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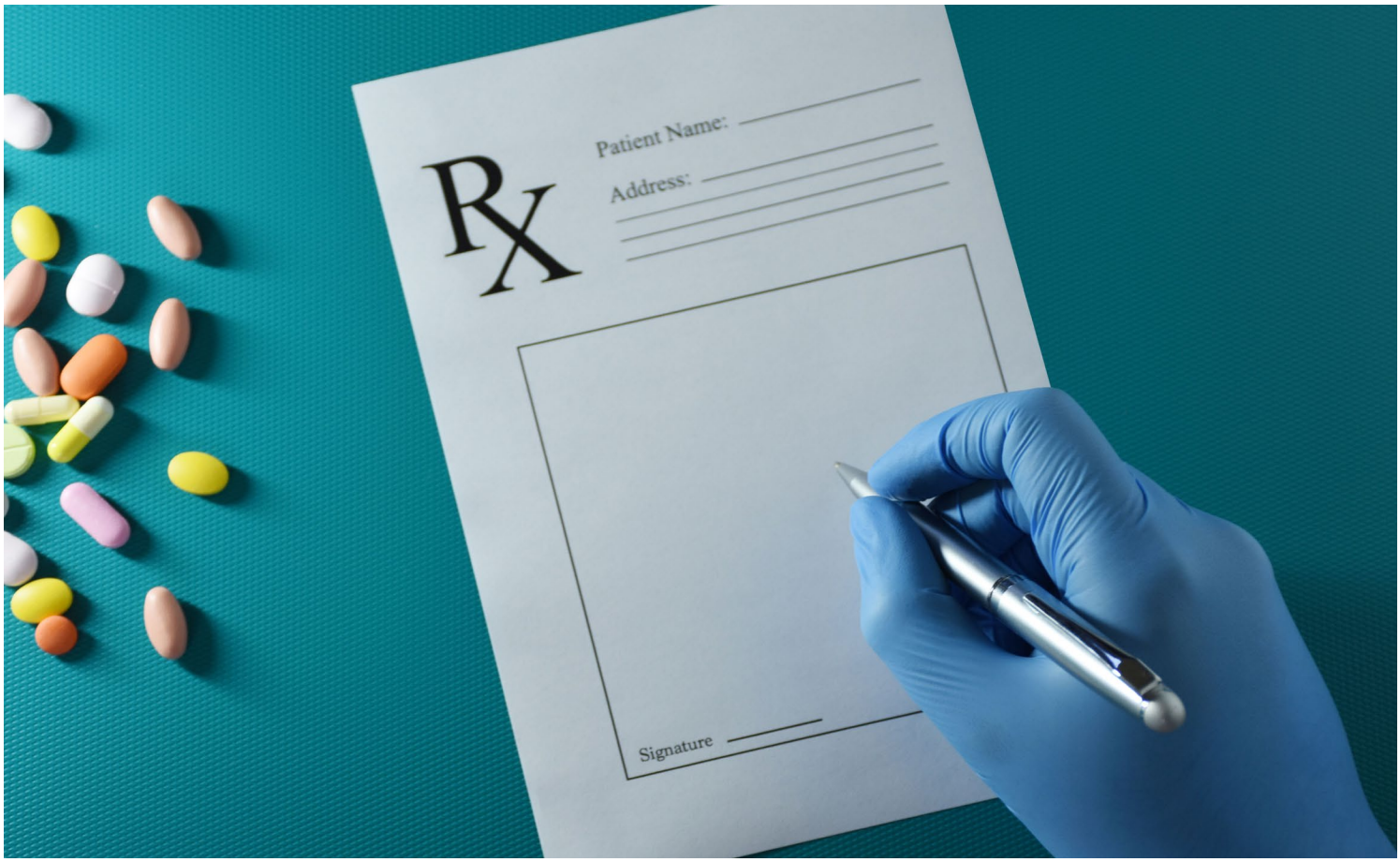

Exploring Medication for Adopted Children: Mental Health and Behavioral Treatment Options

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Overview

Why is medicating children for psychiatric disorders so fraught with challenge and controversy? Very little is known about the effects of psychiatric medications on children's rapidly developing minds and bodies. In fact, many parents are alarmed to learn that most psychiatric drugs are not FDA approved for use in children and there are few long-term studies—critical for understanding effects of medication on brain development,

Editor's Note

This information is intended to be applicable to all children, with special notes and considerations for adopted children and families.

Disclaimer

This article is a brief introduction rather than a complete and comprehensive text. It is not intended as a substitute for medical diagnosis and treatment. Because of the rapid pace of research and new clinical findings, the information it contains is subject to change. If you are concerned about your child, consult your pediatrician, who can refer you to a mental health professional.

Medications used to treat mental health disorders are often called "psychotropic" or "psychiatric" medications. There are five main types of psychotropic medications: antidepressants, anti-anxiety medications, stimulants, antipsychotics, and mood stabilizers. Each type of medication has different uses, benefits, and side effects.

For more information please refer to the resources included at the end of this article.

Sources:

National Institute of Mental Health, "Mental Health Medications" nimh.nih.gov/health/topics/mental-health-medications#part_10490

WebMD, "What Are Psychotropic Medications" webmd.com/mental-health/what-are-psychotropic-medications

growth, and sexual maturation. Because of the additional challenges and risks of studying psychiatric medications in children, such undertakings have not been a priority of the pharmaceutical industry, which is the primary source of funding for psychiatric medication research. The unknown long-term risks of psychiatric medications for children make a strong argument for careful diagnosis, thorough consideration of medical and other possible causes of symptoms that would require entirely different medical interventions, as well as of non-pharmacological treatments.

Given the limitations and risks, known and unknown, of medication, preventive interventions and research to identify preventable causes of psychiatric disorders in children must also be invested in.

Diagnosing psychiatric disorders in children is especially challenging, because there is such a wide range of "normal" behavior in children. Many diagnoses, for example, attention deficit hyperactivity disorder, and anxiety or depression, run along the same continuum of behaviors, thoughts and feelings into the normal that many children without psychiatric conditions experience to lesser degrees. Psychiatrists must often rely on observations from parents and teachers, rather than objective tests or a child's direct report of symptoms. Most of the assessment scales for common childhood psychiatric conditions rely on parent or teacher reports. Often, reported behavior, such as impulsivity or hyperactivity, may signal a wide range of problems to sort through before a diagnosis can be made.

Investing in Prevention

Given the limitations and risks, known and unknown, of medication, preventive interventions and research to identify preventable causes of psychiatric disorders in children must also be invested in. For example, lead poisoning is associated with symptoms overlapping with attention deficit hyperactivity disorder, and other environmental toxins have been associated with autism spectrum disorders. Is the forty-fold increase in the first decade of this century in the number of children and adolescents diagnosed with bipolar disorder simply a matter of increased recognition, or over-diagnosis? Or might there be some preventable cause that has emerged in our changing world for this severe mood instability yet to be identified? Excessive television viewing under age three has been correlated with attention deficit symptoms at age seven, and social media use has been found to correlate with eating disorders, anxiety and depression in older children and adolescents.

One of the many added challenges of raising an adopted child is the unknowns about pre-adoption environments, exposures, and experiences. Although many adoptive parents

Learn more

The Impact of Adoption on Teen Identity Formation, Adoption Advocate Issue No. 149

adoptioncouncil.org/publications/adoption-advocate-no-149

learn to make peace with the things they cannot know or change, such questions about a child's pre-adoption past can be difficult to put aside—no matter how unproductive they may be—when there are behavioral challenges that lend themselves to multiple explanations. It is natural to seek explanations, even in the face of uncertainty. It may be helpful to let go of explanations that are not helpful and hold onto those that might suggest a constructive course of action.

Impact on Identity Development

In addition to rapidly developing brains and bodies, children are also unique in their efforts to learn about themselves. Identity and self-esteem take form in these vulnerable years, but last a lifetime. For children, taking psychiatric medication can be the most tangible symbol of a diagnosis they struggle to understand, and often misunderstand as a label that singles them out as defective or inadequate. Many parents worry about the effects of psychiatric treatment of any kind on their child's self-esteem and self-image, and whether diagnostic labels can become self-fulfilling prophecies.

These concerns are particularly important for adopted children. Many struggle with identity formation, a key developmental process of the teenage years. Adolescents now have the developmental capacity to think abstractly, and their developmental agenda drives them to ask existential questions. This is the time when they may start wondering about their gender, their sexuality, the meaning of their cultures, ethnicities, races, and social class. Adopted children ready to ask "Who am I?" naturally leads them to questions about their origins, and their future potential. Often, of course, they struggle with the belief that whoever they may be, they were not good enough for their birth parents to keep them, or that they will end up being just like their birth parents, who may have had too many problems to be able to raise them. Although parents, teachers, and healthcare providers may wholeheartedly relate to the whole child with encouragement and hope, the medicated adolescent may nonetheless come to reduce his or her identity to the psychiatric diagnosis. However, when treatment can help children function more effectively at home, school, and with friends, it can also protect their self-esteem and protect against stigma.

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Behavior Management or Psychiatric Illness?

Many parents also wonder whether psychiatric medication is being recommended to render their child's behavior more socially manageable and acceptable, when it may be 'normal' but incompatible with behavior expectations in a particular environment. When, for example, is an inconvenient amount of activity in a child a sign of pathology, and when is it simply an indication that the child is in a setting that is not developmentally appropriate? Psychiatric medications may render a child more 'manageable,' and she may become more ready to learn and to mature emotionally (although some medications are sedating and might otherwise interfere with cognition), but for this to occur, her environment must be prepared to offer her more than just behavioral control. For

example, children on the autism spectrum may be prescribed a medication that can cut down on hyperactivity and agitation, readying them for intensive therapies that will improve their abilities to understand themselves and others, to enter into relationships, and to communicate effectively.

An additional wrinkle for adopted children is that some of their behavioral challenges may be attributable to their pre-adoption experiences, or to their struggle to come to terms with that part of their story. On the one hand, these kinds of challenges may be amenable to non-pharmacological treatment. On the other, medication may be needed to preserve basic functioning in school and at home until other treatment modalities take effect, or in order to help the child be better able to benefit from those treatments. Although not a satisfying answer in the moment, the course of development can intensify such behavioral problems as puberty begins and through adolescence, just as it can soften them later on.

Some children who have been adopted may have experienced trauma and/or disrupted attachments prior to adoption. Some may have birth parents and other birth relatives with genetically transmissible psychiatric disorders that may or may not be known to or discoverable by adoptive parents. Mental healthcare providers experienced in treating adopted children may be particularly well prepared to tease out symptoms possibly associated with trauma and attachment-related disorders. At the time of this writing, there are no pharmacologic cures for these kinds of disorders, but medication may play a complementary role in treating some of these symptoms alongside cognitive and interpersonal therapies, as well as therapeutic artistic, musical and physical activities.

Non-Medication Treatments

Such concerns should mobilize a search for non-medication treatments by psychiatric research institutions. But they rely primarily on the pharmaceutical industry for funding, and so there is very little funding for non-pharmacological interventions. Although psychiatric medications can be lifesaving, or life-changing for some individuals, there are growing concerns that, for many others, psychiatric medications may not necessarily be more effective than placebo. There is strong evidence for the effectiveness of non-medication treatments, such as cognitive behavioral and interpersonal therapies. These should be actively pursued by parents, mental health professionals, and researchers.

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In some instances, these may effectively replace medication, or reduce the total needed exposure (dosage, length of treatment) to medication, which can, in turn, reduce the risk of certain side effects.

Increasingly, mental health professionals are recognizing the limitations of psychiatric medications and talk therapy for some children and adolescents at various phases

in their development and healing process, as well as the therapeutic benefits of non-clinical interventions. These include artistic, musical and physical (e.g., walking, hiking, swimming, gardening, team or individual sports, martial arts, yoga) opportunities for self-expression, self-knowledge, self-regulation, positive identity development, and, in some instances social connection and relation healing. Other non-clinical healing activities provide opportunities for children to help and nurture (e.g., caring for animals), and to have a sense of agency, purpose and value (e.g., advocacy and activism). These need not be thought of or referred to as 'psychiatric treatment' and have the benefit of being non-stigmatizing while supporting a child's social acceptance and integration.

Children diagnosed with psychiatric disorders also deserve environmental assessment and intervention –a search for modifications that will make a difference at home and in school- as well as medication. Parents may feel more certain about choosing medication when all other treatment modalities have also been considered. Perhaps the greatest consolation is the child's own sense of relief and greater comfort when an effective treatment plan is in place. Psychiatric medications can contribute to this sense of relief when they are effective for children who are suffering.

When Should Parents be Concerned?

Parents usually know when to worry and often report one or more of the following subjective signals when there is trouble that warrants psychiatric attention. (None of the following signs, however, indicates a specific psychiatric condition, nor that medication will necessarily help):

1. Other children don't like your child, keep their distance, think she's odd, or are afraid of her.
2. You feel constantly worn out by your child's behavior.
3. You feel like you don't know or understand your child anymore.
4. Your child doesn't seem to be the same child you've always known.
5. People in the family are constantly arguing about the child.
6. You seem to be spending more time angry or upset with your child, and/or more time trying to control her behavior than you do having fun together.
7. You realize more often than not that you are not enjoying your child, often worrying that you have fallen 'out of love'.
8. There is a sudden persistent change in your child's behavior—for example, activity level, or choice of friends.
9. Your child spends prolonged periods withdrawn or in isolation.
10. Your child is rarely smiling or happy, her range of emotions seem limited mostly to anger or irritability.
11. Your child's reactions are repeatedly out of proportion to the situation.

Learn more

Family History "Unknown": Understanding Adopted Individuals' Needs in the Healthcare Environment Advocate Issue No. 167

adoptioncouncil.org/publications/family-history-unknown-understanding-adopted-individuals-needs-in-the-healthcare-environment

What to Expect when Consulting with a Child Psychiatrist

You may be referred to a child psychiatrist by your child's pediatrician, a guidance counselor or therapist. Prepare for your visit by gathering together any medical information, reports you have about your child's behavior, and notes about your own observations. When you see the psychiatrist, you can expect that he or she will do the following:

1. Take a thorough history, including asking about allergies, other medications the child takes, past medical and psychiatric history, and whether there is a family history of medical and/or psychiatric conditions. These may not be known, of course, in the case of adopted children. In addition, psychiatrists also should ask which psychiatric medications have been used by family members, and whether they have been effective and/or caused adverse effects. Again, this information may not be available for an adopted child's birth family. The answers to these questions, although helpful, are rarely definitive, and a diagnosis and treatment plan, that may include medication, can be reached despite these unknowns.

The child psychiatrist should also ask about the child's strengths, vulnerabilities, and any recent changes, losses, or disturbing events. He or she should also strive to understand how you and your child understand the problem and your ideas about what will help. Sometimes both the unknowns of an adopted child's pre-adoption life and the challenges particular to the experience of adoption itself can overshadow other important factors contributing to a child's current mental health challenges. It is important for the child psychiatrist to inquire not only about what is known about the pre-adoption past and about what might be challenging at this developmental juncture to the child and/or adoptive family that seems specific to adoption, but also to encourage the child and family to be open to a broader range of explanations.

Because children only grow and thrive in the context of family and community supports, these too must be fully understood in order to understand 'where it hurts,' and how to help.

2. Conduct a careful search for possible medical and neurological causes of the child's symptoms before settling on a psychiatric diagnosis. There are a number of medical and neurological conditions that can manifest as behavioral or emotional symptoms.

3. Plan for regular monitoring and follow up. If psychiatric medications are prescribed, children should be seen at regular intervals by the prescribing physician in order to monitor for improvement or failure to respond to medication, and for side effects, including possible effects on growth and development. Depending on the medication, physiologic parameters may be standard practice, such as height, weight, blood pressure, pulse, blood levels of the medication itself, and/or blood tests to monitor adverse effects on organs (e.g., liver or kidney function, thyroid or sex hormones) that particular individual drugs may cause. The physician should reconsider with you the need for medication on a regular basis.

Antidepressants can often be successfully stopped four to six months after a serious bout of depression has ended. Children who may be thought to need medication for a year or more can often be offered a careful tapering and drug-free period, preferably during a time of predictably low stress, to assess whether the drug is really still needed. Sometimes, though, after a successful taper and discontinuation, symptoms may emerge many months later. Symptoms can also re-emerge or intensify during times of high

stress and/or developmental challenge, such as puberty.

4. Consider a conservative approach. Given the known and possible unknown risks of medications in children and adolescents, the physician should help you weigh the risks and benefits of medication and other treatments, as well as the risks of not using medication. Careful review of the child's full range of strengths and vulnerabilities, and those of the caregiving context, is necessary to ensure that all appropriate non-medication treatment possibilities are considered. If medication is chosen, the physician should strive for the lowest effective dose possible, and, whenever possible, avoid the use of more than one drug at a time, which increases the risk of side effects. At follow-up, solid justification for continuing treatment should be provided.

5. Provide information about side effects. Before your child starts on medication, the doctor should help you understand what benefits your child can expect from the medication, and what to look for to know whether it is working. He or she should also explain what side effects to watch for and what to do about them, and when to call the doctor or to go to the emergency room.

6. Offer contact information. Before your child starts on medication, your doctor should let you know how often the child should be seen in follow up, how he or she can be reached in an emergency, and how to reach a covering physician, if necessary.

7. Provide holistic treatment. The psychiatrist should plan to work in collaboration with your child's pediatrician and other health and mental health professionals who may be involved (for example, psychologists or social workers providing counseling or psychotherapy, speech and language therapists, physical and occupational therapists). With your permission, teachers and guidance counselors should also be enlisted to provide their observations, and to develop a shared understanding of how to help the child in every setting.

8. Be compassionate. The prescribing physician should demonstrate compassion and be ready to respond to the most pressing question that many parents ask—"What would you do if this were your child?"

HOW PARENTS CAN HELP A CHILD TAKING PSYCHIATRIC MEDICATIONS

One of the unfortunate but avoidable consequences of diagnostic labels and medication treatment is that parents may feel that as they place their child's psychiatric care into a professional's hands, they themselves can do little to help. Children too may erroneously be led to believe that their future is no longer in their hands. But they can be helped to understand that even though their struggles are not their fault, their actions remain their responsibility. This should not be presented to the child as more pressure, but as a form of respect.

Parents remain children's most important caregivers and advocates.

Although parents may feel disempowered when they turn to professionals for help, this does not need to be the case. Parents remain children's most important caregivers and advocates. To play this role as effectively as possible, there are several steps that parents can take.

1. Pay attention to your questions and doubts about your child, and to the fears, feelings and memories that these may stir up in you. Parents may have a tendency to blame themselves, or the child's birth parents. They may find themselves vacillating between denial and despair before they find their bearings and are able to get down to the hard work of caring for a child with a psychiatric disorder. Children who are struggling, including adopted children, may remind parents of their own parents, or of a relative who may have had a similar disorder in a way that troubles them and interferes with their relationship with the child. Parents may be haunted by their worst fears for the future, and not dare to speak them.

These can be particularly frightening for adoptive parents if the birth parents are known to have had downward trajectories, or if their trajectories are simply unknown. Such fears, though, may become self-fulfilling prophecies, and interfere with the parent's ability to authentically provide encouragement, hope, and reflection back to the child of his or her potential.

2. Talk about your concerns. Part of the work that any mental health professional offers when caring for a child with a psychiatric disorder is to talk with parents about their feelings and fears. For some parents, it may be more comforting to talk with friends and family members. Many parents find great relief and renewed strength when they meet other parents experiencing similar ordeals, through parent support groups that offer mutual support and resource information. Such conversations can be helpful to adoptive parents in putting words to their fears about their child's birth parents, pre-adoptive experiences, and implications for the child's wellbeing and future.

3. Find supportive allies who can really help, even if just with some of the routines of daily life. They can make the difference between feeling like drowning, and treading water—or, hopefully, grabbing onto a lifeline. The symptoms of a psychiatric disorder in a child can overwhelm a family's ability to cope and derail its usual ways. Often, the associated shame and stigma can make it harder to ask for help. Don't be afraid to ask for and use the help of neighbors, friends and family to try to keep as many of your usual family routines and rituals afloat as possible. Many adoptive parents find it particularly helpful to connect with others, as do parents of children with psychiatric challenges. You may be able to find a group of parents that provides connection, affirmation, as well as concrete advice and resources.

4. Become an expert on your child's condition. Expect doctors and counselors to answer your questions, and to acknowledge what they do not know. Talk with other parents, teachers and school counselors, read, and use the internet. The more you know, the more empowered you will feel. And trust your instincts—you know your child better than anyone.

5. Sharpen your observational skills and your ability to describe clearly and accurately what you observe. Your observations are of critical importance to the child psychiatrist making and following up on medication recommendations as he or she has only have a limited amount of time in the office to get to know your child. All too often, terms such as 'out-of-control,' 'escalating behavior,' 'aggressive behavior,' 'angry outburst,' 'temper tantrum 'or 'melt down' take the place of detailed descriptions of the child's behavior, from beginning to end. Try keeping a journal to record your descriptions, noting the following:

- **Warning signs** – Can you tell that your child is on the verge of an 'episode'

before it starts? What are the signs you watch for? Can he tell? Can he ask for help before it's 'too late'? Is there a pattern of increased vulnerability when he is tired, hungry, anxious, or stressed? Can you predict the kinds of events, settings, or interactions that are likely to set him off?

- **Triggers** – What seems to set the behavior off? Sometimes there is no apparent trigger, but often there is one that goes unnoticed. A truly unprovoked episode is important to distinguish. It is also important to note whether the child's reaction was out of proportion with the severity of the trigger. Ask your child if he thought something happened that made him upset, and get a sense from him of his perception of its seriousness relative to his reaction.
- **Contexts and settings** – Is there a pattern to when and where the troublesome behaviors occur? Always before leaving for school? When there is a transition? Separations? Only with certain friends? Only in private?
- **Symptoms** – What does your child do and say during an episode of problematic behavior? How would you describe his mood? If he's angry, is there some basis in reality to his concerns? Can he continue to converse? Can he be reasoned with? Does he remain responsive to things he cares about, for example, settling down quickly if a friend visits or calls, or taking care not to break his favorite things when he is trashing his room? How long does the episode usually last for? How often does it occur? What kinds of things have you tried that help him settle down? What makes it worse?
- **Aftermath** – Does he go right back to 'normal' after one of these episodes? Or does he seem tired or moody for a prolonged period afterward? Can he remember what happened? Can he talk about it? Does he feel remorse? Does he want help? Can you plan together to watch out for the warning signs and to work together to prevent other episodes or to settle them sooner?
- **Effect on overall functioning** – What is the impact to your child and to the family of his symptoms? Have you had to make changes in the way you and other family members live your lives? Has the child's performance at school or relationships with friends been affected?

6. Develop a partnership with school personnel. Enlist the support of your child's teachers, guidance counselor, principal, and special education staff to provide a consistent team approach to your child's treatment plan. (See more information on this below.)

7. Involve your child in the process. Far too many children are assessed, tested, and interviewed, but never told why or what the findings are. And far too often they are not engaged as partners in working to understand their challenges and learning to manage them. They know, though, that their parents are worried, that they're being treated differently than other children. The fact that the adults aren't talking about it makes whatever is happening seem more frightening, and sometimes even, humiliating. A child is never too young to understand in simple and hopeful terms what parents or teachers are concerned about. Diagnostic labels won't be meaningful to younger children, although older children are sometimes relieved to have a name for the set of challenges they are struggling with.

A child is never too young to understand in simple and hopeful terms what parents or teachers are concerned about.

8. Before you bring your child to the first appointment, ask the child psychiatrist (or other professional evaluator) for advice about how to explain why the child is being evaluated, and what will happen. If children have expressed their own concerns or can endorse non-stigmatizing, non-blaming ones proposed by adults, then the explanation for the appointment can build on what the child already knows or can understand about his or her challenges. Ideally, parents can genuinely explain that the appointment is intended to help with something that the child is bothered by. It is critical that the assessment or treatment be presented as help for the child's wellbeing, and not as punishment.

9. Advocate for your child with healthcare and other professionals. Be sure you know what is reasonable to expect from the physician (child psychiatrist, pediatrician, pediatric neurologist, developmental/behavioral pediatrician) prescribing medications for your child and prepare your questions in advance.

WORKING WITH YOUR CHILD'S SCHOOL

Your child's school can be a useful resource to help you assess, observe and monitor your child's behavior. Often, a teacher might be the first person to alert you to potentially troubling behaviors. By inviting collaboration towards a mutually beneficial resolution, you can minimize disagreement and/or conflict.

Suggestions for Parents to Work Effectively with Schools

- As hard as it may be when your child's wellbeing is at stake, it helps to stay calm and positively focused. When you can, hold off on responding to disagreements or school crises until you've had a chance to gather your thoughts.
- Start with positive, appreciative comments about some aspect of teachers' efforts, even if you disagree with others.
- Invite teachers to provide specific descriptions of the child's behavior, and show them that you are listening carefully, even if it is painful to hear. Then, offer your observations so that consensus on a more complete picture of the child's behavior can emerge.
- Avoid accusations, or responding to them, and instead ask questions: What do you think is causing this behavior? What do you think will help? Be ready with your own answers, and model humility by admitting when you don't have any.
- Show your understanding of the need for classroom rules and expectations so that the child's teacher will be more inclined to balance these with your child's individual needs.

By inviting collaboration towards a mutually beneficial resolution, you can minimize disagreement and/or conflict.

- Keep consensus about a plan of action for your child as your shared goal. It is easier for children to relax and understand what is expected of them when parents and teachers can show that they know how to work together as a team.
- Work on your relationships with teachers and other school personnel, especially when these aren't going well. This is a lot to ask of parents who are already busy caring for a child with challenges, but there really isn't a more effective alternative.
- Although it may not seem fair, it is only human that children whose parents are well liked by school personnel are more likely to receive extra help when they need it than those of parents who are perceived as demanding or unappreciative.
- If the child's pre-adoptive past is invoked by school personnel as the explanation for the child's challenges, this can be accepted as a possibility while also encouraging a thoughtful search for other contributing factors that may be entirely unrelated and far more intervenable. Just because a child is adopted doesn't mean that he or she might not also have, for example, a treatable language disorder that leads to aggressive behavior, or a subtle hearing problem that makes large social settings frightening.

Parents Can Ask School Personnel to:

- Describe their understanding of the child's problems, and of the behaviors they observe that lead them to their concerns.
- Agree to put aside terminology that labels a child and instead provide carefully articulated and nonjudgmental descriptions of their observations.
- Show compassion to you and to care about your child.
- Acknowledge what they don't know, and when they need help.
- Respect your decisions, even if they may disagree with them.
- Try to understand the situation from your perspective.

Additional Resources

The resources below include a wide range of perspectives. Parents may find it helpful to refer to texts that offer a broad view of child behavior and development, and of specific childhood psychiatric conditions, in addition to those that focus primarily on medication for these conditions in order to learn about non-medication interventions that may in some instances suffice alone or that may be complementary to medication treatments.

WEBSITES

American Academy of Child and Adolescent Psychiatry (AACAP)
aacap.org

This site includes "Resources for Families," where parents can view definitions of psychological terms and facts, read a glossary of symptoms, find a child psychiatrist, read statistics and learn about clinical trials and legislative action. There is also up-to-date information related to child psychiatry and medication.

National Alliance on Mental Illness (NAMI)
nami.org

This easy-to-navigate website includes "Find Support," a section (in both English and Spanish) with information on research, treatment and services, and articles on medications and mental health topics.

National Institute of Mental Health (NIMH)
nimh.nih.gov

This comprehensive website includes research about mental disorders and mental health. The home page includes some excellent articles on different issues related to child psychiatry. There are more research studies and links in the "Health & Outreach" section, as well as definitions of disorders affecting youth and treatment information.

The National Child Traumatic Stress Network *nctsn.org*
This site offers resources on child trauma for parents, adoptive parents, resource/foster parents, grandparents, caregivers, and all others who care for children and teens. Click on resources, then training, and filter for families and caregivers. Resources are also available for youth, child welfare professionals, school personnel, healthcare providers, justice system professionals, media, religious professionals and policymakers.

GUIDES & ARTICLES

Attention-Deficit/Hyperactivity Disorder (ADHD): Parent's Medication Guide
American Academy of Child and Adolescent Psychiatry, *aacap.org/App_Themes/AACAP/docs/resource_centers/resources/med_guides/ADHD_Medication_Guide-web.pdf*

Complex Trauma: Facts for Caregivers
National Child Traumatic Stress Network, *nctsn.org*

Complex Trauma: Facts for Educators
National Child Traumatic Stress Network, *nctsn.org*

Making Healthy Choices: A Guide on Psychotropic Medications
Child Welfare Information Gateway, *childwelfare.gov*

Parenting A Child Who Has Experienced Trauma
Child Welfare Information Gateway, *childwelfare.gov*

Parenting After Trauma: Understanding Your Child's Needs: A Guide for Foster and Adoptive Parents
American Academy of Pediatrics, *downloads.aap.org/AAP/PDF/FamilyHandout.pdf*

Psychiatric Medication for Children and Adolescents Part 1—How Medications Are Used
American Academy of Child and Adolescent Psychiatry, *aacap.org*

Psychiatric Medication for Children and Adolescents: Part II—Types of Medications
American Academy of Child and Adolescent Psychiatry, *aacap.org*

Psychiatric Medication for Children and Adolescents: Part III—Questions to Ask
American Academy of Child and Adolescent Psychiatry, *aacap.org*

Understanding Childhood Psychiatric Disorders [Podcast]
Joshua D. Sparrow & Creating A Family, *creatingafamily.org*

Understanding Trauma and Healing in Adults
Brazelton Touchpoints Center, *touchpoints.org*

BOOKS

A Developmental Approach to the Prevention of Common Behavioral Problems
Joshua D. Sparrow & T. Berry Brazelton, 2008

Bipolar Kids: Helping Your Child Find Calm in the Mood Storm
Joanne Greenberg, 2006

Children and Babies with Mood Swings
Stanley Greenspan, Ira Glovinsky & Cindy Glovinsky, 2007

Discipline the Brazelton Way
T. Berry Brazelton & Joshua D. Sparrow, 2003

Helping Your Child Overcome Separation Anxiety or School Refusal: A Step-by-Step Guide for Parents
Andy Eisenberg & Linda Engler, 2006

Mastering Anger and Aggression the Brazelton Way
T. Berry Brazelton & Joshua D. Sparrow, 2005

Overdosed America: The Broken Promise of American Medicine – How Pharmaceutical Companies Distort Medical Knowledge, Mislead Doctors, and Compromise Your Health
Dr. John Abramson, 2004

Parenting a Child with Sensory Processing Disorder
Christopher Auer & Susan Blumberg, 2006

Prozac Backlash: Overcoming the Dangers of Prozac, Zoloft, Paxil and Other Antidepressants with Safe, Effective Alternatives
Joseph Glenmullen, 2000

Quirky Kids: Understanding and Helping Your Child Who Doesn't Fit In- When to Worry and When Not to Worry
Perry Klass & Eileen Costello, 2004

Stop Obsessing: How to Overcome Your Obsessions and Compulsions
Edna Foa & Reid Wilson, 2001

Straight Talk about Psychiatric Medications for Kids
Timothy Wilens, 2004

Taking Charge of ADHD: The Complete Authoritative Guide for Parents
Russell Barkley, 2000

The Antidepressant Solution: A Step-by-Step Guide to Safely Overcoming Antidepressant Withdrawal, Dependence, and "Addiction"
Joseph Glenmullen, 2006

The Child with Special Needs: Encouraging Intellectual and Emotional Growth
Stanley Greenspan, Serena Weider & Robin Simon, 1998

The Truth About the Drug Companies: How They Deceive Us and What to Do About It
Marcia Angell, 2005

The Out-of-Sync Child: Recognizing and Coping with Sensory Processing Disorder
Carol Stock Kranowitz, 2006

Touchpoints Three to Six: Your Child's Emotional and Behavioral Development
T. Berry Brazelton & Joshua D. Sparrow, 2001

Understanding Stress in Children
Joshua D. Sparrow, 2007

Understanding Your Child's Temperament
William B. Carey, 1997

The Attention Deficit Answer Book: The Best Medications and Parenting Strategies for Your Child
Alan Wachtel & Michael Boyette, 1998

By Joshua Sparrow, MD

Adapted from *A Viewer's Guide* to Medicated Kids (Frontlines.)

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Exploring Medication for Adopted Children: Mental Health and Behavioral Treatment Options

BY JOSHUA SPARROW, MD

About the Author

Child, adolescent, and general psychiatrist, Joshua Sparrow, M.D., DFAACAP, is executive director of the Brazelton Touchpoints Center (BTC) in the Division of Development of Medicine at Boston Children's Hospital, where he also holds an appointment in the Department of Psychiatry and is associate professor in psychiatry at Harvard Medical School, part time.

Dr. Sparrow's care in the 1990s for children hospitalized for severe psychiatric disturbances, often associated with physical and sexual abuse, and aggravated by societal abuse and neglect, prompted his interest in the social, economic, and racism-related determinants of health and mental health, and in community self-strengthening, community-based prevention and health promotion.

He has led numerous governmental and philanthropic research, training and technical assistance grants, and advised government agencies, nonprofits, academic centers, and philanthropies. Dr. Sparrow has given hundreds of lectures nationally and internationally, written numerous scholarly papers, hundreds of articles for the general public, as well as nine books translated into more than 20 languages, including the Brazelton Way books on common early childhood challenges and the Touchpoints: Your Child's Emotional and Behavioral Development books, co-authored with the late, renowned pediatrician T. Berry Brazelton, MD.