4th Annual Michael Golds Memorial Conference

CLINICAL CENTER FOR LEARNING & DEVELOPMENT, LLC

1803 Whites Road, Suite 103 • Kalamazoo, MI 49008 • 269/384-2270

DEPRESSION AND MOOD DISORDERS IN CHILDREN AND TEENAGERS

POINTS TO PONDER

1) Diagnosis of Depression in children is relatively new, gaining prominence in the last 15-20 years.
2) One of the most overlooked/misunderstood diagnoses in school-age children.
3) Best understood by the visual illustration of the "Well of Feelings".
4) Important not to underestimate the erosion of performance caused by even low grade depressive symptoms.
5) In teenagers especially, depression may be exhibited through rage, anger, and hostility as opposed to the stereotypical "sadness" - don't be fooled by an angry facade!
6) Mood disorders tend to run in families. Research indicates a genetic susceptibility or vulnerability to depressive symptoms.
7) Need to respect the strong interaction between situational/environmental stressors and brain chemistry.
8) Never take suicidal statements or comments lightly or assume it is "just for attention". This type of verbalization should be a clear indication that the child is in significant emotional pain and is desperately seeking help. Respect it as such.
9) Remember that depressive/suicidal thinking is very irrational thinking. Do not expect rational/reasonable responses from any individual who is depressed.
10) Sustaining effort requires optimism and confidence that you will be successful in your attempt. Depression robs you of both so the student will look like he "doesn't care", isn't trying, is unmotivated.
11) Concept of Shadow Syndromes-mild symptoms of major disorders.

THE SPECTRUM OF MOOD/ANXIETY DISORDERS

1) **Major Depressive Episode**: acute, clinical symptoms
2) **Dysthymia**: low-grade, long-standing, depressive symptoms
3) **Manic Depressive or Bipolar Disorder**: wide mood swings from very sad to very happy or irritated and agitated. One hallmark symptom of Bipolar Disorder is hypersexuality. Mania can be manifested as rage with underlying feelings of power.
4) **Obsessive Compulsive Disorder**: probably less obvious in the classroom. Children will often hide the symptoms since they are aware that the compulsive behaviors are "weird". Ritualistic behavior can also be purely mental and therefore not observable. Compulsive behavior is "driven" behavior and does not respond to consequences. These can include compulsive stealing, lying, sexual behavior, and shopping.
5) **Generalized Anxiety**: may be displayed by shy, withdrawn behavior.

NOTE: Children and teenagers who have been diagnosed with ADD are much more susceptible to mood disorders. Because they have difficulty allocating and prioritizing their attention, they often have difficulty allocating emotions as well. The very nature of ADD, the tendency to overfocus and overreact, makes these children more vulnerable to mood disturbance and anxiety disorders. Because their success is often compromised and quite fragile, they are very susceptible to secondary depression and anxiety.

WHAT TO WATCH FOR:

Decrease in grades, test scores

Flat or blunted affect and emotional response

Increased absences from school

Poor motivation-doesn't seem to care

Acts as if he's just "going through the motions"

Hostile, acting out behavior

Explosive temper-even to minor requests

Uncontrollable rage

Behavior that does not respond to or improve with "normal" consequences

Talks about hurting/killing himself

Excessive sleeping in class

Acts out to get suspended from class/school

Exhibits extreme behavior

Vague physical complaints (headaches, stomachaches)

This is not meant to be a diagnostic "checklist" but rather a brief summary of what you might observe in a classroom setting. The diagnosis of depression, anxiety, obsessive compulsive disorder, ADD, etc. are very complicated and are colored by a myriad of factors that are beyond the reasonable scope of. the classroom teacher. It is important, however, to understand the "nature of the beast" you are dealing with in the classroom in order to increase the child's chances for success.

TREATMENT FOR MOOD DISORDERS

1) **Medication: the role of brain chemistry cannot be underestimated**

A) **Selective Serotonin Reuptake Inhibitors (SSRI):**

Prozac
Paxil
Zoloft
Celexa
Lexapro

B) **Related Medications:**

Effexor-may also improve ADD symptoms
Serzone
Wellbutrin-may also improve ADD symptoms

C) **Tricyclic Antidepressants:**

Tofranil
Norpramine
Deseryl-may help with sleep onset

D) **Mood Stabilizers:**

Depakote-also helps with rage control
Lithium
Lamictol
Topamax
Trileptol

E) **Atypical Antipsychotics** (often help with racing thoughts and rage control):

Risperdol
Zyprexa
Seroque
Abilify

Most antidepressants take anywhere from two to six weeks to reach the optimal dosage, with the exception of Wellbutrin which is faster acting. They are typically started at low doses and titrated upward depending on effectiveness and side effects. Sometimes the "side effects" of the medication are also the very symptoms you are trying to relieve with the medication. For example, the child may be sleeping excessively due to the depressive symptoms as opposed to a side effect of the medication. Teachers should not hesitate to report any observations or concerns to the child's parents or doctor.

Remember that the role of medication is to improve the child's "quality of life" and should be used in conjunction with other treatment methods such as counseling and educational accommodations.

A WORD ABOUT SUICIDE:

A suicide attempt in children and teenagers is usually due to lack of impulse control as opposed to a planned, thought-out action. Feelings of hopelessness and self-destruction can overwhelm the depressed child in a short period of time. In addition, regret over a self-destructive act can occur minutes later so that he may then report his behavior in an effort to reverse it. This does not minimize the seriousness of the act and should not be viewed as manipulative behavior.

WHAT THE TEACHER/SCHOOL CAN DO:

* The diagnostic/therapeutic role of the teacher is by necessity, limited. However, an understanding of and respect for the struggle that the child is experiencing is invaluable in the school setting where the child is spending the majority of his time.

* An encouraging, nonpunitive approach works best.

* Punishing "symptoms" typically will make the problem worse.

* The child must be held accountable for his behaviors but this can be accomplished in a "safe" atmosphere rather than in the context of "teaching him a lesson".

* Remember, the depressed person doesn't "care" about anything by definition of the disorder, don't expect him to "shape up" to avoid consequences.

* It is essential to provide a "safe haven" for the child to go to when he is feeling overwhelmed or out of control that is clearly non-punitive.

* Remember, in the midst of an acute depressive episode, sometimes the primary accomplishment for the day is just getting to school. If you feel worthless and hopeless, the math assignment is pretty irrelevant to you. Patience and understanding on the part of the teacher will eventually pay off.

* Try to start from the assumption that the child would perform if he could and that he is as distressed (and frightened) by his behavior as you are. Explaining the dire consequences of the student's behavior or lack of achievement in an effort to "wake him up" will only serve to increase and reinforce his negativity and pessimism. The adult's role should be one of calm reassurance that this problem is "solvable".

* Mood disorders are one of the most frustrating things for teachers to deal with since they have such a limited amount of time with the student and the problems are often non-academic. Nobody should expect you to be a "therapist" for the student, although a caring supportive "shoulder" can be invaluable. You can also make a significant contribution by understanding the nature of the beast and thereby "doing no harm".

Thank you for attending the

4th Annual Michael Golds Memorial Conference.

Brought to you by:
Oakland Community College
The Michael Golds Memorial Fund
CHADD of Michigan

We hope you'll join us again next year!!!

Information on the 2004 Michael Golds Memorial Conference Should be available by mid-Summer 2004 at www.chaddmi.com.

Keep up on what's new in the Michigan Area World of AD/HD: Join the mail@chaddmi.com e-mail group.