NEUROPSYCH UPDATE

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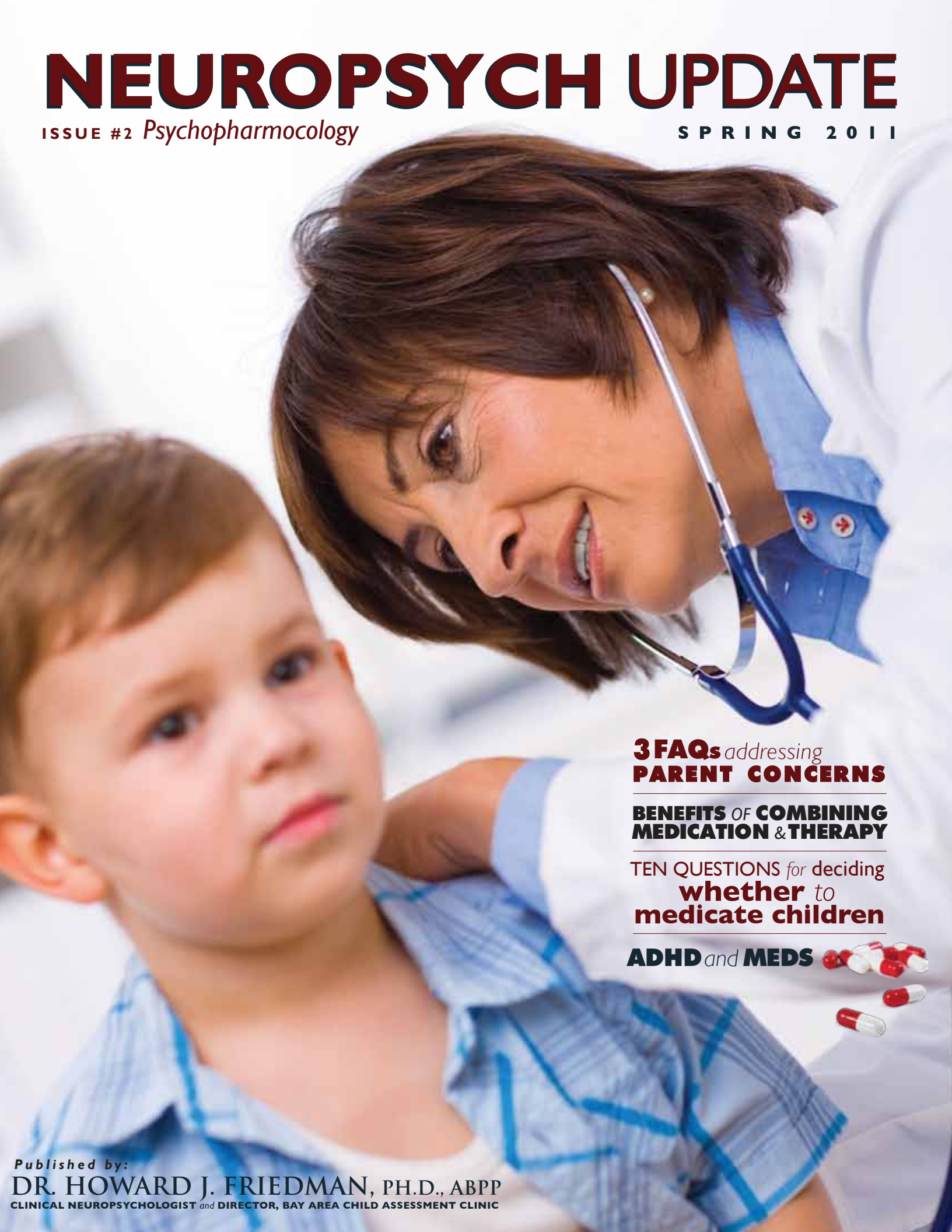

3 FAQs *addressing* **PARENT CONCERNS**

BENEFITS *OF* **COMBINING MEDICATION** & **THERAPY**

TEN QUESTIONS *for* deciding **whether** *to* **medicate children**

ADHD *and* **MEDS**

Published by:

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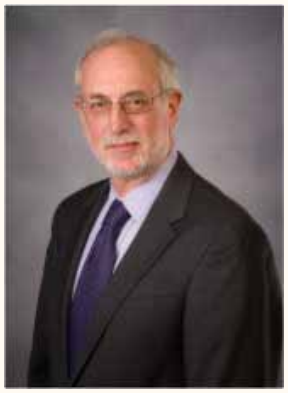
Welcome to Neuropsych Update:

I often receive referrals asking me to help health professionals and their patients document the presence of a condition to provide objective evidence affirming the necessity of using medication – especially for children. As a neuropsychologist, I play a critical role in advising health professionals and families in effective case management. In addition to clarifying diagnoses, I also document improvements in conditions, responses to medication, and highlight specific treatment needs, such as options other than medication. Of course, most parents are concerned about having their children take medication over a long period of time.



Although patients and their families often respect their doctor's expertise and ability to make accurate diagnoses, they sometimes want external, secondary confirmation that the diagnosis is correct before they begin a medication regime. In addition, children often have "invisible" neurological and psychological conditions with overlapping symptoms that can't be read like fever on a thermometer, sometimes complicating the development of an accurate diagnosis. This can, of course, add to parents' reluctance to begin a recommended course of treatment.

The two most common issues in my practice related to medication treatment are depression and ADHD. Sometimes children have overlapping symptoms that can create a confusing diagnostic picture. For example, kids who are depressed can appear to be hyperactive and act out more, without exhibiting specific symptoms one would expect to see in depressed adults. This kind of case calls for an expert evaluation, and particular cautiousness regarding recommendations for medication. If these patients are erroneously medicated for ADHD, for example, the depression is left untreated, although minor improvements may initially occur. This is an even greater concern when there are associated hypomanic or bipolar elements.

The Surgeon General has estimated that 11% of children from 9 to 17 years of age have a diagnosable mental or addictive disorder with significant functional impairment. According to Kiki Chang of Stanford's Pediatric Bipolar Disorders Program, 20 to 30 percent of kids with depression will develop mania. Effective treatment and intervention for adolescents must address multiple risk factors, be tailored to the individual child, have a sufficient duration, and be implemented by qualified staff. Medication alone is seldom the sole answer to young people's difficulties, and in a comprehensive program, it may not be necessary. Nevertheless, it is inevitable that medication will be part of the treatment plan for many young clients.

Howard J. Friedman, Ph.D., ABPP

BENEFITS *OF* COMBINING MEDICATION *AND* THERAPY

Research has shown that medication and therapy can enhance the effectiveness of each other. For example, behavioral therapy, a healthy diet, sufficient exercise and sleep can help to effectively manage the symptoms of ADD/ADHD. In order to balance the appropriate combination of medication and therapy, a clear analysis of the problem must be obtained beyond target symptoms. This allows for the development of a comprehensive program that will address the nucleus of the problem.

According to Dr. Gordon Harper, a Massachusetts child psychiatrist, medication recommendations should be part of a comprehensive treatment plan, arrived at after a full assessment including the identification of current symptoms, determination of current functioning, consideration of developmental history, a history of abuse or neglect, as well as psychological and lab testing when indicated. Family history and an evaluation of the current family situation are also important. Of course, the assessment should recognize and respond appropriately to the culture of the child and the family. Although he suggests that clinicians focus on "target symptoms," Dr. Harper believes that a diagnosis is helpful "for understanding the nature of the patient's problems and their likely response to treatment."

3 FAQs *addressing* PARENT CONCERNS

What if the child has ADHD or depression and the parents don't want to use medication?

Choosing to follow a course of treatment is ultimately the parents' decision, but I usually point out that appropriate medication makes all other treatments more effective, and lessens the child's struggle against the inattention "push." Many skills such as organization, planning, and problem solving can only be corrected and learned when the child can successfully pay attention. I also use the comparison of medicating other conditions; if a family member has diabetes or high blood pressure, you wouldn't ask them to "tough it out" or try using "mind over matter" instead of getting proper treatment with medication. Some conditions simply require it.

What can we do about the increased risk of suicide in children taking antidepressants?

As the child responds to medication, we need to monitor them more extensively, and watch their behavior – is it changing dramatically, is it self-destructive? Beginning meds doesn't immediately reduce the risk of suicide, so we need to be vigilant and work closely with families to see whether medication changes are needed due to side effects. There may be an initial window of improvement in energy and mood, but suicidal thinking can sometimes linger if it was present to begin with. In that window, there is greater risk of the teenager acting self destructively. Medication doesn't produce suicidal thinking, but it can initially enable a person to act on it.

When should a medication or dosage be changed?

It is important to monitor patients closely, as some make considerable gains from medication, while others experience only moderate improvements. Sometimes, when treating ADHD or depression, it is not surprising that teens and children don't report symptoms very clearly. A follow-up evaluation can measure key symptoms objectively to help titrate their dosage and determine whether they are responding to their medication, possibly eliciting a change in medication choice.

ADHD *and* MEDS

When deciding whether or not to put children with ADHD on medication, Jerome Schultz, Ph.D., learning disabilities/ADHD expert and clinical director of the Learning Lab in Cambridge, Massachusetts, recommends pursuing answers to the following questions:

- Has the child been helped by non-medication approaches such as self-calming techniques, deep breathing and yoga?
- Has the school tried to teach the child to be more attentive and less active?
- Is the decision to put the child on medication the result of behavioral observations over time and in different settings, such as in school and at home?
- When is the child at his or her best? This helps doctors understand the pervasiveness or selectivity of the problem.
- Does the child have other conditions that can be mistaken for hyperactivity? Children exposed to toxic chemicals or who have undiagnosed learning disabilities and low-level anxiety disorder may produce similar behaviors.

guest COLUMN

Estelita Marquez-Floyd, M.D.

Challenges in Diagnosing Children

By Estelita Marquez-Floyd, M.D., Child Psychiatrist

An early accurate diagnosis is vital to setting young patients on a healthy trajectory. Today, prevention or early intervention is the optimal medical approach. Gone are the days of letting the medication make the diagnosis, such as when the child responds, the diagnosis is confirmed.

Many of my health care colleagues - pediatricians, psychologists and psychotherapists - observe that the 'complex child' is really the typical case. They often see children who are treated with a psychotropic medication for a seemingly straightforward diagnosis, resulting in only very modest changes, or worsening symptoms. They also see children with inconsistent, unspecific symptoms who don't fit the criteria for any diagnosis, and fail to respond to several medications. And, they treat passive children who limp along, slowly becoming more and more disinterested in everything, or very bright children who underachieve. There are as many complex cases as there are children.

The reasons underlying these challenging cases can include combinations of incorrect diagnoses, co-morbid disorders, sub-clinical symptoms, prodromal states, medication induced behaviors, exacerbated past traumas, family crises, and developmental issues with inadequate coping mechanisms. And this is not an exhaustive list!

Evaluating a child as soon as possible for an accurate diagnosis prevents future, and potentially irreversible complications. In cases that present mental health issues, it's particularly important to seek consultation, given the potential for less obvious issues that lead to complex diagnoses.

Dr. Marquez-Floyd specializes in child, adolescent and adult psychiatry.

CHECKLIST

TEN QUESTIONS *for* deciding whether *to* medicate children

1. What are the various diagnoses that are consistent with the child's symptoms? (There are usually overlapping symptoms between different conditions.)
2. How recently has the child exhibited these symptoms?
3. In what settings does the child experience the most difficulty?
4. Have any family members been treated with psychoactive medications, and if so, how effective have they been?
5. What therapies, services and interventions are recommended in addition to medication?
6. What problem is each of the interventions designed to address?
7. What will happen if the child is inconsistent in taking the medication?
8. What will happen if the child uses alcohol or illegal drugs while taking the recommended medications?
9. What is the time frame for assessing the medication's effectiveness?
10. How will the medication's effectiveness be monitored, and who will monitor it?

BAY AREA CHILD ASSESSMENT CLINIC
ASSESSMENT, DIAGNOSIS *and* TREATMENT PLANNING

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Comprehensive assessments for:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Learning Disability/Dyslexia
- Autistic Spectrum disorders
- Testing for school accommodations/IEP consultations
- Second opinions for complex cases
- Screening for brain injuries such as sports or accident related concussions
- Behavior changes following serious illness, or emotional problems such as depression, aggression, or anxiety

RESEARCH NEWS

BRAIN INJURY AND MEDICATIONS

Medications such as benzodiazepines and neuroleptic drugs are sometimes used following brain injury. Some of these drugs, particularly in combination, can adversely affect cognitive function and inhibit rehabilitation, while their impact can be subtle or imperceptible to the patient. Perna, R. Benzodiazepines and antipsychotics: Cognitive side effects. J. Head Trauma Rehab. (2004), 19, 516-518.

People with post-traumatic impairment in arousal, processing speed, and attention can benefit from treatment with medication that augments cerebral catecholamine function. Post-traumatic impairment in memory can benefit from treatment with cholinesterase inhibitors. Arciniiegas, D.B. & Silver, J.M. Pharmacotherapy of post-traumatic cognitive impairments. Behavioural Neurology, (2006), 17, 25-42.

Atomoxetine is a novel stimulant medication for ADHD. Unlike most medications commonly utilized for ADHD, atomoxetine specifically acts on noradrenergic systems by decreasing the presynaptic reuptake of norepinephrine. Although criticized for its cost and lack of demonstrated efficacy over traditional stimulant medications, there is considerable evidence that it may have a role in "off label" use for treating specific symptoms following TBI such as attentional problems, hypoarousal, and fatigue. Ripley, D.L. & Glenn, M.B. Atomoxetine for individuals with traumatic brain injury. J. Head Trauma Rehab. (2006), 21, 85-88.

The administration of single-dose methylphenidate has an effect in improving cognitive functioning following a TBI. The effects were most prominent regarding the reaction time of the working memory. Kim, Y-H, et al. Effects of single-dose methylphenidate on cognitive performance in patients with traumatic brain injury: A double-blind placebo-controlled study. Clin. Rehab. (2006), 20, 24-30.

A significant proportion of children who sustain traumatic brain injury will go on to experience disturbance in their academic, emotional, and social functioning. There is a role for medication in the treatment of these late onset changes. This review supports the use of stimulant medication for secondary ADHD, despite the small evidence base for use in children. Bates, G. Medication in the treatment of the behavioural sequelae of traumatic brain injury. Devel. Med. Child Neurol. (2006), 48, 697-701.

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