

Chapter Seven: Why Medicating Stress Doesn't Work

Medications can relieve the symptoms of the illnesses they were designed to treat. They can ameliorate stress-induced depression and anxiety. They can also numb a child to the stressful things that caused those symptoms to begin with, reducing motivation to change her life for the better. They can mask a child's symptoms of undisclosed trauma, veiling the eyes of the adults who need to know of the ordeal in order to help the child recover. They can also produce side effects, which simply add to a child's stress level. I believe the rush to medicate childhood stress has diverted us from our core duty of helping these children to heal. And I'm not the only child psychiatrist to express this concern.

Holly had done poorly for years when she first shuffled into my office. Chronically depressed, she had at least two psychiatric hospital admissions while in high school. Counting her inpatient psychiatrists, I was her fourth. And she was only nineteen. She had been diagnosed with as major depression with psychotic features, schizoaffective disorder, and bipolar disorder. When she came to me, she was taking a drug cocktail of lithium, Depakote, Zyprexa, Wellbutrin, and Klonopin.

Each of these medications has its place, but taken at once, they made Holly feel like a zombie. Though she wanted to study child development at the local university, she was too groggy to go to school. Instead, she divided her time between sleeping (about 14 hours a day) at her mother's apartment and hanging around her mother's craft store. Between her inactivity and drug side effects, she had gained 38 pounds over the past two years.

As she told me about her life, she spoke softly and avoided eye contact. She did indeed relay symptoms of depression, bipolar disorder, and schizophrenia. Furthermore, when she was nine, she had also been sexually abused by a neighbor. At that time, she had about six months of therapy. For several years, she seemed to be doing okay. When she was thirteen, she grew steadily more depressed and agitated. When she was fourteen, she attempted suicide.

Although her symptoms were much delayed, it sounded to me as though Holly had posttraumatic stress disorder, which is an extreme stress reaction. Many of her symptoms fit: flashbacks, nightmares, heightened vigilance, and an aversion to touch. It seemed to me that she had coped for a few years, only to unravel with the onset of puberty.

Gradually, I tapered her medications. Once the drug side effects cleared, her true, underlying symptoms became much more clear. I added a medication called clonidine, which can be helpful in posttraumatic stress disorder, as well as herbs and supplements with anti-anxiety effects. I requested she stopped drinking caffeinated sodas, which she had been consuming in abundance, and sent her to a psychologist for EMDR therapy. (EMDR stands for Eye Movement Desensitization and Reprocessing. It's a new but proven form of therapy for trauma that uses eye movement to release traumatic memories.) She also began acupuncture treatments and massage therapy.

Now, four years since our first meeting, Holly is married and runs her own business. She takes one prescription medication – a low dose of an anti-depressant called Serzone. She continues to take the calming herbs and dietary supplements and finds the B-vitamin-like supplement inositol as particularly helpful. Last session, she declared that she wants to get pregnant. Because of the unknown effects of Serzone on the fetus, we've made a schedule to get her off this drug within six months.

Though Holly's story is somewhat extreme, it illustrates that medication can hide the real symptoms of a stress, create side effects, and delay healing. I often see kids whose medications have done more harm than good. Granted, I did prescribe Holly a medication. I do so all the time. But I rarely stop with a prescription. I view drugs as a means to reduce symptoms sufficiently so that a child or teen can work with me on making other positive life changes.

Our culture and our medical system, however, love drugs. My medical training focused not on recognizing or modifying stress, but on learning to treat psychiatric illnesses with medications. Pediatricians, family doctors, and psychologists refer children to me, oftentimes with the specific request that I determine a drug treatment regimen. Parents bring their children to me, asking that I medicate their child. If I tell the parents I don't think their child needs drugs in order to get better, they will often reject my advice and seek another psychiatrist who will write a prescription. It's no surprise that spending for prescription drugs is the fastest-growing component of health care in the U.S. Think about it. Most times you go to a doctor, what do you get? A drug prescription.

Drug treatment in this country has gone out of control, like some manic, power-mad genie let out of the bottle. Take the stimulant medications. The United States consumes 90

percent of the world's stimulant medications, and most of those pills go into the mouths of children with presumed attention deficit disorders. This trend began in the 1980s and '90s, when the number of stimulant prescriptions for children suddenly escalated. For example, in 1975, 150,000 American kids were on stimulant medication for attention deficit or hyperactivity. By the late 1980s, about one million American children were on Ritalin. Over the past decade, the use of the stimulant Ritalin has skyrocketed 700 percent. In some communities in the United States, over 17 percent of schoolboys are on stimulant medication.

Antidepressant use among kids increased three- to five-fold between 1988 and 1994.¹ Antidepressant use has even risen dramatically in *preschool* children, tripling between 1996 and 1999. An explosion in the diagnosis of bipolar disorder in children has been accompanied by the complex medication regimen used to treat this condition, often four or five powerful medications at once.

America's rampant medication of children becomes particularly salient when juxtaposed with the fact that no other industrialized country prescribes so many psychiatric medications to kids. In Canada, the stimulant use per capita is one-half the rate in the United States; in Australia, it is one-tenth the rate it is in the United States. Other countries comprise much smaller fractions of the stimulant use per capita. Either American kids have more mental illness than kids in other countries, or American doctors more blithely write prescriptions for kids. The latter strikes me as more likely.

Why are so many American kids medicated? I think the answer lies in four areas: our frenetic culture, conventional psychiatry, the pharmaceutical industry, and managed care.

Our culture's general attitude is that we don't have time to be sick, and don't have time to care for our sick children. We want symptoms gone, NOW. And often the fastest way to alleviate both physical and psychiatric symptoms is by taking a pill. Of course, the urge to relieve discomfort is natural, particularly when the person feeling unwell is our child.

On the other hand, if a child we love is in distress, it makes sense to find out why, to dig down to the roots of stress. Is someone bullying him at school? Does an unrecognized learning disability make schoolwork difficult? Does he imagine that the family dog's death was his fault? Getting to the bottom of things takes time. Ironic isn't it, that the proper treatment of stress is a time-consuming endeavor in a culture that has no time. But if we simply medicate a child's symptoms so he can function, we may never make the changes that allow him to really get better.

And if we dig deep and find that no outside thing has made him miserable, that he has a biochemical problem that drugs can fix, then it makes sense to get out the prescription pad.

As our culture as a whole has evolved, so has psychiatry. Most of the changes have been for the good. We no longer attribute psychological conditions to imbalances in bodily humours or demonic possession. We don't stone, burn at the stake, or drown the mentally ill. Nor do we incarcerate them in madhouses. We are more likely to discuss mental maladies with friends. We're more open to the need to address and treat psychological issues in children, though too many kids still fall through the cracks.

Sadly, we continue to almost completely ignore stress. And the field has lately become too narrow and too fragmented to address the many issues that interact to influence mental health. As recently as the 1970s, psychiatry viewed mental disorders as having roots in biology, psychology, and sociology. In other words, a person might suffer depression on the basis of genetics, a hormonal imbalance, or a medication (biology). She might feel down because of habits of negative thinking (psychology). Or she might feel emotionally low because she has lost her job, her children are hungry, and the rent is overdue (sociology).

I happen to endorse this broad perspective on psychiatric issues. Unfortunately, the rest of medicine criticized psychiatry as a "soft" science. Over the last several decades, psychiatric research narrowed progressively to biological causes and biological cures. The results yielded valuable insights into brain function, specifically that imbalances in brain chemical (neurotransmitters) can produce psychological illness, and also led to the creation of drugs that augment deficient neurotransmitters to ameliorate the symptoms of these illnesses. As a result, psychiatrists became the specialists who prescribed medications, leaving therapy to the psychologists.

The development of psychiatric drugs with reasonable safety profiles helped propel the biological approach to mental illness into the mainstream. The revolution really hit with the introduction of Prozac in the late 1980s. Its safety compared to older antidepressants, along with aggressive marketing and media attention, galvanized people to "come out of the closet" about depression. Also, the percentage of people who receive psychotherapy for depression and other psychiatric issues has declined significantly, while the percentage given medications has climbed.² Doctors and patients soon discovered that Prozac and similar medications did more than lift severe depression. They also benefited people with mild depression, irritability, anxiety,

social fears and other possible symptoms of stress overload. They buoyed mood and self-confidence. As the public became more comfortable using antidepressants, and doctors freely prescribed them.

In a way, Prozac and her siren sisters unknotted mental health stigmas the way the Pill relaxed sexual mores. The notion of mental illness as chemical imbalance helped whittle away at the myth that mental illness only happens to moral derelicts, that people should pull themselves up by their bootstraps and just get over it. We were able to move beyond a strict Freudian viewpoint of all psychological distress stemming from Oedipal complexes, overly harsh potty training, oral fixations, and other early traumas, people feel more comfortable going to see a psychiatrist. We were freed of the compulsion to blame one's self or one's mother (and mothers were freed from the resultant and often undeserved guilt). And parents didn't need to feel solely responsible for their child's problems. Often I find that parents labor under the mistaken assumption that their poor parenting caused their child's depression or anxiety. When I talk about the genetic and biochemical contribution many parents feel a sense of relief that is almost palpable.

The biological model has increased awareness and acceptance of the fact that kids of all ages can have psychiatric problems. And this recognition allows more children to receive treatment. The lay public is better educated about children's psychiatric issues such as ADHD, depression, bipolar disorder, and anxiety disorders. Media coverage and special training programs prime teachers, counselors, and primary care physicians to note unusual signs and symptoms in a child and refer him to a mental health professional for evaluation and treatment. Indeed, more children are making it to the psychiatrist's doorstep.

Nevertheless, I worry that putting the biochemistry of psychiatric illness in the limelight has eclipsed the impact of thoughts, emotions, behavior, and the stress of the outside world on mental health. It has also rendered assessment and treatment mechanical. If psychological distress is strictly a matter of brain chemical imbalance, then the treatment centers on taking a drug to normalize those chemicals. This biochemical focus has distracted us from the topic of stress, which is more unwieldy and harder to manipulate than chemicals.

Before I continue, I want to point out that I'm not denying that there is a biological component to mental illness. Some people with serious psychiatric disease may indeed need lifelong drug treatment in order to optimize their quality of life. If you or your child is one of

those people who require medication, please do NOT feel guilty or ashamed. All I'm saying is that, oftentimes, doctors put kids on medications without giving them other tools to help them recover, such as teaching them to manage stress. Even if a condition is definitely biologically based, therapy can help families understand the condition and learn how to best take care of it. I am not trying to induce shame, but an awareness that not every psychological problem requires the same (pharmaceutical) solution, that medication is but one of many available tools, and that each of us possesses an innate drive toward healing.

The pharmaceutical industry is, of course, a driving force behind medication use. Granted it has developed medications that help many people. Nevertheless, this industry has grown alarmingly powerful in America. Drug companies influence the practice of medicine by funding research and educational conferences (and influence politicians via lobbying and campaign contributions). These doctors, in turn, influence the medical students and residents to whom they lecture.

Furthermore, researchers often must sign contracts giving the drug company control over the data generated. If the results aren't favorable, the companies may decide not to publish them. In this way, negative information, which might hurt sales, can be withheld or delayed. Thanks to the Freedom of Information Act, a group of researchers were recently able to obtain data the manufacturers of the six most widely prescribed antidepressants (Prozac, Paxil, Zoloft, Celexa, Effexor, and Wellbutrin) had sent to the FDA (Food and Drug Administration). Much of this data was not published because the drug failed to perform significantly better than a placebo (and therefore, the drug companies didn't want the data released). In fact, more than half of the drug-company-sponsored trials failed to find a significant benefit of the antidepressants.³

A recent article in the medical journal *The Lancet* concluded that pharmaceutical companies can influence the direction of medicine towards drug treatment, rather than non-drug options.⁴ Aggressive advertising to doctors, and increasingly to the public, encourages the use of newer, more expensive drugs, despite the fact that they may be no more effective than the older drugs.

Managed care further promotes prescription writing. It has tightened the screws on doctors to perform miracles within the span of a fifteen-minute appointment. Obviously, it takes much less time to write a prescription than do weeks of psychotherapy. Initial symptom relief is also speedier with a drug.

The irony is that, while managed care has reduced the time doctors spend with each patient, the time spent on the phone finagling insurance coverage has gone up. My hardest battles have to do with getting insurance to okay a child's psychiatric in-patient care. Quite often, I need to call this same director every few days to obtain authorization for continued treatment. And quite often, he or she tells me, that unless I prescribe medications, the child will have to be discharged. The implication here is that any child with severe issues needs medication and fast. This belief is simply untrue.

Let me say that medications can, in fact, work wonders. Although I try to be judicious in prescribing psychiatric medications for children, I find these drugs extremely helpful. Sometimes a drug is the only thing to help a child turn the corner; sometimes it reduces symptoms sufficiently that the child and his family can implement other therapies. I continue to be amazed by the dramatic effects a simple chemical can have in the life of a child and his family.

Thinking of dramatic results puts me in mind of my patient Amy. When I first met her, she was tall for seven years, enthusiastic, and as bouncy as Winnie the Pooh's pal Tigger. The problem was she was also hyperactive, restless, distractible, and impulsive. She couldn't focus her attention at home or at school. Her teachers had expressed concerned about her slow progress in reading.

After I asked her parents some questions, I spent time playing with Amy. She was a veritable cyclone of activity. Scurrying about, she grabbed a game, played with it a few seconds, then tossed it aside and moved on to the next toy. She left a wake of playthings. She nearly wore me out, but I enjoyed interacting with her. Her high spirit was infectious. When I tried to engage her in conversation (no easy task), she didn't admit to having any problems and seemed oblivious to her parents' concerns about her.

By my evaluation, she met all the criteria for ADHD. Nevertheless both her parents and I were hesitant about putting her on stimulants because Amy was quite young and like me the parents were conservative about medications. After four months she fell further behind in school, and we decided to try a very low dose of stimulants.

Her mother called me the next day to report the dramatic results. "It's a miracle," she said. "Amy was able to get dressed without us reminding her twelve times. She went off to school, and, for the first time, the teacher reported that she could sit and attend and produce

some reasonable work. ” I was impressed in the dramatic and quick success a low dose of the stimulant Adderall could produce. Such life-changing results don’t occur predictably, but they happen often enough to make doctors and their patients feel grateful and impressed.

Furthermore, when they work, medications can reduce symptoms sufficiently that a child or teen can make much-needed changes in her life. For instance, healthy diet and exercise can improve mood. But a college coed in a serious depression can hardly get out of bed, much less cook a wholesome meal or jog around the park. An antidepressant can help her feel well enough to adopt a healthier lifestyle. In the same vein, a boy who breaks out in a cold sweat at the thought of entering a public restroom cannot do the behavioral therapy that can help him overcome an irrational fear of germs. Taking a medication will reduce anxiety and improve perspective to the point that he can start challenging himself in this way.

Although drugs aptly prescribe can relieve symptoms and do so faster than most other therapies, they do have their drawbacks. For one, they can produce adverse effects. Immediate, short-term risks are common and include such things as significant sleep and appetite disturbances, weight gain or weight loss, headaches, gastrointestinal upset, and lethargy. These ill effects appear while the child is on medication and go away once the drug is stopped. Sometimes they diminish or disappear after a few days or weeks. If they don’t, patients may nonetheless tolerate the side effects because the target symptoms (which are much less tolerable) have improved.

What I alarms me is the dearth of safety data in children. A recent study of four children found that decreases in growth during treatment with serotonin reuptake inhibitors (the family of antidepressants to which Prozac belongs). The two children who stopped taking the medication resumed normal growth.⁵ Given the dramatic increase in antidepressant use among growing children, I find the results of this type of study worrisome. We just don’t know enough about the effects of psychiatric drugs in children, particularly when used long term. We don’t even have the research to confirm whether or not these medications are *effective* in children over the long haul.

In 1999, Peter S. Jensen, M.D., the Associate Director of Child and Adolescent Research at the National Institute of Mental Health in Bethesda, reported that, of the top eight categories of psychiatric medications commonly used in children, only two (stimulants and anti-convulsants) have a reasonable level of long-term safety data. The existing research only addresses adverse

events that occur while the child is on the medication, not the impact that these medications may have later on the child's neurological development.⁶

Possible harm to a child's developing nervous system is the most feared side effect. A significant portion of our neurological development occurs from birth to about age 15. All psychiatric medications work by modifying neurological function. Experiments show that when exposure of certain young animals to antidepressants alters brain development. Researchers don't yet know whether these drugs alter neurological development in humans and if they do, what the impact is on long-term brain function.

Another potential long-term risk lies in the ability of antipsychotic drugs to alter of sexual function. Over the last five years, use of antipsychotics in kids has mushroomed. Drugs in this class include Risperdal (risperidone), Haldol (haloperidol), Zyprexa (olanzapine), and Seroquel (quetiapine). Only about 20 or 30 percent of the time, their use in kids involves treating psychosis (a general term for major mental disorder with deranged thinking and behavior and loss of contact with reality). The remaining 70 percent goes toward treating ADHD, aggressiveness, and other behavior problems.

Regarding sexual function, some of these medications can alter levels of a variety of reproductive hormones. At least one drug raises prolactin, a hormone that can cause breasts to enlarge and produce milky secretions. Other hormonal shifts may lead to irregular menses and sexual dysfunction in adults. We do not yet know the long-term consequences of these drugs in children, but some researchers voice concerns about altered (including premature) sexual development.

Larry Ereshefsky, Pharm D., is a professor of pharmacology and psychiatry at the University of Texas, Health Sciences Center and one of the leading experts on antipsychotics. When I asked what he knows about potential reproductive side effects, he replied, "We already know that one of these agents elevates prolactin levels and alters sexual functioning. What we do not know is the long-term effects these medications have on children. No one has done those studies, and you can be certain drug companies won't fund them."⁷

Fortunately, members of the United States Congress became sufficiently uneasy about drug-safety issues that they passed a law providing a financial incentive for pharmaceutical companies to do more pediatric research. In the meantime, I think physicians and parents must

carefully weigh both the benefits and the potential risks before using these medications in children.

One potential risk people don't often consider is whether psychiatric drugs might actually interfere with healing. Yes, they can relieve symptoms; they don't, however, cure psychiatric problems. Unless other therapies are simultaneously begun, the only way to keep symptoms at bay is through regular, long-term pill-popping. I find this situation particularly common in childhood stress. Unless the stressful thing goes away or the child somehow learns to handle that stressor, medications can only mask psychological distress. I worry that between the rise in childhood stress and the increased importance of psychiatric medications as a treatment strategy many kids will be on medications, perhaps for their entire lives.

Furthermore, medications can numb awareness of stress. Stress can make child uncomfortable and, provided his misery isn't so great as to paralyze her, it might motivate her to take action. If he's medicated, he may no longer feel like making other healthy changes – giving up junk food, exercising, learning to cope with the girls who taunt her during lunch.

The medications may also extinguish behaviors that, while undesirable, might signal parents about serious, yet undisclosed stress overload. A medicated child may stop hitting kids, stealing cars, cursing out teachers, but his parents might never find out that he was behaving that way because the priest molested him.

Some amount of stress (not abuse) can help a children mature and grow mentally and emotionally stronger. They learn by dealing with minor problems. I often wonder how medications influence this maturation process; I wonder whether they hamper the development of strong, successful adults.

Charlie, a street-wise sixteen year old, was admitted to our hospital for episodes of violence. His father was long gone and his mother was an alcoholic. The last time he was admitted to the hospital for violence, the doctor had put him on lithium and the anti-psychotic Zyprexa. When he did take his medications, he was not violent. When he didn't take them (which was often), he went into rages. I was worried he would wind up in jail.

After five days in the hospital, Charlie entered a day-treatment. Because Social Services and not a private insurance company funded his stay, we had eight months to work with him. The other staff and I learned that his childhood was marred by some abuse and a lot of neglect. All he really needed was a chance to understand the impact of those experiences, an opportunity

to learn new ways of operating in the world, and a secure, safe environment in which to attempt those tasks. He also needed to be off his medications to learn to control his violent impulses. Four years later, Charlie works as a roofer. He has needed medications. Though he occasionally drinks too much, he has stayed out of jail.

A similar scenario plays out in children with ADHD. One study compared the longer-term academic performance of teenagers diagnosed with ADHD when they were randomly assigned to treatment with low dose, moderate dose, or high dose stimulants. All the teenagers also received a basic level of behavioral training. By the study's end, two-thirds of these teenagers did best with only 10 milligrams of Ritalin. Many fewer did best with 20 milligrams, and very few did best with 30 milligrams.⁸ It seems that, at low doses, the stimulants acted as tools enabling teens to learn to control their behaviors and improve their concentration skills. At high doses, stimulants became a crutch that eliminates the edge needed for learning new skills. Unfortunately, the trend is toward aggressive drug treatment to control symptoms of ADHD and other childhood psychological issues. Instead, we should be more thoughtful, judicious, and flexible about our use of medications in children.

Also, we need to have a little faith in children's ability to heal themselves. Just as their skin mends swiftly after a cut, so can their minds recover from stressful incidents –particularly when the stressor doesn't persist. But being on medication can thwart that natural process.

When I met her, Michelle had been anti-depressant medication for over two years. She began treatment at seventeen. Because the drug made her feel better, she declined psychotherapy. Every time she tried to stop the medication, her sadness and irritability resumed. She came to me asking if I could help her get off the antidepressant for good. She said she hated feeling dependent upon a drug.

As we gradually tapered the dosage, she began to identify the psychological issues the medication had muted. She decided she did, in fact, need therapy. Over the next six months, we worked through her problems with negative self-image and lack of self-acceptance. She also made changes in her diet and began taking natural supplements that improved her mood. With a modicum of support, she was able to heal herself.

Michelle and other patients have taught me that parents and doctors must recognize that life experiences can create uncomfortable thoughts and emotions, which, in turn, generate awareness about ourselves and the world, which, in turn, provokes inner growth and maturation.

A more sinister aspect of psychiatric drugs is their potential to trigger new problems. A illness psychiatrists most worry about is bipolar disorder. Formerly called manic-depressive illness, this condition produces cycles of depression and its polar opposite, mania. The younger the onset of symptoms, the more serious the course of the illness. Bipolar disorder is a lifelong illness and requires long-term, complicated medication management. Prior to 1990, bipolar disorder in children was considered a rare and very serious psychiatric problem with a stable incidence. (Incidence means the number of new cases diagnosed each year). Ever since then, the rate of diagnosis has rapidly increased. No one knows why.

Recent studies indicate that as many as 40 percent of children diagnosed with childhood depression go on to develop bipolar disorder. Among people with unrecognized bipolar disorder, antidepressant treatment of depression can trigger mania. Joseph Biederman, M.D., professor of psychiatry at Harvard Medical School and chief of pediatric psychopharmacology at Massachusetts General Hospital and McClean Hospital, says, "SSRI's triple the risk of triggering a manic episode in pediatric depressed patients." Some experts argue that stimulant medications such as Ritalin or Adderall may also uncover or trigger bipolar disorder.

No one yet knows whether these drugs are causing bipolar disorder or simply unmasking it at younger ages. Some psychiatrists, myself included, worry that the former may be true.

Psychiatric medications can also cause unexpected mental health problems that, fortunately, do resolve when the offending medication is discontinued. By way of illustration, let me tell you about Will, an 11-year-old boy referred to me by his pediatrician for failure to improve on high-dose stimulant medication. At age six, he had been diagnosed with ADHD and prescribed Ritalin. Though he improved, management of his symptoms required steadily increasing doses of stimulants. By the time he saw me, Will was taking a daily dose of 60 mg of Ritalin (the maximum recommended dose).

He was referred because he had developed obsessive thinking (meaning he had repeated intrusive, unwanted, discomforting thoughts) and had begun compulsively peeling the skin off the bottom of his feet. It turned out that these psychiatric symptoms arose not from underlying obsessive compulsive disorder, but rather from his stimulant medication. I lowered his dose significantly and these issues resolved. Later, I gave him some natural supplements and steered him into therapy. Ultimately, he ended up on low doses of clonidine to manage his anxiety. Last year, he got all As and Bs -- without any stimulants.

Another example is Eric, a nine-year-old boy who was referred to me because of an explosive, violent, and brittle temper. Two years earlier, he had been diagnosed with ADHD and put on stimulants. The medications improved his school performance, but coincided with a gradual increase in irritability and negative mood. By the time he came to see me, he was on moderate doses of stimulants and was being evaluated by another child psychiatrist for the addition of either anti-psychotic medications or mood stabilizers to control his rage and violence. I found that merely tapering his stimulants and using some other treatments (therapy to help him learn self-control and understand his moods, and nutritional supplements) reduced his symptoms to a tolerable level. It seemed that the stimulants had amplified his problems.

These and many other cases convince me that although psychiatric medications in children can have great benefits, at times they merely create additional problems. Unfortunately, the new problems are most often treated by the addition of other psychiatric medications.

The Solution: Wise Use of Medications

Medications have benefits and drawbacks. Because of the great good they can do, I am not about to advocate we never give kids psychiatric drugs. I prescribe medications daily, and am often grateful that we now have drugs that can relieve psychiatric symptoms. For this reason, I have no wish to go backward, to throw out the baby with the bath water.

The solution lies in learning to use medications wisely and judiciously. We must use them with respect for their ability to benefit kids and caution for their ability to cause harm. We must meld the biomedical model of psychiatric illness with wisdom about how what children need to grow, develop and heal and also begin to address the critical relevance of stress in their lives. In the same way that alloying refined iron with other elements yields a stronger metal, combining scientific data with a greater wisdom will provide us with a better psychiatric tool.

Sixteen-year-old Brandy had been depressed for six months. I held off on antidepressants because she was functioning fairly well in school, was not suicidal, and she had her mother wanted to avoid psychiatric medications. We tried antidepressant supplements (St. Johns wort, SAMe, and 5-HTP), all to no avail. While these supplements have research backing and many kids respond to them, Brandy needed more. In the end, she did well on a combination of psychotherapy, regular exercise, a low dose of the antidepressant Zoloft. Had she come to me

severely depressed, I would have gone straight to an antidepressant and added the other therapies once she began to feel better.

Jill was twenty-three when she first came to see me. She was already on a high dose of the anti-depressant Paxil, but was not happy with the side effects of weight gain, fatigue, and emotional blunting. She had a strong family history of depression. In therapy, we explored her emotional issues. Because her moods worsened in the fall and winter (a typical situation), she began light therapy during those dark months. She also began to exercise regularly, reduce her stress, and to explore the spiritual side of her life through meditation and journal writing. These things, plus the antidepressant supplement SAME and a small amount of Wellbutrin were enough to keep her spirits up. And the drug dosage was low enough that she didn't have side effects.

Here are the guiding principles that I have found useful in the use of psychiatric medications in children.

1. Whenever possible, I try other less invasive and risky treatment options first. These options may include improving diet, getting enough rest and exercise, and utilizing herbs and other natural supplements supported by research.
2. Regardless of whether medications are needed, I include treatments that support the educational, developmental, and resilience-enhancing factors needed for true healing. For example, psychotherapy is a long-established modality that can enhance these factors in children. Mental health workers can also help families learn to reduce stress, build resilience, and improve parenting skills and family dynamics. It is surprising how many children are placed on psychiatric medications without basic supportive treatment.
3. When I find medications necessary, I select an agent to target the core issue and not to achieve symptomatic relief. For example, I see stimulant medications being used to “fix” poor attention or behavioral problems when the core issue is anxiety or depression. Problems with attention or behavior stem from the deeper problems with mood and anxiety. Treatment of the deeper problems resolves the more superficial ones. Missing those fundamental imbalances can stunt the child’s psychological development.

4. I use the lowest possible dose necessary to relieve symptoms. My goal is significant relief and minimal side effects. It is not to use maximum doses to completely resolve symptoms.
5. When possible, I use only one medication. When I have a choice of medications, I pick the safest, best-tested medication available.
6. I always incorporate drug treatment into a broader plan. For instance, Jill's family history of depression suggested a biological problem that indeed needed drug treatment. However, she was able to get by with a low medication dosage with the addition of changes in nutrition, exercise, and basic stress-management skills.
7. I try to use medications on a fairly short-term basis whenever possible. I use them of these drugs as a tool for change, rather than a crutch for symptomatic relief. Because children are always changing and because many mental illnesses will resolve, I frequently taper the medications or give periods of time without them to reassess the child's state. If she can do well without the medication, then she stays off.
8. I try to engage the child's natural ability to recover from illness. Thoughts are powerful. If a person thinks a certain treatment will help, then it probably will. I capitalize on this phenomenon by building a rapport with a patient, by encouraging their confidence in me as a healer, and more importantly, in his own self-healing capabilities. I find that, if I use medications in a way that emphasizes this potential, kids will respond to low dosages used for a short period of time.

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