MOOD DISORDERS IN CHILDREN AND ADOLESCENTS

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HISTORY OF CHILD MENTAL HEALTH

- Until late 1800s
  - Children were mini-adults

- Early 1900s – 1960s
  - Big swing to a developmental model
    - Freud
      - Id, Ego, Superego
    - Piaget
      - Concrete, Formal Operational stages
    - Erickson
      - Series of necessary conflicts
  - Some diagnoses were off limits
    - Depression and anxiety—no superego = no disorder
HISTORY OF CHILD MENTAL HEALTH

- Modern view
  - Mixture of developmental and neuro-chemical approach
  - Adult illnesses in a developing brain
    - Increasing use of adult pharmacotherapy
  - Researched based
    - Many impediments to child brain research
  - Influence of media on belief
    - Fact and fiction
    - Billion dollar supplement industry
HISTORY OF CHILD MENTAL HEALTH

• Factors that impede development
  • Trauma
    • Physical
    • Emotional
  • Environment
    • Rich v. impoverished
    • Passive v. active
  • Exposure
    • Chemicals
    • Stimuli
Physical Development
  - Cephalocaudal
    - Raising/manipulating head before hands before feet
  - Proximodistal
    - Arms before fingers
      - Also, gross motor before fine motor

Social development
  - Mirrors this trend
    - Inward focus moves toward outward focus
CHILDHOOD DISORDERS

- Age 0 – 3
  - Intellectual Disabilities
    - Multi-factorial
  - Autism and Pervasive Developmental Disorders
    - Deficiencies in social and language skills
      - “Emotional blindness”
  - Reactive Attachment Disorder
CHILDHOOD DISORDERS

• Age 3 – 10
  • Disruptive Behavior Disorders
    • Attention Deficit Hyperactivity Disorder
    • Oppositional Defiant Disorder
    • Early onset Conduct Disorder
    • Lecture in three weeks
  • Learning Disorders
    • Reading, Expressive/Receptive Language, Mathematics
  • Mood and Anxiety Disorders
  • Tic Disorders
  • Elimination disorders
CHILDHOOD DISORDERS

• Age 10 – 18
  • Disruptive Behavior Disorders
    • Late onset Conduct Disorder
  • Mood and Anxiety Disorders
  • Emerging Personality Disorders
    • But too early to make diagnosis
    • Developmentally appropriate to have some personality extremes
  • Substance Abuse Disorders
    • Some experimentation is developmentally normal
CHILDHOOD DISORDERS

• Differences from adult disorders
  • Children exist in a family unit
    • More likely to be effected by such than adults
  • More likely to have irritability as a symptom
  • More likely not to be recognized by individual
  • May be differently responsive to treatment
    • Anti-depressants
    • Anti-anxiety meds
    • Therapy
  • May be sub-syndromal for years prior to full onset
    • Mood and psychotic disorders in particular
INCREASE IN CHILDHOOD DISORDERS

• Far more cases of every childhood disorder are made than ever before

• Why?
  • More illness is found and diagnosed
    • Education
      • Health care workers
      • Public
    • Scientific advances
      • Depression
      • Autism
      • Bipolar
INCREASE IN CHILDHOOD DISORDERS

• Why?
  • Availability of Patient-Friendly Treatments
    • Anti-depressants
      • SSRIs
    • ADHD meds
      • Long acting
    • Anti-psychotics
      • Lower incidence of Tardive Dyskinesia
      • Weigh gain (less with newer agents)
INCREASE IN CHILDHOOD DISORDERS

• Why?
  • More children are ill
    • Chemical exposures?
      • Alcohol?
      • “Toxins”? 
    • Decreasing parenting skills
  • Screen time
    • Excessive use linked to diminished attention span
  • Internet
    • Excessive use linked to depression in teenagers and young adults—especially social media
WHAT IS DEPRESSION?

• Not just being sad
• A syndrome of symptoms
  • Depressed mood
  • Sleep disturbance
  • Decreased interest in usual activities (anhedonia)
  • Increased guilty, hopeless or helpless feelings
  • Decreased energy, increased fatigue
WHAT IS DEPRESSION?

• More cardinal symptoms
  • Decreased ability to concentrate
  • Change in appetite
  • Psychomotor agitation or retardation
  • Suicidal thoughts or plan
    • May be just a preoccupation with death

• Usually “creeps up” on a person

• Must last at least two weeks
WHAT IS DEPRESSION?

• Other possible symptoms
  • Thoughts of harm to others
  • Irritability – Primary symptom in Adolescents
  • Psychosis
    • Audio, visual hallucinations
    • Paranoia
  • Perceptual disturbances
  • Catatonia
WHAT IS DEPRESSION?

• **Types**
  • **Major depressive disorder**
    • Five or more of the cardinal symptoms
    • Impairments in functioning socially, academically or vocationally
    • Lasts at least two weeks
  • **Dysthymia**
    • Chronic low grade depression
    • Lesser impairment, but much longer course
  • **Depressed phase of cyclic disorder**
    • Bipolar, cyclothymia
WHO GETS DEPRESSION?

• Approximately 1:5 people
• Can occur at any age
• Females more likely than males
  • By a 2:1 ratio
  • 1:1 ratio prior to puberty
• Greatest risk of suicide
  • Latter middle-aged divorced men who have a serious medical illness and have recently suffered a loss
• CO-MORBIDITIES WITH DEPRESSION

• Anxiety
• ADHD
• ODD / CD
• Substance Abuse
• Learning disabilities
• Family stress – Adverse Event Scale (AES)
• Non-completion of High School
• Lower SES
WHY TREAT DEPRESSION?

• Suicide
• Loss of job/school performance
  • May be a bigger influence that any other disease
• Can linger for years if untreated
• Quality of life issue
• Effect on children
  • Depressed parents more likely to have children with behavioral disturbances
HOW TO TREAT DEPRESSION

• Antidepressant Medications
  • Selective Serotonin Reuptake Inhibitors (SSRIs)
    • Six members:
      • Zoloft (sertraline)
      • Lexapro (escitalopram)
      • Celexa (citalopram)
      • Paxil (paroxetine)
      • Prozac (fluoxetine)
      • Luvox (fluvoxamine)
    • Low side effects: upset stomach, diarrhea, sexual side effects (anorgasmia)
HOW TO TREAT DEPRESSION

• Antidepressant Medications
  • Non-selective Serotonin Reuptake Inhibitors (NSRIs)
    • Effexor/Pristiq and Cymbalta
      • Serotonin and Norepinephrine
      • Withdrawal syndrome
  • Wellbutrin
    • Dopamine, Norepinephrine, Serotonin
    • Not with seizure disorder
    • Also, for attention, focus
    • Less sexual dysfunction
HOW TO TREAT DEPRESSION

• Antidepressant Medications
  • NSRIs
    • Serzone
      • Serotonin
      • Liver toxicity (must check labs)
      • Sedation, but less sexual dysfunction
    • Remeron
      • Serotonin, Norepinephrine
      • Sedation, but less sexual side effects, increased appetite
  • Trazodone
    • Serotonin
    • Not a great antidepressant, now used mostly for sleep
HOW TO TREAT DEPRESSION

• Antidepressant Medications
  • Tricyclic Antidepressants
    • Nortriptyline, Imipramine, Desipramine, Amitriptyline
    • No evidence for effectiveness in Children and Adolescents
    • More side effects (generally): dry mouth, constipation, heart conduction slowing (check EKGs), sedation, sexual dysfunction
    • Much more lethal in overdose
  • MAO-Is
    • Parnate, Nardill, Selegaline patch
    • Need to follow strict diet: no aged foods (cheese, meats), no fermented foods (wine, alcohol), or can cause life-threatening elevations in blood pressure
    • Mixed data in Adolescents
HOW TO TREAT DEPRESSION?

• Other medicines used
  • Atypical/Second generations Anti-psychotics
    • Generally adjunctive treatment
    • Risperdal, Seroquel, Geodon, Abilify, Zyprexa, et. al
  • Metabolic syndrome
    • Check weight, fasting blood sugar, lipids
• Lithium
  • Monitor 12- hours blood level: 0.6 – 1.2
  • Toxic to kidney and thyroid – TSH, BUN, Cr.
• Thyroid
  • Cytomel is best studied
HOW TO TREAT DEPRESSION?

• Ketamine
  • Experimental for several years
    • Multiple protocol
    • Some excellent results, some mixed results
    • Best outcome—same day relief of symptoms
  • Newly approved esketamine
    • Nasal spray
    • Twice weekly administration for one month
    • Then weekly, then semi-monthly
    • REMS registry
    • Only available at approved centers
HOW TO TREAT DEPRESSION

- Psychotherapy
  - Cognitive-Behavioral Therapy
    - Aimed at challenging the way a person thinks
    - Designed to restructure a more healthy life
  - Interpersonal
    - Looks at relationships as areas of dysfunction
- Dialectical Behavioral Therapy
  - Targeting personality formation / cognitive distortions
- Psychodynamic
  - “Freudian”, long term therapy
DISRUPTIVE MOOD DYSREGULATION DISORDER

• DSM-V Diagnosis

• A. The disorder is characterized by severe recurrent temper outbursts in response to common stressors.
  • 1. The temper outbursts are manifest verbally and/or behaviorally, such as in the form of verbal rages, or physical aggression towards people or property.
  • 2. The reaction is grossly out of proportion in intensity or duration to the situation or provocation.
  • 3. The responses are inconsistent with developmental level.

• B. Frequency: The temper outbursts occur, on average, three or more times per week.
DISRUPTIVE MOOD DYSREGULATION DISORDER

• C. Mood between temper outbursts:
  • 1. Nearly every day, the mood between temper outbursts is persistently negative (irritable, angry, and/or sad).
  • 2. The negative mood is observable by others (e.g., parents, teachers, peers).

• D. Duration: Criteria A-C have been present for at least 12 months. Throughout that time, the person has never been without the symptoms of Criteria A-C for more than 3 months at a time.

• E. The temper outbursts and/or negative mood are present in at least two settings (at home, at school, or with peers) and must be severe in at least one setting.

• F. Chronological age is at least 6 years (or equivalent developmental level).

• G. The onset is before age 10 years.