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Our Children's Brains Part XV: Drugged: Are Our Children Being Overmedicated?

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Jamie slumps on the couch, watching TV, her eyes glazed over. She barely reacts to the shenanigans on SpongeBob SquarePants, her favorite cartoon. Her mother, Maria Larmen, worries that her daughter "isn't even in there anymore."

Two years ago, Jamie was a knobby-kneed 8-year-old with big blue eyes and long strawberry blond hair. But the child was, as her mother describes her, "out of control."

"She wouldn't sit at her desk at school. At home, she was up and down every five minutes, all day. During dinner, she'd get up, have outbursts. It took hours just to get her fed-then getting her to bed was an ordeal in itself. There were nights when I considered giving her NyQuil or Benadryl, just to get her to sleep," Maria admits sheepishly.

Then, in 2006, Jamie was diagnosed with attention deficit hyperactivity disorder (ADHD) and prescribed Strattera. Her mother says she's never been the same.

"At first I thought it was great: She was calm for the first time since she was 2. I was so grateful to have moments to think, moments of silence. But after the shock wore off, I started to realize that it was an abnormal silence," says Maria.

Jamie had all but gone mute. She stopped being rambunctious and having outbursts at dinner. She went right to bed at night when she was supposed to. But she also stopped talking-almost completely. Her appetite diminished, and now she spends most of her free time at their small home in Shirley in her room, alone, just staring, her mother says. Jamie's doctor told Maria to wait it out, saying this was just the natural course of the medication. But Maria is concerned. She wonders if she should take Jamie off the medication.

"I am scared that it will put her fire out forever. I couldn't live with that," says Maria.

Situations like this are common. An estimated one in 10 American children and adolescents suffers from mental illness severe enough to cause some level of impairment, according to the National Institute of Mental Health (NIMH).

With so many being diagnosed with ADHD, depression, anxiety and other disorders, the number of children taking medication for such problems has surged since the mid-1990s-which was, coincidentally, right around the time that atypical antipsychotics, a new category of medications, came on the market. Between 1993 and 1995, antipsychotic medications were prescribed to 275 per 100,000 children; in 2002, such drugs were prescribed to 1,438 per 100,000 children. Those numbers, from a NIMH study published in 2006 that looked at data from doctors' offices, point to an increase of more than five times.

Some parents, though, say the only way that their kids can get through the day is with medication. The media focused on this in January, on the Public Broadcasting System's *Frontline*. The show examined why more than 6 million children in this country-some as young as 2-are being treated for what doctors describe as serious psychiatric disorders.

Some children are prescribed multiple medications: The first one prescribed causes unwanted side effects, another is prescribed to counteract those effects, the second drug causes other undesirable results, so a third medicine is prescribed to counteract the second medicine's effects. Children can end up on multiple drugs, their prescription "cocktail."

But while many insist such treatment is necessary, are we doing our children more harm than good by giving them these drugs?

UNCHARTED TERRITORY

Holly and Howard Jackson, of Woodmere, believe that without the drugs their son Marcus is on, they'd never be able to survive. Marcus, now 5, was "a monster" at 18 months, says his mother. At 2, he was diagnosed with bipolar disorder and prescribed an arsenal of medications. Bipolar disorder, once known as manic depression, in children is one of the most controversial diagnoses, and a polarized medical community argues whether it exists at all.

But Marcus' parents were at their wits' end. "I was scared that he'd never be able to go to school, be in a play, join a team or really be part of anything because of the way he acts," remembers Holly. "The doctors tried everything and finally we got to a combination that works the best."

While medicating children might seem like a heaven-sent solution for parents, some doctors are concerned about the long-term effects that such heavy use will have on young children, both mentally and physically. And while researchers have started studying children as young as preschool age-because these disorders often start in early childhood-much is not known about such conditions or the medications.

The drugs commonly prescribed to individuals displaying unstable behavior, including aggression and mood swings, are psychotropic medications. They include antipsychotics (to treat schizophrenia and mania), antidepressants, anti-obsessive, antianxiety, anti-panic and mood-stabilizing medications.

But because of the lack of data about such medications' effects on young brains and bodies, many of these drugs haven't been given FDA approval for children. They are being used "off-label," stirring up murky water for physicians.

There's the catch-22.

Most drugs approved for adults have been studied only in adults. Children may react very differently than adults. When drugs are given FDA approval, doctors are free to legally prescribe them to children even though that approval was for adults. They can also prescribe them for disorders other than the one for which they were originally approved.

"Off-label is a legal term that prevents the drugmaker from being held financially liable if a doctor uses the drug for a reason that it was not approved for and the patient has an adverse reaction," says pharmacist Vincent J. Giordano, R.Ph., a former employee of psychiatric children's facility South Oaks Hospital in Amityville.

"The truth is, a lot of drugs are used safely off-label," he adds, citing the use of the antidepressant Wellbutrin as a smoking-cessation aid. But Giordano says that it is difficult for companies to test drugs in children.

"The question here is, how do you ethically do a drug study on children?" asks Giordano. "But even the best drug study can't possibly predict everything, so the FDA relies on pharmacists, doctors, and patients to inform them of any side effects they are noticing. If we find the drug is doing more harm than good, we can get it taken off the market." Some might argue that it's a necessary experiment.

Some parents are up in arms about their children being used as guinea pigs by pharmaceutical companies. Lillian Overton's son (the names have been changed because of involvement in a lawsuit pertaining to this case), Michael, was prescribed the antipsychotic Thorazine as a child, after being diagnosed as schizophrenic. Doctors played with Michael's dosage for years, Lillian says. After about three years, he started rocking back and forth, almost uncontrollably.

"He started to suck in his lips and blow them out, like he was always chewing on something. It was like he had no control over his body or his face," says the Ithaca mother. Michael cannot control his body; he suffers from tardive dyskinesia, an untreatable movement disorder that develops in some patients taking antipsychotic drugs.

"We were never informed; we were never told that this could happen. We were never given any alternatives," says Overton. "These drugs took away a part of Michael's life. You can't put a price on that."

Now, another conundrum has surfaced. Starting around 2003, concerned parents began wondering about whether the antidepressants their children were taking were causing suicidal thinking and behavior, after regulators issued public health warnings—a "black box" label on certain medications—about a possible link. As a result, antidepressant medications for youths decreased by approximately 22 percent nationwide, according to a 2007 Centers for Disease Control and Prevention (CDC) study.

But between 2003 and 2004, more young people committed suicide. Rates increased by 14 percent, the largest year-to-year change in suicide rates in this population since the CDC began collecting suicide data in 1979. Researchers concluded that youth suicide rates increased after the children discontinued medication. More data is being studied, but if the conclusion holds true, it means that the benefit of young people taking such medication—choosing life—far outweighs side effects.

BOUGHT AND PAID FOR

Some observers believe that doctors do not supply information on alternatives. Pino LoGiudice, N.D., a doctor of naturopathic medicine practicing in Manhattan and Syosset, says that nutrition is another approach that can be used alone or as a supplement to other alternatives.

"However, absolutely there are times when medications are warranted and should be the initial treatment," she adds. "My concern with these children is that no other options are then explored. If a child needs to be put on a medication, all the underlying support of nutrition or alternative medicine still should be implemented so that there is an exit strategy on how to get them eventually off the medications."

Others reject that these disorders even exist, calling the diagnosis a ploy for doctors to create lifelong consumers out of children, to keep themselves in business.

Fred A. Baughman Jr., M.D., a neurologist/child neurologist and author of *The ADHD Fraud*, says simply, "It's all profit driven." He insists that there are too many physicians, saying, "When you have plenty of patients, you make each one a lifetime patient by putting a label on them and putting them on drugs they will never come off."

He labels it "consumerism in medicine."

There is also speculation that doctors are being courted by pharmaceutical companies to push certain drugs, so physicians offer no alternative, non-drug or otherwise. Medication manufacturing and marketing has meant big business: In 2000, the U.S. Drug Enforcement Administration estimated that prescriptions to treat ADHD increased by 500 percent during the 1990s; between 1994 and 2001, prescriptions for psychotropic drugs for teenagers rose 250 percent. Another coincidence: After 1999, the federal government permitted direct-to-consumer advertising, along with looser promotion of off-label use of prescription drugs. The same 2006 Brandeis University study that cited the 250-percent increase also found that by 2001, one in every 10 doctor's office visits by teenage boys resulted in the boy receiving a prescription for psychotropic medication.

David W. Oaks, director of MindFreedom International (MFI), believes that many are coerced or forced to take such drugs, because it seems easier to medicate children than to work through a painstaking situation. He works with MFI, in Eugene, Ore., an independent grassroots organization that unites other groups and individuals and advocates for human rights in the mental health system. He was institutionalized after being diagnosed as bipolar, before becoming an activist.

Oaks is careful to say that MFI is not against the use of drugs, but instead supports patients being able to make an informed choice. Alternatives would include counseling, peer support, job programs and supported housing. "Unfortunately, all these kinds of approaches are off the table," says Oaks. "Often, drugs are the only option given."

"There's no diagnostic test. No brain scan, no urine test," says Oaks. "If a doctor says your child has a biochemical imbalance, ask to see the lab results. You'll never see them, because they don't exist."

Dr. Andrew Adesman, chief of Developmental and Behavioral Pediatrics at Schneider Children's Hospital in New Hyde Park, specializes in treating kids who have ADHD and autism spectrum disorders. He disagrees with Oaks, pointing out, "We do not have blood tests for autism or mental retardation; does this mean these are also spurious diagnoses?"

Focusing on the treatment of ADHD specifically, he says, "Yes, the medication is often most accessible and may be perceived as expedient—since it works so quickly and is less disruptive than other forms of treatments—but it is also most effective. Should parents be obligated to settle for less-effective interventions because someone else is not comfortable with a proven therapy? I think not. I believe strongly that patients should discuss all effective treatment options with their treating clinician and then together decide what treatments—or combination of treatments—is most suitable."

YOUNG CANARIES IN COAL MINES

The question of how much medicine is too much struck home in 2006 with the high-profile death of Rebecca Riley, a 4-year-old girl who died from an overdose of antipsychotic medications she had been prescribed by psychiatrist Dr. Kayoko Kifuji at Tufts-New England Medical Center, in Boston. The child had first been taken to the doctor at the age of 2 because she was hyperactive and had trouble sleeping. Though she could barely speak at that age, Rebecca was diagnosed as bipolar. To stabilize her mood, Rebecca was given a prescription drug cocktail: an antipsychotic, an antiseizure and a blood pressure drug. While Rebecca was taking those three medications, her mother gave her children's cold medicine as well, to ease the child's cold symptoms. The combination turned out to be lethal.

Rebecca's parents, Carolyn and Michael Riley, now awaiting trial for second-degree murder, say that they followed doctor's orders. Prosecutors, however, charge that the Rileys deliberately gave their daughter too much medication, so she would sleep.

Who is to blame? Is it Rebecca's parents, who gave the child more than twice the dosage-plus cold medicine? Or is it the doctor, now on paid leave, who diagnosed the 4-year-old as bipolar-because of hyperactivity and trouble sleeping-and prescribed Clonidine, Depakote, dextromethorphan and chlorpheniramine? Each medication Rebecca took had a side effect, and sometimes side effects can be as debilitating as, or worse than, the disease. In this case, the effect was deadly.

Another question is, who is usually given such strong medications? A San Diego State University study of more than 3,000 children and adolescents compared those in the child welfare system with young people not receiving welfare. The study found that, between 2001 and 2002, 13.5 percent of those in child welfare took psychotropic medications. Its conclusion: "These national estimates suggest that children in child welfare settings are receiving psychotropic medications at a rate between two and three times that of children treated in the community." Again, are children in the welfare system serving as guinea pigs? Will they be those who are most often given the latest batch of psychotropic children's medicines, which may cause side effects ranging from the manageable-weight gain-to the horrific: Parkinson's disease or a chemical lobotomy?

The overmedication of America's children has been hotly debated among activists, parents, the medical community and the media for years. Everyone blames someone else.

No medicine comes without risk. But again, what if the drug's beneficial effects make the child's and the family's lives better? What if such medicines make a crucial difference, keeping a young person alive, to look forward to a better future? In the end, it is up to the parents to ask questions, heavily weigh the pros and cons, and make the most informed choice they can to safeguard the well-being of their children.

WHAT TO DO

Many children "act out" after experiencing, say, a move to a new home or a birth in the immediate family. This behavior is temporary and usually resolves in time. But parents should consider problems as being serious and needing attention "when they are severe, persistent, and impact on daily activities," according to the NIMH. This includes changes in appetite or sleep, social withdrawal, or fearfulness; regressive behavior such as bed-wetting; sadness or tearfulness; self-destructive behavior such as head banging; or a tendency to have frequent injuries.

If you are concerned about your child, first, consult your child's doctor and request that a complete health examination be done. Ask the doctor if your child needs evaluation by a specialist in child behavioral problems, such as a psychiatrist/pediatric psychiatrist, psychologist, a social worker, counselor, and/or behavioral therapist. Other resources would include a registered dietitian,

nutritionist, physical therapist, art therapist, alternative medicine practitioner, support groups and, of course, your child's teachers.

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