

The Alarm About Children, Adolescents and Antidepressant Medication

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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 and become psychotic? Are childhood psychiatric medications totally harmless? These are questions that have been posed by patients and increasingly by 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 the use of a number of precautions can go a long way in ensuring safe and effective treatment is provided to our loved ones.

Antidepressant medication are among the most frequently prescribed medication in the United States. It may surprise some that family practitioners likely account for more prescriptions than trained psychiatrists. The reasons for this are many, including stigma associated with seeing a psychiatrist and the extra cost of specialty care. This is often compounded by insurance industry practices which place greater limitations on mental health than more general health benefits, require higher co-payments and managed care pressures to avoid specialty care. Another factor is that in all likelihood modern antidepressant medications are less lethal in terms of overdose potential than the older tricyclics and are generally regarded as having less side-effects.

These medical delivery trends occur in a context of a modern society in which rates of depression are increasing, particularly for children, adolescents and the elderly. Given the large number of prescriptions, and the fact that these medications are prescribed to individuals already having some difficulties do not make it surprising that there are some adverse and even bizarre reactions. The scientific challenge is trying to understand if these incidents are simply co-incidence or pose a significant risk that must be considered by patients, parents and doctors.

These risks must be considered in the context that depression is not entirely a harmless condition in and of itself. 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. Risk of suicide, occupational and educational impairment, lost productivity, loss of self-esteem and impacts on relationships can be substantial. Medical and psychological treatments are known to be effective.

To further complicate matters, all depression is not the same, there are varying types and varying degrees of severity. 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 for many individuals.

A recent 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 SSRI or other antidepressant medication and for even closer monitoring of SSRI use by children

Some reactions and side effects are generally known. Sexual side effects are not uncommon, some GI discomfort is reported, and some antidepressants help with sleep and others may create some sleep disturbance. Some have more activating properties and others more sedating properties. It is true that psychotic reactions which involve hallucinations and other disturbances of reality, although rare, can occur with antidepressant medication. Another rare, but reported reaction is increased agitation and uncontrollable energy and restlessness. 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.

Unfortunately, there is sometimes a failure to recognize medication reactions and individuals may be mis-diagnosed as suffering from bipolar disorder, another, or multiple conditions. While co-existing conditions 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 clinical psychologist to include formal psychological testing. This can avoid months if not years of treating the wrong condition with often even more riskier medication than the antidepressants.

Obviously, all medication involves risk. Careful evaluation such as that described above 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. 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 treatment alone. While we seem to live in a society which subscribes to a pill will solve everything 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.

Despite the costs of such services and mangled care’s trends to circumvent specialist care, it only make sense that if someone is going to take medication for several months, a year or two or in less frequent cases more, 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.

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.

The good news is that most initial trials of therapy or medication involve 6 months to a year of treatment. Medication effects may not be apparent for a few weeks. But in the majority of cases treatment involving medication and/or psychotherapy is successful. If similar success rates 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 the aforementioned insurance industry practices which often create obstacles for those who suffer from such disorders. While there are costs for psychotherapy and this 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: our children and adolescents.

Certainly, antidepressant medications are not entirely benign, there is some risk associated with any medication that impacts on the regulation of our nervous system and emotions. Such treatment should be considered only when a careful diagnosis has been made, and when it is appropriate and necessary. 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.

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 www.cpancf.com 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 or other major purchase. Certainly, our teens and children are worth it.

Biography

Dr. Bordini is a Florida Licensed Psychologist and has been named a Distinguished Psychologist by the Florida Psychological Association. He is executive director of a group private practice with offices in Gainesville and Ocala and has served on the Florida Psychological Association Board of Directors and as an FPA Insurance and Practice Chair. He holds a position as a courtesy assistant professor in the Dept. of Psychiatry at the University of Florida. His primary specialty is forensic psychological assessment and neuropsychological assessment of children, adolescents and adults.