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## COMMENTARY

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# Confirming the Hazards of Stimulant Drug Treatment

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Until recently, no studies have systematically examined the rate of psychotic symptoms caused by routine treatment with stimulant drugs such as methylphenidate (Ritalin®) and amphetamine (Dexedrine®, Adderall®). Doctors who prescribe stimulant drugs often seem oblivious to the fact that these drugs can cause psychoses, including manic-like and schizophrenic-like disorders. Without providing evidence, authors often cite rates of 1 percent or less for stimulant-induced psychoses (reviewed in Breggin, 1998, 1999). Recently on television I debated a well-known expert in child psychiatry who took the position that prescribed stimulants “never” trigger psychoses in children.

The rate of psychotic symptoms that first appear during stimulant treatment has recently been investigated in a five-year retrospective study of children diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD) [Cherland & Fitzpatrick, 1999]. Among 192 children diagnosed with ADHD at a Canadian clinic, 98 had been placed on stimulant drugs, mostly methylphenidate.

Psychotic symptoms developed in more than 9 percent of the children treated with methylphenidate. According to Cherland and Fitzpatrick, “The symptoms ceased as soon as the medication was removed” (p. 812). No psychotic symptoms were reported among the children with ADHD who did not receive stimulants. The psychotic symptoms associated with the use of methylphenidate included hallucinations and paranoia. The authors conclude that, due to poor reporting, the rate of stimulant-induced psychosis and psychotic symptoms was probably much higher.

In my practice of psychiatry, I am frequently consulted about children who are taking three, four, and sometimes five psychiatric drugs, including some that are FDA-approved only for the treatment of psychotic adults. The drug treatment typically began when the children developed conflicts with adults at home or at school. In retrospect, the conflicts could easily have been resolved by interventions such as family counseling or individualized educational approaches. Usually under pressure from a school, the parents instead acquiesced to put their child on stimulants prescribed by psychiatrists, family physicians, or pediatricians.

When these children developed depression, delusions, hallucinations, paranoid fears and other probable drug-induced reactions while taking stimulants, their physicians mistakenly concluded that the children suffered from "clinical depression," "schizophrenia" or "bipolar disorder" that has been "unmasked" by the medications. Instead of removing the child from the stimulants, these doctors then actually went on to prescribe additional drugs, such as antidepressants, mood stabilizers, and neuroleptics. Children who were put on stimulants for "inattention" or "hyperactivity" ended up taking multiple adult psychiatric drugs that cause severe adverse effects, including psychoses and tardive dyskinesia.

It is time to entertain seriously the notion that supposedly increasing rates of "schizophrenia," "depression," and "bipolar disorder" in children in North America may be often the direct result of treatment with psychiatric drugs. These phenomena should be classified as adverse drug reactions, not as primary psychiatric disorders. Doctors need to become more expert at identifying these adverse drug reactions in children and more aware of how and why to taper children from psychiatric medications (Breggin & Cohen, 1999).

When parents are willing to take a fresh approach to disciplining and caring for their children, or when the children's school situation can be improved, it is usually possible to taper them off of all psychiatric medications. The parents are then relieved and gratified to see their children increasingly improve with the removal of each drug.

What's the answer to this widespread, unwarranted use of medication in the treatment of children?

As long as we respond to the signals of conflict and distress in our children by subduing them with drugs, we will not address their genuine needs. As parents, teachers, therapists, and physicians we need to retake responsibility for our children (Breggin, 2000). We must reclaim them from the drug companies and their advocates in the medical profession. At the same time, we must address the needs of our children on an individual and societal level. On the individual level, children need more of our time and energy. Nothing can replace the personal relationships that children have with us as their parents, teachers, counselors, or doctors. On a societal level, our children need improved family life, better schools, and more caring communities.

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