Medication for Life

By Lawrence D. Blum, M.D.

There are some areas of psychiatry that would benefit from more controversy. One of them is the prescription of anti-depressants to young people dealing with romantic disappointments. I have seen a lot of young men and women given antidepressants for the very painful, but ordinary, romantic break-ups characteristic of this phase of life, who then become habituated to the drugs. They take the medication indefinitely, their brains accommodate, neurophysiologically, to the presence of the chemical, and they become unable to discontinue it without intolerable withdrawal symptoms that look like an underlying illness. A parallel phenomenon occurs not infrequently with the use of amphetamines (and other stimulants) for Attention Deficit Disorder (ADD) that is at times mistakenly diagnosed in this age group.

Clinical examples will illustrate the problems. (Patients' identities have been altered while still maintaining the essentials of the clinical problems.)

Mr. A, now in his 30s, became sullen and withdrawn at age 16 after a girl refused his romantic approaches. His well-intentioned parents took him to a psychiatrist, who after a brief evaluation, prescribed fluoxetine. Mr. A is now well adjusted and happily married, but unable to get off fluoxetine. Even when it is carefully tapered, two or three months after it is discontinued he becomes anxious and depressed. This is an iatrogenic problem. It is not related to goings-on in

his mind or his life; rather it is the result of his brain's accommodation to a medication, producing a serious withdrawal syndrome. His original psychiatrist made only a descriptive diagnosis. He did not inquire about what was going on in Mr. A's mind and thus could not make a dynamic diagnosis (that is, a diagnosis of a patient's central emotional conflicts, ability to function in relation to other people, strengths and weaknesses, etc.). Mr. A, like many adolescents, had a lot of anxiety and guilt about sexual and romantic involvement and potential success. He defended against his anxiety and guilt by assuring himself life would never work out for him. When the girl he admired rebuffed him, he immediately concluded this would perpetually be his fate, so the girl's refusal was particularly painful. Mr. A feels that had this dynamic been discussed with him at the time, he may well not have needed medication at all.

Ms B, like Mr. A, was prescribed antidepressants for depressive reactions to early romantic disappointments. Likewise, she self-punitively convinced herself, despite easily attracting men's attentions, that these disappointments meant a lifetime alone. Ms B has a family history of depression (although neither of her brothers struggles with it), and she feels that she needed the medications to help negotiate difficult periods. But should she have been on them for extended periods of time? Therapeutic attention to her emotional conflicts helped her to form lasting relationships, marry, and have children. Unable to get off the medications, she had to deal with the risks of their use during pregnancy, which she then subjected to the same sort of guilty self-accusations as she previously used to limit her romantic prospects.

Ms C came to me on three medications – one for each of her significant romantic break-ups. She, too, was depressively self-diminishing, beginning therapy by letting me know all the things

she could think of that might make me think less of her. Understanding some of the reasons for her self-deprecation helped her toward better romantic relationships but did not give her the courage to get off her medications. Pregnancy, however, led her to promptly and successfully discontinue an antidepressant and a mood-stabilizer (she has never had any symptoms suggestive of manic-depression). She remained on a low dose of an SSRI, had an uneventful pregnancy, and then fell in love with a charming baby.

These case vignettes suggest the following principles for consideration:

- Psychiatrists (and other mental health professionals) should always make a dynamic, and not merely a descriptive, diagnosis. Even with a more clearly biologically-driven problem, such as bipolar disorder, the patient's personality and conflicts matter.
- Psychiatrists should be very judicious about prescribing medications in adolescence and young adulthood, especially for difficulties adapting to the typical events of those phases of life. Expert psychotherapy should be the first choice in these instances.
- Medication, when necessary, should be prescribed for as limited a time as possible. It is important for young people to advance their own development, not feel needlessly beholden to medications, not get iatrogenically dependent on them, and not feel that they have "diseases" they don't have.

There are related considerations in cases of amphetamine prescription.

When Ms D's family moved to a new house, she, her brother, and her sister, each attended a new school. Unlike her sibs, Ms D, who was in high school, had a difficult adjustment. Her grades

fell. She was taken to a psychiatrist who diagnosed ADD and prescribed amphetamines. The psychiatrist paid little attention to her prior lack of difficulty in school or her struggles making new friends. Nor did the psychiatrist learn that Ms D had to ward off the seductive advances of an older teacher (although Ms D would likely not have been immediately forthcoming about this at the time). When Ms D came to me as a college student, for troubles with anger, anxiety, and some depression, she was religiously taking 70 milligrams of amphetamines daily. After I learned a bit about her and raised the question of whether she actually had ADD, and whether it might make sense to consider tapering the amphetamines, she was appalled and looked like a toddler who was afraid I was about to steal her candy. Helping her to get off the unneeded medication was a multi-year process. First she had to recognize that it was prescribed to treat a problem she probably didn't have, and second, that it was failing to help her with the problems she did have. As we attended to some of her actual emotional conflicts, she became willing to experiment with lower doses. She was able to see that her work was little changed as the dose was lowered, and that her difficulties with school had more to do with feelings toward classmates and teachers, than with the presence or absence of amphetamines. After a protracted struggle, finally off the medication, she felt in charge of her life and no longer believed there was something inherently wrong with her mind or her brain.

Mr. E was the only son in a high-powered academic family. His older sisters were all intellectual stand-outs. Early in high school he received his first B as a grade in a course. He was taken to a pediatrician, diagnosed with ADD, and put on stimulants. Like Ms D, he came to believe that he needed them. In college he began to develop some magical aspects to his

thinking, a potential side effect of the stimulants. It was very difficult to help him see either that he had a problem with his thinking or that it might be due to the medication.

Principles to consider:

- If the ADD wasn't there in elementary school or before, it is unlikely that an adolescent or young adult has new-onset ADD. A new, or newly amplified conflict is occurring in the person's mind and life. A dynamic diagnosis, as always, is essential.
- When medication is prescribed for actual ADD, as with anything else, the question of how long it will be taken must be asked. For life? Until other means of adaptation are accomplished? Until adequate outcome studies of long-term us of the medication are performed?

Helping patients to get off of unneeded, or no longer needed, medications can be a difficult task. Their emotional attachments to the medications can be intense and varied. For some the prescription is a sign of being loved and cared for. For others it represents a certification of a deficit, appeasing guilt about success, and/or attesting to the need for special consideration. Insofar as the medication has been helpful, it may have come to be regarded as a dearly loved friend, or even a part of the self. When medication has been helpful there is also of course concern about the potential return of the difficulties for which it was prescribed. Few patients are told at the time of first prescription that there is potential risk of habituation and return of, or potential exaggeration of, symptoms with discontinuation. This type of discussion is more difficult to have in situations in which prescription is urgently needed and the patient is reluctant,

but is still not often done in those instances in which prescription is more optional than essential. The picture is seldom simple.

These few comments only scratch the surface of the difficulties doctors and patients face in helping patients to discontinue their medications. Residency programs pay a lot of attention to helping trainees learn to prescribe medications; rarely do they sufficiently educate residents how to help patients discontinue them. The fact that so many residencies currently pay limited attention to interventions apart from medication contributes further to the difficulty.

Psychiatric medications have saved the life of many a patient. Some patients need medication for life. But some end up on medication for life, even in some instances when the medication may not have been needed in the first place. Although it is often a difficult task, as a profession we need to do a better job of distinguishing which patients are which.

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