Medication as Part of an SM Treatment Plan: Who? What? When? Why? How? How long?

- Presenter: Steven Kurtz, PhD, ABPP
- Moderator: Rachel Merson, PsyD

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Financial Conflict of Interest Disclosures

None

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Other "Conflict of Interest" Disclosures

1. *Invested in developing robust behavioral treatments*
2. *Invested in kids getting better*
   Not just a little better…
   But really better
   To the point they are like they are in your home

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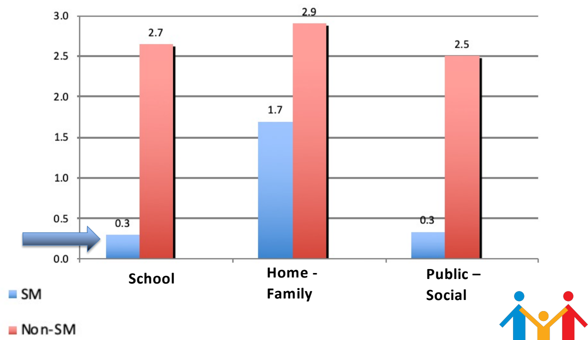
Typical child with SM really is impaired…



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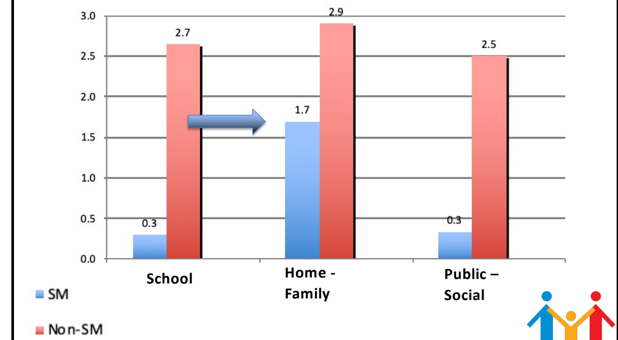
Typical child with SM really is impaired…



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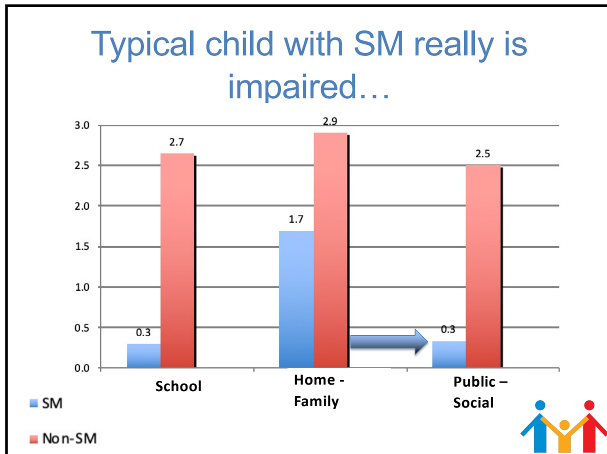

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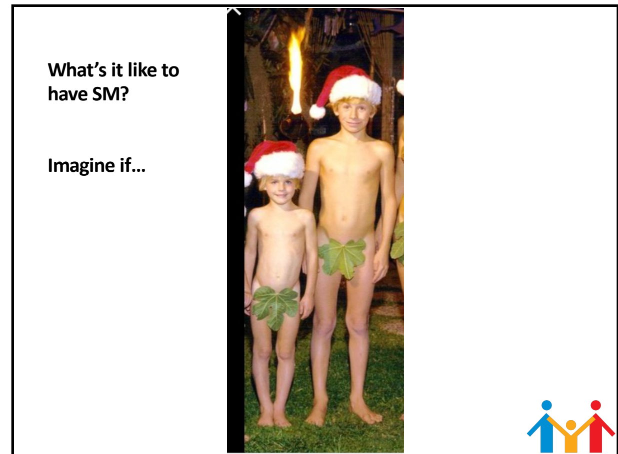

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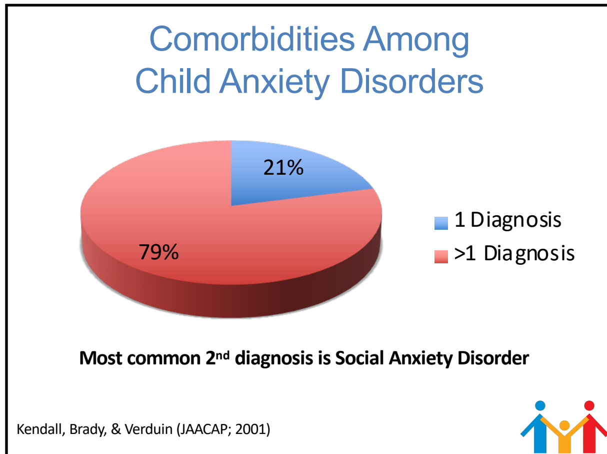

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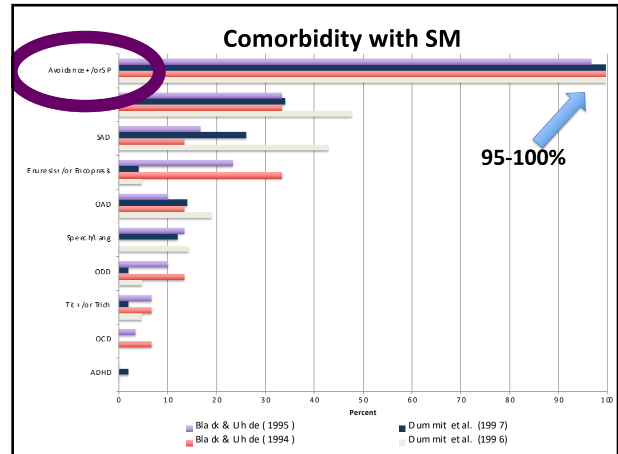

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What do we know about treating child anxiety disorders?

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Child/Adolescent Anxiety Multimodal Treatment Study: The CAMS Study

- 7-17 years old
- 448 children
- CBT, SSRI, Combination, Placebo
- Diagnoses included
  - SAD
  - GAD
  - Social Phobia

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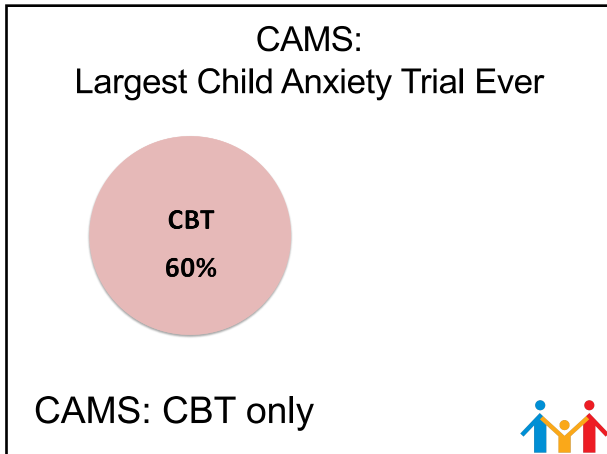

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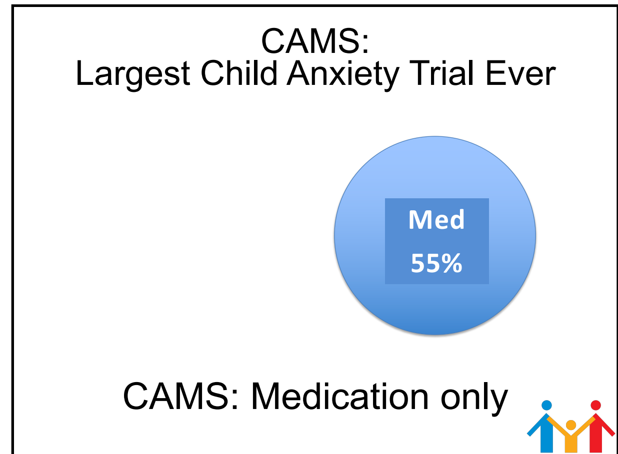

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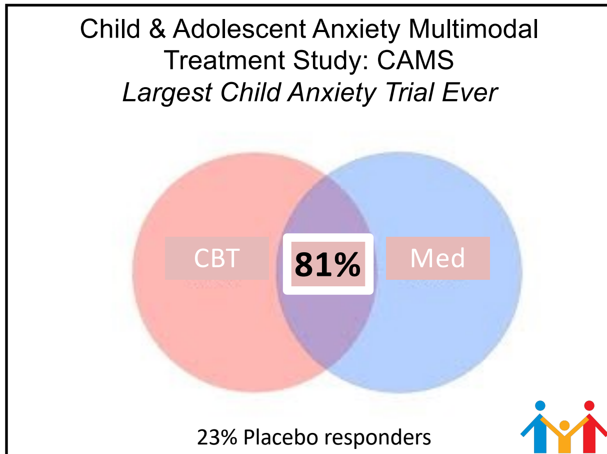

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What do we know about treating SM?

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A lot more now than we did10 years ago

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Integrated Behavior Therapy for Selective Mutism: A randomized controlled pilot study

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ABSTRACT
Objective: To evaluate the feasibility, acceptability, and preliminary efficacy of a novel behavioral intervention for reducing symptoms of selective mutism and increasing functional speech.
Method: A total of 21 children ages 4 to 8 with primary selective mutism were randomized to 24 weeks of Integrated Behavior Therapy for Selective Mutism (IBTSM) or a 12-week Waitlist control. Clinical outcomes were assessed using blind independent evaluators, parent-, and teacher-report, and an objective behavioral measure. Treatment recipients completed a three-month follow-up to assess durability of treatment gains.
Results: Data indicated increased functional speaking behavior post-treatment as rated by parents and teachers, with a high rate of treatment responders as rated by blind independent evaluators (75%). Conversely, children in the Waitlist comparison group did not experience significant improvements in speaking behaviors. Children who received IBTSM also demonstrated significant improvements in

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doi:10.1111/camh.12045

A randomized controlled trial of a home and school-based intervention for selective mutism – defocused communication and behavioural techniques

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[2]University of California San Diego, La Jolla, CA, USA

[3]Norwegian Centre for Violence and Traumatic Stress Studies, Oslo, Norway

[4]Norwegian Statistics, Oslo, Norway

Background: Randomized controlled psychosocial treatment studies on selective mutism (SM) are lacking. Method: Overall, 24 children with SM, aged 3–9 years, were randomized to 3 months treatment (n = 12) or wait list (n = 12). Primary outcome measure was the School Speech Questionnaire. Results: A significant time by group interaction was found (p = .029) with significantly increased speech in the treatment group (p = .004) and no change in wait list controls (p = .936). A time by age interaction favoured younger children (p = .029). Clinical trail registration: Norwegian Research Council/NCT01002196. Conclusions: The treatment ...

Article history: Received 7 February 2013; Received in revised form 21 June 2013; Accepted 1 July 2013

Keywords: Randomized controlled trial; Childhood; Behavior therapy; Social anxiety; Selective mutism

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Examining a novel, parent child interaction therapy-informed, behavioral treatment of selective mutism

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[b] Outpatient Psychiatry Department, British Columbia Children's Hospital, Canada

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ABSTRACT

Background: The purpose of this study was to evaluate a new therapy for children with selective mutism (SM) that combines Parent-Child Interaction Therapy principles and behavioral techniques. Method: Children aged 4–10 with a primary diagnosis of SM were eligible to participate. Comorbidity was allowed with the exception of autism spectrum disorder, intellectual disability, mania or psychosis. Of 54 potentially eligible participants, 33 met inclusion/exclusion criteria of which 31 families consented (94%). Following assessment, children were waitlisted for an average of 4 months before receiving 16 sessions of weekly therapy at an outpatient psychiatry clinic of a children's hospital in Vancouver, Canada; all children completed treatment. Assessments were conducted at time of referral (baseline), pre-treatment, post-treatment, 3 month follow up, and 1 year follow up. Two did not complete follow up assessments (93% retention).

ARTICLE INFO

Keywords: Anxiety; Selective mutism; Parent-child interaction; Intervention

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Intensive Group Behavioral Treatment (IGBT) for Children With Selective Mutism: A Preliminary Randomized Clinical Trial

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Thomas H. Ollendick — Virginia Tech

Steven M. S. Kurtz — New York, New York

Jonathan S. Comer — Florida International University

Objective: Very few controlled trials have evaluated targeted treatment methods for childhood selective mutism (SM); the availability of evidence-based services remains limited. This study is the first controlled trial to evaluate an intensive group behavioral treatment (IGBT) for children with SM. Method: Twenty-nine children with SM (5–9 years; 76% female; 35% ethnic minority) were randomized to immediate SM 5-day IGBT or to a 4-week waitlist ...

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What do we know about treating SM?

- Most kids will benefit from the treatment.
- Treatment response will vary ***tremendously***.
- Some will get really, really, really better!
- Some will NOT get really, really better despite same treatment provided by same good people to parents guiding the same exposures.
- NOT good at knowing who will and will not respond to the behavioral treatment – PCIT-SM or otherwise.

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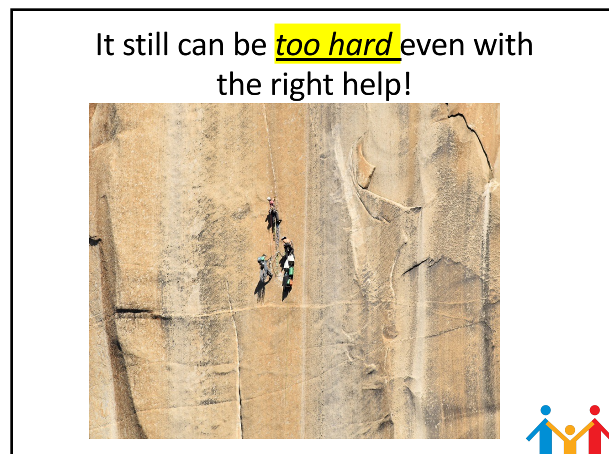

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What are the risks of *under*-treating?

- Every day of impairment
  - Is ***not*** neutral
  - Strengthens the habit of avoidance
  - Strengthens others perceptions that they are the child who doesn't talk
  - May be demoralizing
  - Decreases ***self-efficacy***

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What are the long-term risks of *under*-treating*?

- Anxiety Disorders, if not properly treated, increase the risk for ....
  - School absences
  - Underachievement
  - Impaired peer relations
  - Alcohol and drug use
  - Problems adjusting to work situations
  - Anxiety disorders in adulthood

*Not meant to scare, just inform

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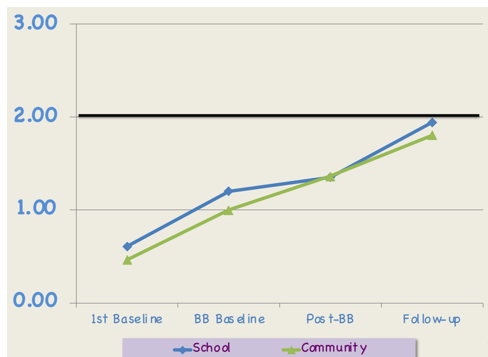
Good enough?



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When and why did I start caring so much about adding medicine to SM treatment plans?

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Rachel*

- 6yo, 1st grade, strong family hx anxiety both sides
- Spoke to parents easily in our clinic
- Spoke when we were in the room as well, with ease
- Quickly started talking to me in clinic, playing games
- Easily talked to Mom and me in her classroom
  - In the 20-30 mins before kids arrived
  - Sudden cessation when children entered

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Rachel*

- Continued talking with ease when teacher was then added to room, before school day began
  - As long as she did not come close
  - Then faded teacher closer and closer, maintained high rate verbal
- Ceased talking when Mom faded more than arms' length
- 23 sessions before talking to teacher with Mom at doorway
  - Still before school

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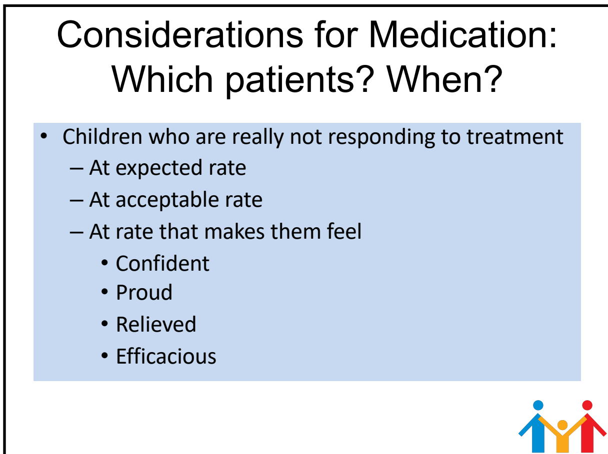

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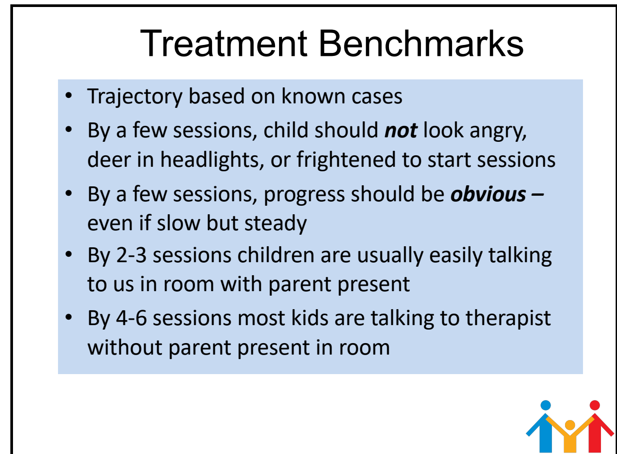

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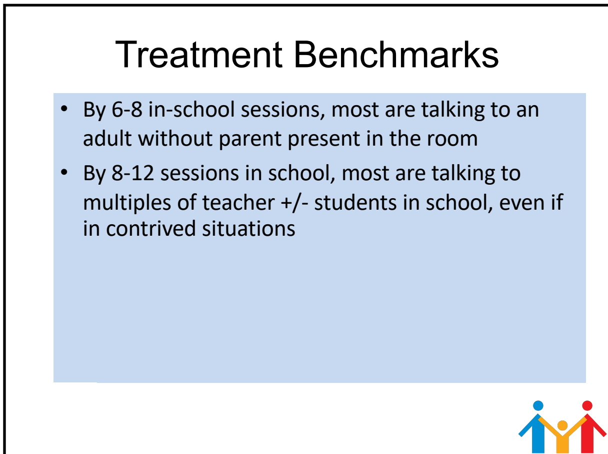

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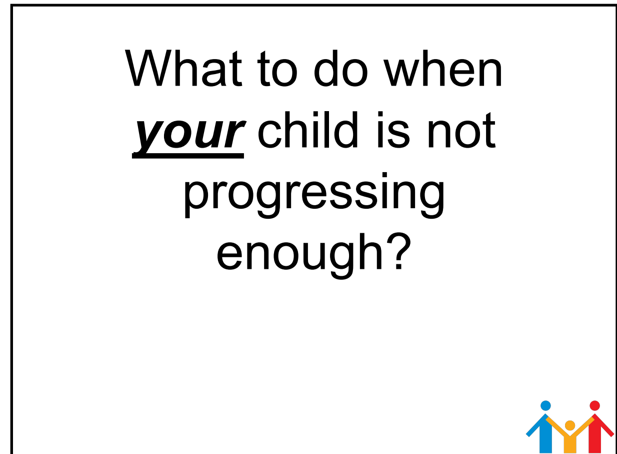

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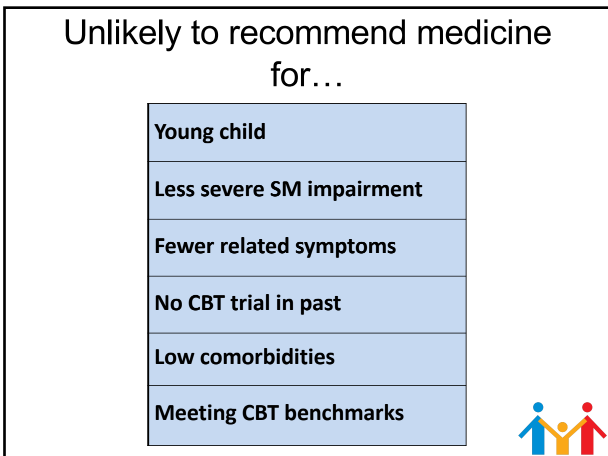

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More likely to recommend medicine for…

Young child	**Older child**
Less severe SM impairment	**More severe SM impairment**
Fewer related symptoms	**High related symptoms**
No CBT trial in past	**Has tried good CBT w/poor response**
Low comorbidities	**High comorbidities**
Meeting CBT benchmarks	**Not meeting CBT benchmarks**

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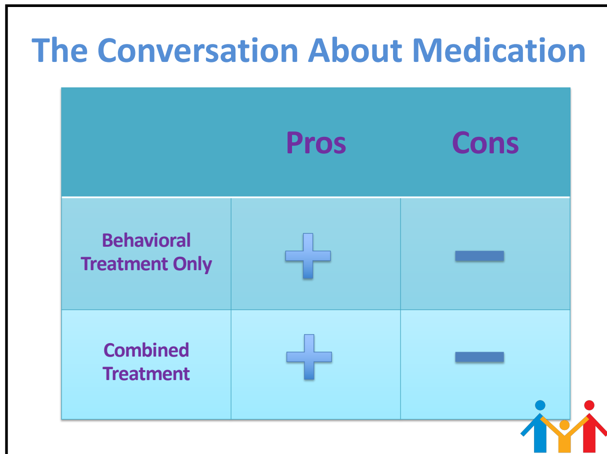

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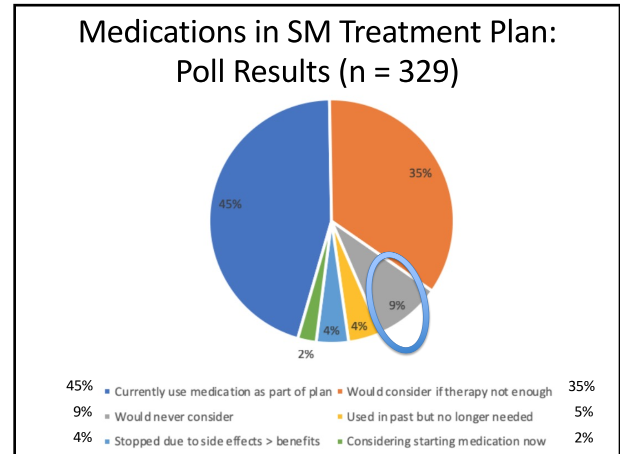

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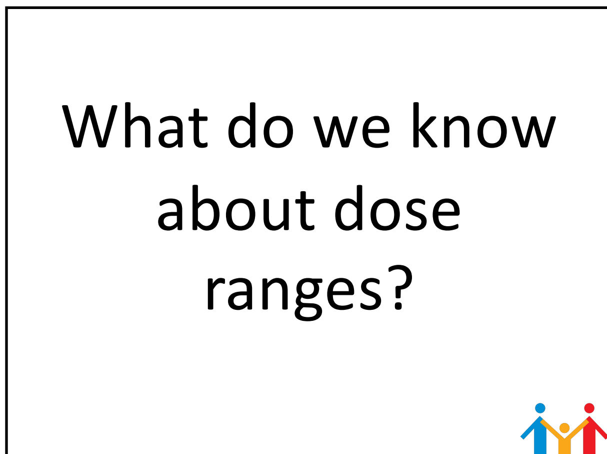

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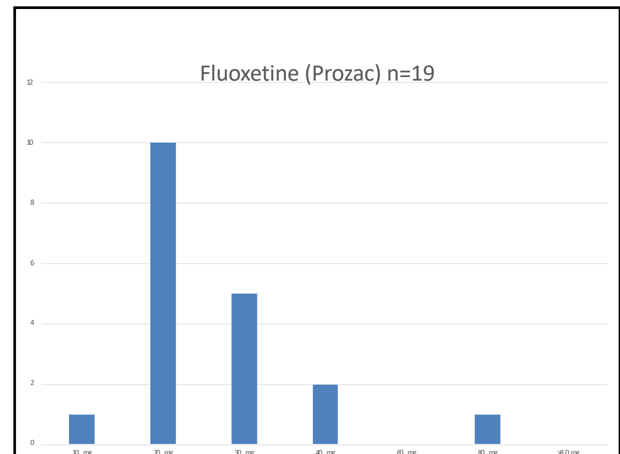

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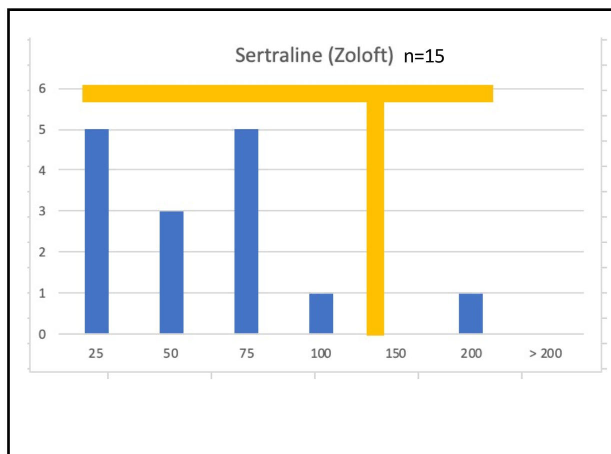

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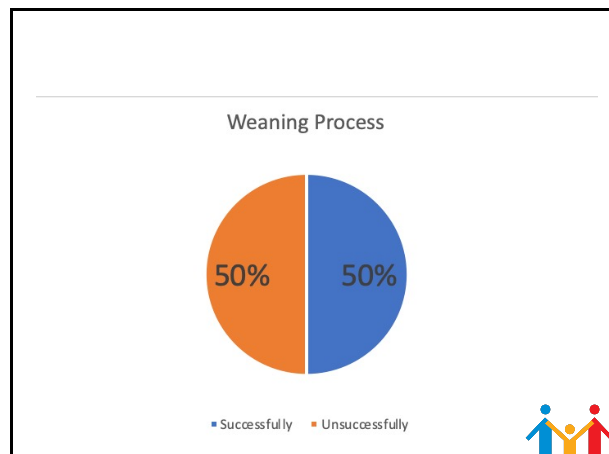

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How to start medications?

- Non-obligatory consultation
- Start low, go slow
- Communicate observations

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How do they work?

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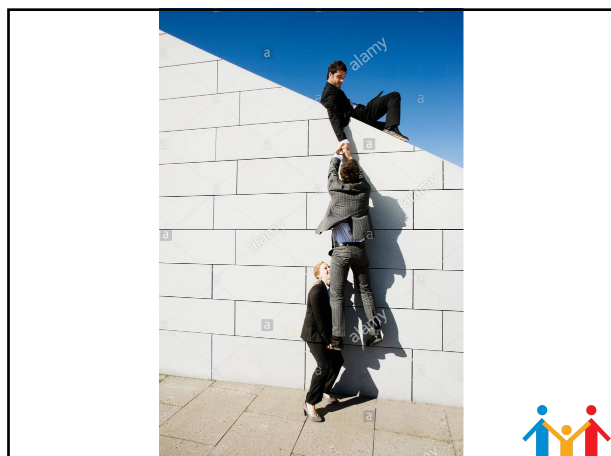

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AACAP Guidelines

- First consider CBT
- Then, SSRIs are treatment of choice for childhood anxiety
- No specific medicines designated for SM
- Consider risks versus benefits
  - What are the risks of not medicating?
  - What are the risks of medicating?
- No one SSRI consistently better than another

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Axiom: Start low, go slow*

1. First likely to see side effects before you see main effects
   1. This is a good thing
   2. Most side effects will be nuisance side effects
2. Main effects may be seen as early as 2-3 weeks
   1. Often see non-specific effects before specific effects
   2. Then see specific effects
      1. Ability to tolerate and initiate exposures easier

*Gleason, Egger, Emslie et al. JAACAP, 2007, 1532-1572

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How to decide which SSRI to use?

- No specific data exists for one over another
- Default is Fluoxetine (Prozac) because used the most
- Family history of + or – response to any specific SSRI

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Serotonin Reuptake Inhibitors FDA-approved for OCD

- **Clomipramine** – FDA approved to age 10
- **Fluvoxamine** – FDA approved to age 8
- **Sertraline** – FDA approved to age 6
- **Paroxetine** – effective for OCD + Social Phobia
- **Fluoxetine** – effective for OCD; MDD to age 7
- **Citalopram** – No controlled trials in children
- **Escitalopram** – FDA approved to age 12 for MDD
- **Venlafaxine** – Not deemed to be effective in childhood GAD (more later) but effective For Social Phobia

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Prozac

- For adolescents and higher weight children, treatment initiated with 5-10 mg/day
- After 3-4 weeks, dose often increased to 20 mg/day
- Additional dose increases may be considered after several more weeks if insufficient clinical improvement is observed.
- Dose range of 20 to 60 mg/day is recommended

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Sertraline (Zoloft®)

- Initiate with a dose of 12.5-25 mg daily in children (ages 6-12), 25-50 mg daily in adolescents (ages 13-17)
- Patients not responding to an initial dose of 25 or 50 mg/day may benefit from dose increases up to a maximum of 200 mg/day

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Side effects?

- How FDA warnings work?
- What is the "black box warning" label
- What is *possible*?
  - Activation
  - GI
  - Others
- What is *likely*?

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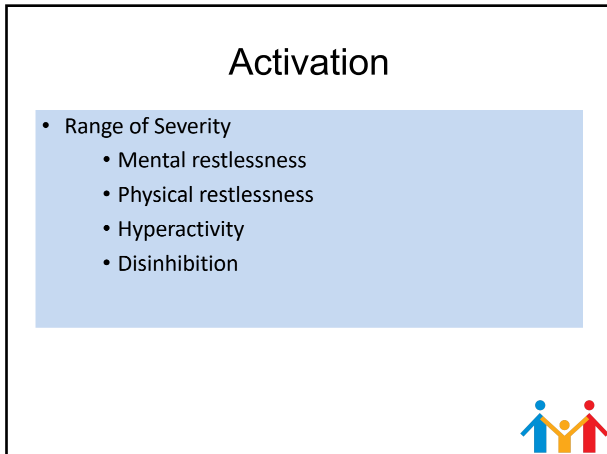

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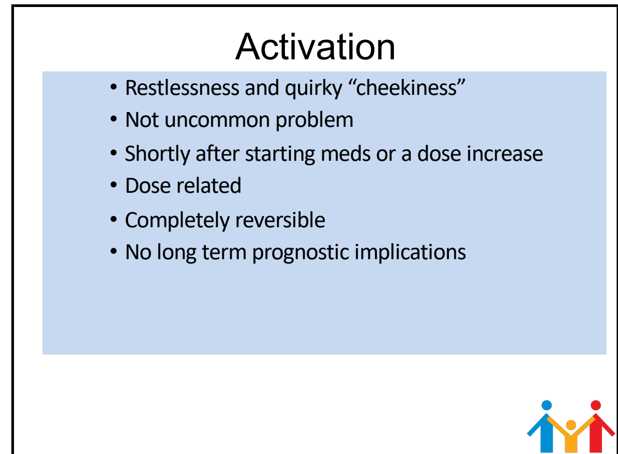

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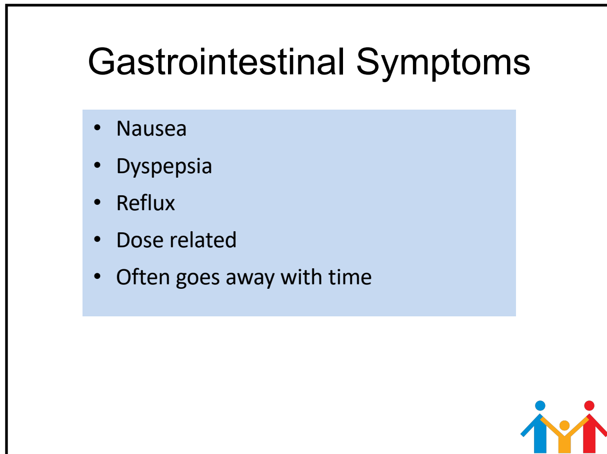

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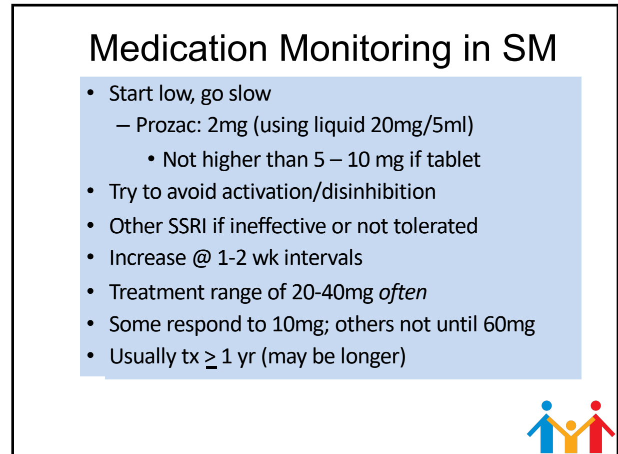

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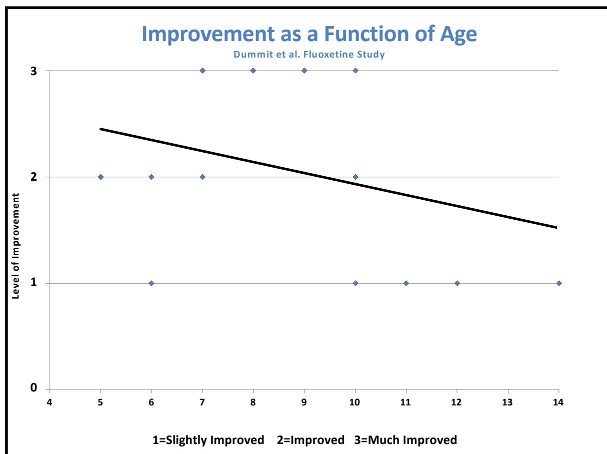

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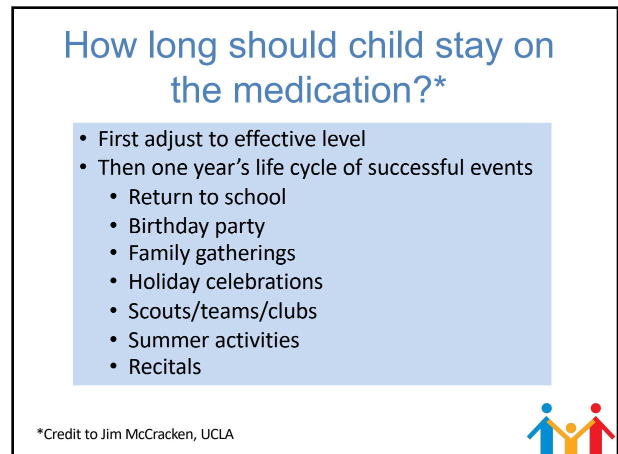

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How Long to Treat?

- Kids need to relearn who they are as they change
- Fears of discontinuing medicines
  - Child?
  - Parent?
- It is never for the "rest of their natural life"
- Speed of discontinuing
  - Slow
- Relapse?

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How to Stop the Medication

- Solid Response
  - No breakthrough symptoms
  - No seasonal slumps
- Continue CBT
- Pick least vulnerable time
- Take it down slow
- Watch like a hawk for a year

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Q&A

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www.kurtzpsychology.com

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Medication Fears & Facts

SM University

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