
The Illusion of Certainty: Do Advances in Psychopharmacology Suggest That Students' Inner Lives Are

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Foreword

Treating the emotional problems of children with medications is increasing as a principal component of contemporary mental health care. That is the reason we included "An Introduction to Pediatric Psychopharmacology" by Sandra DeJong, MD, in this web site section.

Yet it would be a disservice to our readers if we failed to provide an alternative point of view. In the "Illusion of Certainty," Gertrude Carter, MSW, BS/RN, Director of Psychological Services for Students and Jeffrey Winseman, MD, Medical Director of Health and Psychological Services at Bennington College, Vermont, raise questions about the increase in the use of psychotropic medications. The authors make a number of observations that may be of interest to both pediatricians and parents.

- They are concerned that an increasing number of students are coming to college mental health clinics for prescription refills only. They note that the prescribing of psychotropic medications, without adequate psychosocial diagnostic mental health evaluations or counseling, is becoming an accepted standard of care even though such "medications are most effective when used in conjunction with

psychotherapy."

- They point out that a "medication only" approach may not acknowledge these young people's increased capacity for self-examination, for critical thinking, and for developing personal responsibility for their emotional lives. Bennington clinicians provide students with a professional relationship, which gives students the opportunity and the time to "understand the complexities of their development and life experiences."

- They observe that adequate justification for the use of these medications is sometimes lacking upon review of students' medical histories. The authors note, "We live in a culture that loves a quick fix, seeing a myriad of daily visual images that portray a utopian existence without the blemish of ambivalence or struggle." The writers suggest that medications may not always be in the best interest of the child, and propose an alternative approach that respects the students' abilities to work at understanding their life stories, helping them make "responsible, independent decisions about their health and their lives."

- Howard King, MD

The Illusion of Certainty

College mental health clinicians have witnessed a steadily increasing number of students who present for the sole purpose of refilling prescriptions for psychotropic medications. Many of these students tell us they are not interested in working towards an understanding of their lives, asking only that their medication regimes be continued or adjusted. Students often want medications refilled but arrive without medical

records. When we have successfully obtained records of students' mental health histories, they are frequently incomplete. Diagnostic, psychosocial, psychological and psychiatric evaluations are either absent or insufficient. Ongoing treatment plans are not discussed or recorded. Prescriptions for psychiatric medications are maintained over a decade while psychotherapeutic interventions remain brief and intermittent.

These fractured interactions with caregivers seem to mirror the student's past inconsistent interactions with caretakers. Their need to restore and strengthen interpersonal relationships is not recognized in the effort to control symptoms with medication. The message is, "If you are to remain stable emotionally and attain academic success, stay on medications to handle all problems."

What does it mean when medical caregivers reject the complexity of all of the factors contributing to a student's problems, embracing the idea that "pills are sufficient"? Psychotropic medications, which were once only tentative forays into the neurobiology of mental disorders, have for many become the treatment of choice for psychological problems. Developed as a therapeutic tool for psychiatrists in the early part of the twentieth century, these medications are now most frequently prescribed by family physicians, nurse practitioners and physician's assistants, who do not have expertise in the field of mental health. This approach, what Claridge and Healy (1994) have termed the "psychopharmacology of individual differences," has gradually replaced the more traditional, thorough examination

of patients.

A triumvirate of mental health professionals (psychiatrist, psychologist and social worker) used to evaluate a patient's mental functioning, establishing a diagnosis. The diagnosis took into account the patient's symptoms, feelings and intrapsychic configurations as well as the interpersonal dynamics of the family, school or work environment. Once the evaluation was complete, the team would recommend a highly individualized treatment plan. Any prescription of medication was accompanied by recommendations for psychotherapy and necessary changes in the patient's environment.

The prescription of one or more psychotropic medications without accompanying psychotherapy or social interventions has become an accepted standard of psychiatric care. Pharmaceutical industrialization (Eichenwald and Kolata, 1999) and powerful corporate health care organizations have helped to set this standard. Clinical and empirical evidence, however, indicates that medications are most effective when used in conjunction with psychotherapy (Elkin et al., 1989). Despite these findings, Kaiser Permanente, one of the first HMOs, recently published guidelines for the treatment of depression (1998) which suggested that psychotherapy be recommended only after two consecutive trials of antidepressant medication have failed. Thorough psychosocial evaluations and multidimensional treatment plans have been set aside because they are considered too expensive and too time-consuming. As the nature vs. nurture debate increases in complexity, mental health

professionals are encouraged to simplify their conceptualization of the diagnosis and treatment of mental illness. Our attention to the intrapsychic world diminishes just as we are faced with an increasing demand for relief from psychological pain in an increasingly complex society. Perhaps this trend is not surprising, for we also live in a culture that loves a quick fix, seeing in a myriad of daily visual images a utopian existence without the blemish of ambivalence or struggle.

College clinicians are particularly aware of the burgeoning problems associated with the medication Ritalin. Its use and abuse as a recreational and "study" drug is up on all campuses. The abuse of this medication was first noted in New England preparatory schools, according to Dr. Heligenstein, the head of psychiatry at the University of Wisconsin Health Services, where "access is easy because so many students have prescriptions, often not warranted by medical need." The Drug Enforcement Administration (1990) classifies this psycho-stimulant medication as a Schedule II substance. These substances include amphetamines (of which Ritalin is a derivative), cocaine, morphine, opium, and barbiturates. While Ritalin is more stringently regulated in other countries, Americans use five times as much Ritalin as the rest of the world (International Narcotics Control Board Annual Report, 1999). The United Nations has advised the World Health Organization to investigate the phenomenon of Ritalin use in the United States and, similarly, the International Narcotics Control Board has issued multiple warnings about America's dependence on this drug (INCB Annual Report, 1999). The prescription of Ritalin for children continues to increase despite these warnings. Simultaneously, the list of possible disorders for which Ritalin is proposed

as a potential
cure continues to grow.

To further illustrate this problem, consider our experience with Norvartis, the manufacturer of Ritalin. We asked the company to send us a representative to speak to us about the drug, and to discuss current protocols for tracking the abuses of this medication and typical courses of treatment. We were particularly interested in the problems and successes with students who take this medication, on college campuses and in boarding schools. After two months of telephoning, the company representative told us, by telephone, that Novartis had made a decision "not to promote Ritalin" and that information on these topics was not available. Such a response was puzzling coming from a company that is making a fortune from prescriptions of this Class II substance, primarily for children, the majority of whom are students.

The scientific community remains perplexed about the potential hazards of this medication. Some researchers consider amphetamine derivatives "gateway drugs," drugs that make the brain more susceptible to the addictive power of drugs like cocaine and other forms of speed. Articles debating the risk of habitual use of psychostimulants in children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) report contradictory results. For example, one group (Lambert and Hartsough, 1998), linked Ritalin use in children and adolescents with the onset of substance abuse disorders in adulthood. Another group (Biederman, et al., 1999) found its use to be an effective protection against the development

of substance abuse disorders in adult life. The proliferation of psycho-stimulant medications is of concern to both researchers and clinicians, but attempts to tease out useful conclusions regarding these medications are difficult. Confusion over the evidence supporting or disputing biological treatments which are poorly and often insufficiently proven or even explained (Healy, 1997) contributes to the widening rift between caregivers, the public and researchers. Unmanageable tensions between mental health clinicians who support categorically-based diagnoses and psychopharmacological interventions on the one hand, and those who subscribe to multidimensional diagnoses and longer term, in-depth treatments, such as psychoanalytic psychotherapy on the other, make this dilemma particularly difficult for students in need of psychological care.

Psychodynamic psychiatrists and psychotherapists on college mental health services can correct the prevailing trend toward the use only of psychotropic medications without concurrent psychotherapy. To assume that ancient and complicated tensions between concepts of mind and body have been resolved diverts attention away from the richness and interaction of all aspects of mental activity and life experience. As the array of medications available to students from health care professionals and pharmacies on-line increases, college clinicians are pressed to meet increasingly distorted expectations. Some students arrive on campus with abundant supplies of medication with no encouragement to contact a college-based treatment team. Many students come to college health services requesting refills for their medications, anticipating no contact with a mental health provider. Others come in requesting Ritalin, with the specific intent of improving "their ability to study." Can mental health

professionals
on a college campus address the confusion regarding
diagnosis
and treatment? How can they stem the tide of a
burgeoning
pharmacopoeia of drugs?

An Internet survey of campus health services
illustrates
some colleges' attempts to address these questions.
Most problematic
were those students requesting amphetamines for a
presumed
diagnosis of ADHD (the most frequent diagnosis
associated
with amphetamine-like prescriptions). The health
service at
the University of Kansas established a battery of
tests to
tighten diagnostic criteria for ADHD. Tulane
University created
an ADHD Task Force and tried over the last year to
establish
a standardized diagnostic procedure. Though the use
of tools
such as psychological tests remains controversial,
Tulane
researchers, too, have turned to batteries of tests
reviewed
by a psychiatrist who interviewed the student
initially, and
when appropriate, makes the diagnosis.

Most schools, however, do not have staffing that
allows for
a careful and conservative approach to this problem.
At one
school, once stabilized on medication (Ritalin,
Dexedrine,
or Adderall), the students see a psychiatric nurse.
She continues
to review side effects. At the end of the term, the
students
present their grades, and if the grades are
satisfactory,
they remain on their medication. The nurse described
this
procedure as "the efficacy of treatment." Another
school has the staff physician follow the students
on medications,
requiring phone contact each month, maintaining the
prescriptions
which are picked up without a face to face

appointment. The physician sees the students early in each semester, requiring one visit per semester for students who are suffering from anxiety and depression. He stated that these medications make the students able to study more effectively, and indicated that this approach helps fulfill the educational mission of the institution because students are able to study.

Mental health clinicians at Bennington College subscribe to a different mission. Our goal is not just to help students study well. We understand that adolescents arrive in a college community simultaneously struggling with their own unique individual, family and interpersonal tensions, as well as rapidly developing institutional, cultural and political undercurrents. Students arrive on campus with their own unique attitudes about psychopharmacology and psychotherapy. College clinicians also have their own beliefs about optimal care. Both are affected by the policies and standards endorsed by their particular college communities, which are in turn shaped by accommodations and resistances to the continual fluctuations of sociopolitical tides. We encourage students to understand the complex themes affecting their psychological lives, particularly when their previous experiences in the medical community have led them to expect that caregivers will give them prescriptions on demand after fifteen-minute meetings with the college nurse or physician. We discourage professionals from viewing medication management as their only function. For not only can college therapists and physicians encourage debate and reflection on our culture's over-reliance on medication, they can provide students with a therapeutic relationship in which they can work to understand their complicated pasts (disintegrated

family lives, inadequate schooling, fractured communities).

When students arrive on our campus, they are often for the first time responsible for managing and organizing their time as well as pacing their interpersonal lives, their sleep, exercise, eating and work habits. Students who request medicine for problems in these areas often discount their own ability to begin to modulate the rhythms of their lives. Prescribing medications when these elements have become disturbed (for example, disrupted sleep due to college life), without consideration of the personal meaning and context of these disturbances (e.g., the effects of living in the particular college environment), does not encourage self-reflection or responsible self-regulation. A "medication only" approach fails to encourage the hallmark of late adolescent development, the dramatic increase in capacity for self-examination and ability to think critically, the development of responsibility for one's self.

Physicians and other professionals who maintain a laissez-faire stance about prescription medications give students the message that they cannot handle the complexities of their inner worlds without pills or other substances. This dovetails the attitudes of students who are experimenting with all sorts of substances, and is especially problematic for those students who experiment heavily with alcohol and other drugs. By taking a conservative approach toward medication and substances, campus-based clinicians can address students' personal use of substances more effectively. Students are exquisitely sensitive to current social

standards,
and are prone to meld their own attitudes and
resistances
from those of the larger society. When substance
abuse and
prescription medication treatments are present in
the clinical
picture, the difficulty in determining the cause of
symptoms
and effecting change in these students' lives is
formidable.

To intelligently interpret the problems presented
by the
numbers of students who arrive on campus with prior
treatment
histories, our clinicians recognize the usefulness
of medication,
and maintain a view that is respectful of
the complexity
of late adolescent development. This requires a
review of
students' medical histories, contact with students'
previous
caregivers and, when appropriate, contact with their
parents
in order to clarify the history of the problem and
rationale(s)
for treatment. On campus, we require an initial
evaluation
of the student. When students are on psychotropic
medications,
they meet with our psychiatrist for a thorough
evaluation.
We do not refill medications in fifteen-minute
sessions. We
encourage all students who are on medication to
enter or continue
psychotherapy. We take this position out of respect
for our
students' abilities to begin to piece together their
life
stories and to encourage responsible decisions about
their
health. We hope to help students establish a basis
for questioning
current societal values, for analyzing the
biological determinacy
so blithely accepted in current models of mental
health care
and, more importantly, to ask the broader questions
of the
possible meanings in life and one's own
responsibility to
live it thoughtfully.

The process of personal discovery and change, so important in adolescent development, is in danger of being lost within a medical model devoid of the richness of life histories, conflicting motivations, and interpersonal experience. Such a loss affects us all, for the tasks of late adolescence are complex and varied, exhilarating and frightening, and filled with the promise of self-assurance and doubt. We are keenly interested in helping students understand these developmental tasks: the striving for autonomy in the midst of longings for dependency, identity integration in the midst of confusion, and the reorganization and consolidation of a new sense of self intellectually, emotionally, and socially. While we appreciate the advancements in neurobiology, we continue to consider the complexities of the mind and its interactions with the environment. For if we respond to our students' psychological pain in purely biological terms, we exclude the potential for change through understanding important meanings of our experiences, and cement further the false belief that pills are the only effective means to healing and change.

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