

MOOD DISORDERS: DEPRESSIVE AND BIPOLAR DISORDERS

KEY FACTS

- The prevalence of mood disorders in children and adolescents ages 9–17 years is approximately 6 percent (U.S. Department of Health and Human Services, 1999).
- Only one-third of U.S. teenagers with depressive disorders receive treatment (King, 1991).
- Seventy percent of children with a single major depressive episode will experience a recurrence within 5 years (Birmaher et al., 1996a).
- Approximately 20 percent of all patients with bipolar disorder experience their first manic episode during adolescence (Geller and Luby, 1997; McClellan and Werry, 1997).
- More than 4,000 youth (ages 15–24) in the United States committed suicide in 1998 (Murphy, 2000).

It is distressing for parents to see their child or adolescent sad, withdrawn, or irritable. Yet episodes of sadness and frustration are common during childhood and adolescence. How, then, can a parent or primary care health professional determine whether a child or adolescent is showing signs of a mood disorder? Mood disorders are disorders characterized by disturbances in mood and include major depressive disorder, dysthymic disorder, and bipolar disorder.

Depressed mood falls along a continuum. Brief periods of sadness or irritability in response to disappointment or loss are a normal part of growing up and usually resolve quickly in a supportive environment. But some children and adolescents experience intense or long-lasting sadness or irritability that may interfere with self-esteem, friendships, family life, or school performance. These children or adolescents may be suffering from a depressive disorder. Depressive disorders include dysthymic disorder as well as single and recurring episodes of major depressive disorder.

Another type of mood disorder that can present in childhood or adolescence is bipolar disorder. Although bipolar disorder has been considered uncommon in prepubertal children, evidence suggests that it may not be as rare as previously thought, and that it is often difficult to distinguish from severe forms of attention deficit hyperactivity disorder (ADHD). A child or adolescent who presents with recurrent depressive symptoms, persistently irritable or agitated/hyperactive behaviors, markedly labile mood, reckless or aggressive behaviors, or psychotic symptoms may be experiencing the initial symptoms of a bipolar disorder.

DESCRIPTION OF SYMPTOMS

Descriptions of how these mood disorders can present in childhood and adolescence are summarized below.

Dysthymic Disorder

(Diagnostic code: 300.4)

Adapted from DSM-PC. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-PC and DSM IV/DSM-IV-TR for full psychiatric criteria and further description.

The symptoms of dysthymic disorder are less severe than those of a major depressive disorder but are more persistent, lasting for at least 1 year.

Dysthymic disorder is infrequently diagnosed in infancy and early childhood. In middle childhood and adolescence it may present with the following symptoms:

Middle Childhood and Adolescence

- Decreased interest in or participation in activities
- Feelings of inadequacy; low self-esteem
- Social withdrawal; guilt or brooding
- Irritability
- Increases or decreases in sleep or appetite

Major Depressive Disorder

(Diagnostic codes: 296.2x, major depressive disorder, single episode; 296.3x, major depressive disorder, recurrent)

Adapted from Sherry and Jellinek, 1996. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-PC and DSM-IV/DSM-IV-TR for full psychiatric criteria and further description.

While major depressive disorders in childhood and adolescence generally appear similar to adult depression, additional warning signs may be present according to developmental age. Table 14 presents possible signs of major depressive disorder in infancy, early childhood, middle childhood, and adolescence. (Although major depressive disorder has rarely been diagnosed in infants, they can show intense distress, similar to depressive reactions.)

Table 14. Possible Signs of Major Depressive Disorder in Infants, Children, and Adolescents

	Infancy	Early Childhood	Middle Childhood	Adolescence
Failure to thrive, speech and motor delays, decrease in interactiveness, poor attachment	✓			
Repetitive self-soothing behaviors, withdrawal from social contact	✓	✓		
Loss of previously learned skills (e.g., self-soothing skills, toilet learning)	✓	✓		
Increase in temper tantrums or irritability		✓		
Separation anxiety, phobias, poor self-esteem		✓	✓	✓
Reckless and destructive behavior (e.g., unsafe sexual activity, substance abuse)		✓	✓	✓
Somatic complaints		✓	✓	✓
Irritability or withdrawal			✓	✓
Poor social and academic functioning			✓	✓
Hopelessness, boredom, emptiness, loss of interest in activities			✓	✓

Source: Adapted, with permission, from Sherry and Jellinek, 1996.

Bipolar Disorder

(Diagnostic codes: 296.0x; 296.4x–296.8x)

Adapted from DSM-PC with additional information from McClellan and Werry, 1997. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-PC or DSM-IV/DSM-IV-TR for full psychiatric criteria and further description.

Bipolar disorder often presents differently in children and adolescents than in adults. Manic symptoms are the key feature of bipolar disorder. Ways that these symptoms might present in childhood and adolescence are described as follows.

(continued on next page)

Description of Symptoms (*continued*)**Bipolar Disorder** (*continued*)**Middle Childhood**

- Persistently irritable mood is described more than euphoric mood
- Aggressive and uncontrollable outbursts, agitated behaviors (may look like attention deficit hyperactivity disorder [ADHD] with severe hyperactivity and impulsivity) (See bridge topic: Attention Deficit Hyperactivity Disorder, p. 203.)
- Extreme fluctuations in mood that can occur on the same day or over the course of days or weeks
- Reckless behaviors, dangerous play, inappropriate sexual behaviors

Adolescence

- Markedly labile mood
- Agitated behaviors, pressured speech, racing thoughts, sleep disturbances
- Reckless behaviors (e.g., dangerous driving, substance abuse, sexual indiscretions)
- Illicit activities (e.g., impulsive stealing, fighting), spending sprees
- Psychotic symptoms (e.g., hallucinations, delusions, irrational thoughts)

COMMONLY ASSOCIATED DISORDERS**In Children and Adolescents with Depressive Disorders**

According to the American Academy of Child and Adolescent Psychiatry (1998), the following are commonly associated disorders in children and adolescents with depressive disorder:

- Anxiety disorders: 30–80 percent
- Substance abuse: 20–30 percent
- Disruptive disorders (including oppositional defiant disorder and conduct disorder): 10–80 percent
- Somatoform disorders (physical complaint not fully explained by another medical condition or mental disorder)

In Children and Adolescents with Bipolar Disorder

According to Geller and Luby (1997) and Wilens et al. (1999), the following percentages apply:

- Attention deficit hyperactivity disorder (ADHD): 90 percent (prepubertal patients); 30 percent (postpubertal adolescent patients) (See text on ADHD in the introduction, p. 271, for further discussion.)
- Anxiety disorders: approximately 30 percent (prepubertal patients); approximately 10 percent (postpubertal adolescent patients)
- Conduct disorder: approximately 20 percent
- Substance use disorders: approximately 10 percent (child-onset bipolar disorder); approximately 40 percent (adolescent-onset bipolar disorder)

INITIAL INTERVENTIONS

A mood disorder can devastate a child's or adolescent's emotional, social, and cognitive development. Primary care health professionals are increasingly the primary source of care for children and adolescents with mild to moderate depressive symptoms. Even after referring a child or adolescent with mood symptoms for mental health assessment and treatment, primary care health professionals need to collaborate with mental health professionals in supporting the child or adolescent and family. The following suggestions focus on interventions in the key areas of self, family, school, and friends. (See *Bright Futures Case Studies for Primary Care Clinicians: Depression: Too Tired to Sleep* [Hinden and Rosewater, 2001] at <http://www.pedicases.org>.)

Child or Adolescent

1. Ask all children, adolescents, and families about depressive feelings or symptoms the child or adolescent may have (e.g., feelings of sadness, sleep problems, loss of interest in activities). Parents should also be asked about depressive feelings. (See bridge topic: Parental Depression, p. 303.) Depression, even of moderate to severe intensity, may not always be apparent in the child's or adolescent's day-to-day behavior, as many of the symptoms of depression are internal.
2. Consider the use of a depression screening tool for children or adolescents who present with concerning behaviors or symptoms (such as those outlined in Tool for Families: Common Signs of Depression in Children and Adolescents, *Mental Health Tool Kit*, p. 147) or who are identified as being at risk for mood disorders by



general screening tools such as the Pediatric Symptom Checklist (Jellinek et al., 1988; Jellinek et al., 1999) or the Child Behavior Checklist (Achenbach, 1991). (See Tool for Health Professionals: Pediatric Symptom Checklist, *Mental Health Tool Kit*, p. 16.) Screening tools for depressive symptoms include

- The Children's Depression Inventory (CDI) (Kovacs, 1992) and the Beck Depression Inventory-II (BDI-II) (Beck et al., 1996). The CDI, which was derived from the BDI, can be used for children ages 7–17 but is written at a first-grade reading level. The BDI, which is written at a fifth-grade level, may be more appropriate for use with adolescents (Hack and Jellinek, 1998).

- The Center for Epidemiological Studies Depression Scale for Children (CES-DC) (Weissman et al., 1980) and the Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977) for childhood through adolescence. (See Tool for Health Professionals and Families: Center for Epidemiological Studies Depression Scale for Children [CES-DC], *Mental Health Tool Kit*, p. 57.)
- The Children’s Depression Scale (CDS) 9–16 Years (Lang, 1987).
- The Short Mood and Feelings Questionnaire (SMFQ) (Angold et al., 1995) for children and adolescents ages 8–18.

Screening for depressive disorders can be complex because most screening measures have relatively low rates of specificity (i.e., they result in a high number of false positives) (Roberts et al., 1991). Further evaluation is required for any child or adolescent identified through a screening process.

3. For children and adolescents with depressive or bipolar symptoms, assess risk for suicidal behavior. National and local statistics indicate that suicidal thoughts (suicidal ideation) and behaviors are common during adolescence.
 - Up to 60 percent of high school students report having had fleeting thoughts of suicide (Harkavy-Friedman et al., 1987).
 - Almost 20 percent of high school students report having seriously considered suicide (Kann et al., 2000).
 - Almost 8 percent of high school students have made an actual suicide attempt (Kann et al., 2000).

- Teenage boys have a suicide completion rate four times higher than that of teenage girls, although girls attempt suicide more often (Jellinek and Snyder, 1998).

Children and adolescents who have depressive or bipolar symptoms should also be screened for the following risk factors, which may place them at higher risk for acting on suicidal thoughts:

- Previous suicide attempt
- Family history of suicide
- Friends who have committed suicide
- Access to a gun
- Conduct disorder
- Psychotic disorder
- History of physical abuse, neglect, and/or sexual abuse
- Concerns about sexual identity
- Increase in risky behaviors (e.g., reckless driving, unsafe sex)
- History of impulsivity
- Change in school functioning or social functioning
- Alcohol and/or substance abuse

Any child or adolescent with symptoms of a mood disorder or who is at risk for a mood disorder should be asked directly about suicidal thoughts or actions. Some sample questions follow:

“Have you ever felt bad enough that you wished you were dead?”

“Have you had any thoughts about wanting to hurt or kill yourself?”

“Have you ever tried to hurt or kill yourself?”

“Do you have a plan?”

“Do you have a way to carry out your plan? Is there a gun in your house?”

Any child or adolescent who has suicidal thoughts should be asked if he has a plan to harm himself. Immediate mental health evaluation is necessary for any child or adolescent who has a plan or who is at risk for suicide and also describes suicidal thoughts. Referral to a mental health professional is usually indicated for children and adolescents with suicidal thoughts and depressive or bipolar symptoms. See American Academy of Child and Adolescent Psychiatry (2001) for further information.

4. Recognize that disclosing painful feelings is often distressing for a child or adolescent. Consider following up assessment questions with empathic responses such as, “I’m really glad you were able to tell me about how you feel, even though it’s not easy. Your telling me means that we can work together to find ways to help you feel better.”
5. Look for evidence of any co-occurring psychiatric problems (e.g., abuse of alcohol or other substances, ADHD, anxiety), and treat or refer for treatment as symptoms indicate. Work to coordinate care if multiple ser-

vices are needed. (See the following bridge topics: Substance Use Problems and Disorders, p. 331; Attention Deficit Hyperactivity Disorder, p. 203; Anxiety Disorders, p. 191.)

6. Assess the child or adolescent for organic illness as indicated by symptoms and signs (e.g., thyroid problems, anemia, neurological illness, lead toxicity, drugs, alcohol).
7. Children and adolescents may benefit from referrals for a range of therapies and treatments. Following are some examples of therapies, treatments, and techniques that can help:
 - Supportive individual treatment that helps a child or adolescent begin to express and address distressing thoughts and feelings
 - Cognitive-behavioral approaches such as challenging negative thoughts (e.g., helping an adolescent to “reality check” why her best friend might have forgotten to call her)



- Stress management and problem-solving techniques
 - Group approaches that focus on building self-esteem or on handling peer conflicts and pressure
 - Family therapy that addresses areas of concern or communication difficulties
8. Consider options for pharmacological intervention. (See *Pharmacological Interventions*, p. 281.)
 9. Recognize that the child or adolescent may have concerns about the stigma of mood disorder. Discuss these concerns, and work with the child or adolescent to support social interaction, especially with peers.
 10. Encourage the child or adolescent to participate in activities that improve his self-esteem and sense of mastery (e.g., encourage a child or adolescent who likes to draw to take an art class).
 11. Discuss the importance of a healthy lifestyle (e.g., participating in regular physical activity, eating healthy foods) in maintaining a sense of well-being. In particular, regular physical activity can have a beneficial impact on depressed mood (Tkachuk and Martin, 1999) and should be discussed as an important element in any comprehensive treatment plan for adolescents with depressive symptoms.
2. Assess for family history of depressive or bipolar disorders and other psychiatric illnesses. Help family members access mental health services (individual, couple, and/or family treatment) as symptoms indicate. (See Table 2, Referral for Mental Health Care, p. 10, in the *Making Mental Health Supervision Accessible* chapter.)
 3. Educate the family and the child or adolescent about the symptoms of mood disorders, and try to address their questions and concerns. (See *Tool for Families: Common Signs of Depression in Children and Adolescents*, *Mental Health Tool Kit*, p. 147.)
 4. Help the family support the child's or adolescent's development by
 - Discussing with parents any concerns they have about discipline practices or how to manage conflicts at home
 - Encouraging parents to set aside a regular time to talk with or engage in enjoyable activities with their child or adolescent
 5. Help the family find ways to improve communication (e.g., by holding family meetings in which the child or adolescent is included in family decision-making and can raise concerns in a supportive setting).
 6. Ask if there are any weapons in the home, and discuss safety issues.
 7. Consider a referral for parent or family therapy to support families who may be coping with significant levels of stress or who may need additional help with other concerns (e.g., addressing marital discord or parental depression or substance abuse; implementing effective parenting practices; maintaining supportive communica-

Family

1. Ask family members about any recent or current stressors (e.g., death of someone close to the child or adolescent, marital conflict, divorce) that may be affecting the child's or adolescent's mood.

tion). (See bridge topic: Parental Depression, p. 303.)

Friends

1. Encourage the child or adolescent to interact with peers in a supportive environment (e.g., during after-school activities, in clubs or sports, at play dates [for younger children], through faith-based activities).
2. Consider recommending social skills training as a way to improve a child's or adolescent's self-esteem and peer relationships. Group therapy may be particularly helpful for older children and adolescents.

School

1. The child or adolescent should be assessed, and appropriate modifications should be made for a child or adolescent with a learning disorder or school difficulties that may be contributing to her sense of failure.
2. After receiving appropriate permission, obtain information from teachers and guidance counselors about the child's or adolescent's school functioning. Collaborate with the school team to ensure that academic expectations and the level of services are appropriate for the child's or adolescent's needs and abilities. Involve school-based professionals such as school nurses, school social workers, school psychologists, guidance counselors, and teachers in the child's or adolescent's treatment plan.
3. Be aware that children and adolescents with depressive or bipolar disorders may be eligible for special education services under the disabili-

ty category of "emotional disturbance." Support and encourage the adolescent or family in discussing possible options with appropriate school personnel. Some parents may appreciate assistance from the primary care health professional in contacting the school. Ensure that parents know that their child or adolescent may also qualify for services under Section 504 of the Rehabilitation Act.

For further information about eligibility and services, families can consult the school's special education coordinator, the local school district, the state department of education's special education division, the U.S. Department of Education's Office of Special Education Programs (<http://www.ed.gov/offices/OSERS/OSEP>), the Individuals with Disabilities Education Act (IDEA) '97 Web site (<http://www.ed.gov/offices/OSERS/IDEA>), or the U.S. Justice Department's Civil Rights Division (<http://www.usdoj.gov/crt/edo>).

WHEN TO REFER FOR MENTAL HEALTH SERVICES

The decision to refer should be based on the needs of the individual child or adolescent and family (e.g., severity of depressive symptoms, presence of bipolar symptoms, significant external stressors) and the primary care health professional's level of experience and expertise in managing mood disorders.

Primary care health professionals have differing levels of comfort and experience in treating children and adolescents with mild to moderate depressive symptoms. Even mild depressive symptoms can significantly interfere with a child's

or adolescent's social, emotional, and academic development. Therefore, even when a primary care health professional is comfortable assessing and managing a child's or adolescent's symptoms, referral for additional mental health services should be considered. Psychologists, child psychiatrists, and clinical social workers experienced in working with children and adolescents can provide individual and family therapy to support children, adolescents, and their families as they assess and monitor symptoms. School-based services, including additional academic support or ongoing contact with a school psychologist or counselor, may also be needed. For children or adolescents whose symptoms make it difficult for them to interact with peers, social skills groups or group therapy can be helpful. (See also Table 2. Referral for Mental Health Care, p. 10, in the Making Mental Health Supervision Accessible chapter.)

For children and adolescents with more severe symptoms or significant risk factors, referral to a mental health professional, usually a child psychologist, child psychiatrist, or developmental-behavioral pediatrician, for diagnostic evaluation and comprehensive treatment planning is indicated. Referral to a child psychiatrist is especially indicated for children and adolescents with psychotic or bipolar symptoms or for children or adolescents with other significant risk factors who may require medication management, medical/neurological evaluation, or hospitalization. Symptoms and risk factors that indicate referral include

- Suicidal thoughts (See discussion of suicide, p. 276.)
- Psychotic symptoms (e.g., paranoia, delusional thoughts, hallucinations); these require immediate evaluation
- Symptoms suggestive of a bipolar disorder (See Bipolar Disorder, p. 273.)
- Recurrent or unremitting depressive symptoms
- Disturbances in sleep, weight, or activity levels that are significant enough to affect functioning
- Significant impairment in school functioning or relationships with family and friends
- Possibility of abuse or neglect (See bridge topic: Child Maltreatment, p. 213, regarding mandated reporting responsibilities.)
- Health risk or delinquent behaviors (e.g., sexual indiscretions, drug or alcohol use, lying or stealing, truancy)
- Impaired parental functioning
- Strong family history of affective disorder or psychiatric illness

Children or adolescents with bipolar disorder require an intensive level of services. In order to provide adequate care for these children and adolescents, the primary care health professional should closely collaborate with mental health professionals as the following interventions are implemented:

- Assessment of the child's or adolescent's and family's safety while symptoms are being stabilized. (If the child or adolescent cannot be safely kept at home, hospitalization may be required.)
- Medication management by a child psychiatrist, including monitoring and addressing potential adverse effects of medication (e.g., weight gain).
- Implementation of long-term supports for the child or adolescent and the family, including

- Case-management services
- Home-based services to help families develop and implement behavior plans
- Respite and residential services as needed
- Financial or insurance coverage for needed services
- Individual and/or group therapy
- Review of a child's or adolescent's educational plan, and appropriate school placement and provision of school services

PHARMACOLOGICAL INTERVENTIONS

In addition to interventions such as individual therapy and working with the child's or adolescent's family, school, and peers, medication may help some children and adolescents with depressive disorders. The assessment, treatment planning, and medication management issues of depressive symptoms in prepubertal children and young adolescents going through puberty are sufficiently complex to warrant a referral to a child psychiatrist. For older adolescents, primary care health professionals may choose to treat moderate depressive symptoms with medication. In these cases, initial and periodic consultation with a child psychiatrist regarding medication selection, dosing, duration of treatment, and management of adverse effects is highly recommended. Children and adolescents with bipolar symptoms should always be referred to a child psychiatrist (or adult psychiatrist in the case of older adolescents) for assessment and medication management.

While a detailed discussion of medication treatment for depressive disorders in children and ado-

lescents is beyond the scope of this guide, guidelines for considering pharmacological treatment for child and adolescent depressive disorders are offered below. Primary care health professionals are referred to Bostic et al., 1997; Findling and Blumer, 1998; and Wilens, 1999 for further information on specific medications.

- Clinicians should be aware that 20–30 percent of children and adolescents who have experienced a major depressive episode will develop bipolar disorder (McClellan and Werry, 1997). Therefore, any child or adolescent who undergoes a trial of an antidepressant should be closely monitored for signs of increased agitation or irritability. If a child or adolescent exhibits these signs or other bipolar symptoms, referral to a child psychiatrist for assessment for bipolar disorder is indicated.
- Children and adolescents with co-occurring difficulties, such as suicidal thoughts, significant irritability or impulsivity, anxiety, ADHD, substance abuse, or significant conduct problems, are likely to present diagnostic and treatment challenges that are ideally addressed by a child psychiatrist.
- While the safety and efficacy of selective serotonin-reuptake inhibitor (SSRI) antidepressants have not been as well established for children and adolescents as for adults, available data indicate that the short-term use of SSRIs appears safe and potentially useful in the treatment of childhood and adolescent depression (Emslie et al., 1999).
- For an older adolescent with a moderately severe depressive disorder and good family support, primary care health professionals, after thoroughly evaluating the adolescent's symptoms, functioning, and stressors and assessing for potential

medical causes, may consider using an SSRI in certain situations:

- In adolescents with a clear family history of depressive disorders (not bipolar disorder) that have responded well to medication treatment
- In adolescents who had previously been functioning well, with acute impairment due to depressive symptoms
- In adolescents whose depressive symptoms have continued even after individual, group, and/or family therapy
- An adolescent who does not respond to an initial trial of an SSRI or who experiences adverse effects with a medication trial should be referred for further psychiatric evaluation.

Resources for Families

Child & Adolescent Bipolar Foundation
1187 Wilmette Avenue, PMB #331
Wilmette, IL 60091
Phone: (847) 256-8525
Web site: <http://www.bpkids.org>

National Depressive and Manic-Depressive
Association
730 North Franklin Street, Suite 501
Chicago, IL 60610-3526
Phone: (800) 826-3632
Web site: <http://www.ndmda.org>