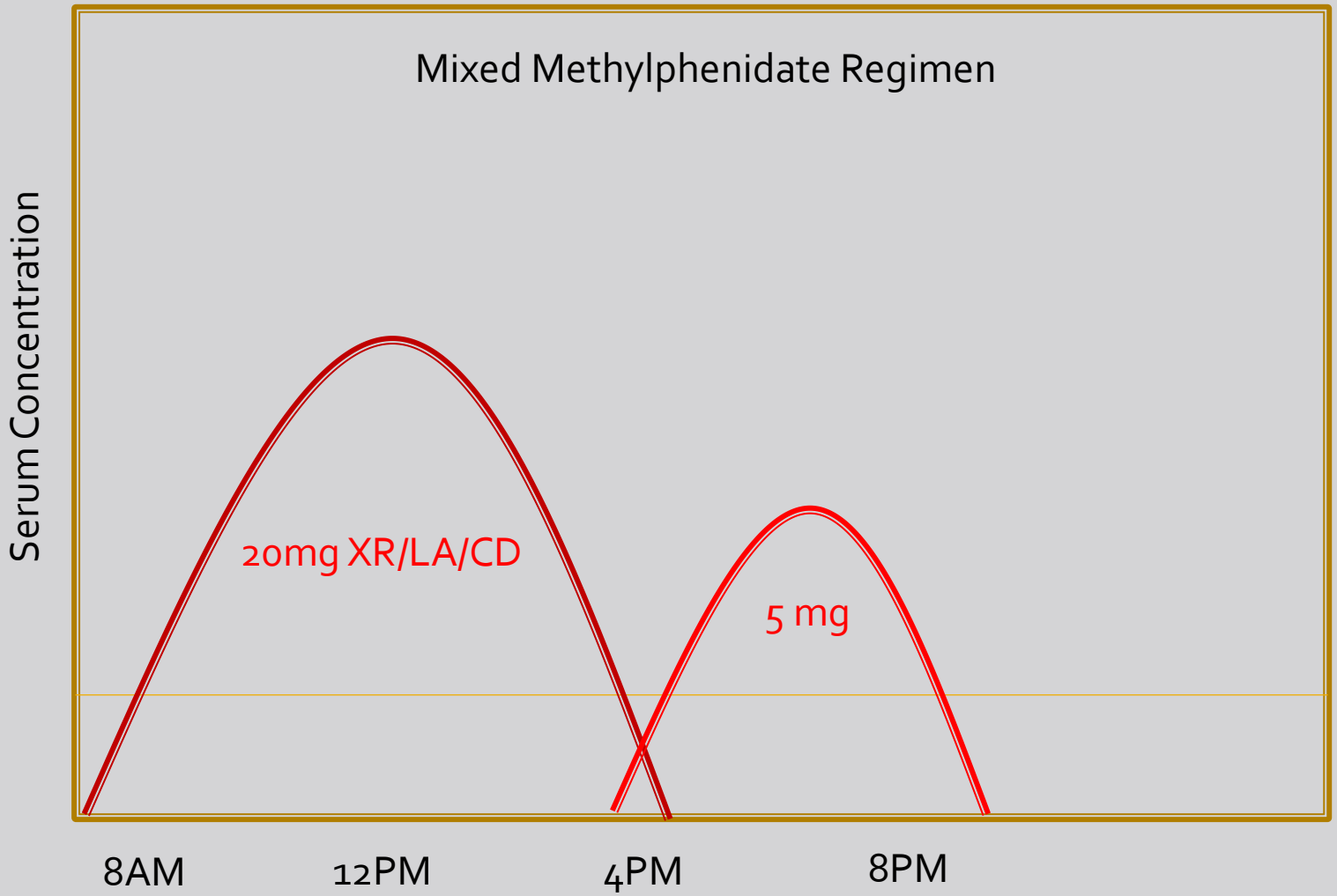

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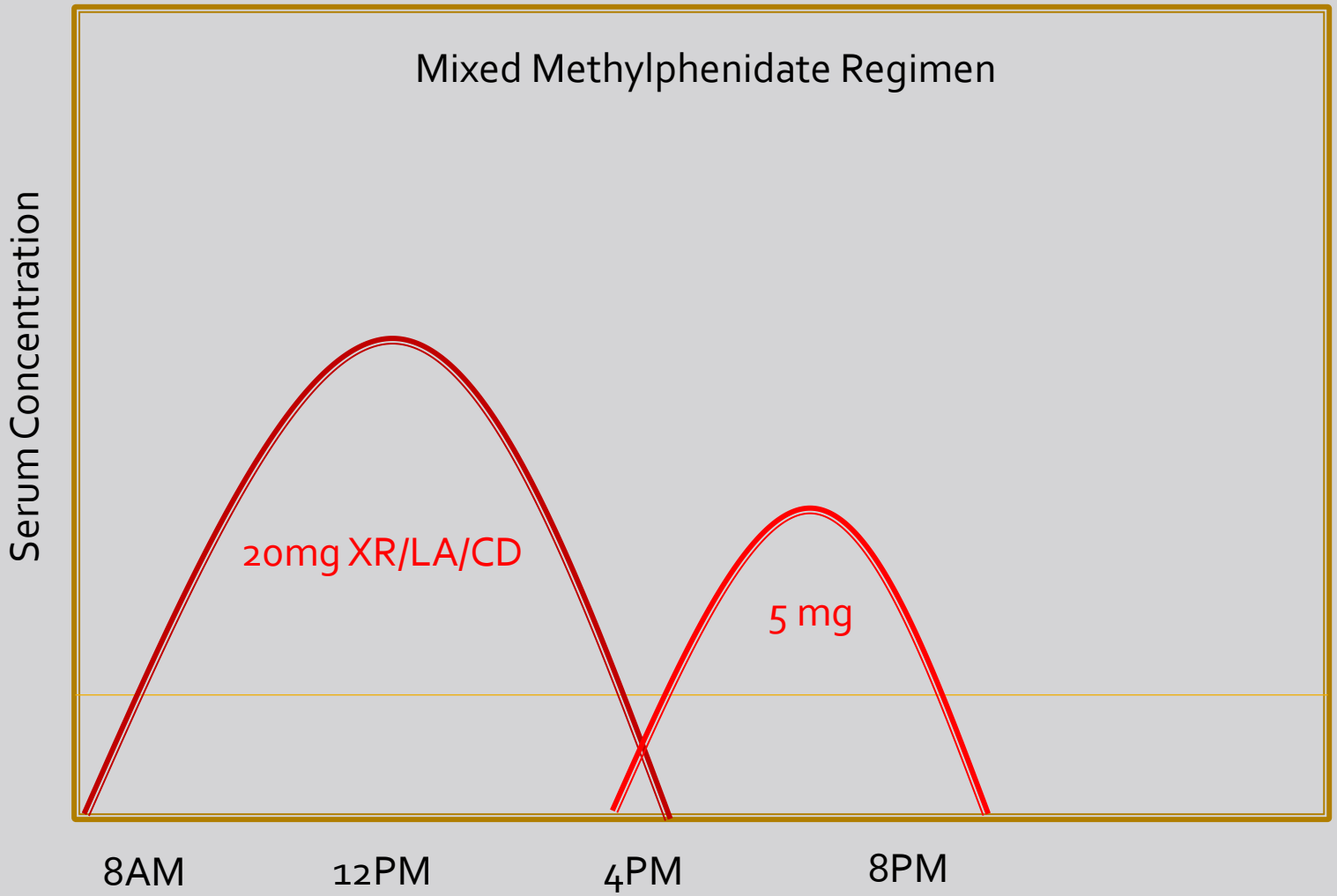
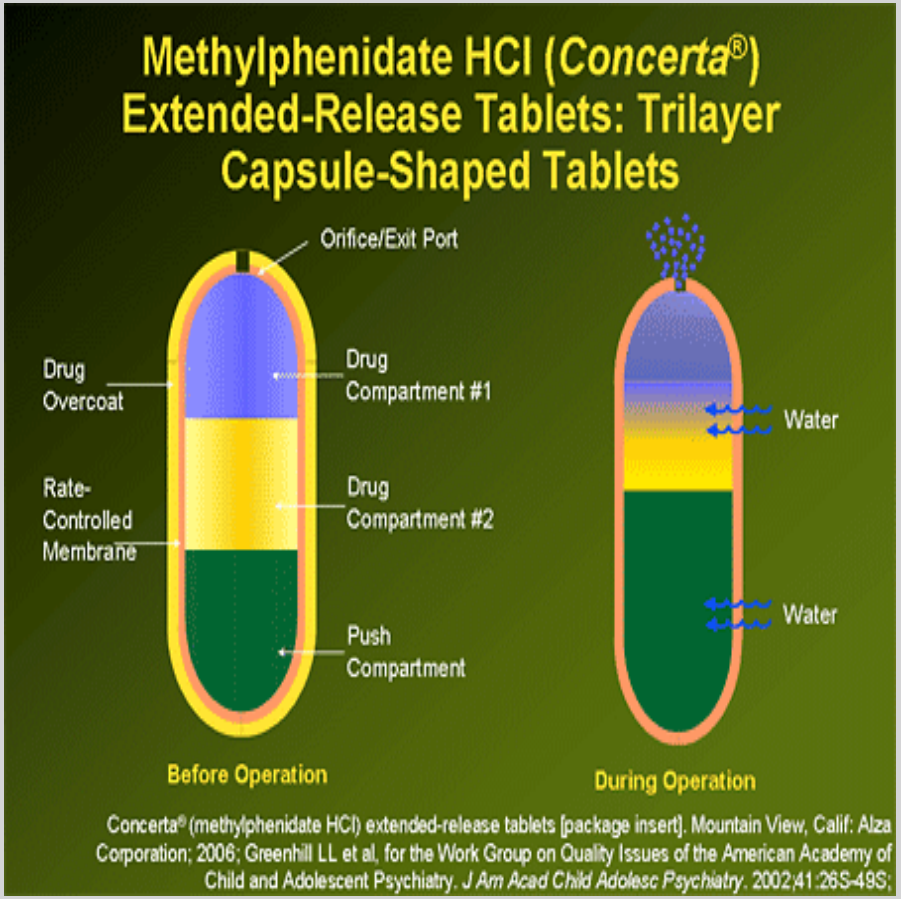


Long Acting Delivery Mechanisms

"OROS: Osmotic [controlled] Release Oral [Delivery] System"

Concerta

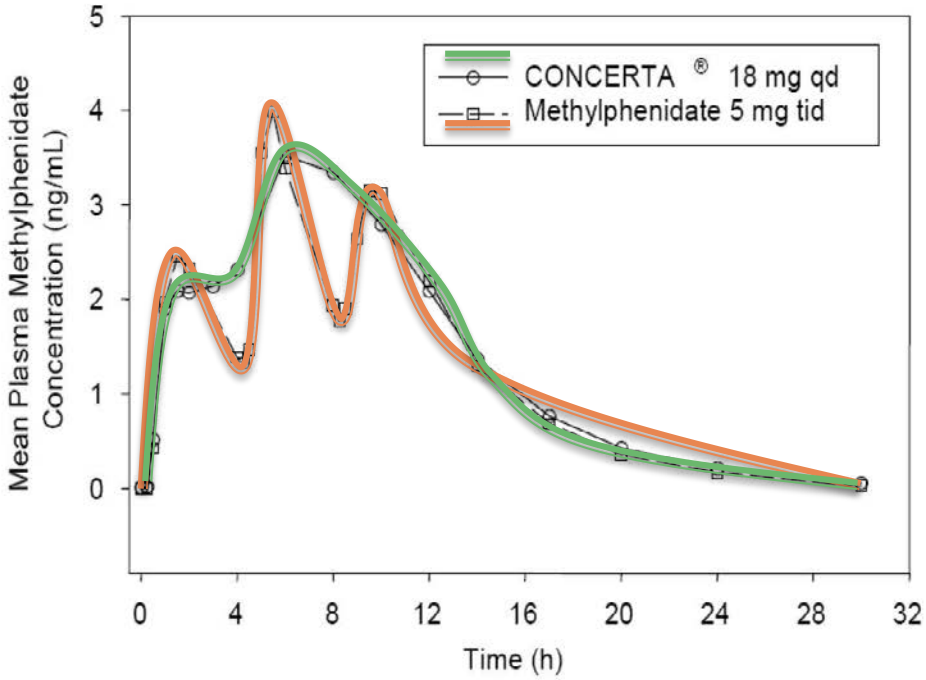
- Osmotic delivery system
- Layer of IR coats the caplet to allow for immediate drug benefits in the first 2 hours after swallowed
- Mimics three times daily dosing of Ritalin IR



Long Acting: Concerta

U.S. Food and Drug Administration
Protecting and Promoting Public Health
www.fda.gov

Mean plasma profiles
Concerta® qd vs IR MPH tid



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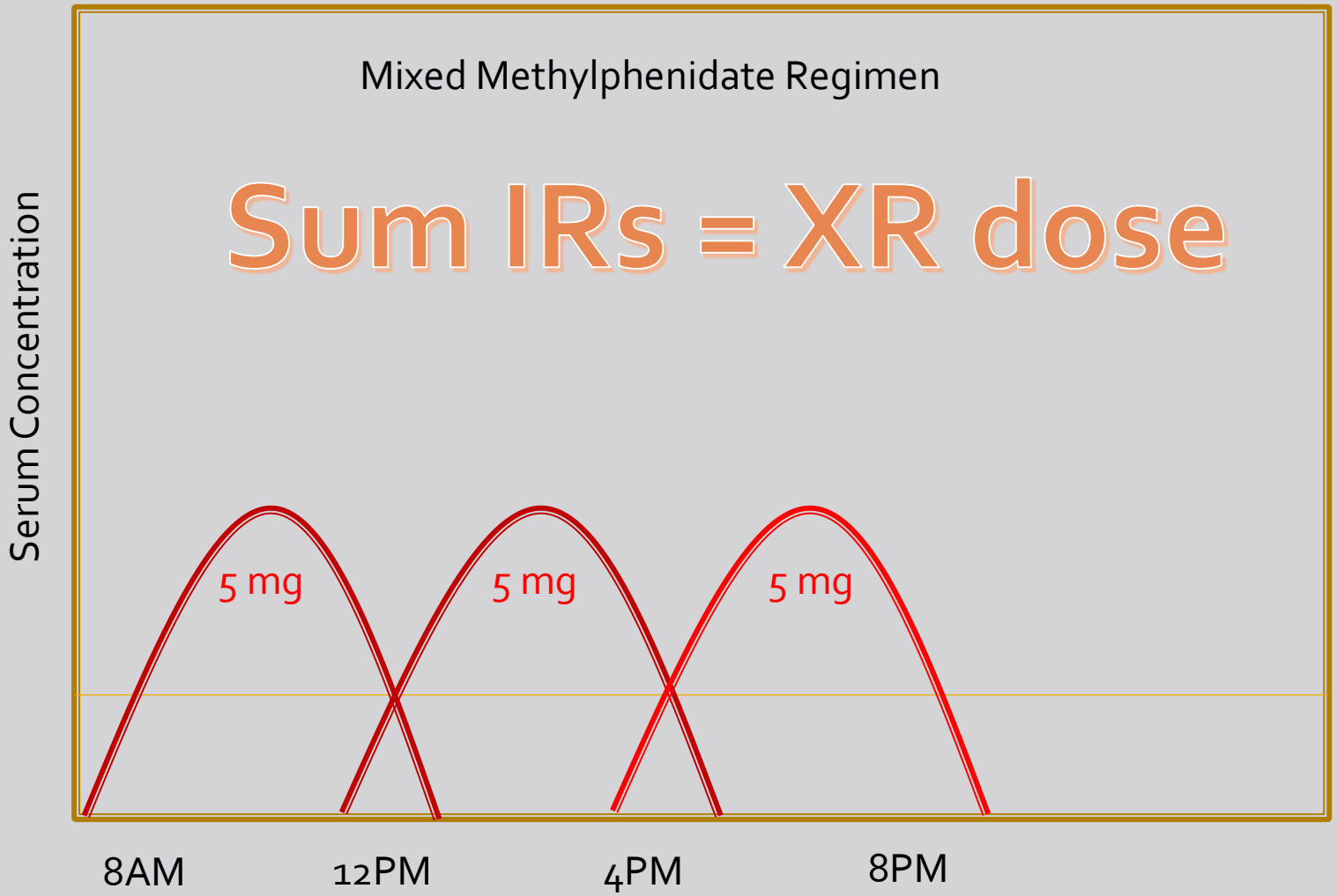

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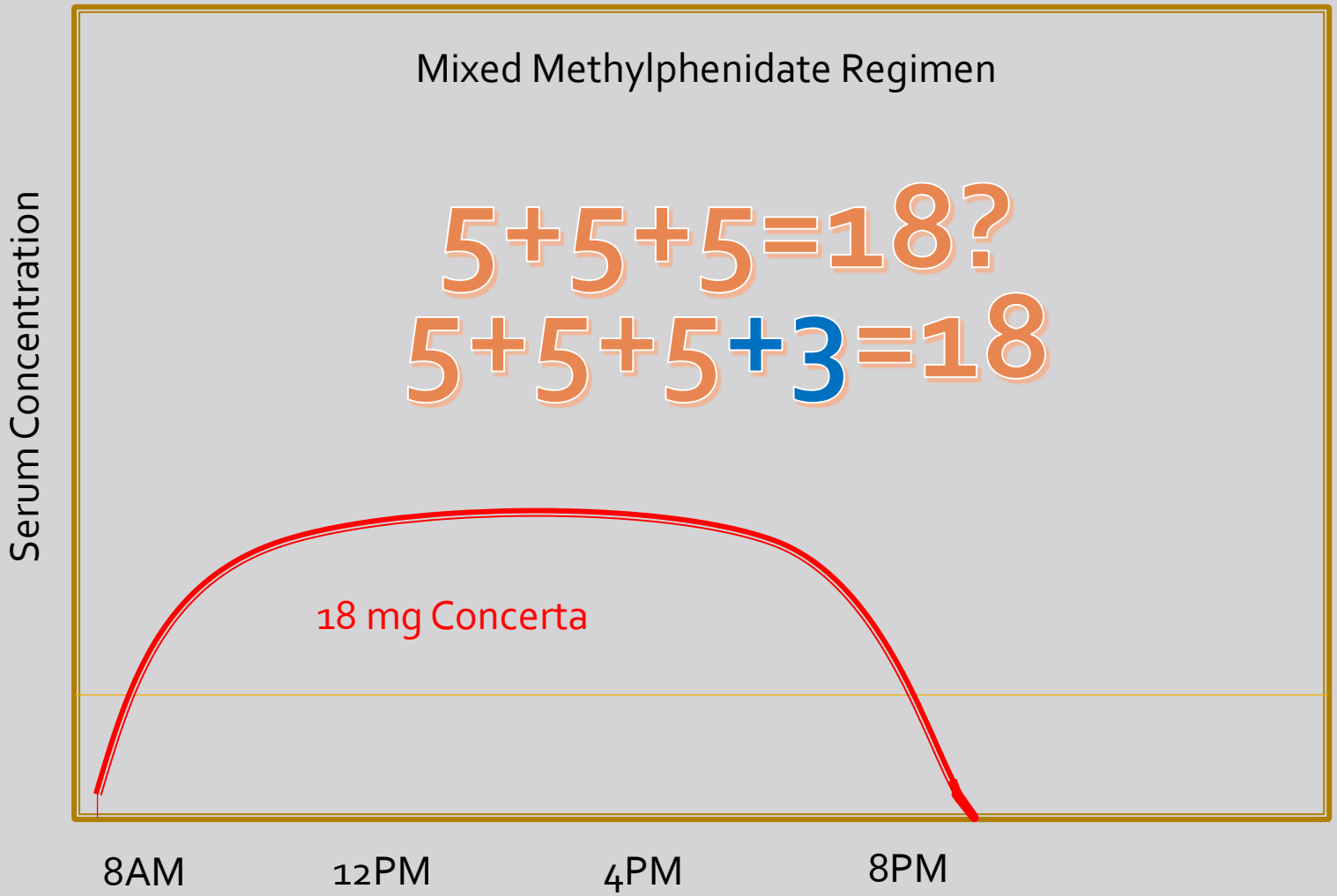
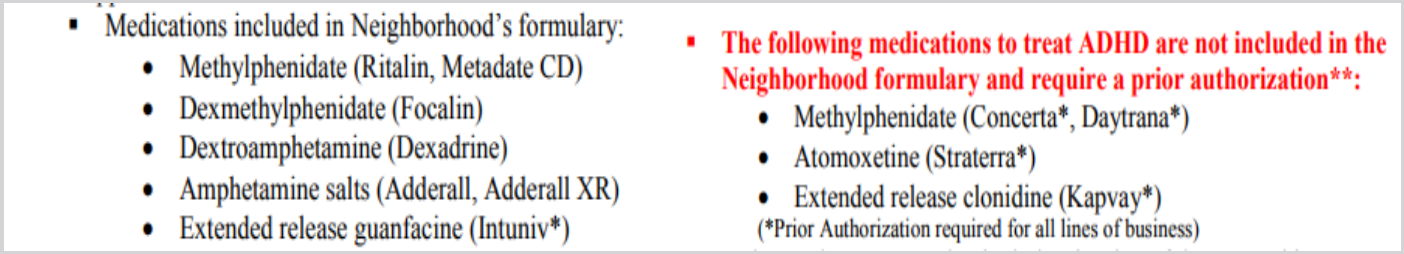


Amphetamine Products

Short Duration(3-5 hrs)	Medium Duration(5-8)	Long Duration(10-12+hrs)
	Adderall IR(4-6hr) Dexedrine IR(4-6hr)	Adderall XR(8-10hr)-dual pulse Dexedrine SR(6-10hr)-dual pulse Lisdexamfetamine "Vyvanse"(12+hr) • Prodrug formulation • D-amphetamine is Inactive when covalently bonded to l-lysine; digestive tract enzymes release the bond Adenzys-XR-ODT • 50:50, IR:XR, dual pulse • Same company that makes Contempla XR-ODT

Note: Adderall is a mixed(d,L enantiomer), DEXtroamphetamine is d enantiomer only

- d enantiomer is more active pharmacologically, so lower dose needed if not a mixed preparation
- i.e. Dexedrine doses will be lower than Adderall doses with same effect



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  - Atomoxetine (Straterra*)
  - Extended release clonidine (Kapvay*)

(*Prior Authorization required for all lines of business)

What does a psychiatrist want us to know about use of mood stabilizers and antipsychotics?

PCP Rules of Antipsychotics and other Mood Stabilizers

- Please don't start (that's our job)
- Refill Mood Stabilizer if Running out
  - If Lithium, check a level and BMP/Ca/TSH +/- UPreg
  - If VPA, check a level and CBC/LFT +/- UPreg
  - If Atypical Antipsychotic, check A1c/Lipids
  - If Lamictal, check for rash and if any pause in adherence more than 5 days must restart at 25mg
- Always assess for Substance Abuse
- Ensure seeing psychiatric providers or insist on return

Pt discharged from inpatient, what's the responsibility for PCP vs. the inpatient psychiatrist?

Inpatient: Ideal vs Actual

- Goals
  - Stabilize and keep safe
  - Start evidence based treatment
  - Connect to community resources for long-term care
- Realities
  - Short duration with insurance pressure limits gains
  - First medicine not always effective
  - Parent/patient follow-up imperfect

So what should we do?

- Review discharge summaries
- Continue started medications for adequate trial
- Ask about follow-up plan…and strongly advocate they use it!
- When in doubt, may call and ask
- If admission #2 comes, advocate for more services WHILE inpatient

How do we most efficiently get kids into psychiatric providers in the community?

1. Encourage therapy EARLY

2. Give OPTIONS

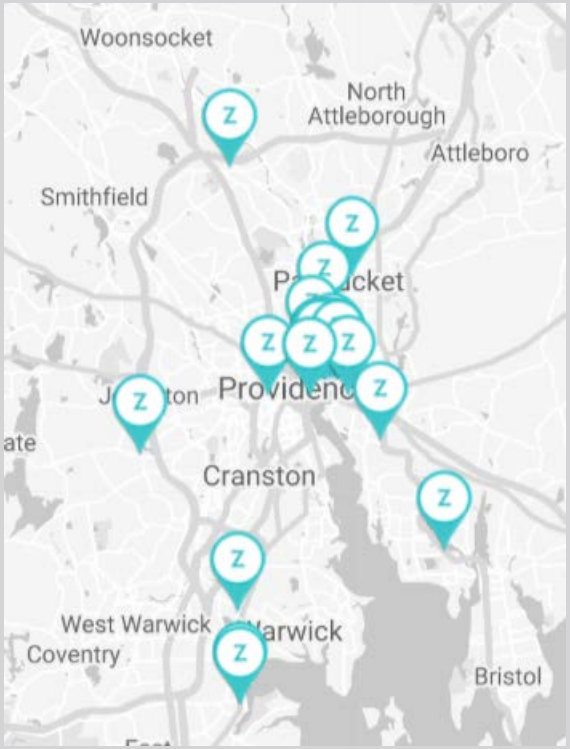
3. Use the Access Services

ZENCARE

Locations ▸ Rhode Island therapists

Find the Best Therapists in Rhode Island

Health Insurances | Therapy Budget | Provider Type (3) | Specialties | Locations | Office Hours



Pediatric Psychiatry Resource Network (PediPRN)

How do I contact PediPRN?

The phone number is 401-432-1543 (1KID), and the fax number is 401-432-1506. General inquiries may be addressed to PediPRN@Lifespan.org

When may I call the PediPRN line?

From 8:30 a.m. to 5 p.m., Monday through Friday, except national holidays.

BH LINK

FOR CONFIDENTIAL SUPPORT AND TO GET CONNECTED TO CARE:

CALL 401-414-LINK (5465)

Crisis but not sure inpatient?

Access Center at Bradley Hospital

The Access Center at Bradley Hospital fields hundreds of calls per week from physicians, parents, schools and community providers.

Our clinicians are specially trained to perform evaluations for children and adolescents in need of inpatient, outpatient or partial hospitalization, and will direct each child to the most appropriate and effective services for his or her needs.

Where to Get Treatment

For access and crisis intervention call:

Bradley Hospital

KIDS' LINK RI

1-855-543-5465

Hasbro Children's Hospital

401-444-4779

Given the short 20-30 minute appointment slots available to PCPs –

How can a pediatric provider maximize his/her limited time with kids when they present with a BH concern? What's the best way to use the few minutes you have?

Teaching Skills to Parents

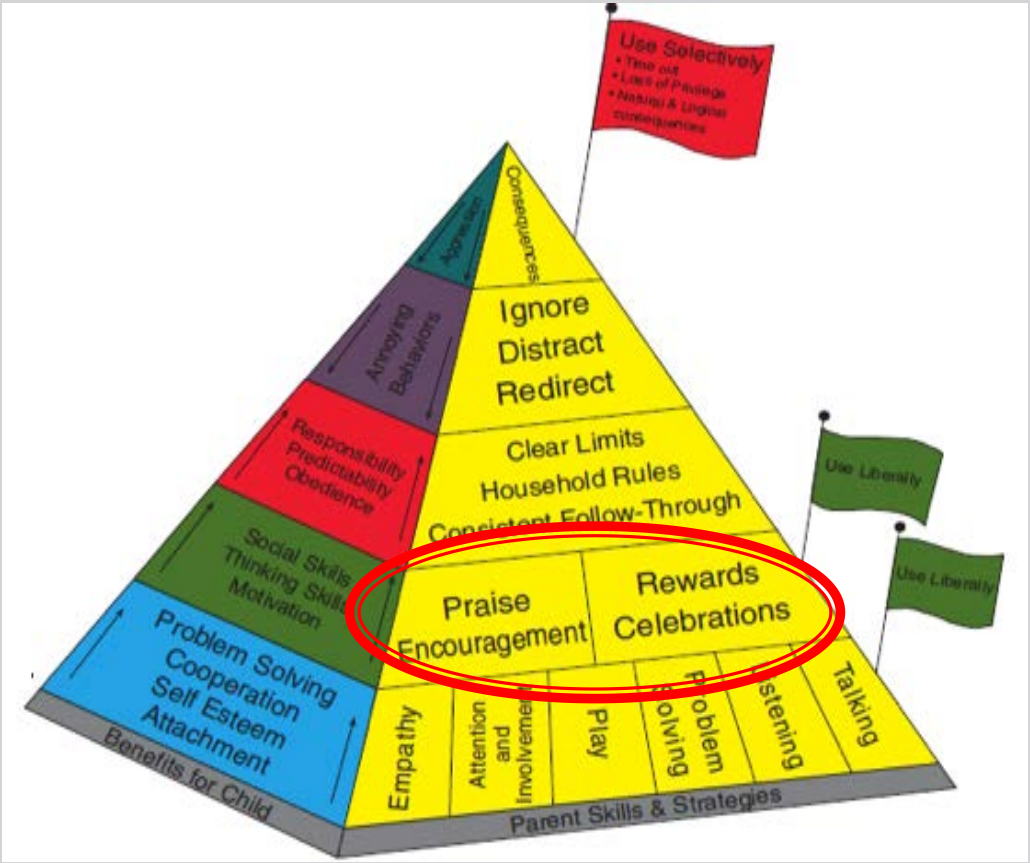
- **Productive Praise**
- Avoiding Avoidance
- Dealing with Distress

Who has the Power?

- To shape a child's behavior through selective attention.
- To teach a child what matters most and is valued.

Your attention = thing they desire MOST

Incredible Years Pyramid



How to Praise?

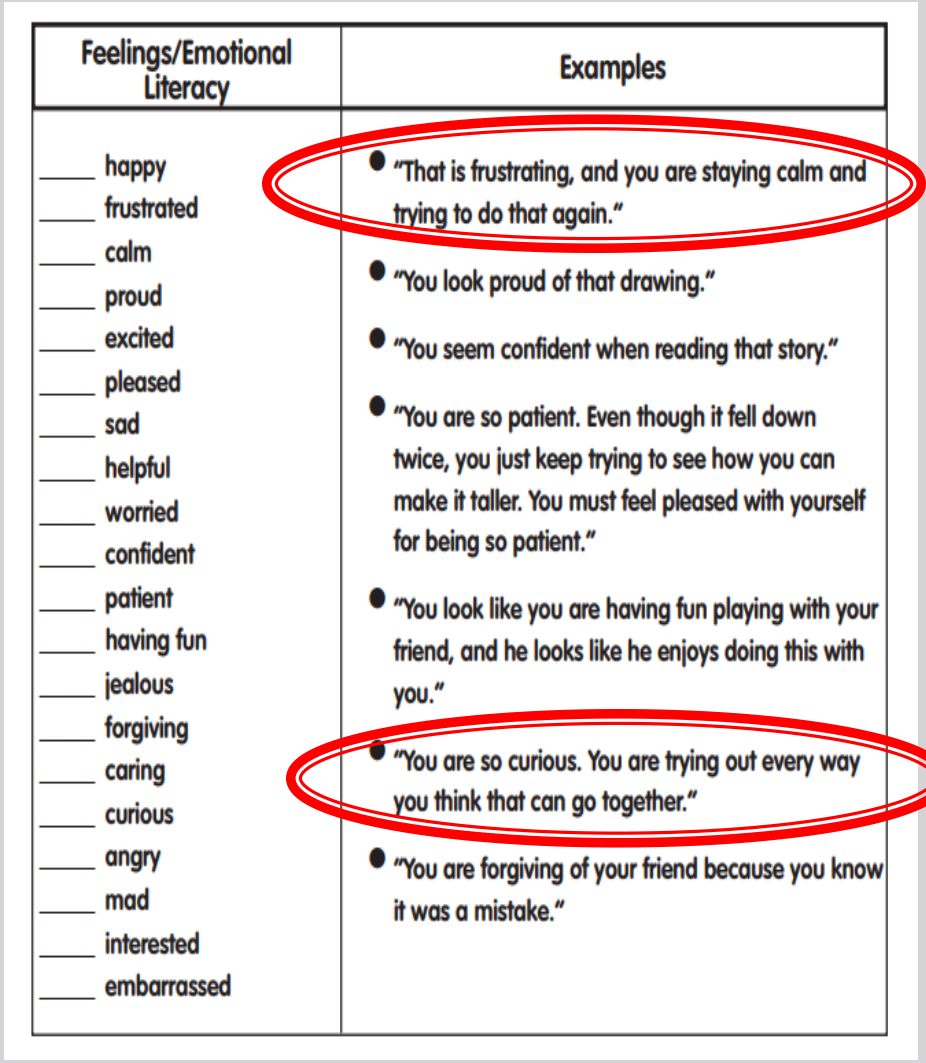
- NOT Empty "Good Job"
- Label **specific desired behaviors with praise** and positive affect
- Ignore undesired but safe behaviors
- Firm limit setting to unsafe behavior, then praise anything positive!
- *"I love how you are playing quietly while I am on the phone"*
- *"Nice work looking both ways to cross the street"*
- *"It is amazing how you shared those blocks with your sister."*
- *"I get really happy when you clear your plate after dinner"*

Skills Coaching

- Praise can just be labeling!
- Positive tone
- Specific and timely
- Develops Social and Emotional Awareness

Social/Friendship Skills	Examples
____ helping ____ sharing ____ teamwork ____ using a friendly voice (quiet, polite)	• "That's so friendly. You are sharing your blocks with your friend and waiting your turn." • "You are both working together and helping each other like a team."
____ listening to what a friend says ____ taking turns ____ asking ____ trading ____ waiting	• "You listened to your friend's request and followed his suggestion. That is very friendly." • "You waited and asked first if you could use that. Your friend listened to you and shared." • "You are taking turns. That's what good friends do for each other."
____ agreeing with a friend's suggestion ____ making a suggestion ____ giving a compliment ____ using soft, gentle touch ____ asking permission to use something a friend has ____ problem solving ____ cooperating ____ being generous ____ including others ____ apologizing	• "You made a friendly suggestion and your friend is doing what you suggested. That is so friendly." • "You are helping your friend build his tower." • "You are being cooperative by sharing." • "You both solved the problem of how to put those blocks together. That was a great solution."

Persistence Coaching



Feelings/Emotional Literacy	Examples
____ happy ____ frustrated ____ calm ____ proud ____ excited ____ pleased ____ sad ____ helpful ____ worried ____ confident ____ patient ____ having fun ____ jealous ____ forgiving ____ caring ____ curious ____ angry ____ mad ____ interested ____ embarrassed	• "That is frustrating, and you are staying calm and trying to do that again." • "You look proud of that drawing." • "You seem confident when reading that story." • "You are so patient. Even though it fell down twice, you just keep trying to see how you can make it taller. You must feel pleased with yourself for being so patient." • "You look like you are having fun playing with your friend, and he looks like he enjoys doing this with you." • "You are so curious. You are trying out every way you think that can go together." • "You are forgiving of your friend because you know it was a mistake."

- Persistence matters…
- "Specifically, children who were rated one standard deviation higher on attention span-persistence at age 4 had 48.7% greater odds of completing college by age 25." ~2014
- You can teach this in what you praise!

You can find something worthy of praise in almost any behavior…

Ok Praise is Good. So now what?

- First, MODEL in the office. Again and again and again
- Second, incorporate assessment of and encouragement for praise in EVERY behavioral question a parent asks
- Third, lay the groundwork early. Infant early. Teach this lesson prior to "Terrible Twos or Threes"

Common Pitfalls

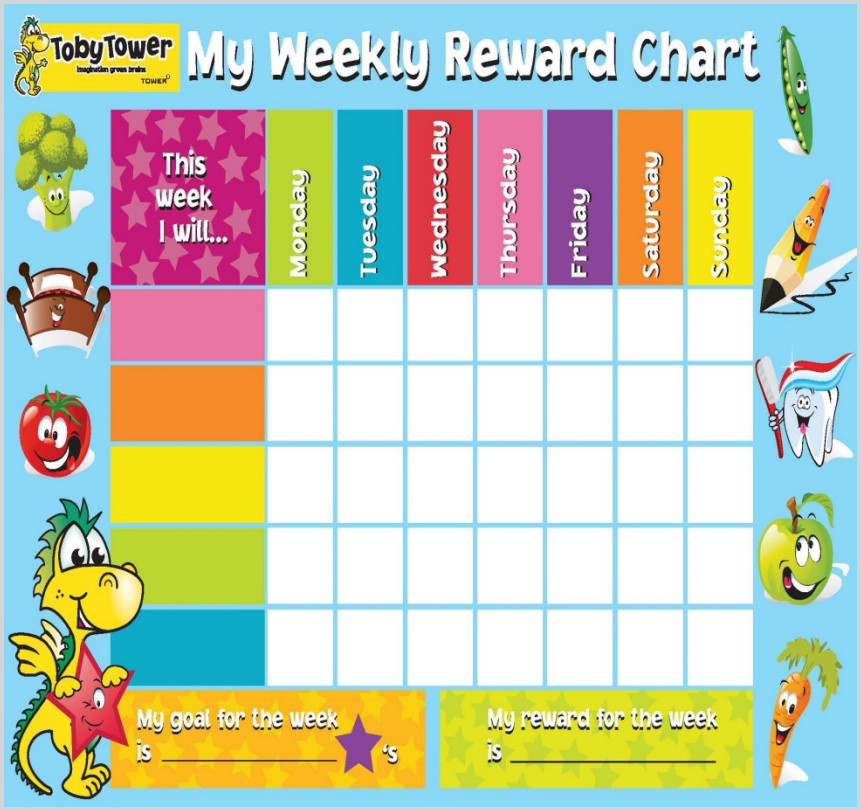
- Divided Attention
- Parent Feeling Powerless
- All or Nothing Fallacy
- Praising Content not Process
- Expectations not Developmentally Appropriate

I am praising and praising but no change? What now?

Up the Ante with…PRAISE

Token Economy is form of Praise

- Should be over 3 years old
- Only 1-2 behaviors at a time!
- Choose a slow-to-change behavior
- Pair it with positive praise
- Parents: Don't break your bank



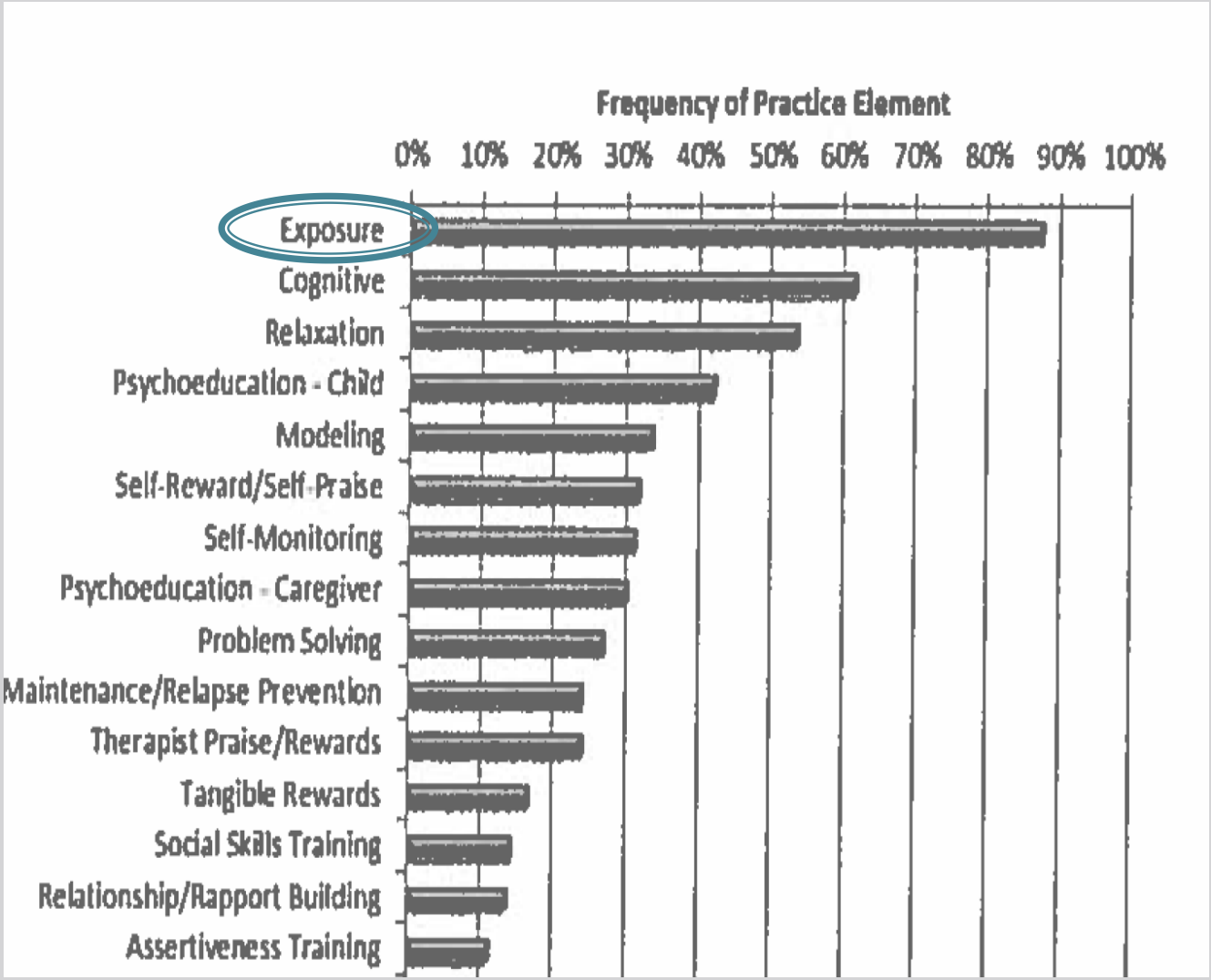
Preferred non-benzo prn for panic/anxiety in kids? Dosing for that? (Gabapentin? Hydroxyzine? Clonidine?). Or do you go straight to low dose benzo?

Largely AVOID PRNS to Kids

- Teach skill not pill based coping
- Connect with therapy!
- Only a few very specific exceptions…
  - Hydroxyzine 25-50mg or Clonidine 0.1-0.2 QHS for sleep short-term for Acute Stress Disorder
  - Single low dose benzo for tolerating procedure (ie intranasal midazolam in ED for suture anxiety)
- PRNs are a form of avoidance, and we want to…

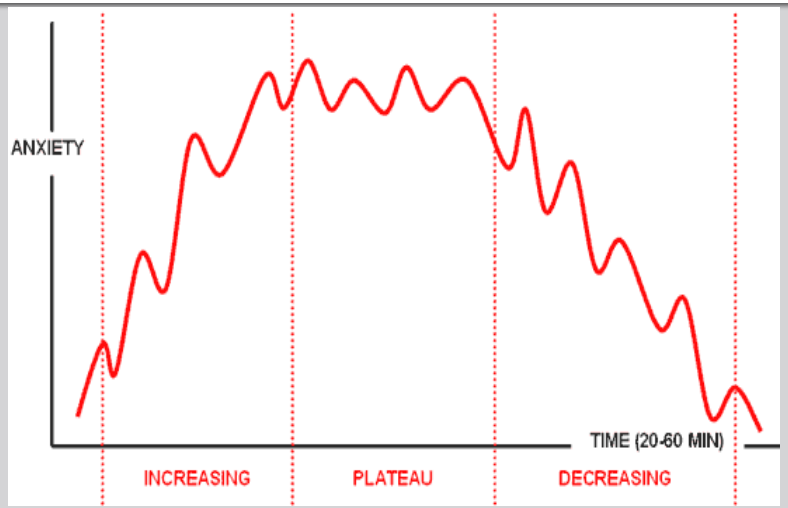
Teaching Skills to Parents

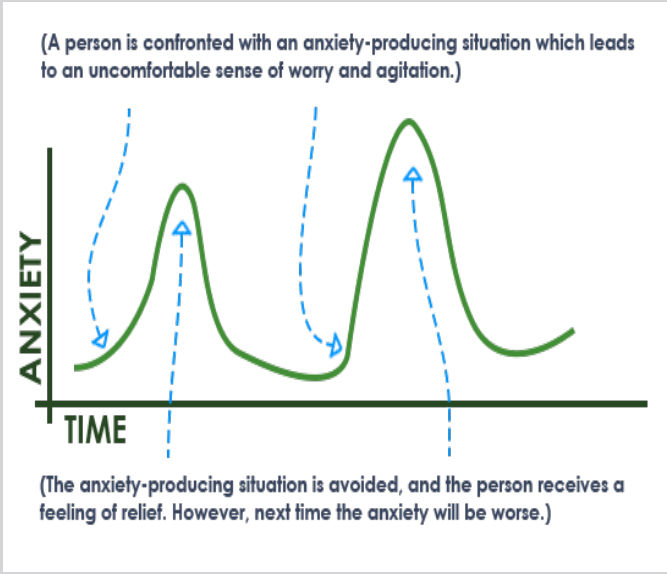
- Productive Praise
- **Avoiding Avoidance**
- Dealing with Distress


Frequency of Practice Element
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Exposure
Cognitive
Relaxation
Psychoeducation - Child
Modeling
Self-Reward/Self-Praise
Self-Monitoring
Psychoeducation - Caregiver
Problem Solving
Maintenance/Relapse Prevention
Therapist Praise/Rewards
Tangible Rewards
Social Skills Training
Relationship/Rapport Building
Assertiveness Training

Parent Anxiety Psychoeducation

- Up and Over the Worry Hill
- Avoidance Rewards Fear, is Reinforcing
- Expect Physical Symptoms
  - Blushing
  - Sweaty
  - "Butterflies" in Chest
- Externalizing Anxiety from Self
  - "Those worries are getting in the way again huh?" or "Mr. Worst Case running the show now?"
  - NOT "She's so shy" or "She can't do it"





It's like learning to bike…

May have Pain to reach Gain

Teaching Skills to Parents

- Productive Praise
- Avoiding Avoidance
- **Dealing with Distress**

Shine a Light on their Feelings

Label

Empathize

Distract

Dressing Disaster

- 3 yo boy yelling, throwing clothes, stomping feet when struggling with getting long sleeve shirt and pants on

- Label: "You look frustrated"
- Empathy: "Wow it can be hard to get dressed"
  - Above "LE" with Eye Contact with Reassuring Look
- Distract: "Pause, Look at Me, Breathe In and Out"
- Praise Effort and Trying (Process not content)

- Who sees the Light (LED)?

Hating Homework

- 10 yo down on self about not able to do a math problem, head in hands, whimpering

- Label: Upset/Unable/Sad…
- Empathy: Simple "I know HW can be tough," maybe Careful use of Own story of failure
- Distract: Positive memory, Joke, Music, Physical Activity, Snack

- Who sees the Light (LED)?

Common Pitfalls…

- Avoid Avoidance
- Be Patient, Don't Invalidate with a "But," Try "And" instead
- Praising Content over Process
- Punishing Turns Off the Light

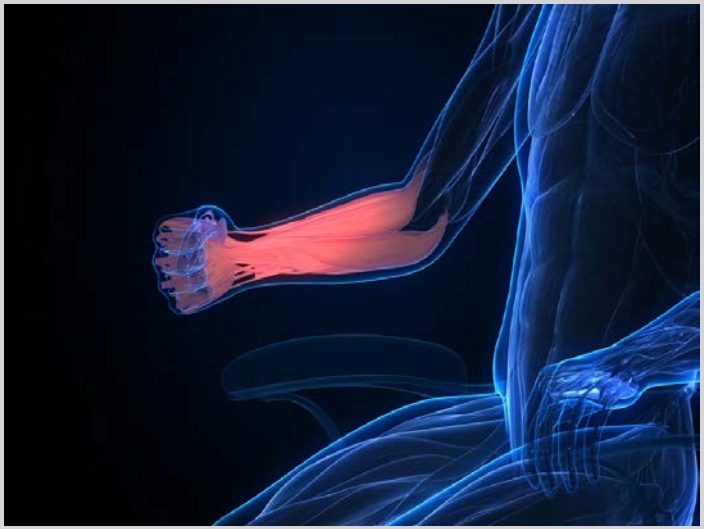
How do I distract?

Look Up

Breathing

Mindfulness Tasks

Progressive Muscle Relaxation



Muscle group	Instructions
Hand	Clench left hand and feel the tension. Relax and let hand hang loosely. Same for right hand
Wrists	Bend hand back, hyper-extending wrists. Relax
Upper arm	Bend elbow toward shoulders and tense biceps muscle. Relax
Shoulders	Bring shoulders up toward ears. Relax; let shoulders drop down
Forehead	Wrinkle forehead, raise eyebrows. Relax
Eyes	Close eyes tightly. Relax
Neck	Turn head so that chin is over right shoulder. Straighten and relax
Neck and jaws	Bend head forward, pressing chin against chest. Straighten and relax
Abdomen, back, thighs	Tighten stomach muscles. Relax Arch back. Relax Stretch legs in front of you. Tighten thigh muscles. Relax
Hamstrings	Push heels down into floor, tighten hamstring muscles. Relax
Calves, feet	Point toes toward head. Relax Curl toes toward the bottom of feet. Relax

Duration of clenching of muscles 7-10 sec and relaxation of muscles 15-20 sec as per protocol

Body Scan Meditation

1. Set aside a time and place in your day where you can sit comfortably and you won't be distracted or disturbed.
2. Find a comfortable but attentive seated position, close your eyes, and bring your attention to your toes.
3. Working up from your toes, bring awareness to each body part in turn: your feet, ankles, calves, knees, etc. up to your head.

Health Benefits:

- Reduced stress
- Decreased muscle tension
- Increased pain tolerance

Why it works to reduce stress:

Body scan meditations encourage self-awareness of sensations we might otherwise be ignoring.

"Begin at the crown of your head. On your exhale, mentally chant "three" as you imagine elevator descending head to chest. Pause for inhale, imagining your breath opening the doors and bringing a fresh breeze into the car. Exhale elevator descends, inhale doors open at abdomen (2) and legs (1).

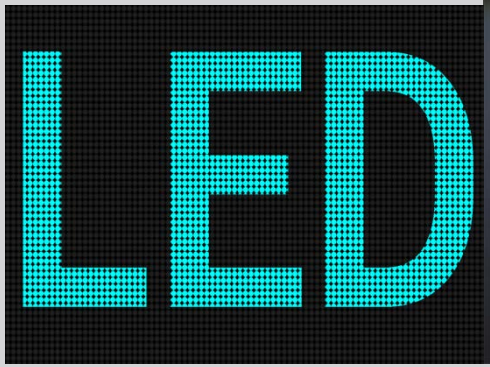
Three Things

Notice what you are experiencing right now through three senses – sound, sight, touch. Take a few slow breaths and ask yourself:

- What are three things I can **HEAR**? (clock on the wall, car going by, music in the next room, my breath)
- What are three things I can **SEE**? (this table, that sign, that person walking by)
- What are three things I can **FEEL**? (the chair under me, the floor under my feet, my phone in my pocket)

Be Creative!

Be You!



You can help Deal with Distress!

What other questions can I answer?

Thanks so much for inviting me!

I have a few more slides about common SSRI side effects, initiation talk if desired…

SSRI Side Effects and SSRI Practice

Initiating/Titrating SSRI

- All SSRIs can cause some "revving" up when first starting…so start lower for anxious/somatic kids
- Start by **dosing in morning** because will impair sleep more often than help it; if getting tired, move to bedtime
- Can increase every 1-2 weeks depending on severity/acuity if indicated and tolerated
- Can take 4-8 weeks to see full benefit of dose, but often see some signal within 2 weeks
- Mood symptoms often improve before anxiety symptoms
- Anxiety disorders and OCD typically require and respond to higher end dosing of SSRIs, including "supratherapeutic" dosing

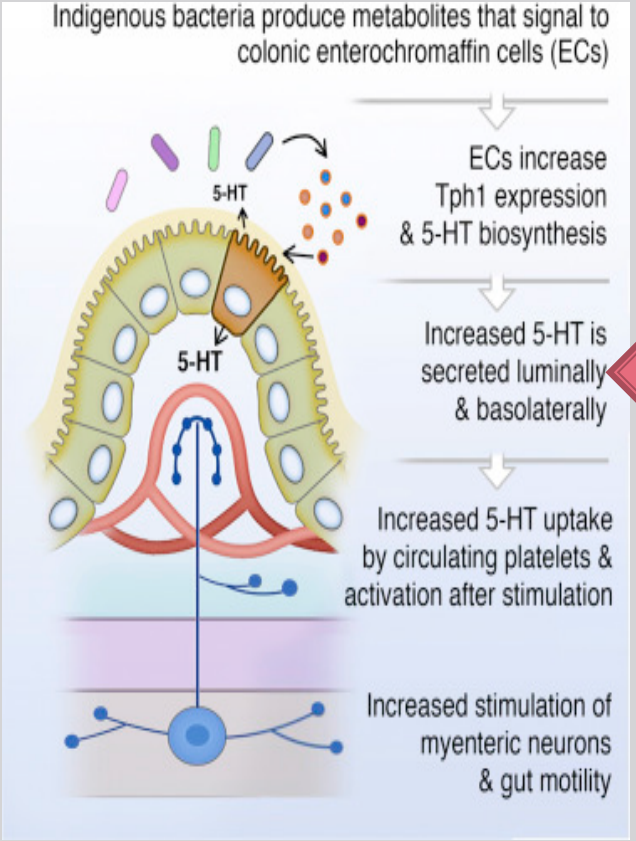
SSRI Side Effects

- For all SSRIs, you usually see side effects BEFORE you see benefits, so requires anticipatory guidance and patience
- Usual side effects:
  - Nausea, loose stools, increased energy/agitation, sedation, sleep disturbance, headache, tremor
- **NNH with any SE: 4-10**
- This can be particularly frustrating when treating anxiety disorders because they're already anxious and the two main SSRIs used in pediatrics (fluoxetine and sertraline) can both cause increased energy/agitation upon initiation and dose increases, so talk about this, start low and go slow (but don't stop too soon)

SSRI on the GI Tract

- Although serotonin is well known as a brain neurotransmitter, it is estimated that **<u>90 percent of the body's serotonin is made in the digestive tract</u>**

- GI side effects are most common
  - Typically diarrhea, flatulence, and/or nausea or GERD type symptoms
  - Sertraline and fluoxetine seem more likely to cause them than escitalopram
  - **<u>Usually will resolve within 7-10 days</u>**; onset of symptoms with fluoxetine is delayed and lasts a little longer due to long half-life



Other Common SSRI Adverse Effects

Disinhibition

- Reducing anxiety can reduce anxious inhibition, and you can get too much of a good thing
- Especially true for kids with underlying ADHD or other externalizing behaviors that were being clamped down by anxiety

Activation

- Insomnia, restless, distractible, silly, irritable, agitated
- Can be transient so worth waiting for a few days if not too impairing; can recur with subsequent dose increases, so often end up needing to go slower or switch SSRIs
- Escitalopram has lower risk of activation but can occur
- This is not the same as "switching" to hypomania or mania, but watch for that, too

SSRI Visit Planning

- Follow up frequency:
  - After initiation & dose changes, check in at least by phone at week 1 AND see in the office at week 2, then see every 2-4 weeks until on stable dose
  - When on stable dose: Every 1-3 months thereafter depending on patient.
- Evaluate:
  - Response and tolerability
    - Reported from child and parent
    - May use scales
  - Any signs/symptoms of serotonin excess
    - Serotonin syndrome: tremor, hyperreflexia, clonus (LE>UE, eyes), diaphoresis, fever, tachycardia, agitation/restlessness, insomnia, nausea/vomiting, diarrhea

Other Things to Consider

- Family History of Bipolar or Mania
- Family History of SSRI Response
- Adherence Issues…If likely, think Fluoxetine

- Meds you can consider but we didn't discuss:
  - SNRIs like venlafaxine or duloxetine
- Meds you'll see but shouldn't start
  - Paroxetine: Increased SI and SE in kids, don't do it
  - Fluovoxamine: Very short half life, needs BID dosing at times, why bother

Let's Try it!

- Partner up with person next to you!
- Person A: You are 16 yo with moderate to severe MDD
- Person B: You are provider. Please discuss and consent them for SSRI (agent, dose).
- GO!

4 Days Later…

- Person A: Please call the office reporting diarrhea
- Person B: Provide guidance that you belief to be appropriate
- GO!

2 Weeks after Starting SSRI

- Person A: Report moderate but incomplete response to treatment.
- Person B: Whatcha gunna do?
- Person B: What might you assess or screen for here?
- GO!

SWITCH ROLES

- Person B: You are mother of a 12 yo with anxiety disorder (of your choice), moderate to severe. You personally are on sertraline with good effect.
- Person A: You are the provider. Please discuss and consent them for SSRI (agent, dose).
- GO!

2 Weeks after Starting SSRI

- Person B: Report child's partial but incomplete response to current dose.
- Person A: Please complete SSRI follow up visit.
- GO!

9 months later…

- Person B: You are happy with child's response, but read an article about how good Lexapro is for kids. You ask if you can switch your child to it.
- Person A: Whatcha gunna do? (Regardless of what you choose to do, outline with doses how you might cross-taper her child)
- GO!

When and How to STOP SSRI?

- Discuss with families that treatment duration for first depressive episode is at **least 6-9 months** (many recommend 12 months) after remission of symptoms; can follow this as general rule for anxiety, too.
- After symptom remission as above, **trial off during a low-stress time**.
- General Taper Off Rule…Reduce by 50% every week.