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thinking children

A newsletter of the **Learning Resource Network**

Psychiatric Drugs and Children II

In the last issue of *Thinking Children*, we wrote critically about what we see as the current trend of too quickly prescribing psychiatric medication as a first intervention for some common behavioral problems of children. This view elicited many responses, for and against our comments, some of which are included in this issue of our newsletter.

As we noted originally, this topic is complex and controversial. People have derived great benefits from the use of psychiatric drugs and they understandably resent views that seem to call these benefits into question. It was not our intention to criticize medication *per se*, but to call attention to what we see as its improper use — prescription without sufficient thoughtful diagnostic assessment. We fully recognize that, if a careful and open-minded assessment has been made and a decision to use psychiatric drugs results, that it indeed may be the proper and most promising line of therapeutic intervention. It can alleviate various troubling symptoms and allow the child to develop in areas that might otherwise be blocked. Drugs, however, are a powerful technology and using them successfully requires care and attention.

We are devoting this current issue of the newsletter to some of the reactions we received to the last issue. We have not published "letters to the editor" before, but there was such an active response to the last issue that we decided to both share some of this with our readers and to continue the discussion by devoting more space to the topic of psychiatric medication and children. One persistent criticism we received was that we did not address the circumstances where parents have engaged in a careful evaluation of the question, with help from professionals who also took great care in evaluating the recommendation, and then decided in favor of using medication to help treat their children's problems. Accepting this suggestion, we have devoted several pages here to some of the questions and considerations that parents face who decide in favor of using medication.

Psychiatric medication is usually a relatively long-term treatment. It does not cure the problems it is meant to address in any quick and easy way, but serves to help work out some of those problems over time. In light of this, parents and children will likely go through a number of steps in getting accustomed to the use of medication. They will need strategies to think about and to talk about this process in order to derive the greatest benefit from it.

For over 100 years, the Jewish Board of Family and Children's Services, Inc. has been at the forefront of providing help and support to New Yorkers in need through a wide range of child and family programs. The Learning Resource Network is one such program, offering consultation and support services to assist parents concerned with child development and learning issues.

If you have any questions or concerns about your child, please feel free to contact us:

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Speaking with Children about Medication

One question faced by any parent who decides to use psychiatric medication is how best to explain this decision to their child. At what age should a child be told how the medication works, for how long it will be taken, what its effects are meant to be, what are possible side-effects, etc.? Should it be the parents or the doctor or both who speak with the child?

It is our view that parents should assume the responsibility of both knowing and talking about the psychiatric drugs they give to their children. And that this responsibility includes being aware of both what we know and what we don't yet know about drugs and the brain. Psychiatric drugs are a relatively new technology, especially in their use with children. We know more about how they work than we did a generation ago, but there is still much to learn. It is wise, although not always easy, to be honest with ourselves and with our children about the scope of our knowledge.

It is valuable for a child to learn how we make certain informed judgments in life, even when we are aware that more information will come in the future that might change our thinking.

Therefore, while we can be confident that drugs will help with certain behavioral problems, and we have a fair idea as to why, we are still not as sure about the causes of those problems. The interactions among inherited tendencies, developmental life experiences, and current circumstances are often too complex to reduce them to a single cause. Therefore, to take one example, it is neither truthful nor wise to tell a child that the only reason that they are taking a pill is because they were born with a brain that works differently than others'. In some cases that may be so, in others it is not. We simply have no way of telling in individual cases. To present this explanation to a child as a certainty, when indeed it is not, is unfair to the child. It also may close off a process of thought regarding the various causes and influences acting upon the problem. Medication is a tool among others for dealing with behavioral and attentional issues, as well as those related to depression. It should not be viewed as a contradictory alternative that, by its very use, rules out other explanations and other approaches.

There may be innate genetic factors that contribute to the child's problems, but the present state of knowledge about how much this is so is still quite limited. In any case, genetic inferences, at this time, do not form the basis for deciding to use psychiatric drugs or not, and therefore it is misleading to present them to the child as a principle reason. It would be far more truthful to refer to the thought process that resulted in the decision, namely that the child has been struggling with certain feelings for quite a while. Other efforts haven't yet helped. It seemed time to try another approach and see if it could be helpful. These are honest, clear, and useful statements and they prepare the child for what is ahead; namely a process of evaluation, feedback, and discussion with the prescribing doctor.

Our communication about psychiatric medications is important in that it includes children as a part of a process of thinking that takes honest account of what we know and what we don't know. Of course it is always best to present such information in a manner that is attuned to the maturity, comprehension and personality style of the particular child. It is valuable for a child to learn how we make certain informed judgments in life, even when we are aware that more information will come in the future that might change our thinking. How we present the current state of knowledge and uncertainty, the effects and possible side-effects, the potential benefits and the careful attention to any possible harm, communicates important values to children and engages them in a process of self-awareness that will be beneficial in the future.

Parents and professionals should make it clear that they are making an informed decision based on present knowledge and that they will evaluate this decision as they evaluate other decisions. The same open-minded questioning that went in to the decision to use medication will be used to reevaluate the use of medication over time.

We would like to know the questions and issues that interest you. We invite you to write to our e-mail address at Learning Resource Network (LRN). The address is lrn@jbfcs.org.

For Parents, There Are Always Questions

The decision of whether to give a child medication for behavioral and emotional problems is difficult for some parents and easy for others. The process for each family will reflect their experience with (and feelings about) medication, the perspectives of the people who are trusted, and the opinions of those professionals who know the child well.

As with most decisions about one's children, there is always a 'new chapter' of questions waiting to be addressed. The ones about medication usually fall in several categories — health/safety of long-term usage, advantages and disadvantages of letting people know that a child is taking medication, the impact on school and home. Although each story of a child and family is unique, what follows is a general perspective on issues that we hear about most frequently.

Is medication all that we need to do to help our child?

For most children, medication should not be the only intervention. Though medication can often take the 'edge' off troublesome behaviors and/or feelings, it is our belief that some type of psychotherapeutic intervention is necessary to help children and families understand the meaning and context of these difficulties and to develop strategies to help them cope in more effective and productive ways.

How do we know if the medication is helping?

Children respond very differently to medication. For some, it's like magic. A child who couldn't sit still is able to, a child who was prone to angry outbursts develops a greater calm. Unfortunately, more often, the shifts are less obvious — and many months can go by without any perceptible changes or improvement.

It is misleading to expect medication to do everything and it is important to observe carefully the pattern of a child's shifts. If you feel that the medication prescribed is either counterproductive or ineffective, further consultation with the prescribing doctor is essential. It is the parents' responsibility to share their observations, questions and concerns in order for the professional to truly understand the "story" of their child, to evaluate the effect of medication and to think about any other interventions that might be helpful.

Shall we tell the school that our child is taking medication?

Ideally, we feel that collaboration between home and school is essential. We also know that many parents are somewhat anxious about sharing personal issues about their child with teachers or other school personnel. We would hope that, in every school, there is a person who is trusted, to whom a parent feels comfortable in confiding. Especially when a teacher has voiced behavioral or emotional concerns about a child, it can only be advantageous for the teacher to be included in the process of supporting the child's development. Any collaboration that can help a child feel competent in his community of peers is very worthwhile.

How do we know when medication is no longer necessary?

A very careful process of observation and thought most probably preceded the recommendation for medication. Possibilities for intervention were considered, perhaps some were tried — and, eventually, it was felt that medication would be helpful. A similar thought process should continue after the child begins medication — to assess any changes in the child's functioning, to evaluate the child's response to medication and to figure out what else needs to be addressed in order to help alleviate the difficulties. Depending on these observations and interventions, many parents will want to consider the possibility of reducing or ending medication. Obviously, one should never make this decision without consulting with the doctor who prescribed the medication. But, depending on a child's age, he is often the best barometer for gauging whether medication is needed and/or whether he feels that he can modulate his behavior and feelings without medication. Helping your child to make wise and self-aware decisions — about any aspect of his functioning — is a wonderful developmental gift. Often, a child will be correct; at other times, he will need to realize that medication is still necessary. Encouraging a child to think about these issues, to be more self-reflective and grown-up is probably our most important goal as parents!

Letters to the Editor

The last issue of **Thinking Children** *dealt with topics concerning medicating children for psychological, emotional, and behavioral issues. These are some of the responses that we received from our readers. All of the letters have been edited due to space constraints. Each author has approved the edits to her/his letter.*

To the Editor:
In responding to the four articles in the March 2004 issue of *Thinking Children,* I find myself remembering the heated debates of the recent past regarding which has more of an influence on human development: *nature* or *nurture*. Looking back on those debates, I wonder how anyone could ever not think that it is really both. It seems to me that the current debate about the use of medication to treat children with psychiatric disorders or behavioral issues has a similar ring to it. In the end the conclusion will be that it is not exclusively organic nor is it exclusively functional. It too is really both. If we operate from that premise, then Dr. Lichtenstein's statement "there is no substitute for careful assessment" *should* be the final word in the debate over whether or not to use drugs to treat childhood psychiatric and behavioral disorders. The rub is that in the current state of affairs, assessment often may not be "careful," and the subsequent treatment — regardless of what form it comes in — might not be sound. Furthermore, the individuals that occupy the child's life space may not see eye to eye about the need for the best method to arrive at proper diagnosis. This is where an individual's biases may influence the assessment process and render the conclusions suspect. It appears to me that the solution lies with expanding Lichtenstein's sentence to say "there is no substitute for careful and unbiased assessment, where parent, teacher and other involved professional input is accepted and considered."

Inappropriate intervention can all have long-term life alternating influence. Yet, too frequently the conclusions drawn from the assessments are taken as gospel and become part of a fixed perception of the child. In plain words, the conclusion drawn about the underlying cause of behavior difficulties becomes fixed. Subsequent interventions are then designed to respond to the diagnosis stemming from the assessment and, if taken as the final word, further exploration and evaluation into the child's changing needs may invariably be ignored.

Paying attention to the changing needs of the child in determining the appropriate ongoing treatment and intervention can mitigate against the pitfalls of overreliance on the initial assessment. This is the safeguard that all children deserve.

— Jeff Ackerman, Ph.D
Director, Elmwood Day Camp

To the Editor:
The last issue of *Thinking Children* discussed the subject of medicating children. The articles were well-researched and well thought-out, but incomplete. The missing area is that of the adult with ADD, who did not have the "benefit" of medication throughout his or her childhood struggles.

As a family therapist, I have had clients with ADD, who would report on his or her life before and after being diagnosed and properly medicated. In order to respond appropriately to the newsletter, I contacted one of my former clients. He is a 56-year-old, retired, bi-lingual educational evaluator. I asked him to describe his life before and after medication. I quote from Dan's report:

Dan's responses to questions about his life *before* taking medication:

Educational: *"I always did poorly in school even though I tried hard. I did poorly on standardized tests getting only low 500s on the SATs. I managed to graduate from college with a C average and attempted to earn a master's degree from two universities but was unsuccessful, withdrawing with incompletes."*

Vocational: *"I had many menial jobs after college including driving a taxi and pumping gas. When I attempted to earn a living as a substitute special education teacher, I had to leave my position because I was fearful of receiving unsatisfactory ratings."*

Emotional: *"Throughout most of my life, I felt depressed and frustrated by my inability to accomplish anything worthwhile. I had no self-confidence and no self-esteem."*

Dan's responses to questions about his life *after* he started on Ritalin, Adderol, and presently Concerta:

Educational: *"I completed my M.S. in special education with honors after receiving straight As. I received superior grades on all Board of Education licensing exams."*

Vocational: *"I worked first as a full-time bi-lingual special ed teacher and then for the last 10 years as a Bi-lingual Educational Evaluator before retiring to work privately."*

Emotional: *"I developed a "can-do: attitude. Each success lead to another and I lost my fear of attempting new challenges. I was able to remain focused on tasks. I had self-esteem"*

Dan's testimonial speaks for itself.

— Sydell S. Sloan, M.A.
Family Therapist

To the Editor:
As I read your newsletter's articles, I was struck and disturbed by the theme of "either-or." Although there was much said about the "mind-body" connection, when it came down to treatment choices, it was medication versus psychological evaluation and understanding.

I am the mother of a thirty-three year old son who was diagnosed, in 1978, with ADHD and learning disabilities. After a neuro-psychological evaluation, he worked with an educational specialist, and a neurologist who prescribed Ritalin to help him with his distractibility. He also worked with a psychotherapist. The medication helped with my son's impulsivity and lack of focus as did the educational specialists and psychotherapists. Medication was not a "first response" nor was it a "method of last resort"; it was one more tool that has been extremely helpful to my child.

Although your newsletter attempts to help parents with the decision of whether or not to begin a trial of medication with their children, I found it to be a biased presentation. Rarely are the benefits of medication addressed, although the negatives and dangers are. Your first article lists only the negative. The second, more subtly, seems to favor psychological intervention over treatment with medication. "Medication should never take the place of solid comprehensive thinking." In my opinion the consideration of medication treatment should be part of that "solid, comprehensive thinking."

As parents and professionals, we are presented with a variety of interventions for the treatment of children. All, whether of a psychological, educational or medical nature, have implications for a child's sense of his competence and should follow from a thorough assessment of the child's "psychobiology."

— Miriam Elin, C.S.W.
Psychotherapist

To the Editor:
As a prospective first time parent counting down the months, days and minutes to the birth of our son, all of my dreams, hopes and desires were that this child would be extraordinary. He is indeed just that.

Let me be very clear from the very beginning that we are most grateful to the Jewish Board of Family & Children's Services, for all that they do, at to everyone at Learning Resource Network for creating this new forum. Anything devoted to easing parental anxiety is much appreciated, but after reading the latest issue of "Thinking Children" (Vol. 2, Issue 1, March 2004) my insecurities and angst resurfaced once again.

After consulting with five (5) separate psychiatrists/psychologists, listening to the feedback and suggestions from the teachers and therapists who work with our son, and exploring most other avenues, we hesitantly agreed to treat our son with medication to help him "focus." As those of you who know from experience, this was not an easy decision to make and I continue to question the efficacy every day.

I truly appreciate that all the contributors were cautioning us from jumping in too early and encouraging us to investigate all avenues before reaching for the elusive elixir. But until such a panacea is discovered, it would be comforting to those of us who agonize every day about choosing the right course of action, to hear from those who have been comforted from positive results from most painful decisions.

— Anonymous
Parent

To the Editor:
All the authors raise serious, valid points. As a neurologist, my bias is that I do use psychopharmacological agents — albeit with significant reservations. Dr. Lichtenstein's comments about the lack of documented evidence and efficacy of medications in the pediatric population, the unknown effects on the developing nervous system, and their undefined role in the treatment process are quite accurate.

Medications are everywhere. Advertising is ubiquitous. Many parents resist *any* consideration of medication. Others seek a "quick fix" to avoid the difficult behavioral work necessary to help their children develop and heal. Dr. Winokur mentioned the aspect of "time" with respect to medical and psychiatric care. Understanding children takes *time*. Assessment requires *time*. The current system penalizes the patient, family and clinician.

How can I, as a solo physician outside a multi-specialty center, provide comprehensive care? There are no easy answers to the obstacles outlined in the preceding sections. First, I must be aware of my own biases for or against particular treatments. Second, I must have as much information as possible from *multiple* sources such as teachers, parents, other observers, and the children. The family must understand the evaluation and treatment process. Where needed, additional evaluations by psychologists, speech and language pathologists, physical and occupational therapists, social workers, and/or educators often help define the issues and treatment approaches. Third, I must define the problems for myself and for the family and child. If there is disagreement between the family and me with regard to the "problem," then I must obtain additional information and modify the diagnoses. We need to define the "target" behaviors and symptoms. Fourth, I must assess the resources available to the family in the school and community. Fifth, I must monitor the response of the child to the intervention. If I believe medication is indicated and prescribe it, then I must monitor the child closely. Doing this is incredibly difficult, especially communicating with teachers on a regular basis. *Time* is against us in this process.

There are no easy answers to these dilemmas, but we professionals must constantly question our approaches and seek to provide the most comprehensive professional and compassionate care possible.

— Jay E. Selman, M.D.
Child and Adult Neurologist

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Letters to the Editor

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To the Editor:
The March 2004 issue of *Thinking Children* published several provocative articles regarding the use of psychiatric medications in treating childhood disorders, which I read to be generally negative towards their use. There were several positions presented that I feel warrant some comment to balance the picture.

In the cover article, David Lichtenstein states that medication is now often "the first response to a number of fairly common behavioral problems." There are no data to support this assertion. In my experience, before a pediatrician recommends medications or a psychiatric evaluation with the prospect of trying medication, other approaches by parents, teachers, counselors, and therapists have already failed. Dr. Lichtenstein raises several good points to consider in using *any* medications with children, but he only labels the trend towards increased use of psychiatric medications as "disturbing." He also misstates the British position; in fact *specific* antidepressants were targeted, while one of the SSRIs, Prozac, remains acceptable based on research that showed it is safe and effective in treating pediatric depression. Further, it is simply insulting to read that these medications are being prescribed without "extreme caution." I believe most physicians exercise appropriate caution in all their prescribing.

Marsha Winokur's article expands on the idea that we do not fully understand the etiologies of these disorders — biological or environmental — but seems to argue that this lack of understanding makes the use of medications undesirable. In truth, many of the non-psychiatric medications commonly in use have mechanisms of action that are only incompletely understood. This does not stop us from applying them, when the evidence suggests there is clear benefits possible which outweighs the chance of adverse reaction.

The overall tone of this issue was that psychiatric medications should be viewed with skepticism, simply because they are medications. There was no meaningful presentation of the pros and cons, risks and benefits of these treatments, or well-established alternatives to medications. There was the suggestion that more time should be spent, more options explored, before resorting to the recommendations of seasoned clinicians and educators. How much time? What other options have been shown to be as effective as medications in these cases? What are the likely results of declining medication?

I hope a future issue will present the experience and evidence that supports our recent acceptance of medications in appropriate situations. It is true that issues of economics, advertising, culture and the shortage of clinical time and personnel have contributed to the rise in using medications for these conditions. However, the rise is largely due to the efficacy of these medications in everyday practice. If non-medication therapies are ever developed that are shown to work better, faster, less expensively, with fewer undesirable consequences, there will certainly be a shift in that direction.

—Richard Gersh, M.D.
Executive Deputy Chief Psychiatrist, JBFCS

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