


A Critical Curriculum on Psychotropic Medications



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CriticalThinkRx was made possible by a grant from the Attorneys General Consumer and Prescriber Grant Program, funded by the multi-state settlement of consumer fraud claims regarding the marketing of the prescription drug Neurontin®


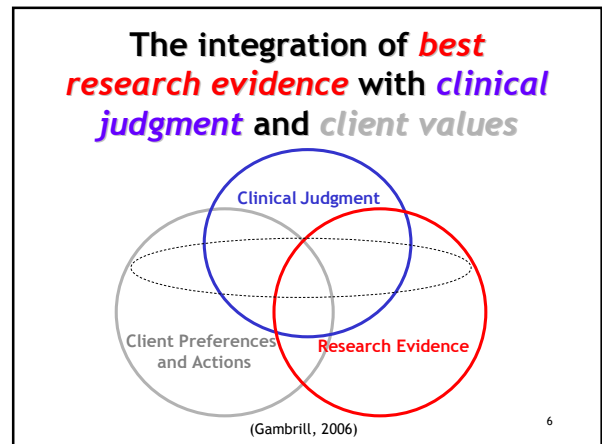
Module 8

Alternatives to Medication: Evidence-Based Psychosocial Interventions




Part A

What is Evidence-Based Practice?

A philosophy *and* a process designed to unite research and practice in order to

maximize chances to help clients
minimize harm to clients (in the name of helping)



(Gambrill, 2006)

Deeply participatory

EBP is “anti-authoritarian”—it urges all involved to question claims about what is known *and unknown* about treatments

(Gambrill, 2006) 8

EBP difficulties

- ☑ Threats to business-as-usual
- ☑ Limited training and supervision
- ☑ Concerns about cultural sensitivity
- ☑ Worries that “cook book” methods mask real-world complexity

(Barratt, 2003; Chorpita et al. 2007; Duncan & Miller, 2006) 9

An intervention should have at least some unbiased observations or tests supporting its usefulness with particular problems and clients

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Some criteria for judging an intervention

- ☑ Sound theoretical basis
- ☑ Low risk for harm
- ☑ *Unbiased* research exists
- ☑ Therapist and client concur

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Available “evidence” no guarantee of usefulness

Published evidence is influenced by funding sources, researcher biases, and conventional wisdom

Statistically significant differences between treatment groups means simply that more clients in one group had some type of response (partial to complete)

(Hoagwood et al. 2001; Ingersoll & Rak, 2006) 12

However, on average, *all major therapies produce equivalent results.*

Clients' improvement may result from *factors common to every therapy*

(Elkins, 2007; Hubble, Duncan, & Miller, 1999) 13

Most improvement has little to do with therapy or technique

Factor	% improvement explained
Client + outside therapy factors	87
Client-therapist alliance	8
Therapist allegiance to model	4
Therapist technique	1

(Hubble, Duncan, & Miller, 1999; Wampold, 2001) 14

Healthy skepticism

“We would do well ... to remain optimistically humble on the matter of evidence-based practices in mental health” by accepting that all assumptions are “provisional and reversible”

(Norcross, Beutler & Levant, 2006, p. 11) 15


A clinician's “rubric” for EBP

“Adhere when possible, adapt when necessary, assess along the way”

(Amaya-Jackson & DeRosa, 2007, p. 388) 16


Choosing proper interventions rests on

- ☑ a clear understanding of the problem from a person-in-situation perspective
- ☑ addressing the complexity of the problem
- ☑ a policy of “First, do no harm”



Part B

Deconstructing the Diagnosis:



What is this child's problem in behavioral terms?

Bio-psycho-social or bio-bio-bio?

- ✓ Complex problems in living reduced to “brain disorders”
- ✓ Complex life events reduced to “triggers”
- ✓ Medicalization of distress and disability leading to false hopes of “quick fix” via pills

(Read, 2005)

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We often ignore environmental influences on behavior

- ☑ Poor parenting, neglect, abuse
- ☑ Schools’ failure to motivate children
- ☑ Poverty, lack of access to resources
- ☑ Violence in media, society, neighborhood
- ☑ Culture’s emphasis on instant gratification
- ☑ Drug culture (“take,” not “talk”)
- ☑ Lack of tolerance for differences

(Bentley & Collins, 2006)

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Children’s distress: “Disorders” or complex adaptations to distressing life experiences?



By seeing children as real persons with their own view of their situation, one ascribes a different meaning to their behavior

(Donovan & McIntyre, 1990)

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“Understanding” rather than “diagnosing”

A developmental-contextual approach views actions as “communicative”: attempts by individuals to cope, adapt, struggle with their life experiences



(Donovan & McIntyre, 1990)

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Here’s a list of feelings and behaviors from DSM-IV-TR criteria of “disorders” commonly diagnosed in children

Note the similarities...

“Attention-Deficit/Hyperactivity Disorder (ADHD)”

Feels:

- Angry, irritable, frustrated



Acts:

- Fidgets, squirms
- Easily distracted, forgetful (difficulty thinking, concentrating)
- Interrupts others (acts impulsively)
- Acts aggressively

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“Major Depressive Disorder”

Feels:

- Sad, empty
- Afraid, anxious
- Angry, irritable, frustrated



Acts:

- Eats, sleeps too little (or too much)
- Moves, speaks slowly
- Acts impulsively
- Acts aggressively
- Easily distracted (difficulty thinking, concentrating)

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“Anxiety Disorder”

Feels:

- Afraid, anxious
- Angry, irritable, frustrated



Acts:

- Cries, throws tantrums
- Freezes, clings
- Fidgets (psychomotor agitation)

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“Conduct Disorder”

Feels:

- Angry, irritable, frustrated, hostile



Acts:

- Bullies and threatens
- Fights
- Steals, lies
- Runs away
- Destroys property

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“Oppositional Defiant Disorder”

Feels:

- Angry, irritable, frustrated, hostile



Acts:

- Disobedient
- Loses temper
- Argues with adults
- Annoys people
- Refuses to follow rules

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“Bipolar Disorder”

Feels:

- Alternating sad and euphoric
- Alternating fearful and reckless
- Angry, irritable, frustrated

Acts:

- Easily distracted (difficulty thinking, concentrating)
- Moves, speaks fast (agitation)
- Acts impulsively
- Acts aggressively
- Does not sleep well

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“Psychotic Disorder”

Feels:

- Sad, empty
- Blunted feelings, expressionless
- Angry, irritable, frustrated
- Afraid, anxious

Acts:

- Apathetic
- Refuses to speak
- Dresses inappropriately
- Cries frequently
- Sees or hears things

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“Post-Traumatic Stress Disorder”

Feels:

- Sad
- Afraid, anxious
- Angry, irritable, frustrated
- Helpless, guilty, shameful

Acts:

- Agitated, impulsive, re-enacts trauma
- Hypervigilant: distrustful, withdraws
- Dissociated: forgets and can't focus



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“Reactive Attachment Disorder”

Feels:

- Afraid, anxious
- Angry, irritable, frustrated

Acts:

- Watchful, frozen
- Avoids attachments
- Seeks approval or can't be comforted
- Disregards danger cues



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The common elements

Experiencing negative emotions
(sadness, fear, anger, irritability)

Difficulty controlling oneself
(impulsivity, aggression, inattention)

Seeing self and world negatively
(hopelessness, helplessness, shame, withdrawal)

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What are we medicating?

Negative emotions leading to disruptive actions—especially under stressful conditions that tax the child's adaptive capacities

(Schorer, 1994, 2003)

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Most commonly medicated

Impulsive aggression
“a key therapeutic target across multiple disorders”



(Jensen et al. 2007, p. 309)

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DSM's scientific value seriously challenged in all disciplines

- ✓ internal inconsistency in the manual (rejects categorical approach in intro but then lists 300+ categories)
- ✓ overlap between categories leads to “comorbidity”—with no increase in understanding
- ✓ persistent problems of unreliability, especially with children's diagnoses
- ✓ lack of fit between categories and empirically observed symptom clusters

(Caplan, 1995; Duncan et al. 2007; Maj, 2005; Kirk & Kutchins, 1992, 1994; Jacobs & Cohen, 2004; Mirowsky & Ross, 1990)

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More recent DSM critiques...

- ✓ more behaviors now seen as “mental disorders” (from 106 in 1952 to 365 in 1994)
- ✓ political lobbying determines inclusion or exclusion of diagnoses
- ✓ all DSM task force members on mood and psychotic disorders tied to drug industry
- ✓ practitioners focus on diagnosis rather than client, losing client’s actual story
- ✓ still no “gold standard” validity—no specific bio-marker linked to *any* disorder

(Andreasen, 2006; Tucker 1998; Charney et al. 2005; Kutchins & Kirk, 1998)

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Critical list of DSM “accomplishments”

- ☑ increases people’s interest to classify psychosocial problems as medical disorders
- ☑ Helps justify more studies to see how many people can fit how many DSM categories (which often change)
- ☑ led to modest increase in diagnostic reliability since 1980
- ☑ now used by most practitioners in main schools of thought—mostly to obtain third-party reimbursement?
- ☑ brings financial revenues to the American Psychiatric Association from sales of DSMs and training materials
- ☑ strengthened psychiatry’s leadership in mental health system (as official definer of mental distress)

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Part C

Empirically-supported psychosocial interventions for children and adolescents



**Focus:
Trauma, Resilience and Child Welfare**



Trauma and early loss

For thousands of children every year, loss and trauma due to disrupted attachments to biological parents result in foster care placements

(Jones Harden, 2004; Racussin et al. 2005)

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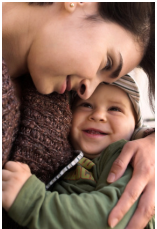
Additional, placement-related traumas

- ✓ Emotional disruption of out-of-home placement
- ✓ Adjusting to a foster care setting
- ✓ Relative instability of foster care
- ✓ High turnover of workers

(Jones Harden, 2004; Racussin et al. 2005)

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Neurobiology of attachment



Brains develop in a *socially dependent manner*, through secure attachments and *consistent, competent* adults attuned to the needs of the child

(Schore, 1994, 2001, 2003; van der Kolk, 2003)

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Child's "job": to form close, trusting attachments with caregivers



Adolescent's "job": to expand attachments using secure base with caregivers

(Gunnar et al. 2006; Mash & Barkeley, 2006; Moran, 2007; Wolfe & Mash, 2006)

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Trauma, abuse, and neglect

- ☑ disrupt a child's ability to form secure attachments
- ☑ impair brain development and regulation
- ☑ make self-control difficult
- ☑ alter identity and sense of self

(Bowlby, 1988; Cook et al. 2005; Courtois, 2004; Creeden, 2004; Jones Harden, 2004; van der Kolk, 1994)

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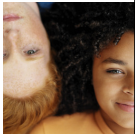

Resilience

The ability to function well despite living or having lived in adversity rests mainly on normal cognitive development and involvement from a caring, competent adult

(Agaibi & Wilson, 2005; Masten et al. 1990; Schofield & Beek, 2005)

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- ✓ Risk and protective factors in the foster child, foster-families, agencies, and birth family interact to produce upward or downward spirals
- ✓ Understanding resilience helps create interventions that produce positive turning points in children's lives

(Schofield & Beek, 2005)

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Three key elements

1. Secure base: is child strengthening sense of security and able to use foster-parents as a secure base?
2. Sense of permanence: is placement stable and foster-parents offering family membership?
3. Social functioning: is child functioning well in school, with peers?

(Schofield & Beek, 2005)

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Treatment goals

- ✓ Enhance sense of personal control and self-efficacy
- ✓ Maintain adequate level of functioning
- ✓ Increase ability to master, rather than avoid, experiences that trigger intrusive re-experiencing, numbing, and hyper-arousal

(Ford et al. 2005; Kinniburgh et al. 2005)

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What could help?

Activating child's internal reparative mechanisms through *dyadic interventions* and creating secure attachments

- dyadic therapy mobilizes the completion of interrupted biological and emotional developmental processes



(Amaya-Jackson & DeRosa, 2007; Courtois, 2004; Ford et al. 2005; Pearlman & Courtois, 2005)

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A sensorimotor approach

Children's internal stimuli, can trigger dysregulated arousal, causing emotions to escalate

- Integration of cognitive, emotional and sensorimotor levels is crucial for recovery

(Ogden, 2006)

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Why would this help?

Child develops the ability to take in, sort out, process, and interrelate information from the environment – leading to self-organization of internal states and self-control of behavior

(DeGangi, 2000; Kinniburgh et al. 2005; Schore, 2003; van der Kolk, 2006)

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How would this help?

By enhancing children's:



- ✓ social skills
- ✓ ability to understand and express feelings
- ✓ ability to cope with anger and distress
- ✓ ability to problem-solve and think helpful thoughts
- ✓ skills to self-direct and create goals

(Bloomquist, 1996; Kinniburgh et al. 2005)

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Alternatives to medication

- ☑ Consistent, structured, supportive adult supervision
- ☑ Opportunities for self-expression and physical activity, to give children a sense of mastery over their minds and bodies




(DeGangi, 200; Faust & Katchen, 2004)

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Helpful activities


- ☑ Teaching problem-solving and pro-social skills
- ☑ Modeling appropriate behaviors
- ☑ Teaching self-management
- ☑ Helping children learn to comply and follow rules



(DeGangi, 2000; Faust & Katchen, 2004) 55

Helpful interactions


- ☑ Desensitizing hyper-reactivity
- ☑ Promoting self-calming and modulation of arousal states
- ☑ Organizing sustained attention
- ☑ Facilitating organized, purposeful activity



(DeGangi, 2000)

Expected outcomes

Children learn to develop appropriate responses, self-organization and control, which in turns leads to




MASTERY AND SELF-ESTEEM

(Kinniburgh et al. 2005) 57

Many treatment alternatives


Symptom-focused: Behavioral, cognitive-behavioral, and interpersonal therapies, attachment-based therapies, trauma-focused therapies

System-focused: Treatment foster care (TFC), Multi-dimensional treatment foster care (MTFC)



(Farmer et al. 2004; Racussin et al. 2005)

Focus: Dysregulated “moods”




“Depression” and “Anxiety”



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The New York Times
Talk Therapy Pivotal for Depressed Youth



February 6, 2007
In Rigorous Test, Talk Therapy Works for Panic Disorder
By [BENEDICT CAREY](#)

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Link to child maltreatment

Abuse leads to “hypervigilance” to threat, resulting in anxiety and hopelessness

Neglect results in dysregulated “moods”

(Greenwald, 2000; Lee & Hoaken, 2007)

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“Traumatized children tend to communicate what has happened to them ... by responding to the world as a dangerous place by activating neurobiologic systems geared for survival, even when objectively they are safe”

(van der Kolk, 2003, p. 309)

Therapy or no therapy?

Some 30-40% recover without intervention

Approximately 50% of treated patients improve within 8 weeks

A friendly sympathetic attitude and encouragement are key

(Roth & Fonagy, 1996)

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Consensus strongly favors cognitive-behavioral therapy (CBT) as first-line treatment above medications

(APA Working Group, 2006; March, 1995; Roth & Fonagy, 1996; Velting et al. 2004)

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Other effective interventions

1. Interpersonal psychotherapy
2. Psychodynamic psychotherapy
3. Exposure-based contingency management
4. Problem-solving and coping-skills training

(APA Working Group, 2006; Roth & Fonagy, 1996)

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Patient preference

When given a choice, patients express a preference for psychosocial interventions over medications



(APA Working Group, 2006)

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“Bipolar Disorder” and “Schizophrenia”

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Very rare in children (~1%)

Diagnosis controversial:

- no laboratory “test”
- “symptoms” may be manifestations of ordinary developmental differences

(Birmaher, 2003; Birmaher & Axelson, 2006; Cepeda, 2007; Correll et al. 2005; Danielson et al. 2004; Irwin, 2004; Findling, Boorady & Sporn, 2007; Roth & Fonagy, 1996)

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High risk of over-diagnosis

NIMH Review: 95% of 1500 children referred for high clinical suspicion of childhood-onset schizophrenia did not meet DSM criteria after careful inpatient observation off all medications

No evidence that they would have developed psychosis if left untreated

(Shaw & Rapoport, 2006)

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Link to child maltreatment

Child abuse and neglect considered a causal factor for psychosis and “schizophrenia”

- Content and severity of psychotic symptoms related to severity of past abuse

(Cepeda, 2007; Morrison et al. 2005; Read & Ross, 2003; Read et al. 2004, 2005)

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Many children improve when treated with family-based psychosocial interventions, even without medications

- High rates of “relapse” observed on medication

(Birmaher, 2003; Birmaher & Axelson, 2006; Cepeda, 2007; Correll et al. 2005; Danielson et al. 2004; Findling et al. 2007; Irwin, 2004; Roth & Fonagy, 1996)

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Effective psychosocial treatments

Child- and Family-Focused CBT combined with interpersonal and “social rhythm” therapy to stabilize mood, activities and sleep

Community support and social acceptance through day programs and sports/cultural activities

(Findling et al. 2007) 73

Who recovers and why?

Psychiatric literature is mostly silent about the characteristics of people who fully recover from psychosis and how and why they do so

(Siebert, 2000) 74

Focus:

Disruptive behaviors



Disruptive behaviors: the most frequent reason for referral of children to mental health services

(Brestan & Eyberg, 1998; Butler & Eyberg, 2006) 76

For disruptive behaviors and conduct “disorders”

Family-based behavioral interventions



(APA Working Group, 2006; Brestan & Eyberg, 1998; Diamond & Josephson, 2005; Kazdin, 2005, 2000, 2000b; Kazdin & Weisz, 2003; Thomas, 2006)

The New York Times (2006, December 22)

TROUBLED CHILDREN
Parenting as Therapy for Child's Mental Disorders



TJ Van de Walle's attention deficit problems have improved in response to parenting techniques, his mother DeWain, right, said.

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Effective parenting: the most powerful way to reduce child and adolescent problem behaviors



(Caspe & Lopez, 2006; Johnson et al. 2005; Kumpfer et al. 2003) 79

Strongest evidence base

1. Parent management training (PMT)
2. Problem-solving skills training (PSST)
3. Brief strategic family therapy (BSFT)
4. Functional family therapy (FFT)

(Brestan & Eyberg, 1998; Butler & Eyberg, 2006; Farley et al. 2005; Kazdin, 2003; Kazdin & Whitley, 2003; Springer 2006; Thomas, 2006)

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Goals of parent training

- ☑ Promote parent competencies & strengthen parent-child bonds
- ☑ Increase consistency, predictability & fairness of parents
- ☑ Produce behavior change in children



(Kazdin, 2003; McCart et al. 2006; Webster-Stratton & Reid, 2003) 81

“Problem” children or “problem” adults?

Coercive parenting was the only factor linked to children’s failure to improve their conduct after family treatment

(Webster-Stratton, Reid & Hammond, 2001)

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Maltreatment consistently linked to aggressive behaviors

- ☑ History of trauma virtually *universal* in youth with conduct “disorders”

(Greenwald, 2000; Lee & Hoaken, 2007)

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Children in foster care

- ✓ have socio-emotional problems **3 to 10 times more often** than other kids
- ✓ Coercive interactions only result in escalation of aggressive behaviors



(Nilsen, 2007)

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Parent-training in child welfare

Promising programs exist to train biological and foster parents

Goal is to break the cycle of coercive parenting and child oppositional behavior

(Barth et al. 2005; Nilsen, 2007)

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“ADHD”

Large evidence base exists for behavioral interventions, incl. parent training, social skills training, and school-based services

- Results equivalent to stimulant medications without the health risks



(APA Working Group; Chronis et al. 2004, 2006)

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Focus: Mentoring



Children’s development depends upon reciprocal activity with others with whom they have a strong and lasting bond



(Jones Harden, 2004; Rhodes et al. 2006)

Mentorship

A relatively long-term, non-expert relationship between a child and non-parental adult, based on acceptance and support, aiming to foster the child’s potential, where change is a desired but not predetermined goal

(Dallos & Comley-Ross, 2005; Rhodes et al. 2006)

Significant effects

Meta-analysis of 55 studies found significant effects of mentoring programs

- Community-based programs more effective than school-based programs

(DuBois & Silverthorn, 2005)

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Mentoring in foster care

Survey of 29 programs found mentoring provides a bridge to employment and higher education, helps with transitional problem-solving

(Mech, Pryde & Rycraft, 1995)

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Common factors for success

- ☑ Frequent contacts
- ☑ Emotional closeness (attunement)
- ☑ Longer duration
- ☑ Structured activities
- ☑ Ongoing training for mentors

(DuBois & Silverthorn, 2005; Gilligan, 1999; Rhodes et al. 2006)

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Mentors enhance resilience

Sensitive mentoring increased self-esteem and well-being, reduced aggression and opened new relationships beyond care system

- *prevents negative outcomes as youth leave foster care*

(DuBois & Silverthorn, 2005; Gilligan, 1999; Lemon et al. 2006; Legault et al. 2005; Rhodes et al. 1999, 2006; Schofield & Beek, 2005)

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Reduces violence

“Having someone to count on when needed” softened the impact of trauma and reduced likelihood of youth engaging in violent offenses

(Maschi, 2006)

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Part D

Conclusions and Recommendations



Medicalized approach to distress and disability pathologizes children's behaviors and ignores the context of their experiences

- “Understanding” rather than “diagnosing” changes the meaning of those behaviors and can lead to more helpful interventions

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Abuse, neglect and trauma disrupt secure attachment and impair the child's ability to self-regulate

- "Repair" occurs through the formation of secure attachments, rather than by medication



Irritability, impulsivity and aggression appear in criteria for most DSM diagnostic labels used on children

- We are medicating children's negative emotions and immature self-control

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Growing consensus

Just Say 'No' to Drugs as a First Treatment for Child Problems

(Duncan, Sparks, Murphy, & Miller, 2007)

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Attempt psychosocial interventions *before* initiating medication

Ample evidence supports their use as effective first-line options for children's behavioral problems, *with no apparent risk of medical harm*

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Fundamental issues of efficacy and safety of psychotropic medications in children remain unresolved

Therefore, medicating children should be avoided



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Module 8

The End



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