FROM BIRTH TO DEATH AND BENCH TO CLINIC

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CHAPTER 22

Mental Health in Children and Adolescents

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mental health in children and adolescents

by Erik Parens and Josephine Johnston

Framing the Issue

In 2000, the U.S. Surgeon General reported that approximately 1 in 5 children and adolescents experiences the signs and symptoms of a mental health disorder during the course of a year, and that about 1 in 10 children experiences "significant functional impairment" as a result. More recent studies support this finding, showing that a majority of disorders begin before 14 years of age, with a significant portion already manifest in preschoolers. In parallel developments, the number of children in the United States taking prescription drugs for these disorders is growing dramatically. Recent trends in the use of psychotropic medication—drugs used to treat behavioral and emotional disturbances—from large population-based studies show substantial growth in pediatric and adolescent use of antidepressants and stimulants. According to a study by Medco Health Solutions, an organization that monitors drug spending, the number of children under 19 years of age taking one or more behavioral drugs rose over 20% between 2000 and 2003, with spending on medications to treat attention deficit disorder rising 183%, spending on antidepressants rising 27%, and spending on medications to treat autism and conduct disorders rising more than 60% in that period. Between 2001 and 2005, the number of children under 19 years of age taking antipsychotic medications rose 73%. Other studies support these findings. This trend has given rise to multiple controversies:

- Are children being overmedicated?
- Is normal childhood behavior being medicalized?
- What is the long-term safety of psychotropic drugs?
- How effective and safe is it to use those drugs that have only been tested in adults?

The Science: Defining Behavioral and Emotional Disorders in Children

Studies show that biological factors, such as genetics and brain chemistry, and environmental factors, such as stress and parenting styles, together play a role in mood and behavior. Some emerging research on gene-environment interactions, for exam-

Erik Parens, PhD, *is senior research scholar and* ***Josephine Johnston, LLB, MBHL,*** *is research scholar and director of research operations at The Hastings Center.*

HIGHLIGHTS

- The U.S. Surgeon General estimates that as many as 1 in 10 American children and adolescents a year have "significant functional impairment" as a result of a mental health disorder.
- The number of children in the United States taking psychotropic medications—drugs that affect mood and behavior—is increasing, and is outpacing use in other countries.
- These trends have raised concern that mental health disorders are being overdiagnosed and that psychotropic drugs are being overused in children.
- However, studies show that for many children underdiagnosis and undertreatment are also problems.
- The behaviors identified as symptoms of mental health disorders are expressed to different degrees in all children.
- Values play an inescapable role in diagnosing mental health disorders.
- Special interest groups—whether organizations opposed to the use of psychotropic medications in children or pharmaceutical companies promoting them—should not be allowed to undermine public debate on the wise use of these medications.

EXPERTS TO CONTACT

Erik Parens, PhD, *Senior Research Scholar, The Hastings Center* •
parense@thehastingscenter.org,
845-424-4040, ext. 224

Josephine Johnston, LLB, MBHL, *Research Scholar and Director of Research Operations, The Hastings Center* •
johnstonj@thehastingscener.org,
845-424-4040, ext. 208

Benedetto Vitiello, MD, *Chief, Child and Adolescent Treatment and Preventive Intervention Research Branch, National Institute of Mental Health* •
bvitiell@mail.nih.gov, 301-443-4283

ple, is helping us understand why some children go on to develop emotional and behavioral disturbances when exposed to difficult environments, while others do not. This evidence suggests that genes sometimes moderate the impact of environmental "pathogens," such as physical maltreatment, on the risk for developing mental health disorders. The evidence also suggests that positive environments sometimes moderate the impact of a genetic predisposition to mental illness. Despite these data, however, we are a long way from knowing whether a particular child's disorder could have been prevented by providing a better environment.

Contrary to popular belief, there are no bright lines between normal and pathological behavior nor between disorders that share symptoms (such as attention deficit-hyperactivity disorder (ADHD), mood disorder, conduct disorder, and oppositional defiant disorder). This does not mean that psychiatric disorders are not real or do not demand attention. It does, however, help to explain why there can be disagreement about whether a particular child has a disorder and which particular disorder it is.

Sometimes we speak as if the diagnostic labels of psychiatric disorders refer to a discrete biological phenomenon, when, in fact, they name collections of symptoms that cluster in predictable ways. Many now argue that, rather than using the "bright-line" or categorical model of psychiatric disorder, we should instead adopt a dimensional approach, which assumes that moods and behaviors exist on a spectrum. As psychiatrist John Sadler of the University of Texas has pointed out, even though the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV), the standard psychiatric reference in this country, employs diagnostic categories, its introduction actually grants that a dimensional approach would better reflect clinical reality.

Despite the difficulties and limitations associated with diagnostic categories, many people reasonably defend their use. For one thing, it is important to recognize that many medical disorders are also dimensional, rather than categorical. Like other clinicians, psychiatrists and psychologists have to make decisions (like whether to treat) that are inevitably categorical. Nonetheless, critics of the categorical approach worry that the various categories of emotional and behavioral disorders are too numerous and nonspecific, and that they can do harm by bringing children with normal temperamental differences within the purview of medicine.

Psychotropic Drugs and Children: Hastings Center Explores Controversies

An ongoing Hastings Center project, led by the authors and funded by the National Institute of Mental Health, is exploring controversies surrounding the diagnosis and treatment of behavioral and emotional disorders in children. For this project, the authors assembled an interdisciplinary working group representing a range of viewpoints on the use of psychotropic medications in children. Some people tend to be skeptical about the trend toward more psychotropic medication, while others are optimistic that it will benefit children and families. Though there are many areas of disagreement, our working group found widespread agreement on the following eight points. We believe that these points deserve recognition by mental health specialists as well as the lay public as a step toward a deeper understanding of the diagnosis and treatment of behavioral and emotional disturbances in children.

- Our society has an obligation to help children (and families) who are suffering from behavioral or emotional disturbances.
- To understand the emergence of childhood emotional and behavioral disturbances, we need to study the biological and environmental causes and their interactions over time.
- The categorical approach to mental disorders—dividing them by bright, diagnostic lines—does not represent clinical reality as accurately as would a dimensional approach, which recognizes that almost all symptoms are present to differing degrees in all children.
- It is up to humans to decide whom to diagnose and treat, which means that values play an essential role in the diagnosis of childhood psychiatric disorders.
- Even when physicians can agree about the boundary between healthy and disordered moods and behaviors in children, misdiagnosis remains a problem.
- Both pharmacological and nonpharmacological treatments can be appropriate for emotional and behavioral disorders in children.
- We should not allow groups with strong ideological commitments or economic interests to undermine a transparent public debate about how to use psychotropic medications most wisely and helpfully to treat childhood psychiatric disorders.

Even when child psychiatrists can agree about the boundary between healthy and disordered moods and behaviors in children, misdiagnosis remains a problem. There are children who need treatment who are not getting it and children who do not need treatment who are. The Great Smoky Mountains study, which examined psychiatric disorders and treatment among youths in the

Southeast, found that stimulant medications were prescribed to more children *without* ADHD than to children *with* ADHD. The study also found that a full 28% of children with ADHD were not receiving medication. Many children with ADHD may not even receive a diagnosis. An epidemiological study of parent reports published in 2007 suggested that "less than half of children who met DSM IV ADHD criteria had reportedly had their conditions diagnosed by a health care professional or been treated with medications."

Ethical Issues in Diagnosing and Treating Children

Values play an essential role in the diagnosis of childhood psychiatric disorders. Because human emotions and behaviors are expressed along a spectrum, deciding whether they are normal or abnormal inevitably involves value judgments. Based on their observation of symptoms and assessments of harmful impairment or dysfunction, it is up to clinicians to determine when an individual's suffering rises to the level of warranting treatment.

Current inter- and intranational variations in the diagnosis and treatment of childhood psychiatric disorders reflect value differences, and not simply differences in occurrence of particular moods and behaviors or differences in the availability and quality of mental health services. These variations may reflect cultural differences in parental and educational expectations of children. They may also result from differences in the diagnostic systems that different countries employ. The diagnostic criteria for many mental health disorders in the DSM IV differ from those in the *International Statistical Classification of Diseases and Related Health Problems*, the reference used in Europe.

Some commentators suggest that the increasing rates of diagnosis in the United States and some other countries reflect access to better mental health care: more children are diagnosed earlier because we are better at recognizing these disorders earlier. Moreover, these commentators rightly point out that values play a role in all diagnoses, whether in psychiatry or the rest of medicine, and that there is nothing surprising or unsettling about the fact that psychiatric diagnoses entail the value judgment that a certain level of suffering is bad. Some go further and say that it is perfectly reasonable to treat dysfunction wherever we see it, whether we call it a temperamental difference or a disorder. After all, if someone is suffering, why should we withhold a medication that might alleviate their suffering?

Critics respond that value judgments play a larger role in psychiatry than in other branches of medicine and, therefore, that additional vigilance is required. As Marcia Angell, former editor of the *New England Journal of Medicine*, has observed, "The DSM IV . . . is the product of judgments of about 170 experts, but not necessarily supported by published data. Of necessity, these judgments are often subjective. [Psychiatric disorders are] not like cancer or heart failure." This subjectivity—combined with the observation that traits are dimensional—leads some observers to advocate for letting natural differences be, and being slower to intervene.

William Carey, a pediatrician at the University of Pennsylvania School of Medicine, argues that children have a huge range of temperaments and ways of adjusting to their social worlds—and that this variation is perfectly normal. But because we lack both an adequate rating system for the variation in normal temperaments and ways of adjusting our environments and expectations to accommodate the wide range of normal, he warns that "given a choice between categorical abnormal diagnosis and nothing, the clinician may be tempted to overuse the abnormal." If a child shows temperamental or adjustment characteristics that differ from those of many of his peers, Carey suggests we should try to leave the child be, or we should seek to change the child's problematic behaviors with treatments like behavioral therapy or parent training instead of drugs.

Rather than be for or against medicalizing children's emotions and behaviors, we need to get better at distinguishing between helpful and unhelpful forms of medicalization. Critics worry that as we define more and more emotions and behaviors as medical problems, we engage in "medicalization." Such medicalization risks obscuring the fundamental difference between "badness" and "madness," between wrongful or criminal conduct and mental illness, between moods and behaviors one could change and should be morally responsible for and those that "cannot be helped." Critics argue that the institution of medicine should focus solely on treating medical problems and that other social institutions (education, religion, criminal justice) should address some of the mood and behavior problems that have crept into DSM IV. For example, critics

RESOURCES

Web sites

- www.nimh.nih.gov – the National Institute of Mental Health. Includes a topic finder, publications, statistics, news, and information on clinical trials.
- www.aboutourkids.org – the New York University Child Study Center. Includes information on disorders and treatments, seeking professional help, and participating in research.

Recent news

- Mary Carmichael, "How Doctors Diagnose Bipolar Disease in Young Children and Why It's Still So Controversial," *newsweek.com,* May 19, 2008.
- Joanne Kaufman, "Campaign on Childhood Mental Illness Succeeds at Being Provocative," *New York Times,* December 14, 2007.
- "When Kids Need Meds" (editorial), *Boston Globe*, June 22, 2007.
- Scott Allen, "Backlash on Bipolar Diagnoses in Children," *Boston Globe*, June 17, 2007.
- Carey Goldberg, "Children Face Delays in Mental Health Care," *Boston Globe*, April 13, 2007.
- Patricia Wen, "Girl's Death Puts Doctor at Center of Controversy," *Boston Globe,* February 19, 2007.
- Gardiner Harris, "Proof is Scant on Psychiatric Drug Mix for Young," *New York Times,* November 23, 2006.
- Benedict Carey, "What's Wrong With a Child? Psychiatrists Often Disagree", *New York Times,* November 11, 2006.

Further reading

- Peter Conrad, *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*, Johns Hopkins University Press, 2007.
- Benedetto Vitiello, "Research in Child and Adolescent Pyschopharmacology: Recent Accomplishments and New Challenges," *Psychopharmacology*, March 2007.
- Peter Jensen, Penny Knapp, and David Mrazek, *Toward a New Diagnostic System for Child Psychopathology: Moving Beyond DSM*, Guilford Press, 2006.
- Sharna Olfman, *No Child Left Different: America's Lost Tolerance and the Psychiatric Overmedication of Our Kids*, Praeger, 2006.
- Jean A. King, Craig F. Ferris, and I. Izja Lederhendler, *Roots of Mental Illness in Children*, New York Academy of Sciences, 2003.

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argue that ADHD medicalizes the once-moral problem of inattentiveness, which could be addressed by changing the way children are raised or improving our education system, and that depression medicalizes sadness, another previously moral problem that could be reduced by attending to a child's socialization or peer and family relationships.

Others argue that we should use medicine if it helps achieve our aims, regardless of whether those aims fall within the traditional purview of medicine. As Benedetto Vitiello of the National Institute of Mental Health has said: "Our society has decided that pain, suffering, murder, and aggression are bad. Getting along with others, respecting the law are good. And these are the same values that medicine has to pursue. In some ways it's irrelevant if disorders are classified as illness or vice." With this view, medicalization can benefit some individuals as well as society.

Both pharmacological and nonpharmacological treatments can reduce the severity of the symptoms of emotional and behavioral disturbances in children and improve their overall functioning in life, but there are differences in which treatment people value. Medication enthusiasts note that the effects achieved by drugs and psychosocial interventions are similar and that, therefore, it makes no moral difference which kind of intervention is used. After all, in the best cases, drugs and psychotherapy both produce long-term changes in the brain. Gerald Klerman, a psychiatarist who studied depression, long ago suggested that a knee-jerk preference for psychotherapy over drugs was a symptom of "pharmacological Calvinism," an unexamined gut feeling about the wrongness of using drugs to treat emotional and behavioral disturbances.

Critics, however, argue that the treatment we choose does matter morally insofar as different treatments can reflect and reinforce different values. If we increase the teacher-student ratio to help students focus better on their work, we may be emphasizing the value of engagement. If, instead, we give students stimulants to help them achieve the same goal, we may be emphasizing the value of efficiency. Engagement and efficiency are both important and compatible values, but they are different, and emphasizing one or the other can influence whether we choose pharmacological or nonpharmacological means to achieve the purpose of reducing emotional and behavioral disturbances.

Helping Children Thrive

As the debates about the treatment of childhood emotional and behavioral disturbances grow more common, complex, and public, it is reasonable to expect similar points of agreement and disagreement to emerge. Being on the lookout for them—and remembering that even where there are disagreements, there are also points of fundamental agreement—might make those debates more productive in the future.

In the meantime, groups with strong ideological commitments or economic interests should not be allowed to undermine a transparent public debate about how most wisely and helpfully to use psychotropic medications to treat childhood emotional and behavioral disturbances. On one side, an ideological commitment against psychotropic drugs can stand in the way of children and families getting help. The Citizens Commission on Human Rights, for example, which was founded by the Church of Scientology, opposes many practices in psychiatry, including the use of many psychotropic medications. On the other side is the pharmaceutical industry, which has a clear financial interest in the increased use of medications. Studies showing a "funding effect" and expressions of concern in scholarly and professional writing suggest that many inside and outside psychiatry are deeply troubled by the impact of industry on research and clinical practice.

Our understanding of the emergence of complex human traits is in its infancy. Particular and contested values inform decisions about which behaviors and emotions deserve treatment and which do not. We should not be surprised that there are differing perspectives. Some individuals will argue that society can reduce the suffering of children by more aggressively diagnosing and treating them, with or without drugs. Others will argue that reducing the suffering of children (and the rest of us) calls for greater acceptance and affirmation of different ways of being a child—that is, eschewing aggressive diagnosis and treatment and paying more attention to changing cultural practices and environments. All should agree, however, that what we might call "therapeutic humility"—being clear about the limits of our understanding—is called for, as is more research on both the causes of behavioral and emotional disturbances and the most effective and respectful ways of responding to them.

This entry is based in large part on the authors' article "Understanding the Agreements and Controversies Surrounding Childhood Psychopharmacology" in Child and Adolescent Psychiatry and Mental Health*, February 2008, which is available in full text at www.capmh.com/content/2/1/5.*