

Children, Adolescents and Psychiatric Medication

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- When your child is misbehaving do people ask you or your child whether he took his medication today?
- Has your child's school counselor or teacher told you that you need to consult a psychiatrist for medication?
- Has your child's school principal told you that your child cannot come back until she is taking medication?
- When your child is sad or upset, do others say that he needs medication?
- When your child throws a tantrum do others warn you that he could have a bipolar illness?
- When your child misbehaves and gets in trouble at school or at home, is her excuse that she forgot to take her medication?

These are good questions to consider as we navigate an increasingly complicated world that places demands on our children and teens as never before! Consider this--- we do not offer our children and teens alcohol to calm them down. There is little research in supporting this intervention, just as there is very little research with the psychotropic medications that are listed below.

In the past three decades, the frequency with which psychotropic medication is prescribed to children has increased significantly. Although psychotropic medication can be beneficial for children struggling with certain psychiatric illnesses, considering the use of medication must be done in a thoughtful manner. There are several short and long-term risks of taking psychotropic medication that need to be considered:

Stimulants (e.g. methylphenidate and dextroamphetamine compounds)

Short-term: decreased appetite, disrupted sleep, weight loss, growth retardation, irritability, headaches, stomach aches, problems with blood pressure and cardiac functioning.

Long-term: dependence and mood instability.

Antidepressants (e.g. Prozac, Zoloft, Celexa, Paxil, Lexapro, Wellbutrin)

Short-term: gastrointestinal distress, restlessness, sleeplessness, apathy, lowered seizure threshold, feeling numbed, feeling helpless and out of control, suicidal ideation.

Long-term: mood instability and recurrent depression.

Antianxiety or sleep medications

Antihypertensives (e.g.: Clonidine, Tenex, Intuniv, Clonidine, Tenex and Intuniv).

They are sedating and may also cause severe drops in blood pressure or, alternatively, sudden rises in blood pressure, if the child misses a dose.

Antihistamines (e.g., Benadryl and Vistaril)

These anti-allergy medications are simply sedating.

Antipsychotics (e.g. Risperdal, Zyprexa, Seroquel, Geodon)

Short-term: sedation, appetite and weight gain, restlessness, some abnormal movements (Parkinson's -like symptoms), and metabolic syndrome including increased cholesterol and lipids and blood sugar.

Long-term: diabetes, chronic mood instability and disability, and possibility of Tardive Dyskinesia (a disfiguring movement disorder).

Mood Stabilizers (e.g. Lithium, Depakote, Tegretol, Trileptal, Topamax, and Lamictal)

These medications are typically prescribed for “stabilizing mood” or for impulse control and/or explosive anger. They are often experienced by children as having a dulling or sedating effect.

Short-term: depending on the agent, may cause tremors, electrolyte imbalance and kidney, thyroid or liver problems, as well as weight gain and sedation.

Long-term: the longer-term consequences of the immediate side effects.

It is important to note that the culmination of decades of studies of differences in brain volumes in individuals with schizophrenia from non-affected individuals was finally acknowledged to be associated with the dose of neuroleptics, including the same neuroleptics that have been increasingly employed as mood stabilizers for adolescents and even young children.⁽¹⁾ If these agents are associated with shrinking brains in adults, what effects might they have on the developing brains of children? Importantly, these drugs have not been adequately studied in children and adolescents.

It is important to consider the underlying message to your child—administering medication has meaning beyond your child simply taking a pill for negative behaviors. It is important to talk with your child about why he or she is taking medication. Giving medication can convey a message to a child that he cannot manage his behaviors or that

there is something “wrong” with him. The implication is that they cannot learn to control themselves and that there is something wrong with them—that their brain is broken!

Children may be told that they will need to be on medication for life but it is difficult to predict this at a young age. In most cases, medications cannot cure but do suppress symptoms. This is distressing and alarming for children and their parents to hear. The scientific research supporting the broken brain concept is not warranted by scientific research.

Medication is often a short-term answer for a behavior problem. In some situations it is necessary, but it is not a panacea. There is increasing awareness and concern about its potential harm. There are few studies of the long-term effects on growth or the bodies or brains of children. Many of the commonly used medications are not FDA approved for use in children.

In 2003, the United Kingdom banned the use of all SSRI antidepressants for children under the age of eighteen, except fluoxetine. Lancet editors stated that the SSRIs were “both ineffective and harmful in children.”⁽²⁾ (Subsequent examination of studies presented to the FDA for approval of fluoxetine suggests that there were exaggerated claims of efficacy and safety for this agent, as well).

An Australian article in The British Medical Journal observed that the research “exaggerated the benefits, down-played the harms or both.” They also added that a review of the fluoxetine trials in children showed that the “evidence for efficacy is not convincing,” adding “recommending any antidepressant as a treatment option, let alone as a first line treatment, would be inappropriate.”⁽³⁾

A thorough investigation of the effectiveness of antidepressants versus placebo by Kirschner⁽⁴⁾ demonstrates that there is no chemical imbalance identifiable in depression, and the significant effectiveness of antidepressants is not statistically better than placebo. Moreover, the chemical effect of the agents that purport to increase various neurotransmitters in the brain may be detrimental to children and adolescents.

There have been reports of increased risk of suicide attempts when treated with antidepressants (particularly SSRIs), leading to the Black Box warning on these medications.⁽⁵⁾ The reason for increased suicidal behavior in teens is not understood—is it due to a pharmacological effect or something else? The question of risk to benefit has been raised. Some have found an increasing rate of suicidal behavior overall in children and adolescents associated with decrease in SSRI prescriptions after the Black Box warning came out.^(6, 7)

Antidepressants should be started with great caution. Again, given that overall these medications have not proven to be very effective in these youngsters, these data are very complicated to interpret.⁽⁸⁾ Thus it is important to approach starting antidepressants with caution.

Early research on stimulants has shown that the medications help the teacher with classroom management but do not positively affect the child's long-term academic performance or the ability to socialize and relate with others. ⁽⁹⁾

Stimulants do not produce lasting improvement in any area of a child's life. A more recent article by the respected developmental psychologist, Alan Sroufe, restates the knowledge that the effects of stimulants are short-term and come with significant consequences. Long-term use is common, but it is not justified by positive effects on learning. ⁽¹⁰⁾

Health Canada suspended the use of the stimulant Adderall XR after twelve children died in the US while taking it. ⁽¹¹⁾ However, the medication was allowed back on the Canadian market later that same year with changes to its labeling to include warnings against the use of Adderall XR in patients with structural heart abnormalities. ⁽¹²⁾

Research suggests that the increased incidence of the diagnosis of bipolar disorder in children began with the increased use of stimulants and antidepressants in children. ^(13, 14) Whether this is due to the unwanted effects of medication on a changing brain, leading to emotional instability, or to the "unmasking" of an underlying bipolar disorder is not yet clear. However, the occurrence of bipolar disorder has so rapidly increased, that it is far more likely that use of these medications may undermine emotional stability.

Although these observations raise doubts about medication effectiveness and concerns about potential harm of psychotropic medication, we still live in an era of dependence on medication. Many parents, teachers, and providers turn to medication to help alleviate acute problems in children. Furthermore, many parents, teachers, providers, and children have experienced some benefit from psychotropic medication. For this reason, we need to be very thoughtful about our approaches to assisting children and families when children are suffering.

It is good to begin with a discussion with your provider about the concerns that we are raising in this paper. The following need to be considered:

- 1) Since the length of time on the medication can impact various hormones, weights, and other metabolic concerns, are the appropriate clinical assessments and laboratory studies being done to monitor these concerns?
- 2) How long will my child need to take this medication? Is your provider willing to discuss short and long-term approaches?
- 3) Is the person assessing your child willing to collaborate with other providers to widen the options needed for a more holistic approach to the problems that brought the child to the office in the first place?
- 4) Are diet/quality of food/fluids and other life style issues being assessed? Is the context in which the child/teen is living being considered?
- 5) Are the strategies in place limited to medication management alone? If so, consider seeking another provider.

It is important for all to be aware of these concerns, as there has been media focus about the necessity of medication for children and adolescents. AND the good news is that there are treatments that are healthy and effective. These options do not involve psychotropic medication, or may use minimal amounts for targeted purposes.

These treatments begin with a thorough assessment of the child in context, beginning with the child within his or her community, family, and school, and narrowing down to the child's personal functioning. Assessment must include both the relational and emotional functioning of the child with family and peers. And it should also include assessment of what accommodations have been or should be made in response to a child's specific learning styles and challenges. Attention should be given to whether there are predictable routines, such as regular and healthy meals, a consistent bedtime, etc. The child's physical health must be carefully assessed including the effects of possible food allergies, nutritional deficits/ability to assimilate nutrients. A physical exam and pertinent lab work should be done to screen for any cardiac or metabolic abnormalities or chronic infections.

Following such assessments, there can be adjustments that will make a huge difference in the child's ability to get along, ranging from dietary adjustments and nutritional supplements, to family interventions, to interventions in schooling to improve the learning experience and help with social adjustment. Be proactive for the health and well being of your child/teen!

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Resources:

Parenting from the Inside Out: How a Deeper Self-Understanding Can Help You Raise Children who Thrive. Daniel Siegel, MD, Mary Hartzell, M.Ed., Jeremy P. Tarcher. Penguin. 2004.

Please Don't Label My Child. Break the Doctor-Diagnosis-Drug Cycle and Discover Safe, Effective Choices for your Child's Emotional Health. Scott M. Shannon, MD, with Emily Heckman. Rodale. 2007.

ADHD without Drugs: A Guide to the Natural Care of Children with ADHD. Sanford Newmark, MD. Nurtured Heart Publications. 2010.

Your Child Does NOT Have Bipolar Disorder. Stuart L. Kaplan, MD.* Praeger. 2011.

***NOTE:** Dr. Kaplan confronts the problem of diagnosing bipolar disorder in children, and offers a fuller way to understand anger, moodiness, and other symptoms that have led people to use this diagnosis. He does advocate use of medication for some of the conditions that he believes are mistakenly called Bipolar Disorder.

Anatomy of an Epidemic. Robert Whitaker. Random House. 2010.

Important Disclaimer

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