7
Mood Disorders

Many parents who bring children to our clinic because of "emotional problems" end up describing what mental health professionals term *mood disorders*. Mood is generally considered your child's ongoing emotional state, and any disturbance in that state that lasts continually for more than 2 weeks or occurs for most of the day over a substantial period of time should be evaluated as a possible mood disorder. Typically, children experience mood as sadness, crying spells, nihilism/negativism and/or irritability, anger, agitation, temper outbursts, and aggression. Mood disorders run the spectrum from just being down to cycling between feeling down and feeling up or giddy/euphoric. Previous and recent longitudinal studies (studies conducted over time) indicate that mood disorders tend to be chronic—that is, many of the children who are diagnosed with a mood disorder will tend to have that mood disorder 2, 5, and even 10 years later. We also know that mood disorders on their own will typically wax and wane—that is, children improve and then relapse, sometimes related to stressors and sometimes for no apparent reason at all. The good news is that treatment can help reduce the fluctuations and also reduce active symptoms and improve a child's functioning.

Mood disorders can be difficult to diagnose. It's not always easy to see that a child has been "down" for an extended period of time. Maybe your son isn't very forthcoming about how he's feeling; perhaps your daughter is too young to articulate her moods clearly. Consider, too, that children often seem moody, sometimes due to normal passing external pressures such as losing a sporting event or peer difficulties and sometimes due to transitions in their maturation. We've all known preteens and teens who seem pretty constantly crabby or glum, and it's difficult to determine when they're just "going through a phase" and when they're

suffering from clinical depression and need help. Younger children may be giddy or goofy naturally—or the giddiness, if excessive, may be an "up" swing in a mood. Finally, we tend to view "real" mood disorders as an adult disease and don't often make the connection between less obvious symptoms—fatigue and listlessness, irritability, lack of concentration—and a mood disorder in a child. Fourteen-year-old Donny was referred to us by his pediatrician because the doctor could find no medical illness to account for his low energy level. It took a psychiatric evaluation to reveal that Donny could not report the last time he had been happy, that he felt blue and cynical "all the time," and that he was quiet and withdrawn. When we do evaluate children for mood disorders, we often find—as we did in Donny's case—that the child's problems began as long as a year or two ago.

As a parent, you can be guided to some extent by the fact that the rate of mood disorders increases with age. For instance, major depression is estimated to affect 0.3% of preschoolers, 1–2% of elementary-age children, and 5% of adolescents. Bipolar disorder is estimated to affect fewer than 0.5% of preschoolers but up to 3% of adolescents. In other words, the younger your child is, the less likely she is to be suffering from a mood disorder. For depression, until adolescence, roughly the same number of boys and girls suffer from the disorder. Then the more typical adult pattern starts, with approximately two-thirds of cases affecting females. Depressive disorders commonly occur together with anxiety, ADHD, conduct, and substance use disorders in older children and adolescents.

Depression versus Bipolar Disorder

Mood disorders in children are classified most commonly as depression alone or bipolar disorder (also called manic–depression). They can also be considered episodic (the child's mood is okay for a while and then gets worse) or continuous (the mood is problematic most of the time with some minor variation). The more typical symptoms of depression in children are sadness, anger, gloominess, nihilism, withdrawal, and loss of interest and enjoyment in life. When a child's "moodiness" falls generally into those categories, the child is likely to be diagnosed with a depressive disorder. But when emotional symptoms that seem the opposite of depression also appear—euphoria or severe and prolonged

irritability or rage attacks, explosive energy, racing thoughts, marked insomnia, and driven behavior—bipolar disorder may be suspected. These "high" or "severely agitated" symptoms are called *mania,* and their contrast with "lows," or depression, results in the term *bipolar* (meaning two poles of mood). Complicating the distinction between depression and bipolar disorder, however, is the fact that depression may manifest itself in children as irritability or anger instead of sadness—and, depending on the frequency and intensity of the anger, may be a symptom of either disorder.

Other Mood Disorders

A less severe form of depression called *dysthymia,* commonly mistaken for a personality or character flaw, should be taken quite seriously because it can significantly damage a child's quality of life. Dysthymia is very long-standing, requiring at least 1 year's duration for diagnosis but often lasting more than 2 years. It does not involve full-blown depression, but the child may have a long-term negative and somewhat irritable mood, appearing somewhat unhappy, low in energy, and uninterested in activity. Not surprisingly, the child may have problems with friends and classmates and with parents and siblings. Often the disorder is a precursor to more severe depression that begins later in adolescence or adulthood. Disruptive mood dysregulation disorder (DMDD) is characterized by severe and frequent temper tantrums without many other continuous mood symptoms. This disorder is newly described, but what we do know about it appears at the end of the chapter.

Depression

The Disorder

As already mentioned, depression in a child may appear as a sad and/or irritable mood or a continued loss of interest or pleasure in favorite activities. Understand, though, that children have difficulty distinguishing sad from mad, so if asked how they feel they may confuse the two or report feeling sad and mad at the same time. Your observations may be more informative to the practitioner than the child's reporting. We frequently talk with kids about sadness and irritability being like a railroad track—one track is sadness and the other irritability.

What Does Depression Look Like?

Be alert for irritability, school difficulties, refusal to attend school, withdrawal, isolation, physical complaints, persistent negative or nihilistic attitude, frequent crying spells, and/or aggressive, antisocial behavior—all indications of possible depression in a child. The physical symptoms that many depressed adults have may also occur in a child: fatigue, changes in appetite and weight, abnormal sleep patterns (either too much or poor quality), physical slowing or agitation, and trouble thinking. Depressed kids and teens may report feeling worthless, hopeless, trapped, guilty, or preoccupied with suicidal thoughts. Many are unable to think positively of the future or see no future at all. Severe depression may even include disturbances in reality (psychosis), most typically hearing voices (*auditory hallucinations*).

You can see why depression may be hard for parents to identify with any certainty. Both overconcern and underconcern can lead you astray. Unless you look carefully at the context of your child's moods, you may have trouble differentiating depression from temperament (such as a tendency toward negativism) or passing emotions such as unhappiness or disappointment that commonly occur during childhood, particularly during high stress. A good distinguishing rule of thumb is that if the mood continues after the stressor that caused frustration or sadness has ended, the child *may* have a depressive disorder. Even if the symptoms do eventually end, a prolonged and exaggerated response, including many symptoms of depression, to a common stressor such as doing poorly on a test may indicate that the child is clinically depressed. As we discussed in Part I, some children inherit the tendency toward depression, which is triggered by certain stressors.

A child who has a full repertoire of depressive symptoms for at least 2 weeks is said to have a major depression. These symptoms may include irritability mixed with sadness, low energy and interest, physical problems (stomachaches, headaches), crying spells, withdrawal, a sad expression, problems with concentrating, and thoughts about harming himself. Adolescents with major depression have more adult-like features, including irritability, cynicism, sadness, low energy and interest, crying spells, social isolation and withdrawal, concentration difficulties, and suicidality.

No blood tests are used to diagnose any of the mood disorders. Psychological tests may help practitioners further understand depres-

sive themes and any discrepancies in the child's thinking, but essentially mood disorders are diagnosed on the basis of the child's history of problems—symptoms, timing, and functioning.

What Causes Depression?

Clearly there is a component that is passed on through families and thought to be genetic—30 to 50% of children with depression have a family member with depression. But the environment and excessive life stressors can also cause depression. Most likely depressed children have a genetic vulnerability that becomes activated with stressors—a typical scenario in which genes and the environment interact. Medical causes can include injuries to certain areas of the brain (some types of seizures may mimic or cause depression), high or low levels of thyroid hormone, and drug abuse (such as cocaine and marijuana).

The Treatment

In general, juvenile-onset depression does not respond as well to treatment as adult depression. Psychotherapy continues to be the first line of treatment for mild to moderate depression, with medications used for moderate to severe depression. Both medication and psychotherapy should probably be considered for all kids with moderate or severe depression, because the combination has had the greatest overall short- and longer-term effect. Although traditional interpersonal and insight-oriented therapies can be helpful, more recently proactive, cognitive-based approaches that work on changing the child's perceptions and belief systems are gaining favor and have been shown effective in large studies. Be patient; these psychotherapies may take 2–3 months to start working. If your child refuses or is unable to engage in psychotherapy, medications should be considered. Likewise, if your child continues to have mood problems despite a reasonable course (8–12 weeks) of psychotherapy, you should consider a medication consultation. *Medication should be considered immediately in kids with previous recurring depression, suicidality, or severe depressive features with a lot of impairment.*

Medications for depression, which are mainly the antidepressants, are summed up in Table 6. The most effective and commonly used antidepressants are the SSRIs, including Prozac, Zoloft, Luvox, Lexapro, and Celexa. Studies of Prozac and Lexapro suggest their effectiveness

for depression in kids. Prozac and Lexapro are the only FDA-approved antidepressants for adolescents and are usually among the first selected. (See more on recent studies of these medications in Chapter 13.)

The SSRI class of medications also appears particularly effective for dysthymia compared to the other antidepressants—20 mg of Prozac was the prescription that helped 14-year-old Donny, introduced earlier. Note, however, that we often use lower doses of these medications for younger children. For instance, we often start with 5 mg of Prozac or Lexapro in children and monitor their response to treatment for 1 month before increasing the dose. While we don't have similar studies of all the other SSRIs, it seems prudent to start younger children on one-quarter to one-half of an adult starting dose.

We increase the dosage of these medications as tolerated and necessary to control symptoms: Prozac or Celexa from 5 to 40 mg daily; Lexapro from 2.5 to 20 mg daily; Zoloft from 25 to 200 mg; Luvox from 50 to 300 mg. It's not uncommon to see improvement in the first week, but it may take up to 12 weeks to know if the medication is going to work. Two years of psychotherapy had helped identify the triggers of 12-year-old Jeff's more severe depression, but the low energy and low interest, the sadness and sense of isolation that went along with his dysthymia persisted. Prozac resulted in Jeff's having a panic attack, so we tried Lexapro. At 10 mg daily, the Lexapro proved instrumental in reducing Jeff's depressive symptoms.

Other antidepressants used less commonly for depression in children include Wellbutrin, Effexor XR, Cymbalta, Remeron, trazodone, and the tricyclic antidepressants (desipramine, imipramine, amitriptyline, and others). Very new medications like vortioxetine remain untested in children.

Less commonly, the mood stabilizers (see the next page) are used for depression that features prominent mood swings, or lability. Lamictal appears to help greatly with depression alone or with bipolar disorder. Another medication, the second generation antipsychotic Abilify, may also be used with an antidepressant for hard-to-treat depression. When using any of the antidepressants, monitor your child for the emergence of worsened mood or suicidal thoughts, as a small percentage of youths receiving antidepressants actually get worse and benefit from stopping the medication if this occurs.

lability: Rapid mood swings or moodiness.

When children exhibit depression and another disorder, the choice

of a broader-spectrum agent that treats both disorders may be preferable. For children who have prominent ADHD and depression, Wellbutrin may be the initial drug of choice. Children with anxiety and depression may be tried initially on an SSRI (a Prozac-like medication), an SNRI (Effexor XR), a tricyclic antidepressant, or trazodone. When none of the antidepressants seems to work, the doctor may try a higher dose of an antidepressant as long as the child is having no adverse effects from the antidepressants. Or a different class of medication may be prescribed. A third approach might be to combine two antidepressants of different classes (e.g., Lexapro and Lamictal) or an antidepressant with another medication, such as lithium, stimulants, buspirone, or other anxiety-breaking medications. Some parents have treated their child's depression with natural substances such as omega-3 fatty acids ("fish oils") or St. John's wort, but results have been mixed. Research on these agents remains relatively scarce, and dosing and duration of treatment necessary for a positive outcome remain under study. If you're considering using natural compounds, speak with your practitioner to ensure there are no warnings about any particular type of compound or any drug interactions. Also be sure to get a well-regarded brand of the natural agents, since they are not regulated for purity in the same manner as standard medications.

Finding the right medication for your child leaves you and the doctor with the question of how long to treat the child, and unfortunately there is currently little information available to answer it. Often doctors are left relying on guidelines meant for adults with depression. Because most adults' mood will improve naturally in 6 months to 1 year, for example, doctors tend to prescribe medication for 6–12 months. In children, however, depression frequently lasts longer and is less likely to remit spontaneously. The solution in our clinic is to continue medication for 6 months or longer, until the child's mood is stable for at least 3 months, and then consider very gradually tapering the medication. If any symptoms of depression reemerge, we know we need to consider restarting the medication or boosting the dosage to the previous level that seemed to be helpful. Often, though, we find we can reduce the maintenance dose of the medication.

We feel strongly that parents and children should *not* feel any pressure to stop the medication if they are concerned about a recurrence of the depression and will continue prescribing it upon request. In the earlier case of Jeff, who had been on Lexapro for 8 months, we and Jeff's

parents agreed to continue the medication for another 4 months before reviewing discontinuance. In that case, the theoretical risks of long-term treatment were outweighed by the real risk of depression and associated problems. This seems particularly pertinent in light of research showing that about half of adolescents with depression still have problems with their mood or anxiety as adults and that long-term treatment of depression continues to lead to improved outcomes.

Bipolar (Manic–Depressive) Disorder

The Disorder

Imagine feeling very depressed but at the same time very agitated and out of control. That, in a nutshell, is the "miserable feeling" that most children with bipolar or manic–depressive disorder and their parents describe. This intertwining of symptoms distinguishes childhood manic depression from its adult counterpart. Where adults are more likely to have broad mood swings, children with this problem typically experience manic and depressive features at the same time, and the symptoms stay with the child for long periods.

In children, mania commonly takes the form of an extremely irritable, rageful, and/or explosive mood, sometimes psychosis, with poor social interactions or functioning that is often devastating to the child and family. On top of the severe mood swings that make everyone's life difficult, the manic child may overflow with excess energy that makes it hard to sleep (without being tired the next day), propels the boy or girl into obsessively goal-directed activity, subjects the child to unrelenting racing thoughts, and turns the child into an overtalkative and loud individual. Many of these children exhibit markedly poor judgment, pursuing thrill-seeking, reckless, substance-abusing, or sex-based activities. Up to half of children with bipolar disorder have a relative with bipolar illness. Although mania in children should be differentiated from ADHD, conduct disorder, depression, and disturbances in reality (psychosis), these disorders commonly occur along with juvenile bipolar disorder. In fact, the younger the child with bipolar disorder, the more likely she is to have other psychiatric disorders.

Controversy continues to simmer over juvenile bipolar disorder. Does the disorder really occur in children? Is it overdiagnosed? The incidence in children and adolescents is reported to be anywhere from

1 to 5%. Also, does bipolar come with many related symptoms, or are these other symptoms an indication of co-occurring disorders (such as anxiety/panic disorder, ADHD)? And how many kids with depression actually go on to be bipolar? One paper says half, a significant figure: is it accurate? More research needs to be done, but we do have longer-term longitudinal studies that indicated a high rate of improvement and relapse with low rates of true remission or "cure" from the disorder 5–10 years later.

The Treatment

For bipolar disorder, it's essential to treat the child with a second-generation antipsychotic or mood stabilizer. As of 2016 a number of second-generation antipsychotics (SGAs) have been approved for treating bipolar disorder in adolescents (and adults), including Saphris (asenapine). Traditional mood stabilizers include lithium and the older anticonvulsants Tegretol and Depakote. More recently, the less-tested anticonvulsants Neurontin (gabapentin), Lamictal (lamotrigine), Topamax (topiramate), Gabitril (tiagabine), and Trileptal (oxcarbazepine) have been used in children with bipolar disorder, generally with mixed or negative results. There have also been positive reports on the use of omega-3 fatty acids ("fish oils") in both adults and children, used alone or in combination with other treatments. Typically, at least 1,000 mg daily of a high-dose EPA/omega-3 is recommended in children with unstable mood disorders.

High doses of these medications may be necessary, which means your child's blood levels should be checked, and she should be watched closely for side effects. While many of the SGAs (such as olanzapine) work within 2 weeks, you may not see the drug's full effect on the child's mood instability and associated problems until 3 months have passed. If, at that point, the child hasn't responded or hasn't been able to tolerate the drug, the doctor should consider other agents. In some cases—such as when the child does not respond to lithium or an anticonvulsant individually—your child may require two mood-stabilizing agents. I (T. E. W.) will combine Depakote or Trileptal with lithium, as I did with 12-year-old Jay, who is now doing well with 600 mg of Trileptal twice a day and 300 mg of lithium twice a day. In my practice it is common to use a full dose of one medication and a lower dose of the second mood-stabilizing agent.

Over the past decade, with the results of multiple trials and FDA approvals, clinicians tend to employ the SGAs as first-line agents for the treatment of children and adolescents who have severe disruptive disorders, self-injurious behavior, and bipolar disorder. The SGAs have been of invaluable assistance in controlling not only the manic symptoms (e.g., explosiveness, grandiosity) but also the depressive symptoms of the disorder. The use of SGAs for a whole host of disorders in children and adolescents (including tic disorders) is predicated on a number of studies demonstrating their efficacy for mania and depression in youth with bipolar disorder, tic disorders, explosive disorders, and disruptive disorders. In addition, these agents appear to work very quickly, with some trials showing vast changes in behavior after only 2 weeks.

We have continued to amass more information on the SGAs—risperidone (and its derivative, Invega [paliperidone]), Zyprexa (olanzapine), Seroquel (quetiapine), Geodon (ziprasidone), and Abilify (aripiprazole)—since this book was first published.

Antipsychotics should be considered immediately for children with prominent mixed symptoms, severe agitation, acute mania, or nonresponse to mood stabilizers, and/or hallucinations. Because the traditional antipsychotics such as Thorazine have longer-term side effects of concern (e.g., tardive dyskinesia), the second-generation ("atypical") class of antipsychotics is being used in the evening to assist with sleep and reduce the moodiness of the disorder; and in the morning for moodiness during the day, with very good success. Some clinicians will shift from Risperdal to paliperidone, an extended-release form of a breakdown product of risperidone, for kids who are having breakthrough symptoms of bipolar disorder or irritability in the afternoon as it may last longer. Others use Invega if risperidone has been helpful but weight gain has been problematic, since weight gain seems to be a bit less common with Invega. We have found that Abilify or Geodon can be effective for bipolar symptoms and are associated with much less weight gain and increases in blood sugar and blood lipids (fats), which potentially cause metabolic issues.

When prominent symptoms of depression (negativism, isolation, looking sad) are part of your child's bipolar disorder, the doctor may prescribe a medication for the bipolar/manic symptoms such as an antipsychotic and an additional medication such as an antidepressant. If an antidepressant is added, it is recommended that it should be short-acting to reduce the risk of severe activation or worsening of mania. The SSRIs

(Prozac, Zoloft, Paxil, Luvox, Celexa, Lexapro) are noted for making mania worse (activating mania) in individuals with bipolar disorder, but Lamictal or Wellbutrin can be introduced gently with less concern about activation. Other agents such as Effexor XR appear to be relatively well tolerated at low doses in youth with bipolar disorder. Other options include the use of Lamictal (lamotrigine), which seems particularly helpful for the depression commonly experienced as part of the "mixed" picture of bipolar disorder in kids.

activation: The stimulation of emotional, cognitive, or behavioral processes.

What are you to do if your child has bipolar disorder and ADHD? Data show that ADHD responds to treatment *only* if the mood (mania or depression) is being treated. Data also show that you can safely and effectively treat the bipolar disorder and the ADHD at the same time. The key: the bipolar symptoms need to be treated completely *first.* Your child's practitioner may try an SGA and/or a mood stabilizer for the bipolar disorder and a stimulant, clonidine, guanfacine, Wellbutrin, atomoxetine, or a tricyclic antidepressant for the ADHD.

Many young people with bipolar disorder have multiple other problems and do not respond to a single antipsychotic. It is unfortunately not uncommon for these children to receive a few different classes of medication. After multiple hospitalizations and medication trials, one 12-year-old boy with bipolar disorder, ADHD, and anxiety whom I (T. E. W.) treat has finally stabilized on Risperdal, Lamictal, and Concerta. As a parent, you must be sure you are aware of what each agent is targeting and the potential drug interactions among all of them. The Risperdal and Lamictal are for the mood and anxiety, and the Concerta for the ADHD.

Usually, SGAs and/or mood stabilizers will need to be continued indefinitely until there is little evidence of mood swings over a period of time. Children and their parents often mistake the long-term effects of these medications for a "cure" and understandably, when the child has been doing so well for a few months, question the need to continue the medication. I strongly recommend that you discuss the matter thoroughly with your child's doctor. Prematurely discontinuing treatment imposes the risk of major relapse and perhaps psychiatric hospitalization (see Chapter 4). If you are leaning in the direction of a trial off the medication, talk to the doctor about trying a very slow taper off one medication at a time so you can observe your child's behavior as he safely comes off the medication. Data in adults suggest that rapid

discontinuation (less than 1 week) compared to slow discontinuation (1 month) may lead to recurrence of the bipolar disorder and more difficulty treating the disorder in the future. Close communication with your child's school and frequent contact with your child's doctor are paramount during discontinuation phases on mood stabilizers or SGAs.

Disruptive Mood Dysregulation Disorder

The Disorder

Severe temper tantrums without many other symptoms appear to be the hallmark of this newly described disorder. Children with DMDD have severe and frequent temper tantrums that interfere with their ability to function at home, in school, or with their friends. These kids appear likely to develop problems with depression or anxiety over time. While occasional temper tantrums are a normal part of growing up, children who have very intense and persistent temper tantrums at least a few times a week over a year may have DMDD. Some children with DMDD also have other issues, such as oppositional defiant disorder, anxiety, and/or ADHD. Some professionals believe that DMDD is really just a manifestation of co-occurring oppositional and mood disorders. Others feel as if children diagnosed with DMDD have a complicated personality disorder referred to as borderline personality disorder, characterized by features including black-and-white thinking, difficulty with mood regulation/irritability, and outbursts at perceived injustices.

The Treatment

The treatment for DMDD is not well established, and clinicians who believe it is not a separate disorder but a manifestation of co-occurring oppositional and mood disorders think it should be treated that way. It is anticipated that psychotherapies directed at stress and anger management will be utilized initially. Medications used for the symptoms suggested for DMDD include the alpha agonists (Intuniv [guanfacine], Kapvay [clonidine]), low-dose atypical antipsychotics (Abilify and others), mood stabilizers, and SSRIs (Lexapro and others). Given that there is no set medication treatment for DMDD, psychotherapies and medication will need to be customized for the needs of the particular child and based on an understanding of co-occurring issues and the objective of reducing potential triggers of the disorder.

Table 6. Pharmacotherapy of Juvenile Mood Disorders

Disorder	Pharmacotherapy
Depression Major depression Dysthymia	SSRIs: Prozac, Lexapro, Zoloft, Luvox, Celexa SNRIs: Cymbalta, Effexor XR
	Atypical antidepressants: Wellbutrin, Remeron
	Lamictal (lamotrigine)
	Tricyclic antidepressants: imipramine, nortriptyline, desipramine, amitriptyline, clomipramine
	Antidepressants + antipsychotics (e.g., Abilify) if problems with hallucinations or problems in reality
	Antidepressants + benzodiazepines (e.g., Ativan) if anxiety
	For nonresponders consider combined medication strategies: antidepressant + lamotrigine, SGA (e.g., Abilify), lithium, stimulants, or modafinil
	Electroconvulsive therapy (ECT)
Bipolar disorder (manic–depressive disorder)	SGAs: Risperdal, Abilify, Seroquel, Invega, Zyprexa, Geodon, Saphris (asenapine)
	Mood stabilizer: lithium (Eskalith, Lithobid), Tegretol/Equetrol/Carbachol (carbamazepine) or Trileptal (oxcarbazepine)
	Valproate (Depakote, Depakene sprinkles, valproic acid)
	Other anticonvulsants (Lamictal, especially if depressed; Neurontin, especially if anxious; Topamax; Gabitril)
	Older antipsychotics: Trilafon, Thorazine, Mellaril, others
	For nonresponders consider lithium and antipsychotic, two anticonvulsants, or two antipsychotics
	If agitation or anxiety, add benzodiazepine (e.g., Klonopin)
	If ADHD, consider Wellbutrin, stimulants, Intuniv (guanfacine), clonidine, modafinil

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