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THE ALARM ABOUT CHILDREN, ADOLESCENTS AND ANTIDEPRESSANT MEDICATION

by

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What's all the media buzz about children and antidepressant medication?

Do medications make people commit suicide, murder relatives, make them grow three heads, make them see things that aren't there, or become psychotic?

Are childhood psychiatric medications absolutely harmless?

These are often scary questions that have been posed by patients, parents and the media. The answers are not always straightforward, but like many things, a bit of common sense, exercise of a reasonable degree of caution and use of a number of precautions can go a long way to ensure that safe and effective treatment is provided to our loved ones.

Antidepressant medications are among the most frequently prescribed medications in the . One factor in increased prescription of antidepressants is that modern antidepressant medications are less lethal in terms of overdose potential than the older tricyclic antidepressants and are generally regarded as having less side effects or adverse reactions. It may surprise some that family practitioners account for more prescriptions than trained psychiatrists. The reasons for this are many, including the perceived stigma associated with seeing a psychiatrist and the extra cost of specialty care.

If similar success rates achieved in the treatment of depression were seen in cardiac disease, diabetes or other serious conditions everyone would be praising the results of these miracle drugs and treatments. Unfortunately, there is still stigma associated with treatment of mental health disorders and some insurance industry practices create obstacles for those who suffer from such disorders. Despite the historical Mental Health Parity Act, insurance companies have continued to discriminate against the mentally ill by the process of "mental health carve outs", sub-par reimbursement to mental health and specialty providers, or general discouragement of specialty care.

These discriminatory medical delivery trends occur in a context of a modern society in which rates of depression and suicide are increasing, particularly for children, adolescents and the elderly. Estimates suggest up to 12% of adolescents may have some form of depressive disorder. Given the large number of prescriptions written and the fact that these medications are prescribed to individuals already having difficulties, it should not be surprising that there are some adverse, and even bizarre reactions. The scientific challenge is trying to understand if these incidents are simply coincidence or pose significant specific risks that must be considered by patients, parents and

doctors. The challenge for clinicians and parents are to provide treatment in a manner that maximizes recovery and health and minimizes risk.

Risks of medication or other treatment must be considered in the context that depression is not entirely a harmless condition. Risk of suicide, occupational and educational impairment, lost productivity, loss of self-esteem, and increased risk of self-medication through alcohol or substance abuse. Furthermore, the impact on relationships can be substantial. Suicide is the most common cause of death in children age 5 to 14, the third most common cause of death in people age 15 to 24, and the fourth most common cause in people age 25 to 44. The fact medical and psychological treatments are known to be effective in decreasing these risks.

To further complicate matters, all depression is not the same, there are varying types and varying degrees of severity. While rare, some individuals will become psychotic, suicidal and even homicidal without medication. Some studies have demonstrated that those who commit suicide and those who commit homicide both share decreased serotonin metabolites. Serotonin and other neurotransmitters play important roles in depression and emotional regulation. Thus, medication in many cases is likely to prevent or reverse severe depression and suicidal or homicidal risk.

Unfortunately, there is sometimes a failure to recognize medication reactions and individuals may be misdiagnosed as suffering from bipolar disorder, another mental illness, or multiple condition. This risk is magnified if careful diagnostic consideration of history of symptoms, medication reactions, and medication interactions is not completed. While co-existing conditions do occur, when such reactions occur it is often wise to consult a trained psychiatrist and conduct a thorough and careful psychological evaluation by a licensed psychologist to include formal psychological testing. This can avoid months if not years of treating the wrong condition, labeling with a more severe psychiatric condition, or long-term treatment with often even riskier medication than the antidepressants.

A UCLA review study by psychiatrists Licinio and Wong noted suicide rates rose steadily from 1960 to 1988, they noted that suicide rates dropped from the 8th to the 11th leading cause of death in the United States after the introduction of Prozac. They noted that the vast majority of suicides did not have antidepressants in their bloodstreams at the time, suggesting that the likelihood is that there are more suicide deaths from untreated depression than from any adverse reactions to medication. Nevertheless they advocated for closer follow up of individuals treated with a selective serotonin reuptake inhibitor (SSRI) or other antidepressant medication and for even closer monitoring of SSRI use by children.

Antidepressant medication reactions and side effects are generally well known. Sexual side effects are not uncommon, some GI discomfort is reported, and while some antidepressants help with sleep, others may create some sleep disturbance. Some have more activating properties and others more sedating properties. Psychotic reactions which involve hallucinations and other disturbances of reality rarely occur with antidepressant medication. Another rare, but reported reaction is increased agitation and uncontrollable energy and restlessness (a manic or hypomanic reaction). These usually resolve with careful monitoring and medically prescribed reduction or discontinuation of medication. Sometimes, medication to counteract the reactions is prescribed on a short-term basis.

The American Academy of Child and Adolescent Psychiatry (AACAP) recommends psychotherapy, a selective serotonin reuptake inhibitor (SSRIs), or a combination of both as first line for acute treatment for major depressive disorder. In fact, the National Institute of Mental Health reviewed studies and found that adolescents not responding to medication alone are more likely to improve if treatment involves both psychotherapy and medication. Furthermore when there are significant signs of weight loss, inability to concentrate or function, and significant sleep disturbance a combination of medication with psychotherapy has been demonstrated to be more effective than either treatment alone.

Obviously, all medications involve some degree of risk. Careful psychological and psychiatric evaluation can assist in decisions involving medication and can help identify other psychotherapeutic approaches to treating depression. If immediate risks are not high, and depression not severe, psychotherapy is a proven treatment for depression that carries minimal risk of harm.

While many children or adolescents can be safely treated with antidepressants without complication, prudent and conservative care suggests the use of psychotherapy as a primary mode of treatment in mild child or adolescent depression and as an adjunct to pharmacotherapy in moderate to severe cases. While medication may often be necessary and sometimes critical, pills don't provide skills.

While we seem to live in a society which subscribes to a "pill will solve everything" mentality and one in which insurance companies (especially those of the "mangled care" flavor) undervalue

psychological assessment and psychotherapy services, there are things that can be done to minimize the risk of harm to your child or adolescent. Careful psychological assessment by a licensed psychologist to ensure proper diagnosis and identify risks is especially important in children and adolescents. This can also identify conditions such as anxiety disorders, sleep disorders, learning disorders, and behavioral issues which may be creating, contributing to, maintaining, or worsening the depressive disorder.

Despite the costs of such services and "mangled " trends to circumvent specialist care, it only makes sense that if someone were to take medication for several months or up to a year or two, that an investment be made in thoroughly assessing the nature of the problem to be treated. This is doubly true if it is your child or adolescent.

The good news is that most initial trials of therapy or medication involve 6 months to a year of treatment. A good response to medication may not be apparent for a few weeks. In the majority of cases, treatment involving medication and/or psychotherapy is successful. While there are costs for psychotherapy and therapy requires the devotion of time and effort to effect self-change, therapy allows for reduced risk through closer monitoring for what most of us value most: the well being of our children and adolescents.

Psychoactive medication for children and adolescents should not occur in a vacuum. While the risks of not treating must always be considered, the risks of treating with medication can be reduced by specialty consultation and psychotherapeutic follow up.

Parents always play an important role in these very serious treatment decisions as well as in monitoring treatment responses, adverse reactions, and reducing risk. NAMI has published the following guide for families: What Families Should Know about Adolescent Depression and Treatment Options.

Dealing with childhood or adolescent depression is a serious issue. Establishing a therapeutic relationship with a child or adolescent can take time, financial sacrifices, and effort, but the benefits of another safety net cannot be underestimated as this often represents a source of hope in the child's world. This is an important countermeasure to the hopelessness which often precedes suicidal or other desperate acts (see other articles on teen suicide in our articles and archives section on our website). Even without insurance the costs of a quality psychological evaluation or six months of therapy is often less than that of a big screen television, dental work, or other major purchase.

Certainly, our teens and children are worth it.

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