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The Meaning of Psychotropic Medications for Children, Adolescents, and Their Families

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Outline

Despite the dramatic increase in the use of pediatric psychopharmacology (Jensen et al., 1999), there is a surprising paucity of discussion about the psychological meanings of medication to both children and parents. Shapiro (1996) presents some clinical examples that explore the meaning of medication. He points out that in the early years of pediatric psychopharmacology, there was an artificial polarization between doctors who were alleged to have a primarily biological view and those who very reluctantly used medication secondary to a largely psychodynamic formulation. Shapiro encourages clinicians to maintain a rigorous standard of care that is attuned to developmental and temperamental issues when considering medication for children.

Bastiens (1995) advocates that clinicians pay attention to the efficacy and side effects of medication, as well as to whether parents are comfortable giving medication and children are comfortable receiving it. Clinicians' attention to the wishes, fantasies, and fears of children and their families will enhance the therapeutic relationship.

Parents' Attitudes

While parents are often willing to give cough medicine or antibiotics to their children (even though antibiotics are not efficacious for viral syndromes), they understandably are much more apprehensive at the prospect of giving medications to alter their child's mood and behavior. By the time that parents are considering psychotropic medication, they have often exhausted their repertoire of behavioral and psychological interventions to change their child's behavior. If their child's symptoms are improved by medication, parents may feel less self-critical about their prior efforts and recognize that with the benefit of medication they have another chance to demonstrate their effectiveness as good parents.

Some parents are relieved when a physician suggests medication for their child because it validates their concern about the serious nature of their child's problems. They may no longer feel that they are perceived as overreacting or exaggerating their child's difficulty.

Parents who have responded well to their own medication may be more receptive to a medication trial for their child. In other instances, if a child responds well to medication the parents may be motivated to seek their own assessment or treatment, especially if they believe there is a genetic component to the disorder (e.g., attention-deficit/hyperactivity disorder [ADHD], anxiety disorder, or major depression).

Sometimes parents' refusal to give medication to their child can be problematic for teachers. For example, if a student is disruptive in class because of untreated ADHD, teachers and school personnel may be frustrated and feel that the parents are making unrealistic demands on the school. They may see the parents as withholding helpful medication and as undermining the potential progress of the child. Parents in turn may feel pressured by the school to give medication. They may feel that their child's behavior would be better addressed by increasing personnel and adapting the content of the child's program to suit the child's needs.

Parents can experience a sense of loss and even grief because their child warrants a medication trial and is labeled with a diagnosis. A diagnosis may raise for parents the possibility of chronic psychiatric illness. When the psychiatrist inquires about inherited family problems, particularly for a parent who has relatives with major mental illness, the parent can feel guilt and shame for causing an inherited problem. Remembering Shapiro's concerns regarding polarization, clinicians should

be cautious about over-emphasizing the inherited or biological basis for the child's problematic behavior. By carefully explaining the complex etiology of psychiatric problems, the clinician can advocate for comprehensive treatment that may include not only medication but also psychotherapy, after-school programs, and behavior modification (Wilens, 1999).

Both parents should be contacted early in the assessment because they may disagree with the use of medication for their child. This step is particularly critical when parents are divorced and there is heightened potential for miscommunication. In the case of a bitter divorce, parents may use the child's disorder as an opportunity to argue about their conflicting theories about the cause of the child's problem; they may blame each other. With intractable disagreements, a guardian ad litem may need to be appointed to protect the child's interest.

Children's Attitudes

Children's age-appropriate capacity to report on medication response, side effects, and ability to understand their family dynamics should not be underestimated. Often when children cooperate by taking medicine, it is an extension of their trust in their parents' decision and/or reflects their belief that the medication maintains their link with the psychiatrist and his or her involvement with the family.

Even if the clinician has reassured the parents, children are also often apprehensive about taking medication and commonly believe that this is final proof that they are defective. Although they may not initially express these thoughts, many children will at some point call themselves "crazy," "bad," or "stupid" as an explanation for why they are taking medicine. Others may fear that they are brain-damaged. One 10-year-old boy who had both attentional problems and depression was seen in play therapy and initially did well on medication. He then repeatedly enacted, in play, a doctor poisoning his patient. When the psychiatrist wondered aloud whether the boy felt that his doctor was poisoning him, the boy replied that he was on one medicine for being stupid and another for being crazy. He defiantly said that he was neither. Later, he revealed that his brother had been teasing him relentlessly about the medication. The clinician inquired whether the brother's teasing might stem from jealousy. If the medication made the patient function better, the brother might be threatened. The patient was relieved that he may be more capable at competing with his brother by taking medication; he then could tolerate taking the medication.

Children are likely to be self-critical because most have experienced difficulty with peers, teachers, and parents who have reacted negatively to their behavioral problems prior to diagnosis (Frankel et al., 1999). Medication is likely to reinforce any sense of inadequacy. Some children will obstinately reject medicine rather than tolerate the daily reminder of their perceived defect. This can be quite dramatic when apparently cooperative children may regress and shift in their attitude about medication. An 8-year-old girl with ADHD did quite well on methylphenidate. She was compliant with medication until her pediatrician recommended that she take a daily vitamin as well. Then the patient told the psychiatrist that she was going to take only one pill a day because she was healthy and did not need any pills. It was helpful to both (1) explore the child's indignation that she would need any medication and (2) examine her impatience at the implication that she was imperfect because she was taking medication. The clinician empathized with the girl's need to avoid self-criticism and doubt while still providing a supportive therapeutic relationship that made it tolerable to take the medications.

For certain children, especially children younger than 10, the tests used for monitoring medication (such as ECG) may also have certain scary meanings. As many children do not have a clear understanding of how their body works or why they need medication, they can interpret the tests as an ominous sign. One boy feared that the EEG would "scramble his brain" and make him more disorganized. In trying to understand specific meanings to a child, the psychiatrist may find that a child with a history of seizure disorder is more likely to see the need for medication as evidence of brain damage and a child with a learning disability as confirmation that he is stupid.

Some children feel as if they are responsible for the family's problem when they take medication. Children with impulse disorders, for example, may feel that they are being criticized yet again for lacking self-control or are being punished for sexual or aggressive impulses. Many of these children know that they need help controlling their impulses, but they may derive some pleasure or sense of power from acting on their impulses. Better behavioral control as a result of medication may be both valued and resented. For example, one child in therapy began regularly playing with handcuffs after he started medication for ADHD. The play seemed to be about his bad impulses; the handcuffs, like medication, were an external means required to control them. Pelham et al. (1992) showed that even when medications help children with their behavior, children are likely to attribute their improvement not to the medication but to themselves. As he points out, this has the potential advantage of improving self-esteem, but it is possible that this positive interpretation may not enhance compliance.

Adolescents' Attitudes

Adolescents are often desperate to fit in with their peers and to establish themselves as separate from their parents. They may perceive requests to modify their behavior as others' attempts to control them. They are capable of being assertive while also feeling painfully vulnerable and dependent.

It is critical to address confidentiality concerns with adolescents and their parents to allow adolescents to be as comfortable as possible in reporting potentially risky situations. For example, a teenager may stop medication abruptly and then confide to the psychiatrist that she has done so because she is worried that she may be pregnant. The clinician must manage a delicate balance of privileged information and responsibility to keep the patient safe (Towbin, 1995). To be effective, the clinician may tacitly acknowledge the adolescent's effort to appear separate from his or her parents. However, if the patient cannot manage his or her own treatment because of severe depression, suicidal behavior, or psychosis, the psychiatrist and parents may need to make nonnegotiable decisions to maintain the teenager's safety.

It is not uncommon for adolescents to have periods in which they rebel against the idea of needing medication. Their reasons should be explored in a nonjudgmental way. Are they worried that their feelings will be dulled by medication? What happens if they have a beer at a party? Adolescents may stop taking medicine because it interferes with their image of themselves as autonomous, perfect, or invulnerable. Possible sexual and other physical side effects may frighten them. This anxiety is highlighted by the teenage boy who called his doctor in a panic because he had heard that dextroamphetamine can interfere with growth and was worried that it would make his penis shorter.

Even positive results from medication can be troubling for adolescents. For some patients with traumatic history of abandonment, improvement can lead to uncomfortable feelings of dependence on the clinician. They may worry that getting better means losing their caretaker, which may lead to noncompliance in order to maintain their relationship with their doctor. If a clinician anticipates this reaction, it may be wise to reassure the patient of the need for future monitoring despite improved mental health. For other adolescent patients, as with adults, improvement raises important concerns about whether success should be attributed to the medication or to the patient. For example, one depressed 15-year-old girl who was much less irritable on medication abruptly stopped taking it. She told her psychiatrist that her parents loved their daughter only when she was taking a pill.

Girls who have been sexually abused present a separate challenge for psychiatrists. They understandably have major concerns that losing control of their body will generate feelings of danger and panic. Medication recommendations may easily be perceived as blaming them for their traumatic experience. Efforts to convince these adolescent girls to try medication to alleviate symptoms may be perceived as coercive. Clinicians can avoid a standoff if they take the approach that they are trying to provide the adolescents with accurate information so that they can make an informed choice about whether to try medication.

As child and adolescent psychiatrists, we need to understand the meaning of medication to our patients and their families. With increasing frequency, we are asked to consult to patients who have previously been seen and given a presumptive diagnosis; often there is an expectation that we will conduct a brief evaluation and initiate medication. While this sometimes is feasible, often it is unrealistic and undermines quality of care to the child and family.

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