

## ETHICS CASE

### Should Clinicians Medicate against Structural Violence? Potential Iatrogenic Risks and the Need for Social Interventions

Commentary by Lauren E. Hock, MD, and Niranjan S. Karnik, MD, PhD

#### Abstract

This paper examines how a child psychiatrist might approach treatment of aggression in foster care youth. We argue that a multimodal approach is best. Physicians should weigh not only the iatrogenic risks of off-label antipsychotic medications but also the possible consequences of failing to treat complicating social factors at hand. Advocates must address structural violence and failures of imagination in their efforts to improve mental health equity among vulnerable youth.

#### Case

Jordan threw himself down on Dr. Eitel's couch. He stared into the distance with a scowl on his face. Anger and frustration emanated from him—he was in no mood to talk. Jordan had once again gotten into a fight at school resulting in a five-day expulsion. Although the police had been called, thanks to the school's misconduct policy, an official arrest had not been made with the understanding that the school would handle the situation. Nevertheless, this was no victory for Jordan. "He knew exactly how to piss me off!" Jordan yelled at Dr. Eitel, "He did it on purpose. He was *trying* to push me over the edge because he knew this was my last shot!" A string of muttered expletives followed. The principal had warned him that one more misdemeanor would meet criteria for permanent expulsion from the school. Following his five-day expulsion, Jordan would have to attend a committee meeting to determine whether he would be allowed to remain at St. Joseph's Academy. Dr. Eitel felt bad for Jordan—she knew that he had been trying hard to stay out of trouble. He was making an effort, but it just was not good enough. Jordan's demeanor changed to one of resignation and defeat. "Whatever, I heard the alternative school makes you wear jumpsuits. It'd be nice, like wearing pajamas all day," he joked.

Jordan had not been dealt an easy hand in life. At the age of eight he had been placed in the foster care system and was presently in his third foster home. His current foster family seemed to take a greater interest in Jordan than his prior placements, but Dr. Eitel could sense that even their patience was running thin. They had worked hard to get Jordan placed in this school and Jordan knew that his poor behavior had disappointed them.

Jordan was now a junior in high school, and his more recent activity worried Dr. Eitel and his foster parents. His violent actions were escalating, and the possibility of his being incarcerated seemed increasingly likely. He would soon be considered an adult by the state and his behavior would have a permanent impact on his future.

Dr. Eitel shared Jordan's frustration. She was tired of the failing systems that let kids like Jordan down, and she wondered if there was a way to help "level the playing field" for him via an "off-label" prescription for the antipsychotic risperidone. In Dr. Eitel's professional opinion, Jordan did not meet standard criteria for psychosis, yet she wondered if placing him on an antipsychotic such as risperidone could help him control his outbursts and keep him out of the penal system, possibly even affording him opportunities in the future. However, she was also aware of the substantial side-effect profile of risperidone and other atypical antipsychotics. These drugs were known to increase young patients' risk for weight gain and metabolic syndrome, which could predispose them to developing chronic illnesses such as type 2 diabetes and cardiovascular disease. Dr. Eitel wasn't sure which was worse for Jordan: possibly living out the rest of his days behind bars or, assuming risperidone would be helpful for him, living with its iatrogenic consequences. "Maybe there's still something I can do for this kid," she thought as she considered her blank prescription pad.

### **Commentary**

In this case, we have an adolescent boy with behavioral problems who has lived in three different foster homes since the age of eight. Who ends up in foster care? In general, children are removed from the family home due to threats to their safety, including physical or sexual abuse, inadequate housing, parental substance abuse, or neglect [1]. These children are exposed to chronic, heightened stress levels that place them at high risk for mental and behavioral health problems [2]. In Illinois, where these authors reside, over half of school-age foster children were reported to have a mental illness or behavioral problem that made fostering them "very challenging" [3]. Given the high risk of mental health issues among foster youth, the American Academy of Pediatrics (AAP) recommends a formal mental health assessment of all children at entry into foster care and periodically thereafter [4]. The most common mental health diagnoses for children in foster care are attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder, and [conduct disorder](#) [2, 5]. Nonexternalizing disorders, including anxiety disorders, eating disorders, and mood disorders, are also common [2].

Not only are children in foster care more likely to be diagnosed with mental illness than their peers without a history of foster care [2], they are also more likely to be treated pharmacologically. Foster care youth covered by Medicaid receive psychotropic medications at more than three times the rate of nonfoster care Medicaid youth [6]. Moreover, atypical antipsychotics like risperidone are disproportionately prescribed to

males, youth in foster care, and those covered by Medicaid [7]. But how is risperidone used? And what reservations, if any, should Dr. Eitel have about prescribing it to Jordan?

Here we discuss common concerns regarding risperidone use in children, especially as it pertains to increasing rates of off-label treatment of aggression. We consider the ethical implications of using medication to mitigate social risks, with a focus on justice and structural violence as they pertain to mental health care within the foster care system. Finally, we propose a multimodal treatment strategy that incorporates psychotherapy, mentorship, and advocacy in possible combination with pharmacotherapy.

### **Risperidone Use in Children**

Approved by the United States Food and Drug Administration (FDA) in 2006 for treatment of irritability in autistic children [8], risperidone has been used off label with increasing frequency to help manage childhood aggression [9], because it is believed to target the impulsivity inherent in reactive aggression [10]. In children with ADHD and oppositional defiant disorder or conduct disorder who exhibit severe physical aggression, risperidone added to stimulant and behavioral therapy has been shown to significantly improve impulsive behaviors [11]. It has also been shown to have significant benefit in reducing aggression among children with disruptive behavior disorders [12]. Although we aren't given psychiatric diagnoses for Jordan, his record of physical violence in response to threats from peers suggests impulsive behavior with real social consequences. In the context of this case, it seems reasonable to consider augmenting Jordan's current treatment with risperidone.

High rates of off-label atypical, or second-generation, antipsychotic (SGA) use nationwide [9] indicate that Dr. Eitel is not alone in augmenting therapy. However, off-label SGA practice patterns have triggered controversy. A 2011 US Health and Human Services Inspector General review [13] of 687 Medicaid payment claims for SGAs cited quality-of-care concerns in 67 percent of claims. A small proportion of all claims (7 percent) cited the iatrogenic side effects that Dr. Eitel considers, such as increased risk for metabolic syndrome. However, far more common were concerns regarding poor monitoring (53 percent), wrong treatment (41 percent), and drugs being taken too long (34 percent) [13]. This report suggests that psychiatrists are initiating SGA treatment in children but that many of these children are not being followed appropriately. Given Jordan's history of placement instability, these challenges are perhaps unsurprising.

In addition to being concerned about risperidone's side effects and monitoring, we should also question Dr. Eitel's assumption that risperidone alone could help mitigate Jordan's risk of social marginalization. We know that children in the foster care system, like Jordan, face a high risk of negative outcomes like homelessness, incarceration, and dropping out of high school [14, 15]. The social pressures on Jordan will continue to increase as he "ages out" of the child welfare system into independent adult living in a

few years. While risperidone treatment may reduce Jordan's impulsivity short term, an SGA alone is unlikely to aid him in improving the prosocial skills he needs to thrive as an adult. Therefore, in the absence of an ongoing active treatment plan, risperidone use to mitigate risk of future criminality seems doomed to fail and not without iatrogenic consequences.

### **Therapeutic Considerations**

Jordan's case illustrates two key social justice concepts that we borrow from medical anthropology: *structural violence* and *failure of imagination*. Structural violence describes the economic, political, legal, religious, and cultural structures that impair individuals, groups, and societies from reaching their full potential [16]. Applied to foster care, it implicates the larger forces of poverty, gender inequality, and racism that likely contributed to Jordan being removed from his birth home. The concept also allows us to evaluate foster care's "failing systems" in a broader context. In the justice literature, the "fair opportunity" rule suggests that we should evaluate the justice of social institutions, including the foster care system, by their efficacy in counteracting people's lack of opportunity caused by unpredictable misfortune over which they have no meaningful control [17]. By applying this rule, it can be seen that the foster care system is unjust to demand more (e.g., self-discipline in the home) of the estimated 427,910 children living in it [18] to whom society has given less (e.g., family stability, economic resources, mentoring relationships). It is even possible that the foster care system fails to counteract lack of opportunity and instead exacerbates the problem with the structures it has created.

If structural violence perpetuates social injustice, then our failure of imagination as clinicians and students is what self-limits our efforts to improve health equity. Failure of imagination includes failure to consider solutions outside the realm of what is considered realistic, "sustainable," or "cost effective" [19]. Instead, we focus on small-scale interventions like pharmacotherapy that risk iatrogenic consequences without correcting the culpable forces at play. Dr. Eitel, perhaps like many clinicians, feels frustrated and trapped in her consideration of two possible maleficent outcomes: incarceration and increased social marginalization versus iatrogenic harm to a child. The paths to helping Jordan manage his aggressive behavior in the context of structural violence, however, are far from binary.

We favor a multimodal treatment approach that addresses some of the social injustices Jordan has experienced and that offers opportunities to correct his maladaptive behavior in a supportive environment. Like children born into stable families that attend well-resourced schools, Jordan deserves an effective trial of individual evidence-based [therapy](#) focused on reducing impulsivity, anxiety, and reactivity in possible conjunction with pharmacotherapy. Risperidone might increase his response latency to stressful triggers, but psychotherapy could help identify why he is reacting maladaptively

to teasing at school and help him avoid future altercations that could jeopardize his future. Given the strong support of his current foster family, another option might be multisystemic treatment (MST), which includes high-intensity case management and specially trained therapists who would follow Jordan's current family. These therapists emphasize empowerment and work to draw on collateral support from community and friends [20].

Strategies for addressing Jordan's behavior in the context of structural violence aren't limited to therapy and possible medication, however. A fair and, perhaps, more imaginative approach might attempt to counteract Jordan's behavioral issues by placing him in a stable, supportive community with opportunities for longitudinal relationships with foster family members, teachers, friends, social workers, and physicians. Fortunately, models for this approach already exist.

Hope Meadows is the first of at least five operational "intentional intergenerational neighborhoods" designed to promote sustained, caring relationships between members of vulnerable populations [21]. Established in Rantoul, Illinois, in 1994, it places new adoptive families of foster children alongside older adults [22-24] who receive a discount in rent in exchange for supporting the families with volunteer activities [25]. Hope Meadows reframes some of the stigma against foster children and the elderly through emphasis on multigenerational neighboring relationships. Children like Jordan who may have experienced multiple foster placement changes suddenly have the opportunity to develop long-term mentoring relationships in close geographic proximity. Structured community-based mentoring programs have been shown to reduce symptoms of trauma, anxiety, and depression and to promote prosocial behaviors among foster children [26, 27]. At Hope Meadows, foster children can learn prosocial behaviors in a more equitable, purposefully structured community that will help them better handle life's challenges as adults.

We recognize that the impact of intentional neighboring communities is limited to a small minority of children lucky to be adopted out of the foster care system [28]. However, the allying of groups traditionally victim to structural violence in a community redesigned to their mutual benefit should inspire us to imagine more just approaches to social inequalities. Meaningful institutional change requires advocacy and political engagement from individuals like Dr. Eitel who directly encounter the effects of structural violence but are more empowered to make their voices heard. This engagement could include serving on the board of a mentoring program for foster youth or lobbying for state support of evidence-based psychosocial interventions targeting foster youth as an alternative to psychotropic medications [29, 30]. In the meantime, we suggest that Dr. Eitel use a combination of interventions that have the highest efficacy and lowest risks. In most circumstances, this would tend to favor psychotherapy along with or in combination with medications.

There are various ethical issues in Jordan's case that have been discussed by other authors. These include ethical concerns regarding prescribing off label [31], such as informed consent [32] and coping with a child's conduct disorder [33].

### Conclusion

We argue that leveling the playing field for Jordan and other foster children requires going far beyond modest reductions in impulsive behavior with psychotropic medications. Jordan deserves a multimodal treatment approach that provides stability, psychosocial support, and opportunities to remodel his aggressive behavior through long-term mentoring relationships. Foster care children need both advocates like Dr. Eitel to fight for more equitable mental health care and imaginative stakeholders to help reshape the institutional forces stacked against them and their success as adults.

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**Lauren E. Hock, MD**, is a medical intern in the Department of Ophthalmology and Visual Sciences at the University of Iowa Carver College of Medicine in Iowa City. As an American Academy of Child and Adolescent Psychiatry Summer Medical Student Fellow at Rush Medical College, she analyzed correlates of substance abuse in Chicago homeless youth. She is interested in research and advocacy to reduce health disparities among underserved populations.

**Niranjan S. Karnik, MD, PhD**, is the vice chair for innovation and the Cynthia Oudejans Harris, MD, Professor in the Department of Psychiatry at Rush Medical College and a conjoint faculty member in the Department of Community, Systems and Mental Health Nursing at Rush College of Nursing in Chicago. He concurrently serves as an associate faculty member of the MacLean Center for Clinical Medical Ethics at the University of Chicago. His research focuses on community-based interventions for high-risk youth with psychiatric and substance use disorders.

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