

## Prescribing for Behavior

### **Medical treatment for child development problems should not come before a complete biopsychosocial evaluation with appropriate therapies.**

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What are the major pitfalls in prescribing behavior-changing drugs for children, especially young ones (ages 3-10), on the basis of symptoms alone?

First, there is the risk of perpetuating the myth that medication alone will take care of all problems for the child and parent. An aging pediatrician colleague of mine quipped, "Aspirin was the drug of my generation. It looks like Ritalin is the drug of yours!" His comment ignited my concerns about the unintended consequences of the utilization of many psychotropic medications for very young children and their families. Slowly we are accumulating information regarding safe and appropriate dosages of drugs which are commonly used in the United States and Europe; however, the US outstrips other countries in utilization. We need to ask ourselves why that is.

When the first intervention is medication, there is another risk—namely that the medication will lead to obfuscation of the child's actual diagnosis. Another related potential difficulty presents itself when the young child's response to medication for hyperactivity is used as a "diagnostic tool" in clinical practice. This is particularly common with stimulant medications used for ADHD. More often than not, these potent mood elevators obscure a child's underlying depression, causing the subsequent inability to address the multiplicity of clinical factors (biological, psychological and social) which must be addressed in cases of childhood depression as well as other anxiety disorders of early childhood. Young children's behavioral actions have various meanings, not to mention causes, which require further investigation.

Finally, there is the risk of leaving unanswered the question, "For whom is the medication given?" Are the drugs given for the overworked and underpaid preschool/day-care teacher in an understaffed setting? Are the drugs given for the frustrated, distressed parents who need support and guidance? Are the drugs given for the physicians who are pressured by teachers and parents to do something immediately and have little time to assess the multiple determinants of behaviors in young children?

Disruptive behavior gets attention. Let me illustrate with William's case. William is an adopted child whose parents are in their late fifties. His adoption was "open;" his adoptive parents were present at his birth. His 17-year-old biological mother's general health history was uneventful except for a period of substance abuse (marijuana) during her 15th year. She had dropped out of high school and knew nothing about the personal, family, or individual health history of William's biological father except his age of 25 years. The prenatal delivery and postnatal period were uneventful. William is her first and only child. He weighed 8 ½ pounds at birth.

A wiry, freckle faced little boy of 4 ½ years, William had been "expelled" from his third pre-school. He had trouble sleeping by himself and wet his bed at night. His most recent expulsion replicated the others. His teachers felt he was unable to take naps, sit still or follow directions. School directors felt medication would help him attend to his preschool tasks. Volatility and mood swings were also noted during his first preschool experience. He had bitten several children. The family's

physician had known William since birth and followed up on the observations of the parents and teachers. William was given several trials on stimulant medications and mood stabilizers to treat his attention problems and his "mood swings," respectively. He was given a tricyclic antidepressant to treat his "sleep disturbance" and bed wetting. William was on a "cocktail" comprising Ritalin (Methylphenidate-hydrochloride), Tegretal (Carbamazepine), Tofranil (Imipramine) and Klonopin (Clonazepam) when a referral was made to the Harris School, a therapeutic school for children ages 3 to 10 years old.

William's parents were concerned and confused. William's situation was not new to the Harris School. Gradual reduction of his drugs revealed an anxious boy who had not mastered the ability to sleep by himself, to dress by himself, and to eat by himself. He had no difficulty telling others what to do; however, he had enormous difficulty when others told him what to do. He used his actions to speak for him rather than using his words. In short, William was "stuck in toddlerhood," evidencing extreme separation anxiety from his adoptive mother. How can we avoid the pitfalls William and his caregivers fell into? It is very important to develop a diagnostic/therapeutic relationship with the perplexed parents. Rushing into symptomatic medical treatment without assessment of the many issues surrounding and involving disturbed children and families often leads to a rushed, reductionistic approach to their treatment. It is better to take a more patient approach and do a careful biopsychosocial evaluation even in the face of the many appeals for immediate symptomatic relief.

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