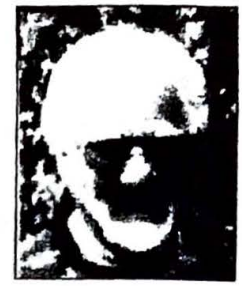
GETTING KIDS OFF THE MEDS



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Although I have a general practice, I specialize in testing, treating and mentoring adolescents and young adults. In the last year, I have found a considerable number of clients who are eager to "get off" medications prescribed for a variety of symptoms and conditions. What is especially interesting is that many of the teenagers have a *powerful* desire to find alternative ways to control problems that interfere with their lives.

Why they do should not be surprising. At an age when there is a surge of desire to be independent, physically strong, properly assertive and socially equal to peers, medication can be perceived as alien to these age-appropriate pulls.

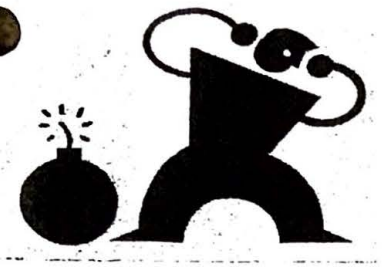
To need a medicine to be in control of yourself, whether that control is over anxiety, anger, attention, or impulsiveness is demeaning to many teens, and a slap in the face to the autonomous and competent person they are striving to find within themselves. Indeed, most of the teens are more eager to "get off the meds" than are their parents, whose ambivalence is understandable. On the one hand, many parents do not want their youngsters to require medication and have concerns about side effects and the meagerness of clear research into the dangers of drugs for non-adults. On the other hand, parents have also found that the medicines have often helped reduce behaviors that had perplexed and frightened them.

When faced with this situation in therapy, a number of questions need to be confronted. Is this a teen who must be medicated? Are there psychological strategies that can reduce this teen's problems significantly? If so, can medication be reduced as these strategies are learned and mastered? Is it possible that over time, the medication can be terminated? Especially important, will this teen's psychiatrist be willing to collaborate in this regard?

Fortunately, most of the psychiatrists working with my clients are most eager to work with me. I suspect that they appreciate psychologists who see them as colleagues and not "the enemy." Enlightened psychiatrists see the value of psychological intervention just as enlightened psychologists appreciate the value of medical intervention. Professionals dedicated to the welfare of their clients do not have that much trouble finding the proper balance between approaches and working together.

Most often, the psychiatrist and I first determine the target areas we are trying to control. Anxiety and obsession are examples. Often, the parents and the teen are included in this determination, so that, as it is said, "we are all on the same page." Then a system for monitoring target areas is determined. Most often, it involves weekly ratings, from one to ten, provided by the parent, the teen, and sometimes a teacher or coach. A conference is held in which the plan is clearly explained, and in some cases written down. The teen is aware that, after obtaining baseline ratings of the targeted problems for two weeks, we will begin to gradually reduce medication. He or she is also aware that there is the possibility that medication may have to be restored, either in part or in whole depending upon the results of our "experiment." The specifics of how frequency and dosage will be reduced will have been determined by the psychiatrist. During the first two weeks, the teen and I explore non-medical strategies that can relieve the symptoms that his or her medication is now controlling. Some of these strategies include relaxation techniques (breathing exercises and self-hypnosis), identifying "bomb alarms" (the sequence of feelings that lead to explosion or panic), discovering appropriate expressive outlets to arrest the problem before it starts (e.g., a physical activity, playing music, or calling a friend), modeling such behaviors as concentration (i.e., by playing chess and

internalizing the mood), and braking and reflecting (freezing and then considering the validity of the "bomb alarm").



Braking and reflecting, as I have termed it, seems to be especially meaningful to many of the teens with whom I work. It leads to a deeper exploration of their psychodynamic (explained to them as the image of the feelings that pull them either away from things they really want to do, or into things they really don't want to do). An example of images of feelings is "I feel like I'm invisible," or "I'm in a prison cell and can't get out." A brief consideration of how these feelings may have developed leads to a differentiation between whom they think they *were* and whom they think they are *now*. As the client begins to realize that his or her "bomb alarms" are related to whom they thought they *were*, they begin to add to their alternative strategies by stepping into whom I am *now*. This is often aided by a physical cue such as standing by a surfboard and remembering how you felt when the *you who you are now* mastered surfing Big Rock. Often, it also leads to a charting of their process, a graphic that many of the teens tape to their bedroom wall, and a procedure that will require its own article.

In general, although there are ups and downs, the curve of progress seems to rise, and the teens delight in their victory of having "gotten off the meds" either totally or in part. Blake has said, "I feel like I scored a winning touchdown." Sarah has said, "I feel like, even though I've been putting it off, I'm now ready to take driving lessons." A number of parents tease me by complaining that the increased empowerment their teens feel has created a new set of dilemmas, and this is probably true.

The response that has pleased me the most has been that of Cameron. He is as determined a teenager as I have ever met, has lowered his obsessions by working at being determined without being desperate, and is now, with the approval of his psychiatrist, totally off medication. Cameron has decided to collect "PCEs." He is redoing many of the things he did while on medication to obtain *Pure Cameron Experiences*. He is very happy about everything. And so am I.