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Clinical Cases

Medicine for Malcolm

Although there is a strong tendency to medicate children and adolescents for all types of behavioral problems, physicians must be prudent in also using nonpharmaceutical treatments.

Commentary by Mary G. Burke, MD

Malcolm Simmons' pediatrician, Dr. Hill, referred him to Dr. DePaul, a psychiatrist, for an evaluation of possible anxiety and depressive illness. Malcolm described himself as worried much of the time, with his specific worries including school performance, getting into college, and dissatisfaction with his friendships. His parents described him as irritable. He complained about going to school, which he said he hated, and wasn't able to talk with his parents or the physician about what was bothering him. The pediatrician's note stated that there was no history or evidence of trauma, psychosis, or substance abuse. Malcolm showed some obsessive behavior, including a preoccupation with cleanliness and germs and indecision that led to procrastination, so that he spent most of the evening in his room, ostensibly doing on his homework. The next morning he would insist that he had some fixing to do on it; he'd check it over and over again. He also became preoccupied with his appearance. Malcolm's parents were frustrated with his behavior, and tended to get angry at him. Malcolm's pediatrician had known the lad from the time he was a small, happy-go-lucky kid, and was contemplating starting Malcolm on an antidepressant. Before doing so, he wanted Dr. DePaul's evaluation.

When Mrs. Simmons and Malcolm came in, Dr. DePaul saw a good-looking teenager who greeted him politely and shook his hand. During the introductory session, after Mrs. Simmons had left, Dr. DePaul asked Malcolm why he had agreed to come. "I guess cause I hate school and Dr. Hill said maybe you could prescribe something that would help me 'cope' with it better." What did he most hate about it? "I don't know," Malcolm said. "Everything." Was the work tough? "Yes, and most of the kids are smarter than me," Malcolm said. Did he worry about grades? "Well," Malcolm said, "I usually get As and Bs, but I spend all night on it. I should be doing homework right now." Did he play on any sports teams? "No. Sports is a really big deal at our school. Only super jocks make the team." Malcolm did not look like a super jock. He was not overweight, but not particularly fit, either. At first, Malcolm spoke about his dislike of school—and life in general—as though he were talking about someone else's problems. After about 20 minutes, he began checking his watch, and his answers got shorter and less informational. He wanted out of there saying, "I thought you were going to give me some Prozac." Dr. DePaul began to observe some of the anxiety Dr. Hill had mentioned, as he thought about the many factors that would influence his prescribing decision.

Commentary

The dilemma in which Dr. DePaul and his pediatric colleague find themselves is common. However, it is not a clinical dilemma. A thorough psychiatric evaluation of Malcolm, a psycho-education about anxiety, depression, and sadness, and a collaborative discussion about the risks and benefits of different treatments with Malcolm and his family will make Dr. DePaul's clinical decision easier and also get Malcolm and his parents more actively involved. There is concern that unhappiness in children has become "medicalized," reflecting larger social trends that devalue children's fundamental needs, especially for relationships and legitimate autonomy. The promotion of SSRIs to treat mild to moderate anxiety in children is partially the product of managed care business practices and clever marketing by the pharmaceutical industry.

Dr. DePaul would be on firm clinical ground if he insisted that Malcolm participate in a complete evaluation that includes at least 1 family session before he wrote Malcolm a prescription. Dr. DePaul's "bio-psycho-social" evaluation should start with an examination of Malcolm's constitutional and biological vulnerabilities including family history, his early and current relationships, his external stressors including trauma and violence, and the larger cultural and economic context that may be affecting him [1-7]. Dr. DePaul would be doing Malcolm a significant disservice if he ignores these "nonbiological factors." Of course, Dr. DePaul also needs to rule out several significant psychiatric illnesses that commonly present with symptoms of anxiety such as psychotic illness, bipolar affective disorder, severe depression, post traumatic stress disorder, incipient personality disorder, and substance abuse. Several medical conditions such as thyroid disease, though less common, can also present with psychiatric symptoms.

After careful evaluation Dr. DePaul should have a more comprehensive understanding of the sources of Malcolm's distress. Let us say, for the purposes of this paper, Malcolm has mild symptoms of obsessive compulsive disorder (OCD), mild-to-moderate pervasive anxiety that is both free-floating and related to performance, and some mild symptoms of depression, which affect his ability to function. He has no history of trauma, but his relationship with both parents is significantly conflicted. At this point Dr. DePaul might take the opportunity to talk to Malcolm and his parents about the biology of the limbic system, explaining that anxiety, per se, is not a disease but a feeling that plays an important biological role in the perception of, and response to, threat [8,9]. Dr. DePaul can also describe sadness and involution as biological responses to loss and chronic subordination and helplessness. Within this framework, he can acknowledge that certain individuals are biologically more likely to respond to threat, stress, loss, or subordination with excessively anxious or depressed feelings that can evolve into disorders. Dr. DePaul should then ask Malcolm and his parents to think about circumstances that might be contributing to Malcolm's distress.

Dr. DePaul will be able to address Malcolm's search for a "magic pill" by talking with Malcolm and his family about the possibility of other treatment interventions. The American Academy of Child and Adolescent Psychiatry (AACAP) has stated that "pharmacologic treatment should not be used as the sole intervention" for anxiety disorder in youth [10]. Dr. DePaul can recommend various psychotherapeutic strategies—individual, group, family, or cognitive behavioral—which all have demonstrated efficacy when used appropriately by trained clinicians [10-13]. When compared to pharmacologic therapy, these treatment options have the advantage of being free of side effects. Dr. DePaul must act as Malcolm's advocate in this discussion by helping him and his family reorganize his world to make it less stressful and provide more opportunities for developing relationships that are meaningful to Malcolm.

Dr. DePaul should specifically discuss the risks and benefits of the SSRIs. The SSRIs are "the most rapidly increasing psychotropic to be used to treat children and adolescents in the United States" [14]. Although there have been no long-term studies of the safety or efficacy of these agents in children, the use of anti-depressants in pre-schoolers approximately doubled between 1991 and 1995 [14-16]. Of the 4 most commonly prescribed SSRIs, only sertraline (Zoloft) has been approved for the treatment of OCD in children. Neither citalopram (Celexa) nor fluoxetine (Prozac) has been approved for use in children. The FDA issued a warning in June of 2003, that the fourth, paroxetine (Paxil) should not be used to treat major depressive disorder (MDD) in children because of the concern that it increases suicidality. With the exception of treatment of OCD, the benefits of SSRIs in children and adolescents are not robust especially when compared to the benefits of various forms of psychotherapy.

Dr. DePaul should also bring up other concerns about pharmacotherapy such as the concern that SSRIs may induce "behavioral activation." There is now significant debate about whether these drugs induce rapid mood cycling even in patients who are not biologically vulnerable to bipolar affective disorder [17]. This potentially serious side effect may outweigh the benefits of the drug therapy for a patient like Malcolm who has mild to moderate symptoms. The SSRIs often cause weight gain, and a recent case series also has shown cessation of growth secondary to abnormal growth hormone, related to SSRI use [18]. Besides the commonly discussed side effects, they can also cause a (reversible) "amotivational (frontal lobe) syndrome," which can be subtle enough to escape early detection. In this condition, the child becomes unmotivated in many areas, which can be particularly damaging in school. The child himself is unaware of the syndrome, due to the brain structures involved [19]. In my own practice I have also seen teens develop anti-social behaviors due to the loss of necessary anxiety (article in progress), without any evidence of either behavioral activation or the "amotivational syndrome."

Let us now explore the implications of using the SSRIs in children. These drugs alter the limbic functioning, changing

a child's emotional response to the external world. A large body of research on attachment and affect regulation has documented the vital role that emotion plays in organizing memory, effecting relationships, cognition, and behavior [9]. The physician must carefully weigh the risks to Malcolm of introducing this chemical agent into his system, which may blunt or otherwise alter his innate signaling system. Dr. DePaul must also recognize that the long-term risks of the drugs are poorly understood; the documented benefits are unclear; and Malcolm, as a minor, may not truly be able to give informed consent.

Clearly, there are psychiatric illnesses for which medications play an essential treatment role. In the last 10 years we have seen a sophisticated effort led by the pharmaceutical industry and its marketers to describe mild to moderate dysphoria as a disease entity [20-24]. This has resulted in prescribing more SSRIs to children without clear medical justification [15-16, 25]. In this case if Dr. DePaul prematurely writes a prescription, he may not fully address Malcolm's need for healthy relationships and may pass up the opportunity to develop a new relationship that will be potentially therapeutic for Malcolm.

As both the public and psychiatrists pursue pharmaceutical remedies for childhood distress, we neglect the obvious. Common sense and developmental research show that the large majority of children thrive when they are raised in cohesive families and strong communities [7]. These essential factors have rapidly eroded in the last 30 years [26,27]. Psychiatrists, pediatricians, and parents need to be much stronger advocates for the social institutions that make happy, stable children.

Finally, should Dr. DePaul give Malcolm a medicine? I think he should feel confident recommending a time-limited trial of the nonpharmaceutical interventions listed above. He and Malcolm can agree to reconsider medication after 2 months for Malcolm's symptoms of OCD if Malcolm is still experiencing significant distress or sooner if Malcolm deteriorates.

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