

Antidepressant use in adolescence: We're asking the wrong questions

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The rate of prescribing psychotropic medications to children and adolescents has risen dramatically over the past 10 years. Just under 2% of the paediatric population in Canada are prescribed antidepressants alone (1). The incidence and prevalence of disorders such as depression, however, has not risen to the same degree. What are we to make of this gap?

Controversy over the safety and efficacy of selective serotonin reuptake inhibitors (SSRIs) in patients younger than 18 years of age has exploded onto the front pages of the general and professional press (2,3). There are accusations of suppressed (negative) evidence levelled against the pharmaceutical companies, as well as complicity among our colleagues (4).

Despite all the attention being given to this debate, a number of important issues are being missed.

Reviewing signs, symptoms and functional impairment – the traditional medical model used to assess outcome and efficacy – leaves out the question of meaning. Teenagers often wish for a magical solution to their internal distress or psychosocial chaos. Pills can – at least symbolically – offer such relief, and so they are sometimes welcomed. Pills also let children off the hook. A biological explanation for their behaviour allows them to proclaim, “It’s not me, it’s my neurotransmitters!” No effort to change is required. Perhaps the wish for a magical solution to their problems explains why the placebo effect is so strong in young patients.

On the other hand, medication sometimes represents punishment for being bad, confirmation of insanity, uncomfortable identification with a mentally ill parent, shameful proof of character weakness, an extension of parental authority, an instrument of medical mind control or even poison. Teenagers often ask themselves, “If I feel better, is it because of me or the pill?” Fear of losing their ‘authentic’ personality (eg, creativity in the bipolar patient) can exacerbate identity struggles. And adolescents who abuse drugs note the irony – or perhaps hypocrisy – in asking them to simply exchange one substance for another.

The current debate also neglects context – Who is the patient? Whose needs are being met and whose agenda is being followed? To understand this, it is crucial to ascertain

who is requesting the medication. Is it the psychotherapist, who is frustrated with the lack of progress? Is it the harried and hassled parent or teacher on the receiving end of the depressed teenager’s irritability?

The best interest of the adolescent is often subject to the greatest needs of the adults around the teenager. Those needs may be in direct conflict with the patient’s wishes, or with each other. (I was recently consulted about a depressed child’s need for medication. The divorced parents, who had joint custody, vehemently disagreed about the presenting problem. As a result, depression questionnaires were useless – the results were diametrically opposed).

In Ontario, the Health Care Consent Act (5) does not have a lower age limit. Children are presumed competent unless proven otherwise. And yet, studies have shown that the decision-making capacity of patients younger than 16 years of age is poor. Future consequences, vested interests and need for second opinions are frequently ignored (6). In general, young people’s capacity to consent applies most effectively to situations which are immediate and familiar. If abstract thinking (formal operations) hasn’t yet developed, then the consideration of new and/or experimental treatments may be beyond their grasp. Even if it has developed, emotional lability and lack of ‘executive functions’ (which is correlated with immature frontal lobe development) may affect rational analysis of risks and benefits.

The role of psychotherapy needs to be paid greater attention. Evidence for the efficacy of cognitive behaviour therapy, interpersonal therapy, group therapy, social skills training and some psychodynamic therapies exists (7,8). Even more fascinating, emerging data suggest that psychotherapy can effect physiological changes in the brain, on par with medication-related changes. These results challenge us to come up with new paradigms which truly unite mind and body. We may one day (soon) titrate the ‘dosage’, frequency and type of psychotherapy, monitoring for side effects, according to magnetic resonance imaging or positron emission tomography scan images.

Finally, the chill being sent through the medical community by actions such as the United Kingdom’s outright ban of SSRIs with young patients (which may reflect litigation

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phobia) necessitates an improvement in the training of paediatricians and family doctors in the area of childhood psychopathology and pediatric psychopharmacology. The recent controversy has caused many more primary care physicians to request a consultation from a child psychiatrist before prescribing medication. This, in turn, has exacerbated the problem of waiting times for families, especially given the current shortage of child psychiatrists.

Curriculum reform in the postgraduate programs of paediatrics and family practice is urgent because there will never be enough child psychiatrists to meet the need for more. And models such as 'Shared Care' or Collaborative Mental Health Networks (9) need to proceed 'full speed ahead', so that continuing education can make service delivery more effective.

When prescribing SSRIs to teenagers, we should remember that dependence on caregiving adults and incomplete psychological and physiological development makes consideration of context, meaning and consent crucial. Outcome criteria need to incorporate multiple sources of information. Improved postgraduate and continuing education systems will point the way to the future, in concert with new conceptual paradigms which avoid 'mind-brain' dichotomies.

In conclusion, the question of whether antidepressants are being used inappropriately and unnecessarily in young patients leads to another (perhaps more difficult) consideration: in trying to solve psychosocial or developmental

problems with biochemical products, are we colluding with our patients? Like the substances that teenagers abuse, does the medicine we prescribe have dubious efficacy, or cause greater symptoms when discontinued? Only time will tell.

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BOOK SHELF

Pagliari L, Pagliaro AM. Problems in Pediatric Drug Therapy, 4th edn. Washington, District of Columbia: American Pharmaceutical Association, 2000. ISBN 1-58212-001-3; 900 pages; CDN\$163.35

The fourth edition of this textbook is a welcome addition to any paediatric bookshelf. The audience for this book is stated to be nurses, psychologists, pharmacists, family physicians, paediatricians and social workers. With such a varied readership, some chapters will be of more interest to certain groups; however, overall, the book covers a broad range of topics relevant to paediatric drug therapy. Rather than being a book that one reads from cover to cover, it serves best as a reference textbook. The many tables are a useful practical resource. Scanning through the list of authors, one finds many individuals who are renowned and well respected in their field.

New chapters on "Pediatric Pharmacogenetics" and "Pediatric Antineoplastic Drug Therapy" have been added. The first, although supplying more details on specific CYP alleles than is likely required by the average reader, does include a discussion of the clinical consequences of polymorphic activity. The chapter on "Pediatric Antineoplastic Drug Therapy" is very comprehensive and provides useful and practical information on the suggested monitoring for various antineoplastic drugs.

Other chapters of interest include the first chapter, which deals with special considerations regarding the administration of drugs to infants, children and adolescents. This informa-

tion is not readily available in many other paediatric texts. Almost 300 referenced monographs are included in the chapter entitled "Drugs as Human Teratogens and Fetotoxins", providing generally up-to-date information on the effects of the use of these drugs during pregnancy. This reviewer would like to have seen some discussion of the limited usefulness of the FDA codes in clinical practice. The chapter on "Pediatric Poisonings", although not providing the American Academy of Pediatrics' most recent recommendation that ipecac no longer be used routinely as a home treatment strategy, is a very good review of common poisonings. In the "Adverse Drug Reaction" chapter, Table 5.6 titled "Diseases and Clinical Conditions That Can be Caused by Drugs Used Commonly in the Pediatric Age Group", will also be very useful for paediatric prescribers. The chapter on "Pediatric Drug Interactions" is a thorough overview of information that is difficult to find in other paediatric books. Finally, the chapter on "Pediatric Pharmacokinetics" provides the basics in an easily understandable way.

Overall, this book is an excellent collection of relevant information regarding paediatric drug therapy that is not often available all in one location. That the book is affordable and user-friendly is a welcome bonus.

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