Sixteen-year-old Rob takes Advanced Placement classes at a high-achieving upper-class high school. He's in the marching band, is a Life Scout, and reads and thinks for pleasure. I happen to know from meeting with him that he is curious, intelligent and quite relational. I also met this week with his mother, who is deeply concerned and distressed about her son's behavior, telling tales of his apparent laziness, avoidance behavior, unreliability, impulsivity and explosive emotionality. They want my help and I will try, but my role as a counseling psychologist is much more complicated than the issues that I studied in graduate school more than 30 years ago, or in the continuing education I've taken since then.

There are several societal changes in the last 30 years that impinge heavily on human development; consider the fact that for the first time in history, young people spend hours upon hours in front of various electronic screens. In Rob's case, as in countless others, the involvement of certain kinds of drugs represents the most clear and present danger. Amy Philo and I had a previous article in Pathways [Issue 30, Summer 2011] that provides some of the details of our society's tragic movement toward the use of psychiatric drugs from the cradle to the grave. In any event, the greatest obstacle to Rob's well-being and success in life is the heavy load of five psychiatric drug prescriptions he is currently taking— two stimulants, one blood-pressure drug also used for so-called ADHD, one anticonvulsant presumably meant to function as a "mood stabilizer," and one serotonergic (SSRI) antidepressant. Rob's and his mother's situation is a good example of the great challenges and complications of working with young people on psychiatric drugs, examining how previous help has harmed them and made it exceedingly difficult to help them now.

Rob's drug load includes three prescriptions for so-called ADHD, the most popular psychiatric diagnosis that justifies giving millions of school-age children stimulant drugs, which the Drug Enforcement Administration has pointed out are basically equivalent to cocaine and methamphetamine in their effects profile. The adage from my generation that "speed kills" remains true (see ritalindeath.com for proof). Rob also takes daily an anticonvulsant, frequently used as a mood stabilizer to treat bipolar disorder. Subsequent to ADHD, bipolar disorder became the next exploding epidemic of "mental illness" among children in our society. The primary treatment of bipolar disorder, of course, is psychotropic drugs, specifically mood stabilizers like Depakote, and antipsychotics like Abilify or Zyprexa. They are known to have caused probably the largest epidemic of neurological disease in history—Tardive dyskinesia—in millions of adults around the world.

A close look at the epidemic of "bipolar kids" shows that a tremendous percentage of children diagnosed as bipolar started off with an ADHD label. Typically, these kids took stimulants for years before they were diagnosed as bipolar. Given that psychosis, agitation, anxiety, mania,

and cognitive and mood deterioration are all effects of stimulant drugs, it is easy to see that the end result is often a tragic and pathetic example of an iatrogenic disease (a disease caused by medicine or medical doctors). The clear implication is that much of this disability is due to the damage caused by long-term use of psychiatric drugs. This suggests one obvious way to prevent many of the behaviors that psychiatry uses to justify its creation of the budding epidemic of “bipolar disorder”—simply do not put young children on toxic stimulants. As investigative journalist Robert Whitaker lays out in his outstanding book, Anatomy of an Epidemic, with dramatically increasing frequency the end result of long-term psychiatric drug use is permanent disability.

It is ironic, given that Rob is already taking a drug commonly used to treat bipolar disorder, that when his mother shared with me her distressed concern about her son’s behavior, she worried that he might be bipolar. At this point, Rob is not taking an antipsychotic, but barring greater awareness and active decision-making on the part of Rob and his mother, he could soon enough be adding one to his drug cocktail. Given he is already taking five different medications, his psychiatrist certainly has no problem with polypharmacy.

To summarize, Rob’s mom is convinced he is mentally ill, at the very least suffering from ADHD and depression, and showing signs of being bipolar. She is also convinced that the drugs are working, as without them she knows his behavior would be worse. Rob has been continuously on psychiatric drugs for five or six years, with occasional increases when they seem not to be working as well; his mother attributes this to increasing weight that requires increased dosages to get the same effect. So helping Rob and his mother is exceedingly difficult. What follows is my brief analysis of a few of the reasons why.

## Conflation of Drug Effects and Human Dynamics

As long as Rob is on the drugs, we have no way of determining causal dynamics of his behavior. Since all of his behavioral “symptoms”—apathy, avoidance, impulsivity, and emotional outbursts—are documented effects of the drugs he is taking, there is no way to separate those drug effects out from other causes. I learned early on in my practice that applying my education and training as a psychologist was secondary to alleviating the harm caused by my own colleagues in the mental health profession. However brilliant psychodynamic or behavioral or family systems analyses might be, they are inevitably tainted. A study of Peter Breggin’s work, beginning with his 1991 book, Toxic Psychiatry, would be a good place to start in understanding the dangers of psychiatric drugs. His more recent book, 2008’s Medication Madness, follows that up, showing how various psychiatric drugs impair self-awareness, self-control and decision-making, often dramatically.

The fact is, no problem routinely seen by psychiatry has been scientifically demonstrated to be of biological or genetic origin. Neither Rob nor any young person given psychiatric diagnoses of ADHD or bipolar disorder, has been shown to have a specific physical or chemical abnormality that is an indicator of that "illness." The title of neurologist Fred Baughman's book, The ADHD Fraud, applies not only to so-called ADHD but to the entire theory that problems in living are due to specific chemical imbalances or genetic defects. Mental illness is a metaphor, and diagnoses are strictly based on behavior. In my view, the conversation really should be about the ethics of using these powerful, toxic drugs to control children's behavior.

## Drug Withdrawal

A second, related, point has to do with the effects of drug withdrawal. Virtually all psychiatric drugs are addictive, so those who take them experience tolerance, dependency and withdrawal—hence the need for increasing dosages to get the same "therapeutic" effect, and a wide array of problematic physical, emotional, mental and behavioral effects caused by withdrawal. Making matters worse, withdrawal effects are typically minimized or denied by prescribers, and resulting symptoms are generally attributed as evidence of the mental illness and justification of the need to keep taking the drugs. This is a classic catch-22. Another book by Breggin (and coauthor David Cohen), Your Drug May Be Your Problem, provides good information on the process of withdrawal. Since the drugs often feel bad to people, it is common to try getting off them, but very often this is done too rapidly, or even cold turkey. This can be dangerous, so patience and gradualness are important; the so-called 10 percent rule provides a general guideline.

Rob's mom informed me that Rob has to avoid the drugs at times in order to eat or sleep, since the drugs are stimulants and suppress his appetite. Thus, he is regularly going through short-term drug withdrawals. I asked her whether he had ever tried to wean himself off the drugs in the last few years. She said no, but thinks that his growth and added weight meant he was in effect weaning. This was, of course, interpreted as a reason to increase the dosages.

There is much more to be said about the effects of drug chemistry, but I want to focus now on a few of the key psychological, and life, dynamics that must be faced in efforts to help young people on psychiatric drugs. These dynamics may be seen as mechanisms of what I call psychiatric oppression; perhaps the most important from a counseling perspective is that psychiatric drugs suppress thought and emotion.

## Suppression of Emotional Expression

We heal by expressing ourselves emotionally in the presence of good attention from another warm, caring human being. There is a strong trend in our society toward suppressing expressions of emotion (crying, shaking, sweating, storming, screaming, yawning, etc.) which help to discharge emotional or physical hurts. Such sayings as “big boys don’t cry,” “get a grip on yourself,” or “just be positive,” and epithets like “crybaby,” “whiner” or “sissy,” keep outward displays of emotion in check. Other words or labels express a key part of psychiatric oppression— sayings like “they’re going to come take you away,” or getting described as nuts, crazy or sick, and on and on. As a result, we all have reason to experience shame and fear around intense, uninhibited emotional expression.

Counseling ought to be about helping people regain and benefit from the natural healing mechanisms of emotional discharge. But psychiatry tends to interpret emotional discharge as a symptom of mental illness, then supply a pathological label, then administer medical technology for suppression of feeling—i.e., psychiatric drugs, which often shut down the natural process by which people resolve the effects of hurt and trauma. Furthermore, as suggested above, psychiatric drugs can actually create impulsivity and undue emotionality, confusing things even more. From a counseling perspective, psychiatric drugs can be a terrible impediment to the work. Tears and tantrums are actually a very good thing for children, and emotional expression helps adults, too.

A small task I have taken on as part of my teaching is an effort to rehabilitate the tendency to refer to toddlerhood as “the terrible twos.” I suggest instead that we call this period “the terrific twos,” in celebration of the power and defiance that signify the beginning development of an authentic self. Adolescence is another major period of individuation that often involves testy resistance to authority. Rather than worrying so much and suppressing that energy with psychiatric labels and drugs, I suggest that this is something to be encouraged and celebrated. Psychologist Bruce Levine is an ardent defender of the rebellious spirit of young people. His 2013 piece for Alternet—“Are the Young People that Shrinks Label as Disruptive Really Anarchists with a Healthy Resistance to Oppressive Authority?” is a good place to start learning about this.

## Responsibility

Rob’s mom wants her son to be more responsible, yet the basic message he has received for years (and still is receiving) is that he is not capable of full responsibility because of his mental illness, and needs all these drugs to keep it under control. Responsibility is a core issue embedded in the theory of biological psychiatry that justifies the labeling and drugging of

children. According to biopsychiatry, problem behaviors say nothing about social issues, community issues, or physical or emotional issues. The assumption is very simple: Problems are due to “mental illness,” and we are absolved of responsibility to think any further.

Once an individual is labeled with a biologicallybased “mental illness,” his school, his family, his community, and society are all magically absolved from the need and responsibility to keep thinking, to examine themselves, to question the nature of the community, to look at oppression at any level in the society. Instead, everyone can act as if the situation were explained by bad genes or biology causing “mental illness” in the poor soul who is the identified patient. Just as we all are absolved from responsibility to face societal oppression, so also are we absolved from the need to do whatever it takes to care for the individual and support his recovery and well-being.

However much parents or other adults get frustrated and challenge Rob, as a “patient” he cannot be considered fully responsible because he is said to suffer from a disease that renders him irrational and incompetent. Given this logic, psychiatrists are completely justified in giving drugs to Rob and millions of other young people and adults. By extension, they are also justified in the ongoing psychiatric practices of coercion, and administering brain-damaging electroshock. The public is justified in leaving it all to the professionals. Most importantly, everyone is absolved from any responsibility to keep thinking about what is really going on, and to keep working to find ways to create a compassionate society and to respond to individual human needs.

## In Session with Rob

I discussed three recent events with Rob that his mother had identified as seriously problematic. In the first, a conflict with his peers at Scout Camp escalated to an intense frustration and a scene with the camp leaders. The second involved an emotional scene in the car with his sister that ended with Rob’s mom taking over the driving from Rob, who was supposed to get his license in a few days. Regarding the third, Rob shared with me that he had used his mental illness as an excuse to avoid recrimination from his band leader for skipping practice due to fatigue from a very late movie night. The strategy worked, but Rob said it was not worth it due to the flack he caught from his mother. To his credit, he also realized it was self-defeating, as he really does enjoy and want to excel in band.

Rob attributed the incidents in the car and at Scout camp to being off his medication; this may be true, but it is clearly not an interpretation that fosters responsibility. In a similar vein, keeping

in mind Bruce Levine's point about resistance to authority, a biopsychiatric attribution undermines individual power, as the spirited motto to "Question Authority" is utterly lost when resistance is interpreted as evidence of mental illness. Rob thinks that being off his medication caused his problems of "impulsivity" and "persistence" to become worse in these two incidents.

Rob's biopsychiatric interpretation that his behaviors are symptoms of his underlying mental illness not only undermines responsibility, but also disempowers him. It is no doubt true that impulsiveness and stubborn lack of flexibility can be faces of distress, but interpretation of these behaviors as psychiatric pathology regularly interferes with the actual work of conflict resolution and emotional healing. To recognize that, even if these events are colored by emotional distress, Rob is doing the best he can to defend and assert his essential needs for autonomy, self-determination and power. This is a much better way to go. To disregard that at least part of the problem may be due directly to drug effects, including withdrawal, is tragic.

## Emotional Hurdles

I have identified three major emotional obstacles to withdrawing from psychiatric drugs—fear, shame and hopelessness. In my experience, the biggest is fear. Rob has had a hard time over the years, and is so scared about his situation that it is very difficult to engage about his drug regimen. Our conversations consist of my letting him know that I am skeptical that he needs all these drugs to function in life.

Rob's mother is more ambivalent, as she is at least somewhat aware that these drugs have significant downsides, but when we talk about the possibility of withdrawal, her fear comes up strong. Despite her ongoing worry and frustration about her son's behavior, she is convinced that without the drugs he would be much worse. I can empathize and let her know I understand her thinking on this; I have learned that it is a bad idea to tell people they're wrong if your goal is to help them open their minds to new information and approaches. It is much better to listen and acknowledge, and gradually give relevant information, such as what is discussed in this article. Regardless, fear remains the biggest obstacle.

Rob's mother is understandably concerned about how drug withdrawal would demand reserves of time and energy, and likely impinge on Rob's short-term ability to keep up with the demands of his academic and extracurricular life. The antidote to fear is courage, but the emotion is huge. She is terrified that her son would become even more of a challenge for her, and that he would utterly fail in life if he were to come off the drugs. Rob is several years down the road of continuous drug use, and on a heavy load, so there looms a most daunting path of drug

withdrawal and emotional recovery. That it can be done is the hope I carry to contradict the hopelessness she and so many others feel. Helping them work on their fear is a necessary condition for the possibility of success and a good place to start.


This article appeared in *Pathways to Family Wellness* magazine, Issue #46.

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