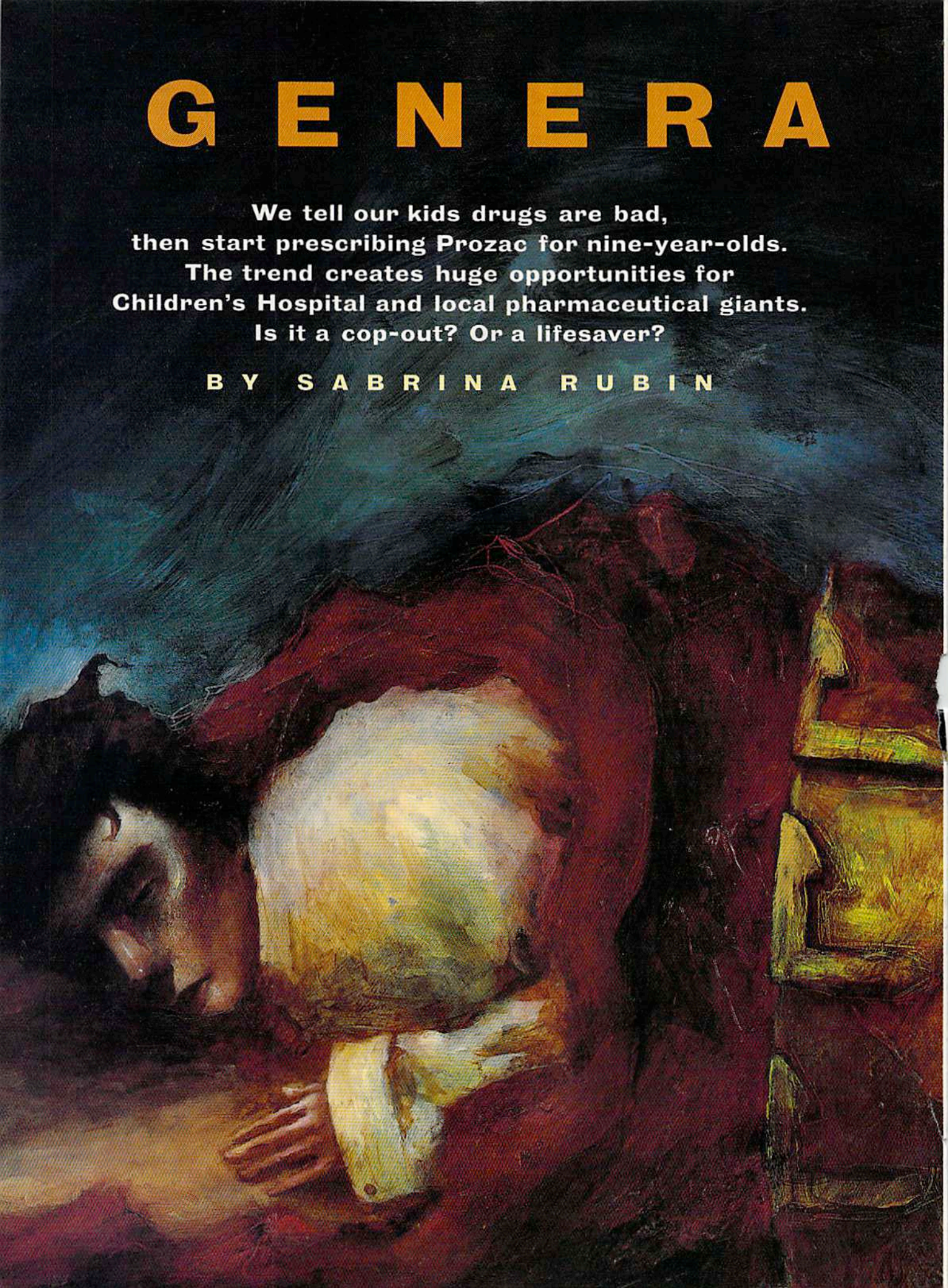
GENERA

We tell our kids drugs are bad, then start prescribing Prozac for nine-year-olds. The trend creates huge opportunities for Children's Hospital and local pharmaceutical giants. Is it a cop-out? Or a lifesaver?

BY SABRINA RUBIN



TION Rx

Jeremy Overton didn't know it yet, but the course of his young life was about to change forever. He sat at his desk, clutching his stomach with both hands, a pained expression creasing his face as he watched the clock in his fourth-grade classroom. Jeremy (names and certain identifying details have been changed) was a quiet, sandy-haired boy of nine, sweet and shy, with a terrible tummyache that had been building since lunchtime—ever since he ate that bagel with cream cheese that tasted a little weird, he thought. He could hardly wait to go home. When at last the clock hands inched their way to the final bell, Jeremy tore to the back of the room along with the throng of kids grabbing bookbags from cubbies and winter coats off of pegs. The next moment, Jeremy was throwing up all over the floor. Kids were screaming and running away. The teacher was rushing over. Jeremy couldn't stop sobbing.

By the time his mom arrived, Jeremy was distraught. Even after his stomachache had subsided, he lay around the house for the rest of the afternoon, and then for the entire weekend, sluggish and irritable. His parents, Steve and Kathy, let him watch TV and drink ginger ale, figuring a virus was taking its course. But Jeremy knew it was something very different. He felt utterly empty—and when he wasn't feeling empty, he was flooded with panic at the thought of going back to school: *What if I throw up again?* At night, while his parents slept, Jeremy stared fearfully at his alarm clock as it turned 2 and 3 a.m. When Monday morning

Illustration by David Rankin

came, his mother had to drag him out of bed. "I don't want to go to school!" Jeremy screamed, still clutching his pillow.

Over the coming months, things became very wrong with Jeremy. The struggle to get him to school grew fiercer by the morning. His teacher called to report that he was having strange, unprovoked outbursts in class, crying and sweating and shaking.

Soon Jeremy was having panic attacks in malls, restaurants and movie theaters as well, trembling as he gripped his father's sleeve, gasping "Take me home!" The only place Jeremy felt comfortable was their Delaware County rancher, where he draped himself across the furniture like a rag doll. Meanwhile, he was developing odd idiosyncrasies, like a total aversion to flannel and black T-shirts—clothes that made him think of Vomit Day—and picky eating habits, carefully inspecting each bite of food for dirt. A sprig of parsley in his spaghetti or a charcoal stripe on a hot dog—or, especially, the mere sight of a bagel—was enough to send him into a fit. When summer came, Jeremy rarely made it to day camp. His tenth birthday came and went without a party. He couldn't have cared less.

His parents tearfully dragged Jeremy to his pediatrician, three psychiatrists and a psychologist, all of whom were baffled; none was even able to come up with a diagnosis. By the time Jeremy started fifth grade, the stress had taken a heavy toll on Steve and Kathy, rendering them tense, weary and snappish. Jeremy's fear of leaving the house became so acute that Kathy would have to push him out of her car in front of the school each day. When she couldn't handle the morning madness, she'd cave in and let Jeremy stay home, calling in sick to her legal practice so that she could keep an eye on his despondent form. His already baggy jeans began to hang off his thinning frame, and his eyelids drooped. But he was no longer the only insomniac in the family; his parents were lying awake at night as well, agonizing. What had happened to their son? How had they failed him?

Finally, with diminishing hopes, the Overtons made an appointment with doctor number six: Dr. Laura Sanchez, a child psychiatrist at Children's Hospital of Philadelphia. To the Overtons' surprise, Sanchez came up with a diagnosis for Jeremy: depression, paired with general anxiety disorder. Jeremy's parents felt like weeping with relief; it was their first ray of hope after eight months of desperation. But there was more. Sanchez stressed that after so many months of illness, Jeremy needed immediate and drastic help. And she had a very specific solution in mind: Prozac.

Steve and Kathy Overton looked at each other. They were willing to try just about anything to heal Jeremy and mend their family. But there was one ominous fact to consider, printed in matter-of-fact black and white across the label of the Prozac bottle: SAFETY AND EFFECTIVENESS IN CHILDREN HAVE NOT BEEN ESTABLISHED. They looked at their suffering son, slumped in his chair. They wanted whatever was best for him. Did that mean making ten-year-old Jeremy a guinea pig in a potentially dangerous experiment? One that could alter the course of his life—for the worse?

Into the future: CHOP's expert psychiatrists Laura Sanchez, left, and her mentor Elizabeth Weller.

His parents wanted what was mean making him a guinea pig

Hot on the heels of the adult Prozac craze comes a pharmacological revolution no one wants to talk about. Quietly, with little fanfare, antidepressants like Prozac have been seeping into the pediatric market. Whereas prescriptions for kids ages six to 18 didn't make a dent in antidepressant sales before the late '80s, last year 735,000 children under 18 were prescribed a Selective Serotonin Reuptake Inhibitor (SSRI)—the class of drugs to which Prozac belongs—an 80 percent increase in just two years. During that same two-year period, prescriptions for ages six through 12 rose 212 percent. Surprising statistics, perhaps, considering that no drug has ever been FDA-approved to treat depression in kids under 18. Until recently, there has never even been any research conducted, no data produced as to what an adult antidepressant could do to a growing brain like Jeremy Overton's.

The rise of antidepressant use in kids is especially amazing considering that the study of childhood depression is, as it were, in its infancy: Although child psychiatry has been practiced for the better part of this century, childhood depression wasn't even an official disorder until 1980. Now we know childhood isn't always the idyllic time we'd like to imagine, but fraught instead with mental disorders much like those that plague adults. Depression has been diagnosed in kids as young as four and is now thought to affect 5 percent of the under-12 crowd, 10 percent of adolescents. Left untreated, depression in the young can be devastating, placing them in high-risk groups for substance abuse and suicide. Last year, 1,801 15-to-19-year olds in the United States killed themselves—as did 305 kids ages four through 14.

Faced with these hazards, then, a growing number of physicians have been crossing their fingers with one hand and writing prescriptions with the other. "We're not usually willing to take big risks with our children," reasons Peter Kramer, author of the best-selling *Listening to Prozac*. "In this case, we don't even know the risk factor. You're taking a developing brain and forc-

PHOTOGRAPH BY SABINA LOUISE PIERCE

ing it to handle a certain chemical. Does it establish a new equilibrium for the better? Or are you doing something damaging? We just don't know."

But for drug manufacturers, many based in this area, the new generation of school-age customers is appearing not a moment too soon. With the growth of adult antidepressant sales having slowed the past three years, companies like Center City's SmithKline Beecham and Radnor's Wyeth-Ayerst are counting on orange-flavored liquid Paxil and children's Effexor to boost sagging profit margins. That's part of the reason why the FDA established a policy in August that pressures manufacturers to test the drugs on children instead of just relying on adult data. And why virtually every one of them has rushed to launch such a study, hoping to earn the FDA's blessing within the next couple of years.

Some of that research is being done at a new institute for mood and anxiety disorders at CHOP. There, in perhaps the leading center of its kind in the country, Sanchez and other child psychiatrists spend their days listening to the pain of little boys like Jeremy Overton, trying to answer the big questions: How will a drug known to dampen adult sex drive affect a child's sexual development? How can we be sure when normal childhood sadness and personality quirks cross the line into disease? Could the rush to medicate just be a way to let people off the hook for bad parenting? Could it send a mixed message to children about other mood-enhancing drugs? The scientists try to assuage parents' fears and guilt along those lines. Then they go back to their studies funded by the drug companies and Washington, back to the desperate business of proving they're right.

Jeremy had no doubt that something terrible had happened inside his head. But the fact that no one had been able to figure out *what* was wrong was the worst part of those miserable eight months. Jeremy felt like a freak. He'd see other kids doing regular kid stuff and realize he wasn't like them anymore. Jeremy just wanted to be Jeremy again. Instead, he had been seen by doctor after doctor who talked to him like he was some kind of dummy. "Come on," they'd prod with big, fake smiles, "answer the question, Jeremy!" He couldn't handle the way they talked. So he found a way out: He'd tune them out and fall asleep, right there in the office chair. "I find his condition very alarming," he distantly heard one doctor telling his parents. "I suggest you get help." No one could even venture a guess as to what kind of psychic trauma had been dislodged in Jeremy's mind. After all, he was certainly not the first little boy to throw up in public, and surely far from the last. Why did it throw him into such tumult?

One explanation is to point a finger at destiny, that Jeremy's fate had already been mapped out deep within his genes. "What causes depression is not bad parenting or bad teachers, it really is DNA roulette," explains Dr. Harold Koplewicz, author of *It's Nobody's Fault*. "The same way your mother might have given you blue eyes and blond hair, so you might have inherited the predisposition to develop a mental disorder." In this view, the fact that his father had a tendency for anxiety and his mother had been battling depression all her life squarely seated Jeremy at that roulette table.

But other doctors feel that placing too much emphasis on biology can lead to treatment that does more harm than good. "Speaking from 25 years of experience, childhood depression and anxiety can be effectively treated with psychotherapy," says Dr. June Greenspan-Margolis, a leading psychiatrist and psychoanalyst at Penn, ironically just down the street from Laura Sanchez. "It's an extreme and rare case that a child needs psychotropic drugs. Pushing medication on children is a way for managed care to cut costs, and a way for parents who are feeling upset and guilty about their child's illness to quickly dismiss the problem. For doctors, it's easier to write a prescription than to work with a patient and help them understand themselves." She sighs. "In using medication like this," Greenspan-Margolis continues ominously, "we're dehumanizing psychiatry. We're taking a step backward in time, back to when patients weren't being spoken to but were just lined up and put into institutions. Same concept—just line them up and give them their pills."

Jeremy's parents were in Greenspan-Margolis' camp, at first. They spent some $10,000 (only half of it reimbursed by their insurance company) dragging their son to all the best therapists they could find. But talk therapy didn't seem to be working—the doctors were having a tough time keeping Jeremy awake, much less prompting him to talk. Come to think of it, psychotherapy hadn't worked on Kathy's depression, either; but she had been put on Prozac three years earlier, and it had transformed her. "God bless whoever invented this stuff!" she was fond of saying. They had read how drug responsiveness, like mental illness, seems to run in families—that if Kathy had been made well with Prozac, it was more likely that Jeremy would be too. But when the Overtons broached the subject with the doctors Jeremy visited, they all dismissed the idea as rash.

Jeremy could tell almost from the start that Dr. Sanchez wasn't like the other doctors. He sat in his chair limply, waiting for the usual onslaught of questions that would send him into sleep. They never came. Gazing at him gently from behind owlish glasses, Sanchez was sincere and patient. She had the softest voice he had ever heard, so quiet it seemed as if words left her lips and then evaporated into the air. When she began asking questions, Jeremy answered her. His parents looked like they were going to fall out of their seats from shock. They glanced at each other, sharing a silent realization: *She knows what she's doing.* So when Sanchez proposed trying Jeremy on Prozac for a year, with weekly visits to a psychologist, Steve and Kathy Overton were all ears.

best for ten-year-old Jeremy. But did that in a potentially dangerous experiment?

They sat for a moment and considered their options. It was their decision to make on Jeremy's behalf, a decision that they knew might haunt them.

They said yes.

"Appropriate use of medication works," says Laura Sanchez emphatically, in her windowless office in CHOP's basement. She is a petite woman with a dark bob and glasses, at 36 one of the youngest psychiatrists on the hospital's staff. "People wouldn't consider not giving their child an antibiotic if they had an ear infection, or insulin if their child had *(continued on page 144)*

Generation Rx

(continued from page 119)

juvenile diabetes. But even though mood disorders are much more prominent than juvenile diabetes and just as, if not more deadly, they have reservations about that." She shakes her head, wide-eyed. "It all boils down to a lack of understanding."

This is exactly why Sanchez became a psychiatrist in the first place: She was intrigued by the human brain and outraged by the prevailing negative attitude toward mental illness. "I had professors saying 'You're so bright! You're so talented! Why are you going into psychiatry?'" she remembers with a short, angry laugh. "I thought, Why wouldn't you want to go into an area where we have the most to learn?" Realizing that many adults' disorders seem to have begun when they were children, Sanchez wondered if early intervention could be a key to recovery, and devoted herself to child psychiatry. Her ideas meshed perfectly with those of her mentor, Dr. Elizabeth Weller, an expert on mood disorders in children under whom Sanchez did her training at Ohio State. After Sanchez came on staff at Penn—where her husband, behavioral geneticist Dr. R. Arlen Price, was already working—Weller soon followed to head up CHOP's psychiatry department.

One look at Jeremy Overton was enough to tell Sanchez that she had a difficult case on her hands. The moment they made eye contact, Jeremy burst into hysterical tears. When she tried to speak with him alone, he had a panic attack and made a desperate attempt to flee the room. "The diagnosis was quite clear to me," remembers Sanchez. "I saw a boy who had withdrawn from activities he had previously enjoyed. I saw a boy with difficulty concentrating, whose grades had dropped, who was terrified for no reason. Who was obsessing over illness and death."

Perhaps the most essential bit of information for Sanchez was Jeremy's "genetic loading," providing her with the family background crucial to diagnosing Jeremy as anxious and depressed. "It's very rare for a child to come in and not have anyone in their family who doesn't have the same disorder," says Sanchez. Jeremy's parents, according to this theory, gave him the genes for brain quirks that would make him vulnerable to depression—such as nerve cells without enough receptors for the neurotransmitter serotonin. It also didn't help that his parents probably provided him with the perfect environment in which to nurture those genes; between Steve's anxiety and Kathy's depression, Jeremy learned to adopt their behaviors,

making him something of a "worry wart." Through his temperamental filter, the world became a more menacing place, more filled with hurt and rejection than other kids felt. And he wasn't entirely imagining things: As the world reacts to our inborn temperament, it either rewards or punishes our behavior. It's possible that as Jeremy went through life a shy, retiring, anxious boy, his classmates treated him as such, relegating him to the status of outsider, adding to the pile of environmental stresses that were nudging his depressive genes awake.

And then came Vomit Day. After years of being deprived of serotonin, it's possible that Jeremy's nerve cells finally hit a threshold at which they simply couldn't go on. "There was a disruption in his brain chemistry, and he fixated on that episode of vomiting as the cause," Sanchez explains. "That's just his way of organizing what happened to him. If he hadn't vomited, something else would have happened that he would have fixated on instead." Once a brain reaches that point, it has a tough time bouncing back: A bout with depression takes a major toll on the brain, making it even more vulnerable to another depressive episode, meaning an even smaller trigger can set it off—which is why many researchers are now advocating early treatment to nip depression in the bud. "If you catch it early, you can not only treat it, but you can dramatically change that person's life," avers Sanchez. "You can prevent the problems in their work or studies, the poor peer relationships, the drug abuse. But first," she adds, "you have to catch it. If Jeremy had come to me three months earlier, he would have been that much better off."

To Sanchez, Prozac was the logical choice for Jeremy. Prozac's SSRI class of drugs forces serotonin to linger in the synapses, the gaps between nerve cells, saturating the receptors in the area so that enough is finally absorbed. It usually works in adults—after serotonin levels have been restored for about a month, depression tends to lift. But the fact that it takes weeks for the mood to change points to some flaws in the current theory of depression: If it were just a matter of getting the serotonin levels up to par, why would there be a delay? In addition, some antidepressants have been discovered that have no effect on serotonin at all. What part of the brain chemistry could they be affecting? And what role does *it* play in a child's development?

At 16th and Race streets, at the American headquarters of the pharmaceutical giant with whom Sanchez's boss Dr. Weller currently works most closely, the mood is upbeat. "Sure, I know *exactly* who you should speak with," enthuses SmithKline's public relations officer Sharon Arnold when asked for someone who could articulate the view from inside the industry. However, a week later, Arnold calls to report that her choice, the head of drug development, is "on the road"—having gone somewhere, apparently, with no phones or e-mail, for an indeterminate length of time. Is anyone else available? "No," Arnold answers quickly. "I'm sorry we can't be of help." Subsequent calls are not returned.

It turns out, SmithKline's erratic behavior is typical of drug companies when it comes to the subject of antidepressants and children. At least Arnold would confirm what Weller had already said about the company's study of Paxil for depression in children, namely that data collection has recently been completed and they are now into the analysis phase. Wyeth-Ayerst ("We don't feel comfortable talking about clinical trials right now"), Pfizer ("I cannot say whether we have or haven't") and Bristol Myers Squibb ("I really couldn't tell you how far we've gotten") should only be so forthcoming about their Effexor, Zoloft and Serzone trials.

Part of this attitude, of course, has to do with the sensitive nature of research on children. Fearing potential harm, the FDA has never required drug companies to test medication on children, much to the relief of the pharmaceutical industry. Untested, adult medicines found their way to kids anyway, as doctors wrote "off-label" prescriptions of those they felt would be beneficial. While this kind of prescribing is the exception for adult patients, it accounts for the vast majority of all medication reaching children today.

But then in August, the FDA issued plans for its new policy, at the very moment when adult antidepressants appear to have hit the wall. Whereas new prescriptions for SSRIs rose 58 percent in 1994, they increased only 17 percent in 1996, and have slowed down even further this year. Now, the companies are tripping over one another to be the first to slap on a label sticker proclaiming its antidepressant safe and effective in children. The companies are in such a mad rush to capitalize on the billions in potential sales, in fact, that they're running the risk of cutting corners. At this point, the FDA has remained unconvinced by the data on Prozac, asking Eli Lilly to supply more information; Pfizer's trial of Zoloft has been criticized by some experts as having been badly supervised.

And none of the current studies even begins to address the issues of *long-term* safety and efficacy. Thus far, everyone acknowledges the need for more long-term

Generation Rx

studies, but no one outside of a few in academia are doing anything about it. Since other drugs are known to have side effects over time—for instance, lithium tends to raise the risk for thyroid abnormalities and kidney disease, and Ritalin can stunt a child's growth by two centimeters—it's just a matter of time before Prozac's long-term risks emerge. And it's not even known whether antidepressants will stave off future episodes; one of the few long-term conclusions from the Prozac trial seems to suggest that they won't. "It seems now that children who got medicine are just as likely to get a recurrence as those who didn't get medicine," says Graham Emslie, the psychiatry professor at University of Texas Southwestern Medical Center who led the study. Of the 96 depressed eight-to-18-year-olds in the study, 56 percent were helped in the short term, but 35 percent suffered another episode of depression within a year.

Regardless, the drug companies are already gearing up their marketing machines. Georgia-based Solvay Pharmaceuticals offers the first glimpse of how information will get to a psychiatrist or pediatric office near you—since the approval this past summer of Luvox for obsessive-compulsive disorder in kids, Solvay representatives have been taking special pains to remind doctors of its successful study, leaving behind trinkets emblazoned with the Luvox name. Advertisements trumpeting Solvay's pediatric uses have been appearing in medical journals. The antidepressant makers are eager to do the same: Already, some pharmaceutical reps have been gently reminding pediatricians and child psychiatrists of their ongoing clinical trials on children.

"Look, if a drug company has done its homework, it's within their rights to promote their drug," bristles Sanchez. "The onus is on the physician. All good physicians are responsible to their patients. Not to anyone else."

While waiting for the Prozac to kick in, Sanchez put Jeremy on the anti-anxiety drug Klonopin. Within a week, he was already noticing a difference. He was feeling lighter somehow, freer. When he overheard someone talking about sickness, he didn't shiver and have flashbacks to Vomit Day the way he used to. Compared to the previous eight months, this qualified as pure pleasure. "I'm feeling pretty good," he told his parents. Sanchez then switched him to Prozac alone. After a month, Jeremy's battles over going to school were being fought only half-heartedly, and his panic attacks were

becoming milder; when he would feel one building, he'd use relaxation techniques he was learning from his psychologist (Sanchez recommended medication only in conjunction with talk therapy) to talk himself down. By the second half of fifth grade, the difference in Jeremy was startling: He was up each morning without any coaching, unafraid of malls and restaurants, doing well in school, wearing flannel and black T-shirts with hardly a second thought.

In some respects, Jeremy was even *better* than before he had been depressed. He had always been a shy child, but Prozac coaxed a braver, more confident Jeremy to appear, a social and outgoing Jeremy who made friends easily and wasn't afraid to speak up in class. His parents marveled at the change. Even the neighbors wondered at Jeremy's miraculous transformation.

To the throngs of overanxious suburban parents already set upon molding their kids through expensive private tutors and tennis lessons, kiddie Prozac and Paxil clearly has the potential to be the next Big Thing. "More parents have come into my office lately telling me that their child has been acting out because of a chemical imbalance and needs medication," says Swarthmore psychiatrist Dr. G. Brock Roben. "I suppose parental guilt plays into it. It's nice sometimes to be able to say it's a chemical problem and not something else." Several psychiatrists interviewed say they've seen antidepressants used in scenarios that wouldn't have merited medication in the past, including one 12-year-old Philadelphia-area girl currently being medicated for seasonal affective disorder, a malady in which a person feels blue during winter's shorter days.

At what point does a kid's fear of monsters under the bed indicate an anxiety disorder? Is a sad child just sad, or showing early signs of full-blown depression?

"It doesn't take a lot to make a parent nervous that a kid's quirk is a handicap," notes Art Caplan, director of Penn's Center for Bioethics. "Among adults, Prozac has gotten to be just another step in optimizing ourselves through pharmacology. In the long run, the issue will be the same in children: To what extent do you want to enhance your kid's mental state, or minimize even the risk of something in their personalities being off?" He adds with a wry chuckle, "People might imagine that an evil government would be the one to use personality-perfecting drugs to weed out bad behavior in kids. But actually, it'll be legions of nervous, competitive parents."

We've seen it happen with Ritalin, which has been overprescribed for attention-deficit disorder. We've seen it happen with human growth hormone, a compound intended for use on dwarfs, but which was appropriated by the parents of healthy short children—until it was discovered to carry a risk of the human equivalent of mad cow's disease. With antidepressants, however, the lines between sick and healthy could be even blurrier. At what point does a kid's fear of monsters under the bed indicate an anxiety disorder? Is a sad child just sad, or is she presenting the early symptoms of what will one day become full-blown depression—and if so, would medicating her qualify as getting a jump on the situation or tampering with a normal mind? Much of what we consider personality, after all, is formed by how we respond to life's challenges; giving a child an easy escape from problems would be anathema to a newly forming sense of self.

And then there's the concern that medicating our kids for mere unhappiness sends them a confusing message. Already, there have been reports of Main Line teens mixing Prozac with Ritalin to snort the concoction. As Roben allows, "These are probably the same kids who sniff Scotchguard and furniture polish to get high"; still, justifying certain mood-enhancing drugs does make it more difficult for parents and teachers to condemn others.

Laura Sanchez becomes a bit testy, hearing all this talk. If any abuse or misdiagnoses have taken place, she maintains, it's because of the pressure managed care puts on physicians to find quick, cheap solutions—forcing pediatricians in particular to handle health problems that are outside their realm of expertise. "An average pediatric visit takes seven minutes," she begins. "That's okay if your child has a cold or an ear infection. But it's not possible to make a diagnosis of depression in seven minutes. I have seven years of superspecialized training, and it takes me an hour and a half to three hours!

"The misperception of psychopharmacologists is that all we want to do is give pills," she says. "That's not what I do. I don't want to medicate everyone, not by a long shot. But think about the consequences when children *don't* get the help they need." Her voice drops. "We get calls from parents who have lost their child to suicide, not infrequently. Many of

those kids had mood disorders and weren't treated for them. It's almost always the same story. Everyone hoped they'd grow out of it. Instead, they didn't grow up at all."

That said, after Jeremy Overton had been on Prozac for a full year, Dr. Laura Sanchez thought it was time to try to get him off of it. The hope was that after the drugs had restored his brain's chemical balance for a while, the brain might have caught on and learned to function normally on its own. Of course, Sanchez wouldn't have been so anxious to take him off Prozac if she weren't also worried about what else the Prozac might be doing. "The possibility of putting a nine-year-old on medication for the rest of his life—that's a serious thing," she says. "No ethical physician feels good about that, because we don't know what the long-term outcome could be."

It's one of the things Sanchez and her colleagues at CHOP's institute for mood and anxiety disorders hope to resolve. Along with their other work—sleuthing genes, trying to correlate in-utero complications with mental illness later in life—they'll also be tracking children as they grow, assessing how much of each medication helps, and how much time spent taking a drug is considered safe. For now, though, even sophisticated clinicians can only fumble through as best they can.

It's a tricky business, trying to separate a kid from his antidepressant once he, and his family, have grown attached to it. Unlike adults, whose lives are fairly stable from one week to the next, children are in a near-perpetual state of transition. There's never a good time to have a relapse. "It's like, 'Please, don't touch the Prozac! Please, don't touch the Paxil!'" Sanchez says, relating the attitude of many of her patients' parents. "'At least wait until after the holidays, or after school starts, or after his birthday!'"

When it came time for Jeremy's turn, the Overtons braced themselves. Within a week of stopping his medication, he became withdrawn, irritable and lethargic all over again. He resisted going to school, returning to the morning fights his parents remembered so well. Eight weeks later, much to everyone's relief, Sanchez put Jeremy back on the drug, after which he continued to pick up right where he had left off two months earlier: enjoying school, volunteering for violin solos in the school orchestra, making honor roll for the first time.

Six months later, Sanchez decided to

give Jeremy another break. This one lasted only two weeks, after which Jeremy himself asked Sanchez if she would please put him back on Prozac.

Jeremy sits on the sectional sofa in his living room, sweatpant-clad legs tucked under him. A black T-shirt peeks out from the neck of his pullover. The tiny family dog clambers onto the couch beside him; Jeremy sweeps the dog into his arms to give his belly a good rub. Steve and Naomi gaze fondly at their son.

"He's been a good boy," Steve observes. "Or a brat, same as any other 12-year old."

"Daaaad..." Jeremy mock-complains.

Jeremy is now on a ten-milligram maintenance dose of Prozac, and has been panic-attack-free for a full year. He has been doing so well that he recently ended his talk-therapy sessions with his psychologist—he told her that he didn't feel their meetings were necessary anymore. Dr. Sanchez plans to leave Jeremy on Prozac for the rest of the school year, then will try taking him off for a third time this summer—the thought of which gives Jeremy a twinge of nervousness, since he's considering going to sleepover camp for the first time.

"I do hope that Jeremy's maturation process means that one day he can go off the medication and stay off it," says Steve. "But if he has to go back on and stay on, that's fine with us."

"Fine with me too," Jeremy pipes up. Through hard work he has come to understand and manage his illness. In fact, he's become secure enough with it that when his class was assigned to write essays about their greatest accomplishments, Jeremy wrote about his triumph over anxiety and depression:

"The way it started was in fourth grade. I vomited and ever since I've been scared about it. I think this is the worst problem I ever had to face in my life. My parents were a wreck over how miserable I was. Sometimes I missed school I was so miserable. Now I have two doctors working with me on my problem. My parents are also trying to help me out by talking to me when I get nervous. My pets also help me out by rubbing against me and that really helps out a lot. I think that this is the greatest accomplishment ever in my life and will always be."

From her seat in the crook of the couch, Naomi reaches out to touch Jeremy's white-socked foot.

"Do you remember what Miss Lewis did when she read it?" she asks gently.

Jeremy nods. "She cried." ■■