CHILDREN AND ADOLESCENTS WITH MOOD DISORDERS:

A REVIEW OF LITERATURE

by

Sarah K. Hanke

A Research Paper

Submitted in Partial Fulfillment of the
Requirements for the
Master of Science Degree
With a Major in

Guidance and Counseling

Approved: 2 Semester Credits

_____

Dr. Amy Schlieve
Research Advisor

The Graduate School
University of Wisconsin-Stout
May, 2004

The Graduate School

University of Wisconsin Stout

Menomonie, WI 54751

ABSTRACT

Hanke	Sarah	K.
(Last Name)	(First Name)	(Middle Initial)

Children and Adolescents with Mood Disorders: A Review of Literature
(Title)

Guidance and Counseling	Dr. Amy Schlieve	May, 2004	50
(Graduate Program)	(Research Advisor)	(Month/Year)	(# of Pages)

American Psychological Association, 5th edition
(Name of Style Manual Used in this Study)

A review of the literature on children and adolescents with mood disorders was conducted in spring of 2004. Through this review it was found that mood disorders can be very complicated and the symptoms manifest differently in children and adolescents than they do in adults. Children and adolescents are likely to be irritable and have angry outbursts rather than the depressed or sad mood that adults experience. Mood disorders consist of both depressive disorders and bipolar disorders. Depressive disorders have been researched more in children and adolescents where as bipolar disorders have only recently begun to be accepted as a possibility for this age group. It was also found that there are several other disorders that overlap in symptoms with bipolar disorders. The most commonly mentioned disorders were Conduct Disorder, Attention Deficit

Hyperactivity Disorder, Oppositional Defiant Disorder, and Schizophrenia. Treatments were found to be similar for youth and adults with a growing popularity of using pharmacological treatments such as antidepressants and atypical antidepressants for depressive symptoms and mood stabilizers, anticonvulsants, and anti psychotics for bipolar disorders. Other treatment techniques that were commonly recommended for children and adolescents within the literature were Cognitive Behavioral Therapy, Interpersonal Therapy, and Social Skills Training. Finally, the role of the school counselor in working with children and adolescents with mood disorders was assessed. School counselors have an increasing responsibility in assisting children and adolescents in the school environment. School counselors can assist by becoming more aware of these disorders, how they affect children and adolescents, and sharing this information with teachers and parents.

ACKNOWLEDGEMENTS

I would like to thank my family and my friends for being supportive throughout my educational experiences and during the development of this paper. I would also like to thank Dr. Amy Schlieve, my thesis advisor, for her assistance and time even though she was busy.

TABLE OF CONTENTS

CHAPTER ONE

Introduction

Mood disorders were once thought to be nonexistent among children and adolescents (Lock, 1997; Schroeder & Gordon, 2002). However, in the mid 1970s mood disorders with depressive symptoms such as Major Depressive Disorder and Dysthymia were recognized as childhood disorders and a decade later bipolar disorders were included (Fristad & Goldberg-Arnold, 2004). Currently, nearly four to six percent of individuals under age 18 eighteen suffer from some form of mood disorder. It is important to recognize that these are only the individuals who are formally diagnosed with a disorder. Mood disorders among youth are often not recognized. Therefore the percentage of youth suffering from a mood disorder is probably higher (Merrell, 2001).

The American Psychiatric Association (1994) lists several mood disorders in the fourth edition of the *Diagnostic and Statistical Manual of Mental Health Disorders*. These disorders are as follows: Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder Not Otherwise Specified, Bipolar Disorder I and II, Cyclothymic Disorder, Bipolar Disorder Not Otherwise Specified, Mood Disorder due to a medical condition or substance abuse, and Adjustment Disorder with depressed mood. Fristad and Goldberg-Arnold (2004) indicate that these disorders can be divided into two categories according to what a person is feeling. One category is the depressive disorders such as Major Depressive Disorder, Dysthymic Disorder, and Depressive Disorder Not Otherwise Specified where the feelings are of sadness, despair, and irritability (for children and adolescents). On the other hand, disorders such as Bipolar Disorder I and II, Cyclothymic Disorder, and Bipolar Disorder Not Otherwise Specified are included

together in a category of bipolar disorders. These disorders also involve depressive symptoms, but the key to a diagnosis in this category includes periods of extreme euphoria or rage.

Children and adolescents struggling with a mood disorder can very different than adults with the same disorder (Empfield & Bakalar, 2001; Fristad & Goldberg-Arnold, 2004; Merrell, 2001). For instance, adults with a depressive disorder have feelings of excessive sadness, fatigue, loss of interest in activities, sleep difficulties, weight loss or gain, inability to concentrate, and suicidal thoughts. However, children and adolescents can experience the same things but they are more likely to be irritable rather than sad and have somatic complaints (Merrell, 2001). On the same note, bipolar disorders involve cycling between a depressive episode (a combination of the symptoms listed above) and a manic episode (Papolos & Papolos, 2000). In adults the manic episode involves feelings of grandiosity, lessened need for sleep, unusual talkativeness, racing thoughts, distractibility, an increase in goal directed activity, and an excessive engagement in high risk activities (Schroeder & Gordon, 2002). On the contrary, children and adolescents can experience intense rage or angry outbursts for no apparent reason (Fristad & Goldberg-Arnold, 2004).

The symptoms in bipolar disorders are not the only reason why adults look so different than children and adolescents with the disorder. Children and adolescents cycle between depressive episodes and manic episodes much more rapidly (Fristad & Goldberg-Arnold, 2004). Adults will tend to have fewer manic episodes a year and the period in which they have an episode lasts from several days to several weeks. Children and adolescents might experience several cycles (switching between moods) in a day or

even an hour (Papolos & Papolos, 2000). This rapid cycling does not meet the criteria for any of the specific bipolar disorders so many children are diagnosed with Bipolar Disorder Not Otherwise Specified (Fristad & Goldberg-Arnold, 2004).

The more commonly diagnosed depressive disorders are Major Depressive Disorder and Dysthymic Disorder (Carlson, 1995; Empfield & Bakalar, 2001). The main difference between the two is the longevity of the symptoms and the intensity of the symptoms (Fristad & Goldberg-Arnold, 2004). Major Depressive Disorder lasts for less than a year and the symptoms can be very debilitating. Additionally, six symptoms, including the depressed or irritable mood, need to be present in order to diagnose an individual with Major Depressive Disorder. On the other hand, Dysthymic Disorder is present for at least a year in children and adolescents (two years for an adult) and only four total symptoms are required to make a formal diagnosis (Schroeder & Gordon, 2002). Someone with Dysthymic Disorder can experience a major depressive episode and then return back to Dysthymic Disorder never experiencing normal emotions. When this occurs the person is diagnosed with Double or Dual Depression (Empfield & Bakalar, 2001).

The symptoms in mood disorders may be caused by the side effects of medications, illegal drugs, or a physical illness so it is important to see a physician before a formal diagnosis is made (Empfield & Bakalar, 2001; Fristad & Goldberg-Arnold, 2004). For example, asthma medications can often cause irritability and marijuana will create fatigue. Additionally, there are several physical illnesses which may look like a mood disorder such as too much or too little thyroid, diseases of the central nervous system, endocrine system malfunctions, head injuries, mononucleosis, chronic fatigue

syndrome, and lupus (Papolos & Papolos, 2000).

The consequences suffered by children and adolescents with a mood disorder are serious and can stunt their social, emotional, and academic development. Those struggling with a mood disorder often have poor social skills, difficulty making decisions, very few coping skills, and may turn to drugs and alcohol (Naparsteck, 2002). Many times they do not do well in school which creates a downward spiral of events. First, they develop a form of a depression, then they do not do well on their schoolwork, and then they become even more depressed. Therefore, teachers and school personnel can be very powerful in breaking this downward spiral (Merrell, 2001). The most severe consequence is death; Suicide is a leading cause of death in adolescents which many times is a result of the difficulty and confusion in dealing with the intense emotions of a mood disorder (Empfield & Bakalar, 2001).

There are options for the treatment of mood disorders in children and adolescents. Medications are widely used for both the depressive disorders and the bipolar disorders (Papolos & Papolos, 2000). Psychotherapy is also often used to not only help the child or adolescent but to also support the family. Currently, the main difficulty with diagnosing and treating mood disorders in children and adolescents is that mood disorders are a new discovery to this age group, therefore little understanding exists regarding the differences between adults and children and adolescents with mood disorders (Fristad & Goldberg-Arnold, 2004).

In summary, mood disorders among children and adolescents are serious and if untreated can have long term negative effects on their lives. It affects all areas of their lives and can be not only chronic, if not treated, but also deadly (Empfield & Bakalar,

2001). These mood disorders can be very complicated and there is still a lot to learn about them and the way they affect children and teenagers versus adults. School personnel are with children a significant portion of their day and they are in a unique position to assist youth because they spend a significant amount of time with them during the school day. School counselors in particular are in a position to assist children and have a positive impact on the lives of the students. Developing an overall understanding of mood disorders and the behaviors and symptoms that occur within each disorder will assist in early detection of the disorder, finding good treatment, and communication between professionals and parents (Fristad & Goldberg-Arnold, 2004). School counselors should be knowledgeable of the different treatments and strategies in promoting good mental health so they can supplement and support the therapy that the students undergo.

Research Questions

There are three research questions that this literature review will address which are as follows:

1. How do the symptoms and behaviors of children and adolescents with mood disorders differ from adults with similar disorders?
2. What treatments are available for mood disorders?
3. What role do school counselors have in the treatment of mood disorders?

CHAPTER TWO

Literature Review

Introduction

This chapter provides a review of the literature that is available on mood disorders in children and adolescents. Recognizing mood disorders through behavioral indicators is expressed as well as the specific symptoms that are required for the diagnosis of a mood disorder. Depressive disorders such as Major Depressive Disorder and Dysthymic Disorder are discussed along with available treatments for them. Additionally, Manic and Hypomanic Episodes are explained with a description of their relationship to specific bipolar disorders. Differential diagnosing, risk factors, and treatments are also described for bipolar disorders. Finally, the role of a school counselor in the treatment of mood disorders is evaluated.

Recognizing Mood Disorders

There is a stepwise process involved in recognizing mood disorders in children and adolescents. To begin with, mood disorders are often difficult to detect and diagnose because the disorders are focused on disrupted thoughts and feelings versus actions (Empfield & Bakalar, 2001). However, those thoughts and feelings can provoke behaviors which become strong indicators of a mood disorder; therefore the first step is to become familiar with these behaviors (Fristad & Goldberg-Arnold, 2004; Hockey, 2003). The next step is recognizing how immediate the problem is which can be done by paying attention to the duration, intensity, and severity of the behaviors (Empfield & Bakalar, 2001; Fristad & Goldberg-Arnold, 2004). Finally, after a possibility of a mood disorder is recognized other causes for the behaviors such as drugs and medical problems need to

be examined (Papolos & Papolos, 2000).

There are numerous behavioral indicators for both depressive and bipolar disorders. Children and adolescents with depressive disorders are experiencing sadness, despair, and irritability which in return affect what they say or do. They might complain of somatic difficulties such as headaches or stomachaches, have difficulty making decisions, and show no desire to plan long term goals (Empfield & Bakalar, 2001). Additionally, they could be late to school, have a negative attitude, make negative comments about themselves, have poor posture, and show little energy (Naparstek, 2002). Hockey (2003) adds behavioral indicators such as easy frustration, social isolation, slipping grades, self-mutilation, restlessness, and inability to finish projects. The significance of an obsession with death is also stressed by Hockey (2003) which could involve talking, writing, singing, drawing, listening to music, or reading literature about death or suicide.

Since there are periods in which children and adolescents with a bipolar disorder experience feelings of sadness, despair, and irritability they will display some of the same behaviors listed above (Papolos & Papolos, 1999). However, the euphoria and rage of a manic episode may come out in behaviors such as excessive giggling, increased goal directed activities, reckless behavior, temper tantrums, uncontrollable laughter, and a decreased need for sleep without fatigue (Fristad & Goldberg-Arnold, 2004; Hockey, 2003). Not every child or adolescent looks the same because there may be different combinations of behaviors. One child may have little energy, appear tearful, and sleep a lot while another child may be restless, violent towards others, and have trouble falling asleep (Empfield & Bakalar, 2001).

Sorting through these behaviors and determining what is and what is not normal can be very confusing and complicating. Fristad and Goldberg-Arnold (2004) suggest paying attention to whether or not the behavior fits the situation and if it is creating difficulties for the person exhibiting the behavior or for a bystander.

After clusters of these behaviors are observed the duration, frequency, and severity of them need to be examined. This will determine the immediacy of the problem, guide treatment solutions, and can assist in differentiating between depressive and bipolar disorders (Empfield & Bakalar, 2001; Naparstek, 2002). Duration involves how long the child or adolescent is demonstrating the behaviors. Constant crying, talking about suicide, and self-mutilating are serious as are constant periods of rage or euphoria. In bipolar disorders many children cycle rapidly between two extremes within a few minutes which is also a concern because of the period of time that a child or adolescent spends in destructive behaviors (Fristad & Goldberg-Arnold, 2004). The frequency of a behavior refers to how often it is occurring. For instance, does the child or adolescent cry when something bad happens, does he cry every day, or does he cry every few hours? The more frequent a behavior is, the more important it is to find immediate help (Fristad & Goldberg-Arnold, 2004). Finally, the severity of the behaviors will indicate how intense the treatment needs to be (Fristad & Goldberg-Arnold, 2004). There are three different levels that a mood disorder can be categorized as which are mild, moderate, and severe. Mild is the bare minimum that is needed to diagnose the person and usually life is not completely affected. Moderate is a little more intense while severe may involve not being able to carry out daily tasks such as showering and clothing oneself (Empfield & Bakalar, 2001). The best way to determine the severity is to compare the current

behavior to how the child or adolescent has always been or to peers that are the same age (Fristad & Goldberg-Arnold, 2004).

The final step in recognizing a mood disorder is to rule out drug and medical problems that might be eliciting the behaviors. The best way to do this is to order random drug testing and/or have a full examination done by a physician (Fristad & Goldberg-Arnold, 2004). There are several medical illnesses that may create the symptoms of a mood disorder. For instance, too much or too little thyroid hormone, endocrine system malfunctions, diseases of the central nervous system, head injuries, mononucleosis, chronic fatigue syndrome, and hepatitis will show the same signs as mood disorders (Empfield & Bakalar, 2001). Furthermore, low iron could cause signs of fatigue and asthma medications have a side effect of irritability (Fristad & Goldberg-Arnold, 2004). Papolos and Papolos (1999) add diseases such as Wilson's disease, AIDS, diabetes, hypoglycemia, syphilis, Kleine-Levin syndrome, and temporal lobe epilepsy to look for. When all three of these steps are taken in recognizing a mood disorder the physician can write a referral to see a psychiatrist or a child psychologist and from there a specific diagnosis will be made (Papolos & Papolos, 2000).

Symptoms and Diagnosis of Depressive Disorders

Depressive disorders are common in adults, adolescents, and children (Carlson, 1995; Empfield & Bakalar, 2001). Major Depressive Disorder is a very serious disorder and involves intense treatment where as Dysthymic Disorder involves fewer symptoms and is a chronic disorder. The American Psychiatric Association (1994) has identified specific criteria that an individual must meet before officially being diagnosed with one of these disorders. However, for children or adolescents who do not meet the criteria for

one of these disorders and their social, academic, and/or work lives are significantly affected by their symptoms a diagnosis of Depressive Disorder Not Otherwise Specified can be made (House, 1999). Although the criteria of the American Psychiatric Association (1994) are very specific a child or adolescent may experience symptoms or display behaviors that are not acknowledged in the criteria (Carlson, 1995; Empfield & Bakalar, 2001; Hockey, 2003).

According to the American Psychiatric Association (1994) Major Depressive Disorder is diagnosed if five of the nine following symptoms are present for at least two weeks:

1. Depressed or irritable mood (only for children or adolescents)
2. Loss of pleasure in activities
3. Feelings of worthlessness or guilt
4. Inability to concentrate or make decisions
5. Excessive movement or slow movements
6. Fatigue or lack of energy
7. Sleep difficulties
8. Weight gain or loss
9. Suicide attempts or thoughts about suicide

It is also specified that one of the symptoms that must be present be either depressed/irritable mood or loss of pleasure in activities.

This criterion was originally established for diagnosing adults and therefore a few adjustments should be made in recognizing Major Depressive Disorder in children and adolescents (Fristad & Goldberg-Arnold, 2004; Hockey, 2003; Merrell, 2001). To begin

with, irritability or aggressiveness is often seen in children and adolescents rather than depressed mood or sadness because they have a more difficult time communicating their feelings (Friedberg & McClure, 2002). Additionally, children and adolescents are likely to have somatic complaints such as headaches, stomachaches, backaches, and bowel disturbances (Empfield & Bakalar, 2001; Merrell, 2001). Finally, a failure to make expected weight gains is often substituted for the symptom of weight gain or loss when working with children (Hockey, 2003; House, 1999; Merrell, 2001; Schroeder & Gordon, 2002).

There are also symptomology differences between children and adolescents. For instance, adolescents are more likely to have a preoccupation with death and have lethal suicide attempts (Friedberg & McClure, 2002; Merrell, 2001). Furthermore, they are more likely to verbalize their feelings and symptoms, have weight changes, and loose interest in activities (Curry & Reinecke, 2003; Friedberg & McClure, 2002).

There are several symptoms that the American Psychiatric Association (1994) does not include in their description of Major Depressive Disorder (Carlson, 1995; Fristad & Goldberg-Arnold, 2004; Hockey, 2003; Lock, 1997; Papolos & Papolos, 1999). For example, sensitivity to criticism or correction is something that many children and adolescents with Major Depressive Disorder experience (Carlson, 1995). They can be very sensitive to what others say about or to them and may interpret any negative comments into meaning that they are bad people. They may also experience self-hating or self-defeating thoughts and pessimism in most situations (Hockey, 2003). Additionally, they may have a low tolerance for frustration when they can not do things or when there are sudden changes in routines. At this point temper tantrums may be used

by the child or adolescent to cope with the situation (Carlson, 1995). It is also possible for a delay in language development or developmental regression in previously learned behaviors, such as potty training, to occur (Friedberg & McClure, 2002). In more severe cases delusions or hallucinations may occur which would be referred to as "Psychotic Depression" and the child or adolescent would most likely need to be hospitalized (Empfield & Bakalar, 2001). These symptoms are important but singular occurrences of them do not indicate that Major Depressive Disorder is the correct diagnosis. The symptoms need to occur in a cluster and the duration should be at least two weeks to make sure the child or adolescent is not reacting to a situational event. It is also important to note that even though there is a cluster of symptoms some are going to be stronger and clearer than others (Debattista, Solvason, & Schatzberg, 1998).

Attention Deficit Hyperactivity Disorder (ADHD) is commonly confused with cases of Major Depressive Disorder where psychomotor agitation (restlessness and constant movement) is one of the strong symptoms (Merrell, 2001). It is important to look at all of the other symptoms that the child or adolescent is experiencing and see which fits best for him or her. Usually in Major Depressive Disorder irritability and loss of interest in activities occur where as in ADHD intense impulsivity and excess motor activity are the main symptoms (Merrell, 2001). It may also be the case that the child or adolescent is experiencing both disorders and it would be important to diagnose and treat both of them (Fristad & Goldberg-Arnold, 2004).

Dysthymic Disorder has similar symptoms to Major Depressive Disorder but they are less severe and they last much longer. In fact, the long duration of the symptoms can lead the child or adolescent to believe that it is a personality trait or that something is

wrong with whom she or he is (Debattista, Solvason, & Schatzberg, 1998; Merrell, 2001). This makes Dysthymic Disorder very difficult to detect and treat because many people do not see a change from previous behavior or an immediate need to change things. The American Psychiatric Association (1994) identifies Dysthymic Disorder with the following criteria:

1. Depressed or irritable mood most days
2. Insomnia or sleeping too much
3. Low energy
4. Inability to concentrate or make decisions
5. Low self-esteem
6. Hopelessness
7. Poor appetite or eating too much

Depressed or irritable mood and two to three of the six other symptoms must be present for at least a year with no more than two months free of the. Again, this list was made for adults and children and adolescents may experience restlessness, aggressive behavior, and complaints of backaches, stomachaches, and headaches (House, 1999). The other main difference is that adults must experience the symptoms for at least two years and irritability is not a listed symptom for them (Merrell, 2001).

About ten percent of children and adolescents diagnosed with Dysthymic Disorder will develop Major Depressive Disorder and then cycle back to Dysthymic Disorder, never experiencing normal or happy emotions (Merrell, 2001). When Major Depressive Disorder is superimposed on Dysthymic Disorder the diagnosis is referred to as “dual depression” or “double depression” (American Psychiatric Association, 1994;

House, 1999; Merrell, 2001). Because of the longevity of the disorder approximately fifteen percent of children and adolescents fail to develop appropriate coping mechanisms and turn to drugs and alcohol for relief (Fristad & Goldberg-Arnold, 2004).

Risk Factors for Depressive Disorders

There are several risk factors that could lead a child or adolescent to developing a depressive disorder. Some of the risks factors are a family history of depression, a history of parental alcoholism, experiencing the loss of a loved one before age thirteen, chronic illness, trauma (prolonged stress can change the brain's chemistry), and continuous parent-child conflict (Hockey, 2003; Lock, 1997). Naparstek (2002) explains that single parent homes, low socioeconomic status, a high number of negative life events, poor sibling relationships, and parenting styles are also risk factors. There are three parenting styles that Naparstek (2002) specifies as potential risk factors. One is a parent's difficulty in communicating and expressing emotions and affection. Another is an inconsistent and negative disciplinary method and the final is increased controlling and rejecting interactions between parent and child or adolescent. Some of the other risk factors are a parent struggling with a mental disorder, a lack of a stable value system, and if the child or adolescent has other mental health problems such as anxiety disorders, Obsessive Compulsive Disorder, ADHD, or Oppositional Defiant Disorder (Hockey, 2003). A final risk factor to be aware of is the thought patterns of the child or adolescent. In children this may be difficult to detect because of their lack of verbal fluency however, in adolescents this should be monitored (Merrell, 2001). There are three different patterns of cognitive thoughts. One is learned helplessness where the world is viewed as having complete control over everything and they have no control over anything.

Another pattern is negatively thinking about everything and the final is the Self-Control Model. In this model there is a focus on negative versus positive things, attention is given to immediate consequences versus delayed consequences, there are perfectionist and unrealistic expectations, and they punish themselves more than they reward themselves (Merrell, 2001). Identifying and becoming familiar with all of these risk factors can reduce the chances of a child or adolescent developing a depressive disorder because some of the risks can be changed or prevented from getting worse (Hockey, 2003).

Treatments of Depressive Disorders

Depressive disorders do not just go away on their own where some people believe that if they wait long enough the child or adolescent will snap out of it (Fristad & Goldberg-Arnold, 2004). Major Depressive Disorder lasts for an average of seven to nine months which is almost an entire school year where the child or adolescent can miss out in important academic and social development (Empfield & Bakalar, 2001; Thorpe et al., 2001). Therefore, early, effective treatment is extremely important. Depressive disorders have biological, psychological, and social components to them so treatments such as pharmacological, psychosocial, electroconvulsive therapy (ECT), and alternative treatments have been developed to concur each of these components (Fristad & Goldberg-Arnold, 2004). Pharmacological and psychosocial treatments are the most commonly used and are often used to supplement one another (Forness, Walker, & Kavale, 2003).

Pharmacological treatments have become a very popular treatment and many different classes of medications have been developed and used to treat depressive

disorders (Debattista, Solvason, & Schatzberg, 1998; Thorpe et al., 2001). The selective serotonin reuptake inhibitors (SSRIs) such as Prozac, Zoloft, Paxil, Luvox, Lexapro, and Celexa, are the newest and most commonly used class of medications (Empfield & Bakalar, 2001). They are usually tried first in children and adolescents because they have the least amount of serious side effects and they have been researched more often in this age group (Empfield & Bakalar, 2001; Forness, Walker, & Kavale, 2003). Naparstek (2002) states that Zoloft tends to be the first one that is tried from this class of medications because it has been extensively researched. Some of the less serious side effects of the SSRIs are dry mouth, tremors, weakness, drowsiness, insomnia, agitation, nausea, dizziness, and stomachaches. The serious, less common side effects are triggering manic episodes or suicide attempts and seizures (Fristad & Goldberg-Arnold, 2004). The SSRIs do take approximately two to eight weeks to begin to notice any changes in symptoms and doses of the medication may need to be adjusted if there is not a change in this time period (Naparstek, 2002).

Another class of medications are the atypical antidepressants (they are not like other classes and they are not like each other) which are Wellbutrin, Effexor, Serzone, Remeron, and Desyrel (Empfield & Bakalar, 2001). Wellbutrin is often used if ADHD and a depressive disorder are present at the same time and it is also less likely to trigger manic episodes. The drawbacks of Wellbutrin are that it is at higher risk for inducing seizures and can cause or worsen tics, insomnia, and irritability (Fristad & Goldberg-Arnold, 2004). Remeron, Serzone, and Desyrel are more sedating and can be used with children who have sleeping difficulties (Fristad & Goldberg-Arnold, 2004).

Tricyclic antidepressants (TCAs) is another class of drugs that can be used if the

SSRIs do not seem to be effective (Forness, Walker, & Kavale, 2003). The brand names in this class are Elavil, Pamelor, Tofranil, and Anafranil (Debattista, Solvason, & Schatzberg, 1998; Fristad & Goldberg-Arnold, 2004). The main concern with using this class of mediations with children and adolescents is that cardiac conduction problems have been associated with them (Thorpe et al., 2001).

The final, oldest class of antidepressant medications is the Monoamine Oxidase Inhibitors (MAOIs) such as Nardil, Parnate, Marplan, and Eldepryl (Empfield & Bakalar, 2001). These medications are very rarely used with adolescents and never used with children partly because of the strict dietary restrictions while taking this drug (Empfield & Bakalar, 2001; Fristad & Goldberg-Arnold, 2004). This drug works differently than other antidepressants and should not be taken with the other classes (Empfield & Bakalar, 2001).

There are also a variety of psychosocial techniques that are available to treat depressive disorders. Cognitive-Behavioral Therapy (CBT), Interpersonal Therapy (IPT), Social Skills Training, Emotional/Affective Education, and Problem Solving are all examples of these techniques that are commonly used with children and adolescents (Carlson, 1995; Curry & Reinecke, 2003; Empfield & Bakalar, 2001; Forness, Walker, & Kavale, 2003). CBT and IPT are used most often and more empirical support has been established for them. They are both brief in duration and directive (Empfield & Bakalar, 2001; Thorpe et al., 2001). It is common for these psychosocial techniques to be combined and used to compliment one another.

CBT has been derived by combining the techniques of a cognitive approach and a behavioral approach to address a variety of the symptoms associated with depressive

disorders (Curry & Reinecke, 2003; Merrell, 2001). There are several variations of cognitive approaches but the common assumption is that negative, automatic thought patterns and maladaptive belief systems create depressive symptoms. These symptoms can be relieved by challenging the thoughts and creating healthier, more positive and realistic replacement thoughts (Carlson, 1995; Curry & Reinecke, 2003; Friedberg & McClure, 2002; Schroeder & Gordon, 2002). Examples of negative thoughts are: always expecting the worst, focusing on unstable external factors to measure success, expecting only perfectionism (makes decisions very difficult), thinking that bad things will happen over and over again (overgeneralization), disqualifying positive events and focusing on the negative, magnifying the difficulties of every situation, and jumping to conclusions even though there is little evidence to support it (Carlson, 1995; Empfield & Bakalar, 2001; Friedberg & McClure, 2002).

Merrell (2001) states that one of the most commonly used models of cognitive therapy is Aaron Beck's Model, which involves four steps. The first step is to focus on emotions and their variations throughout the day, which can be done by keeping a daily mood log or by journal writing. Merrell (2001) emphasizes that the different emotions and personal emotional awareness needs to be taught to younger children. A suggestion is made of using an emotional thermometer where a situation is described and a child would pick an emotion for that situation and where that emotion would lie on the thermometer. The second step is to detect automatic thoughts by using thought charts and using cognitive replay (think of a negative situation and thoughts that occur during it). The third step is to evaluate how realistic and helpful the thoughts are and how much evidence is there to support them. The final step is to replace the thoughts with more

realistic, positive alternatives. This model was originally developed for adults and has been applied to adolescents and children. However, it is more effective with adolescents and older children because of the interpersonal awareness and higher cognition levels that are used (Thorpe et al., 2001). Some adaptations should be made when applying cognitive therapy to older children and adolescent. Examples of these adaptations are finding a psychiatrist or counselor trained in working with this age group, developing psychoeducational sessions on emotions and depressive disorders, including family members in the process, and acknowledging and treating co-occurring disorders (Curry & Reinecke, 2001; Merrell, 2001).

Behavioral approaches are much more applicable to the developmental levels and abilities of younger children and are also particularly useful in a school setting. Behavioral techniques focus on reducing behaviors that are associated with depression and increasing positive behaviors. Some of the positive behaviors are smiling, making eye contact with others, volunteering to participate in class, leading activities, using positive self statements, and complimenting others (Merrell, 2001). The goal is for these behaviors to be reinforcing; however the goal may need to start out smaller such as using tangible rewards or social praise to encourage the behaviors (Curry & Reinecke, 2003). Furthermore, the behavioral approach assists in developing social and problem solving skills and preventing isolation (Curry & Reinecke, 2003). One way this is done is by developing activity schedules for the day or week with the child or adolescent. Activities can be found by looking at activities that use to be fun for the child or adolescent or that peers and television characters like to do (Friedberg & McClure, 2002). It is also helpful to have the child or adolescent record on the activity schedule what moods she or he is

experiencing during the activities. Merrell (2001) suggests using pictures or stickers for younger children and informing the parents about the schedule so they can help encourage and reinforce the activities.

Another type of psychosocial treatment is Interpersonal Therapy (IPT) which works on communication skills and improving the child or adolescent's relationships by focusing on currently occurring problems (Empfield & Bakalar, 2001). This approach attends to how behaviors that the child or adolescent is engaging in makes him feel versus the cognitive approach that looks at how thoughts make him feel. Some of the techniques involved in this approach are reassurance, clarification of emotional states, and improvement of interpersonal communication (Carlson, 1995). The interpersonal problems that are usually the focus of treatment are new transitions, grief, resolving disputes, and communicating effectively with others (Empfield & Bakalar, 2001).

Some of the other psychosocial treatments are emotional/affective education, social skills training, and problem solving. These are great intervention techniques and they are excellent prevention techniques particularly for children. Some experts indicate that a lack of skills in these areas can result to depressive symptoms and later on a depressive disorder (Hockey, 2003). Emotional/affective education is often used in the first step of a cognitive approach, but can be a part of a prevention program in a school through teachers and school counselors. The information that is usually covered is comfortable and uncomfortable feelings, learning to express feelings, identifying and expressing feelings, and reacting to emotional situations (Merrell, 2001). Social skills training develops skills in communication and interacting with others by role playing, modeling, direct instruction, or story telling. Topics that particular sessions may address

are assertiveness, maintaining eye contact, proper facial expressions, giving compliments, conflict resolution, and reading body language (Friedberg & McClure, 2002). Problem solving is often very difficult for a child or adolescent with a depressive disorder and educating the child on both good and bad problem solving methods can assist with this difficulty (Friedberg & McClure, 2002). Some poor problem solving skills that may be extensively used by a child or adolescent with a depressive disorder are avoidance of the problem, a need to control the situation, always taking responsibility for the problem, and minimizing problems. The use of these by the child or adolescent can be decreased by teaching them assertiveness versus aggressive and passive skills and teaching them to respect another person's point of view (Merrell, 2001).

There are several alternative treatments such as St. John's Wort, SAMe, omega-3 fatty acids, EM powerplus, and light therapy available for the treatment of depressive disorders. St. John's Wort and SAMe are herbal remedies and have been empirically supported for adults but their effects on children and adolescents are unknown. The Food and Drug Administration (FDA) has not approved them and therefore their purity and correct dosage amount is variable within and between brands (Fristad & Goldberg-Arnold, 2004). For these reasons extreme caution should be taken in considering them and administering these treatments to adolescents and children (Empfield & Bakalar, 2001). Omega-3 fatty acids and EM powerplus (a broad spectrum mineral-vitamin complex) are dietary supplements that assist in decreasing the severity of symptoms of depressive disorders. They should not be used as the sole treatment in severe cases but sometimes will assist in very mild cases (Fristad & Goldberg-Arnold, 2004). Light therapy is mainly used in cases where the depressive symptoms worsen in fall and winter

months. It involves sitting in front of a light box for forty-five minutes two to three times a day (Fristad & Goldberg-Arnold, 2004).

The final and most controversial treatment for depressive disorders is Electroconvulsive Therapy (ECT). This treatment is sometimes used with adults, rarely with adolescents, and should never be used with children (Thorpe et al., 2001). It is used in severe cases when several trials of medications have not been effective and a second opinion from a psychiatrist or physician should be obtained (Empfield & Bakalar, 2001; Thorpe et al., 2001). The treatment involves administering anesthesia and then an electric shock is supplied to the brain (unilaterally or bilaterally) creating a seizure (Fristad & Goldberg-Arnold, 2004). There are some modifications that should be made for adolescents. One is anesthesia that is associated with shorter seizures should be used such as thiopentone, methohexitone, and profofol. Furthermore, a brief pulse wave should be used because the seizure should not last greater than two minutes. Finally, adolescents should only undergo six to twelve sessions (Thorpe et al., 2001). The side effects of this procedure are short term memory loss (should not last longer than two months), headaches, and rarely a persistent memory loss occurs (Empfield & Bakalar).

All in all, a variety of treatments are available for depressive disorders many which can be combined and some modifications need to be made when working with children and adolescents. It is important to detect and treat these disorders early because of the profound effect they can have on their lives.

Symptoms and Diagnosis of Bipolar Disorders

Bipolar disorders (previously referred to as manic-depressive disorders) have recently become more recognized in children and adolescents. According to Papolos and

Papolos (1999) approximately fifty percent of youth diagnosed with a depressive disorder will develop a bipolar disorder. However, an accurate diagnosis of a bipolar disorder in children and adolescents is extremely difficult to accomplish for several reasons. To begin with, children and adolescents struggling with a bipolar disorder display different symptoms than adults and the diagnostic criteria is directed towards adults (Birmaher, 2004; Carlson, 1995; Efrain, 1991; Papolos & Papolos, 1999; Scholzman, 2002). Additionally, a bipolar disorder usually begins with the development of Major Depressive Disorder and treatment is then focused on the depressive part of the disorder but the manic part is neglected or overlooked when the symptoms emerge (Fristad & Goldberg-Arnold, 2004; Seligman & Moore, 1995). Furthermore, each child or adolescent is unique in his or her specific symptoms and in the duration, severity, and frequency of those symptoms. Finally, other disorders such as ADHD and Schizophrenia can be confused with bipolar disorders because of their overlapping symptoms (Birmaher, 2004; House, 1999; Papolos & Papolos, 1999).

Bipolar disorders involve the cycling back and forth between a Manic or Hypomanic Episode and a depressive disorder. A Manic Episode can involve several different symptoms. The American Psychiatric Association (1994) specifies these symptoms to be grandiose ideas, decreased need for sleep, increased talking, racing thoughts, distractibility, increased goal directed activity, and participating in high risk or dangerous activities. For a formal diagnosis to be made three to four of these symptoms must be present with an expansive, irritable, or elevated mood. The unrestrained elevated mood may be demonstrated in behaviors such as excessive giggling, uncontrollable laughter over things that are not appropriate to be laughing at, and overexcitement

(Birmaher, 2004; Carlson, 1995). The irritable mood is much different than the irritability that is seen in depressive disorders. Uncontrollable anger and rage is felt, which can create long, intense temper tantrums. These tantrums can be provoked by the child or adolescent not getting his way, if he is interrupted from doing something, or if things are not exactly the way he wants them to be (Birmaher, 2004).

Grandiose ideas involve a very high self-esteem and overconfidence. The children or adolescents may believe they can do things that are not very realistic such as being a movie star or taking over the school as the principal (Fristad & Goldberg-Arnold, 2004; Schroeder & Gordon, 2002). The decreased need for sleep means that even though only a few hours of sleep a night are obtained energy levels remain constant and/or elevated (Schlozman, 2002). Unusual talkativeness can involve talking a lot, talking very rapidly, or talking inappropriately loud and it is very difficult to interrupt the child or adolescent (Debattista, Solvason, & Schatzberg, 1998). One explanation for the excessive talking may be the numerous thoughts that are racing through the mind of the person experiencing a Manic Episode (Birmaher, 2004). These thoughts can be related but are very rapid or they can be completely unrelated. This is where the person can become very creative and be successful at developing new ideas and beginning new projects. However, when the Manic Episode subsides and the depressive disorder begins these projects remain unfinished (Papolos & Papolos, 1999). Reckless, impulsive behaviors could include sexual promiscuity, spending large sums of money, shoplifting, vandalism, breaking the law, driving recklessly, and jumping out of vehicles while they are moving. Judgment of the child or adolescent is significantly impaired creating danger and therefore hospitalization is required to protect him or her (Birmaher, 2004; Empfield

& Bakalar, 2001; Papolos & Papolos, 1999; Seligman & Moore, 1995).

The diagnostic criterion was developed for adults and the symptoms are manifested differently in children and adolescents (Birmaher, 2004; Carlson, 1995; Empfield & Bakalar, 2001; Fristad & Goldberg-Arnold, 2004; Papolos & Papolos, 1999; Schlozman, 2002). The cycles of children and adolescents, most often, are much more rapid and continuous whereas adults have longer lasting, fewer Manic Episodes a year. The episodes in adults can last anywhere from two and a half to four months and they may only have two or four in a year (Seligman & Moore, 1995). On the other hand, children and adolescents can change moods within a few minutes with a manic phase lasting a couple hours therefore experiencing numerous cycles in a day (Birmaher, 2004; Fristad & Goldberg-Arnold, 2004; Schlozman, 2002). Children and adolescents also show more signs of anger and rage creating extreme temper tantrums along with inflexible and oppositional behaviors (Papolos & Papolos, 1999). Finally, Mixed Episodes are often faced by children and adolescents where the two extremes of depressive symptoms and manic symptoms are experienced at the same time (Carlson, 1995; Debattista, Solvason, & Schatzberg, 1998; Schlozman, 2002). An example of this may be that the child or adolescent has suicidal thoughts and a low self-esteem but also engages in dangerous activities and sleeps very little without fatigue.

There are many other symptoms and behaviors that are seen in children and adolescents that are not addressed in the diagnostic criterion. Papolos and Papolos (1999) collected information, through a survey, from parents with a child or adolescent struggling with a bipolar disorder. There were several common symptoms or behaviors seen among this age group. Some of these behaviors included a fear of death and

annihilation, bedwetting or smearing feces around the house, calling one nine hundred numbers with sexual connotations to them, and acting very goofy. Approximately seventy percent of the children or adolescents were reported to have difficulty with peer relationships because they were too bossy, controlling, and aggressive. Other common behaviors were intense cravings of sweets and carbohydrates, heat intolerance, night terrors (nightmares inducing a semi-conscious, fearful awakening), and sensitivity to stimuli. The reported stimuli were sight, touch, sound, and smell where the parents indicated that their children would many times have to remove themselves immediately from the situation.

In severe cases of Manic Episodes psychotic symptoms such as hallucinations and delusions occur (Birmaher, 2004; Carlson, 1995; House, 1999; Fristad & Goldberg-Arnold, 2004; Papolos & Papolos, 1999). When a person can see, hear, smell, or taste things that others can not he or she is experiencing hallucinations. More specifically, children or adolescents may hear voices telling them to do things, they may see a person and talk with that person, or they might feel as though someone is touching them (Birmaher, 2004). According to Papolos and Papolos (1999) hearing voices and having conversations with people that are not there are most commonly experienced and visual hallucinations are often satanic figures. Delusions are believing or thinking things that are not true (Birmaher, 2004). These delusions could be grandiose delusions where the belief is that special powers such as being able to fly or indestructibility are held or paranoid delusions could be present where the belief of the individual is that people are after him or her (Birmaher, 2004). Hallucinations and delusions are different than normal fantasies or fears that children have. Some children will see shadows in the night and

interpret them as monsters, which is different than seeing things that are not there. Additionally, most children fantasize about being a famous person or that they are superheroes. The difference here is that children who are experiencing delusions believe that they are true and will act on them (Birmaher, 2004; Schroeder & Gordon, 2002).

If the symptoms present are similar to those of a Manic Episode but their severity is mild or moderate then a diagnosis of a Hypomanic Episode might be appropriate. A Hypomanic Episode is an elevated or irritable mood but much less severe and intense than a Manic Episode (Birmaher, 2004; Debattista, Solvason, & Schatzberg, 1998; House, 1999). The required duration for an official diagnosis of this episode is four days versus the week for a Manic Episode (House, 1999). In fact, individuals experiencing a Hypomanic Episode can function fairly well in most areas of their lives with the exception of some possible social problems (Fristad & Goldberg-Arnold, 2004; Merrell, 2001). In comparison to the depressive symptoms a person experiencing a Hypomanic Episode can concentrate better, becomes creative, has more energy, and becomes more outgoing. Birmaher (2004) suggests that this makes the Hypomanic Episode enticing because of the surge of energy and productivity that occurs and treatment is frequently resisted. However, these Hypomanic Episodes can turn into a more severe Manic Episode so encouragement of treatment is highly recommended (Papolos & Papolos, 1999).

Specific bipolar disorders such as Bipolar Disorder I, Bipolar Disorder II, Cyclothymia, and Bipolar Disorder Not Otherwise Specified are diagnosed according to which depressive disorder is present and whether a Manic or Hypomanic Episode is diagnosed. Bipolar Disorder I involves the occurrence of Major Depressive Disorder

with cycles of Manic Episodes whereas Bipolar Disorder II is the occurrence of Major Depressive Disorder with a Hypomanic Episode (American Psychiatric Association, 1994). Cyclothymia is less intense and less severe where Dysthymic Disorder and Hypomanic Episodes are present. However, either the depressive or the manic parts can become more severe and therefore the diagnosis would change (Seligman & Moore, 1995). Most children and adolescents do not meet the minimum manic length requirements, due to their continuous cycling, so they are diagnosed with Bipolar Disorder Not Otherwise Specified (Birmaher, 2004; Fristad & Goldberg-Arnold, 2004).

Disorders that Mimic Bipolar Disorders

The extreme and rapid fluctuations of depressive and manic episodes in bipolar disorders provoke several behaviors and symptoms that are similar to other disorders making it difficult to differentiate between them. Disorders that commonly mimic bipolar disorders are ADHD, Schizophrenia, Oppositional Defiant Disorder, and Conduct Disorder (Birmaher, 2004; Efrain, 1991; Empfield & Bakalar, 2001; Papolos & Papolos, 1999).

Children and Adolescents experiencing a Manic Episode have excessive amounts of energy making it very difficult for them to sit still, pay attention, and make good judgments. The key symptoms in ADHD are hyperactivity, fidgeting, inattentiveness, and impulsivity. Therefore, the overlapping symptoms are hyperactivity, impulsivity, short attention span, irritability, lack of judgment, and daring behaviors (Birmaher, 2004; Efrain, 1991). Another reason these disorders are confused with each other is many children who struggle with ADHD also experience depressive disorders so both behaviors are present. Moreover, medications for ADHD only stay in the blood stream

for short periods of time so the child appears to be experiencing two moods, a calm more subdued mood and then when the medications wear off the hyper and restless activities. These medications for ADHD are stimulants and can cause excessive irritability similar to the anger seen in bipolar disorders (Birmaher, 2004). In contrasting the two disorders, bipolar disorders often involve more intense irritability creating longer and more severe temper tantrums and the tantrums are forced by the child or adolescent being denied something. On the other hand, ADHD involves shorter temper tantrums that are created by over stimulation of information (Papolos & Papolos, 1999). Furthermore, besides the appearance of mood fluctuations created by the short lived effects of the drugs children and adolescents with ADHD do not fluctuate in their symptoms and moods (Birmaher, 2004). The other symptoms that exist in bipolar disorders that are not seen in ADHD are elation, grandiose delusions, decreased need for sleep, hallucinations, creativity, and strong sexual interests. Additionally, Lithium (a mood stabilizer) will have an effect on the symptoms of bipolar disorders but not ADHD (Birmaher, 2004; Papolos & Papolos, 1999). Papolos and Papolos (1999) suggest that before a diagnosis of ADHD is formally made an analysis of the possible presence of a mood disorder should occur.

Schizophrenia is commonly confused with cases of bipolar disorders involving symptoms of hallucinations and delusions (Birmaher, 2004; Efrain, 1991; House, 1999; Papolos & Papolos, 1999). Many people believe that any signs of hallucinations or delusions automatically require a diagnosis of a psychotic disorder. However, other disorders do involve these symptoms inclusive to bipolar and depressive disorders and an inaccurate diagnosis would lead to inaccurate treatment and a unneeded lengthening of suffering (Papolos & Papolos, 1999). The type of hallucinations and delusions are

different in each of the disorders. Schizophrenia involves more complex hallucinations that are not related to moods whereas in bipolar disorders the kinds of delusions and hallucinations are related to the moods. More specifically, when children or adolescents are experiencing the depressive symptoms their hallucinations may be that voices are telling them how horrible they are and how they should hurt themselves. If a Manic Episode is present the hallucinations may be voices telling them that people are out to get them due to jealousy (Birmaher, 2004). To distinguish the disorders it is important to look at the family history because both disorders have shown strong connections to genetic links (House, 1999; Papolos & Papolos, 1999). Schizophrenia also involves a flat affect, low ability to function in life, strange or bizarre behaviors, a lack of motivation, and illogical thought patterns. Children and adolescents with bipolar disorders are often higher functioning and their moods fluctuate in contrast to the flat affect of Schizophrenia (Birmaher, 2004). The American Psychiatric Association (1994) added Schizoaffective Disorder because of the common confusion between these disorders.

Oppositional Defiant Disorder (ODD) and Conduct Disorder are defined by the presence of defiant, negative, and hostile behaviors with Conduct Disorder being more extreme and more severe than ODD (Fristad & Goldberg-Arnold, 2004). Examples of ODD behaviors are arguing, irritability, aggression, temper tantrums, and noncompliance. On the other hand, Conduct Disorder behaviors involve physical aggression towards people and animals, violations of laws, destroying property, stealing, and lying. Birmaher (2004) has outlined some ways to differentiate these disorders from bipolar disorders. First, if the behaviors and symptoms are parallel with the fluctuations in moods then a mood disorder would be a proper diagnosis. Additionally, if the behaviors

are not constant and the child or adolescent does not respond to treatment of ODD or Conduct Disorder it is likely that a mood disorder is present. Furthermore, look for a family history of mood disorders and pay attention to whether or not sleep is being affected. If sleep is being affected most likely a mood disorder is present especially if there are intervals of decreased sleep without fatigue. Finally, the presence of mood disorders should be thoroughly evaluated if hallucinations and delusions are present.

Before a diagnosis is made of ADHD, Schizophrenia, ODD, or Conduct Disorder a possibility of a bipolar disorder should be carefully examined. It is important that both parents and school personnel are involved with this process because they have observed these children and adolescents in several different situations and longer periods of time, which gets a more holistic view of the situation. The short visits to the office of a psychiatrist may not be accurate displays of the child or adolescent's true behavior (Birmaher, 2004).

Risk Factors for Bipolar Disorders

There are a few risk factors that could lead to the development of a bipolar disorder. One risk is a family history of bipolar disorders, especially if both parents have experienced the disorder (Efrain, 1991; Fristad & Goldberg-Arnold, 2004). This is important information in making an accurate diagnosis because if there are several symptoms present that look like other disorders then a strong conclusion can be drawn of the presence of a bipolar disorder if it tends to develop in the family (Birmaher, 2004). Another risk is a very early onset of a depressive disorder especially if psychotic features are present (Efrain, 1991). The final risk is if mania or hypomania is generated by drugs such as antidepressants, steroid medications, Pseudoephedrine in cold and cough

remedies, caffeine, cocaine, and ecstasy (Cicero, El-Mallakh, Holman, & Robertson, 2003; Efrain, 1991; Fristad & Goldberg-Arnold, 2004). These risk factors should be taken seriously and a careful monitoring of moods should occur if any of the factors are present.

Treatments of Bipolar Disorders

There are several pharmacological treatments available to treat bipolar disorders. Some of these medications need careful monitoring and the side effects can be debilitating. The oldest, most widely used medication for bipolar disorders is a mood stabilizer called Lithium which is used to manage the manic episodes (Fristad & Goldberg-Arnold, 2004; Naparstek, 2002). When this medication is used it must be monitored by consistently testing blood samples to check on its therapeutic effect and to make sure that it does not reach toxicity where the levels of the medication are too high and begin to affect organs (Fristad & Goldberg-Arnold, 2004; Papolos & Papolos, 1999). Signs of Lithium toxicity are fatigue, sleepiness, confusion, weakness, heaviness of limbs, slurred speech, hand tremors, and muscle twitches (Papolos & Papolos, 1999). Caution must also exist when taking other medications with Lithium because they may increase or decrease the amount of Lithium in the blood. Additionally, Lithium could have an effect on they way that the other medication is reacting in the body. Some medications to be avoided are diuretics, anticonvulsants, anti-psychotics, anti-inflammatories such as ibuprofen, and antibiotics (Birmaher, 2004; Fristad & Goldberg-Arnold, 2004). Furthermore, a low sodium diet should be avoided and plenty of water needs to be provided to the body to protect damage to the kidneys from this medication (Papolos & Papolos, 1999). There are some of the less severe, common side effects to

this drug which are likely to go away when the body has adjusted to the Lithium. These side effects include nausea, cramps, fatigue, weakness, dry mouth, diarrhea, vomiting, and weight gain (Birmaher, 2004; Fristad & Goldberg-Arnold, 2004).

Another type of medication that has proven to control the manic symptoms are anticonvulsants such as Depakote and Tegretol. These also need to be carefully monitored by withdrawing blood because they can impact the liver if the levels of them are too high (Fristad & Goldberg-Arnold, 2004; Schlozman, 2002). Signs of toxicity to the liver are nausea, vomiting, fatigue, swelling in ankles, and easily bruised skin (Papolos & Papolos, 1999). Depakote is commonly used to treat children and adolescents because it seems to control the rapid fluctuations in moods more effectively (Papolos & Papolos, 1999). Caution in diet should be taken when giving this medication to children because in can cause an intense appetite increase and therefore rapid weight gain (Birmaher, 2004). Moreover, blood cell and platelet counts along with serum iron concentration should be monitored carefully when a child or adolescent is using Depakote (Papolos & Papolos, 1999). Tegretol focuses on decreasing aggressiveness and can be very helpful in controlling the rage and temper tantrums. The main concern with this medication is Aplastic Anemia where there is a sensitivity to light, fever, sore throat, and purple spots on the skin (Papolos & Papolos, 1999).

Finally, anti-psychotics are used to treat some of the symptoms in bipolar disorders. There are two classes of anti-psychotics which are the older class that only affect the dopamine in the brain and the newer, atypical anti-psychotics that effect the dopamine and serotonin levels in the brain (Birmaher, 2004). The atypical anti-psychotics are most commonly used to treat bipolar disorders because the side effects are

much less severe and also mood levels are most likely to be leveled more because of the effects of the medications on the serotonin levels in the brain (Fristad & Goldberg-Arnold, 2004). Papolos and Papolos (1999) do state that the older class is used in more severe cases where intense hallucination and delusions occur. However, it is added that the movement disorders (e. g. Tardive Dyskinesia, Akathisia, and Akinesia) that these drugs create are very uncomfortable and difficult to live with. Some of the more commonly used newer medications are Risperdal, Zyprexa, Seroquel, Geodon, Abilify, and Clozaril (Birmaher, 2004; Fristad & Goldberg-Arnold, 2004). Common side effects with these drugs are an increase in appetite, drowsiness, abnormal movements, tremors, low blood pressure, and dizziness. These should go away within the first month of treatment (Birmaher, 2004).

It is important to note that psychosocial treatments should be applied to decrease and manage the depressive and manic symptoms. The same techniques that are used in depressive disorders can be applied to bipolar disorders. However, in regard to CBT the thoughts that may need to be managed during a manic phase would be the grandiose or paranoid thoughts, but the process would still be the same (Fristad & Goldberg-Arnold, 2004; Papolos & Papolos, 1999; Psychosocial treatments of bipolar disorder, 2004).

The Role of the School Counselor in Treating Mood Disorders

Mood disorders have a profound affect on children and adolescents. Academic problems such as not doing well on tests or class work, failing to hand homework in, or lack of attendance is one area that is likely to be affected (Empfield & Bakalar, 2001; Naparstek, 2002; Schroeder & Gordon, 2002). In fact, students spend more than half of their day in school for three fourths of the year. Therefore, the presence of a mood

disorder is going to tremendously impact their functioning in school. Moreover, mood disorders will affect peer relationships because of the child or adolescent's lack of social skills, inability to cope with or control emotions, and the presence of irritability or angry outbursts (Fristad & Goldberg-Arnold, 2004; Merrell, 2001). A negative self-concept, the occurrence of other mental health disorders, and abuse of drugs and alcohol are also possible effects of a mood disorder (Empfield & Bakalar, 2001; Merrell, 2001). Often there is the presence of poor coping skills and an inability to deal with stressful situations, which could result in suicide or a suicide attempt (Fristad & Goldberg-Arnold, 2004; Schroeder & Gordon, 2002). Not only is the child or adolescent affected by the mood disorder but the whole family is impacted. There might be disagreements between members as to what kind of treatment should be utilized, how much money is spent (treatments can be very expensive), and what discipline methods should be used. Furthermore, if the child or adolescent has several angry outbursts the family might continuously avoid any upsetting situations and can be reluctant to attend social gatherings. Finally, blaming other members of the family and self blame also occur in a family struggling with a mood disorder (Fristad & Goldberg-Arnold, 2004).

Since, school counselors are trained to work with students on behavioral, social, personal, and academic difficulties teachers and parents are likely to turn to them for their expertise (Ramsey, 1994). Lockhart and Keys (1998) state that school counselors did not work with mental health problems as much as they currently are. The needs of students have dramatically changed because of an increase in single parent homes, homelessness, poverty, and heightened rates of emotional and behavioral problems. School counselors are sought out for reasons other than their expertise. Due to economical difficulties,

fewer public services are available and private practices are reluctant to offer sliding scales (Lockhart & Keys, 1998).

For the reasons mentioned above school counselors have many responsibilities to ensure that students and families are receiving appropriate services and interventions. Mood disorders can be complicated; therefore it is important that school counselors become aware of the specific disorders within this group and the criterion established by the American Psychiatric Association in the fourth edition of the *Diagnostic and Statistical Manual for Mental Health Disorders* so they are able to communicate effectively with other professionals and interpret the information to teachers and parents (Malley & Kush, 1994; Ramsey, 1994). School counselors also have the responsibility to become aware of the behavioral indicators of mood disorders and the differences between children and adolescents versus adults. This information can be shared during in service trainings for school personnel and educational groups with parents (Lockhart & Keys, 1998). They should also become familiar with treatment strategies that are effective in working with children and adolescents with a mood disorder because other help might not be available (Herring, 1990). Ramsey (1994) explains that areas such as a poor self-concept, isolation, and self destructive behaviors and cognitions are important to address in the treatment of mood disorders. Finally, Lockhart and Keys (1998) indicate that an awareness of family systems, individual crisis interventions, and mental health assessments should be obtained by the school counselor.

CHAPTER THREE

Summary, Conclusions, and Recommendations

Summary

Mood disorders have only recently become recognized in children and adolescents. The symptoms, behaviors, and diagnostic criterion for children and adolescents are very different than adults with the same mood disorder with only some of them being officially recognized. The differential symptoms that are acknowledged by the American Psychiatric Association (1994) are children and adolescents are more likely to experience irritability versus a sad or depressed mood, they have more somatic complaints, there is a failure to make expected weight gains, and the required length of time for chronic disorders such as Dysthymic Disorder is decreased from two years to one year. Moreover, each child or adolescent can cope with the disorders differently and display different symptoms and behaviors from each other, which can make the detection of mood disorders very difficult. Some children and adolescents might show signs of hopelessness, sadness, and constant sleeping while others are irritable, restless, and have difficulty sleeping.

Mood disorders can be divided into the two different categories of depressive disorders and bipolar disorders. Depressive disorders involve one mood such as sadness or irritability and a loss of interest in activities. Major Depressive Disorder and Dysthymic Disorder are the two most recognized disorders in this category. Major Depressive Disorder is very intense and debilitating where as Dysthymic Disorder is chronic and less intense. The depressed or irritable moods in depressive disorders create behaviors such as tardiness, uncooperativeness, self-mutilation, isolation, and suicide

attempts. There are a wide variety of treatments available for depressive disorders including pharmacological, psychosocial, and alternative methods. Pharmacological treatments have become very popular in treating many disorders in children and adolescents. The SSRIs, atypical antidepressants, and TCAs are commonly used to treat depressive disorders. Cognitive Behavioral and Interpersonal therapies are also used to address negative cognitions and ineffective social skills. Finally, Electroconvulsive Therapy is sometimes used with adolescents who have not benefited from several attempts of other treatments and the depressive symptoms are tremendously impacting their lives.

Bipolar disorders also involve the intense low but there are cycles of intense highs referred to as manic or hypomanic episodes with the later being less severe. During these episodes grandiose thoughts and an elevated mood or increase in irritability occur. Behaviors that are commonly seen during an elevated episode are recklessness, sleeping very few hours a night, and excessive talkativeness. Children and adolescents are more likely to have continuous cycling throughout the day while adults might only experience a few cycles a year with a manic episode lasting a few weeks. Temper tantrums created by the intense rage are also seen in children and adolescents and never in adults. Additionally, several disorders mimic bipolar disorders in children and adolescents such as ADHD, Schizophrenia, and Conduct Disorder. It is very important to be aware of the risk factors of bipolar disorders to assist in the differential diagnosis from these disorders. A family history of bipolar disorders is a strong risk factor and careful monitoring of moods should occur. Also, an early onset of severe Major Depressive Disorder and/or mania induced by antidepressants, caffeine, Pseudoephedrine, or recreational drugs are

risks for later occurrence of a bipolar disorder.

Treatments specifically for bipolar disorders include mood stabilizers and anticonvulsants which need to be carefully monitored by blood tests because toxicity of the drug can occur which effects organs. Antipsychotic medications are also used to control aggressive behaviors and hallucinations or delusions that might be present with the disorder. Psychosocial treatments are used to treat both the depressive and manic phases of the bipolar disorders. Symptoms that need to be specifically addressed during a manic episode are impulsive and reckless behaviors, grandiose cognitions, and anger management.

The role of the school counselor in treating mental health disorders has changed throughout the years. School counselors are now relied upon by school personnel and parents for their expertise in several mental health disorders. This makes it extremely important for them to be aware of the symptoms and specific criterion established for a formal diagnosis of a mood disorder. This knowledge should be communicated to school personnel and parents so they are aware of the impact of mood disorders and how they differ in children and adolescents as opposed to adults. Finally, school counselors should also be aware of different treatments that are used in treating mood disorders and be able to apply them to the specific developmental levels of children and adolescents.

Conclusions

There is extensive availability of literature and research on adults with mood disorders. However, just recently, children and adolescents with these disorders have been addressed in literature. It was once the belief that children and adolescents did not fit into the categorical diagnosis of a mood disorder and now it has become more

apparent that not only do they develop these disorders but they also express the moods, symptoms, and behaviors much differently. School counselors need to be aware of this information so they can share it with staff and parents who turn to them with behaviorally challenged students. The internal discomfort of mood disorders provoke overt behaviors such as defiance, irritability, fidgeting, impulsivity, recklessness, and aggression which could lead to a misdiagnosis of behavioral disorders such as ADHD and Conduct Disorder. A lack of a diagnosis of a mood disorder misdirects treatment and the suffering and development of the child or adolescent is greatly delayed. Clearly, an awareness of mood disorders and their symptoms need to be highly acknowledged.

School counselors have a wide range of responsibilities within the school system with one of them being individual counseling. There is an increase in children and adolescents with emotional and behavioral difficulties and the many types of disorders they struggle with. The amount of time that programs in Guidance and Counseling focus on these topics is minimal and does not prepare the counselor to directly and efficiently treat these disorders as expected and needed by teachers and families. Therefore, it is the responsibility of the school counselor to continuously expand his or her knowledge and expertise in these areas. It would also be important and beneficial to become aware of the outside resources in the area to assist in working with the child or adolescent and the family.

Recommendations

After an extensive review of the literature on mood disorders in children and adolescents a lack of research on this topic has been found. More specifically, many conclusions were drawn in the literature on the basis of adults with the disorders recalling

how their symptoms manifested when they were children and adolescents. Depressive disorders have been more accepted and researched in youth than bipolar disorders. It is recommended that the symptoms, behaviors, and treatments of mood disorders in children and adolescents are studied more closely. It is also recommended that school counselors work towards developing awareness in their school district on these disorders and develop prevention strategies for at risk students. These are very serious disorders which can result in the consequence of death by suicide.

REFERENCES

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Birmaher, B. (2004). *New hope for children and teens with bipolar disorder.* New York, NY: Three Rivers Press.

Carlson, T. (1995). *The suicide of my son: A story of childhood depression*. Duluth, MN: Benline Press.

Cicero, D., El-Mallakh, R. S., Holman, J., & Robertson, J. (2003). Antidepressant exposure in bipolar children. *Psychiatry*, 66(4), 317-322.

Curry J. F., & Reinecke, M. A. (2003). Modular therapy for adolescents with major depression. In M. Reinecke, F. M. Dattillo, & A. Freeman (Eds.), *Cognitive therapy with children and adolescents: A casebook for clinical practice* (2nd ed.) (pp. 95-127). New York, NY: The Guilford Press.

Debattista, C., Solvason, B. H., & Schatzberg, A. F. (1998). Mood disorders. In H. S. Friedman (Ed.), *Encyclopedia of mental health: Volume two* (pp. 721-732). New York, NY: Academic Press.

Hockey, K. P. (2003). *Raising depression free children: A parent's guide to prevention and early intervention*. Center City, MN: Hazelden.

House, A. E. (1999). *DSM-IV diagnosis in the schools*. New York, NY: The Guilford Press.

Efrain, B. (1991). Mood disorders in children and adolescents. *Bulletin of the Menninger Clinic*, 55(2), 182-205.

Empfield, M., & Bakalar, N. (2001). *Understanding teenage depression: A guide to diagnosis, treatment, and management.* New York, NY: Henry Holt and Company.

Forness, S. R., Walker, H. M., & Kavale, K. A. (2003). Psychiatric disorders and treatments. *Teaching Exceptional Children*, 36(2), 42-50.

Friedberg, R. D., & McClure, J. M. (2002). *Clinical practice of cognitive therapy with children and adolescents: The nuts and bolts*. New York, NY: The Guilford Press.

Fristad, M. A., & Goldberg-Arnold, J. S. (2004). *Raising a moody child: How to cope with depression and bipolar disorder*. New York, NY: The Guilford Press.

Herring, R. (1990). Suicide in the middle school: Who says kids will not. *Elementary School Guidance and Counseling*, 25, 129-137.

Lock, J. (1997). Depression. In H. Steiner & I. D. Yalom (Eds.), *Treating school-age children* (pp.65-92). San Francisco, CA: Jossey-Bass Publications.

Lockhart, E. J., & Keys, S. G. (1998). The mental health counseling role of school counselors. *Professional School Counseling*, 1(4), 3-7.

Malley, P. B., & Kush, F. (1994). School-based adolescent suicide prevention and intervention programs: A survey. *School Counselor*, 42(2), 130-138.

Merrell, K. W. (2001). *Helping students overcome depression and anxiety: A practical guide.* New York, NY: The Guilford Press.

Naparstek, N. (2002). *Successful educators: A practical guide for understanding children's learning problems and mental health issues.* Westport, CT: Bergin and Garvey.

Papolos, D., & Papolos, J. (1999). *The bipolar child: The definitive and reassuring guide to childhood's most misunderstood disorder.* New York, NY: Broadway Books.

Psychosocial treatment of bipolar disorder. (2004, March). Harvard Mental Health Letter, 20(9), 4-7.

Ramsey, M. (1994). Student depression: General treatment dynamics and symptom specific interventions. *School Counselor*, 41(4), 256-263.

Schlozman, S. C. (2002). An explosive debate: The bipolar child. *Educational Leadership*, 60(3), 89-90.

Schroeder, C. S., & Gordon, B. N. (2002). *Assessment and treatment of childhood problems* (2nd ed.). New York, NY: The Guilford Press.

Seligman, L., & Moore, B. M. (1995). Diagnosis of mood disorders. *Journal of Counseling and Development*, 74(1), 65-70.

Thorpe, L., Whitney, D. K., Kutcher, S. P., Kennedy, S. H., & CANMAT Depression Work Group. (2001). Special populations. *Canadian Journal of Psychiatry*, 46(5), 635-649.