

THE DEPRESSED CHILD

No. 4 (10/92)

(Updated 8/98)

Not only adults become depressed. Children and teenagers also may have depression, which is a treatable illness. Depression is defined as an illness when the feelings of depression persist and interfere with a child or adolescent's ability to function.

About 5 percent of children and adolescents in the general population suffer from depression at any given point in time. Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. Depression also tends to run in families.

The behavior of depressed children and teenagers may differ from the behavior of depressed adults. Child and adolescent psychiatrists advise parents to be aware of signs of depression in their youngsters.

If one or more of these signs of depression persist, parents should seek help:

- Frequent sadness, tearfulness, crying
- Hopelessness
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self esteem and guilt
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self destructive behavior

A child who used to play often with friends may now spend most of the time alone and without interests. Things that were once fun now bring little joy to the depressed child. Children and adolescents who are depressed may say they want to be dead or may talk about suicide. Depressed children and adolescents are at increased risk for committing suicide. Depressed adolescents may abuse alcohol or other drugs as a way to feel better.

Children and adolescents who cause trouble at home or at school may actually be depressed but not know it. Because the youngster may not always seem sad, parents and teachers may not realize that troublesome behavior is a sign of depression. When asked directly, these children can sometimes state they are unhappy or sad.

Early diagnosis and medical treatment are essential for depressed children. This is a real illness that requires professional help. Comprehensive treatment often includes both individual and family therapy. It may also include the use of antidepressant medication. For help, parents should ask their physician to refer them to a child and adolescent psychiatrist, who can diagnose and treat depression in children and teenagers. Also see the following Facts for Families: #8 Children and Grief, #10 Teen Suicide, #21 Psychiatric Medication for Children, and #38 Manic-Depressive Illness in Teens.

TEEN SUICIDE

No. 10

(Updated 11/98)

Suicides among young people nationwide have increased dramatically in recent years. Each year in the U.S., thousands of teenagers commit suicide. Suicide is the third leading cause of death for 15-to-24-year-olds, and the sixth leading cause of death for 5-to-14-year-olds.

Teenagers experience strong feelings of stress, confusion, self-doubt, pressure to succeed, financial uncertainty, and other fears while growing up.

For some teenagers, divorce, the formation of a new family with step-parents and step-siblings, or moving to a new community can be very unsettling and can intensify self-doubts. In some cases, suicide appears to be a "solution."

Depression and suicidal feelings are treatable mental disorders. The child or adolescent needs to have his or her illness recognized and diagnosed, and appropriate treatment plans developed. When parents are in doubt whether their child has a serious problem, a psychiatric examination can be very helpful.

Many of the symptoms of suicidal feelings are similar to those of depression.

Parents should be aware of the following signs of adolescents who may try to kill themselves:

- change in eating and sleeping habits
- withdrawal from friends, family, and regular activities
- violent actions, rebellious behavior, or running away
- drug and alcohol use
- unusual neglect of personal appearance
- marked personality change
- persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.

- loss of interest in pleasurable activities
- not tolerating praise or rewards

A teenager who is planning to commit suicide may also:

- complain of being a bad person or feeling "rotten inside"
- give verbal hints with statements such as: "I won't be a problem for you much longer," "Nothing matters," "It's no use," and "I won't see you again"
- put his or her affairs in order, for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
- become suddenly cheerful after a period of depression
- have signs of psychosis (hallucinations or bizarre thoughts)

If a child or adolescent says, "I want to kill myself," or "I'm going to commit suicide," always take the statement seriously and seek evaluation from a child and adolescent psychiatrist or other physician. People often feel uncomfortable talking about death. However, asking the child or adolescent whether he or she is depressed or thinking about suicide can be helpful. Rather than "putting thoughts in the child's head," such a question will provide assurance that somebody cares and will give the young person the chance to talk about problems.

If one or more of these signs occurs, parents need to talk to their child about their concerns and seek professional help when the concerns persist. With support from family and professional treatment, children and teenagers who are suicidal can heal and return to a more healthy path of development.

PSYCHIATRIC MEDICATION FOR CHILDREN AND ADOLESCENTS PART I: HOW MEDICATIONS ARE USED

No. 21

(11/99)

Medication can be an effective part of the treatment for several psychiatric disorders of childhood and adolescence. A doctor's recommendation to use medication often raises many concerns and questions in both the parents and the youngster. The physician who recommends medication should be experienced in treating psychiatric illnesses in children and adolescents. He or she should fully explain the reasons for medication use, what benefits the medication should provide, as well as unwanted side-effects or dangers and other treatment alternatives.

Psychiatric medication should not be used alone. As undertaking a medication trial may mean adjusting doses of medicine over time and/or the use of additional medications to meet an individual youngster's needs, the use of medication should be part of a comprehensive treatment plan, usually including psychotherapy, as well as parent guidance sessions.

Before recommending any medication, the child and adolescent psychiatrist interviews the youngster and makes a thorough diagnostic evaluation. In some cases, the evaluation may include a physical exam, psychological testing, laboratory tests, other medical tests such as an electrocardiogram (EKG) or electroencephalogram (EEG) , and consultation with other medical specialists.

Child and adolescent psychiatrists stress that medications which have beneficial effects also have unwanted side effects, ranging from just annoying to very serious. As each youngster is different and may have individual reactions to medication, close contact with the treating physician is recommended. Do not stop or change a medication without speaking to the doctor. Psychiatric medication should be used as part of a comprehensive plan of treatment, with ongoing *medical assessment* and, in most cases, *individual and/or family* psychotherapy. **When prescribed appropriately by a psychiatrist (preferably a child and adolescent psychiatrist), and taken as prescribed, medication may reduce or eliminate troubling symptoms and improve the**

daily functioning of children and adolescents with psychiatric disorders.

Medication may be prescribed for psychiatric symptoms and disorders, including, but not limited to:

1. **Bedwetting**-if it persists regularly after age 5 and causes serious problems in low self-esteem and social interaction.
2. **Anxiety** (school refusal, phobias, separation or social fears, generalized anxiety, or posttraumatic stress disorders)-if it keeps the youngster from normal daily activities.
3. **Attention deficit hyperactivity disorder**-marked by a short attention span, trouble concentrating and restlessness. The child is easily upset and frustrated, often has problems getting along with family and friends, and usually has trouble in school.
4. **Obsessive-compulsive disorder**-recurring obsessions (troublesome and intrusive thoughts) and/or compulsions (repetitive behaviors or rituals such as handwashing, counting, checking to see if doors are locked) which are often seen as senseless but which interfere with a youngster's daily functioning.
5. **Depressive disorder**-lasting feelings of sadness, helplessness, hopelessness, unworthiness and guilt, inability to feel pleasure, a decline in school work and changes in sleeping and eating habits.
6. **Eating disorder**-either self-starvation (anorexia nervosa) or binge eating and vomiting (bulimia), or a combination of the two.
7. **Bipolar (manic-depressive) disorder**-periods of depression alternating with manic periods, which may include irritability, "high" or happy mood, excessive energy, behavior problems, staying up late at night, and grand plans.
8. **Psychosis**-symptoms include irrational beliefs, paranoia, hallucinations (seeing things or hearing sounds that don't exist) social withdrawal, clinging, strange behavior, extreme stubbornness, persistent rituals, and deterioration of personal habits. May be seen in developmental disorders, severe depression, schizoaffective disorder, schizophrenia, and some forms of substance abuse.
9. **Autism**-(or other pervasive developmental disorder such as Asperger's Syndrome)-characterized by severe deficits in social interactions, language, and/or thinking or ability to learn, and usually diagnosed in early childhood.
10. **Severe aggression**-which may include assaultiveness, excessive property damage, or prolonged self-abuse, such as head-banging or cutting.
11. **Sleep problems**-symptoms can include insomnia, night terrors, sleep walking, fear of separation, anxiety.

BIPOLAR DISORDER (MANIC-DEPRESSIVE ILLNESS) IN TEENS

No. 38

Updated 5/2000

Teenagers with Bipolar Disorder may have an ongoing combination of extremely high (manic) and low (depressed) moods. Highs may alternate with lows, or the person may feel both extremes at the same time.

Bipolar Disorder usually starts in adult life. Although less common, it does occur in teenagers and even rarely in young children. This illness can affect anyone.

However, if one or both parents have Bipolar Disorder, the chances are greater that their children will develop the disorder. Family history of drug or alcohol abuse also may be associated with Bipolar Disorder in teens.

Bipolar Disorder may begin either with manic or depressive symptoms.

The manic symptoms include:

- severe changes in mood compared to others of the same age and background - either unusually happy or silly, or very irritable, angry, agitated or aggressive
- unrealistic highs in self-esteem - for example, a teenager who feels all powerful or like a superhero with special powers
- great increase in energy and the ability to go with little or no sleep for days without feeling tired
- increase in talking - the adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted
- distractibility - the teen's attention moves constantly from one thing to the next
- repeated high risk-taking behavior; such as, abusing alcohol and drugs, reckless driving, or sexual promiscuity

The depressive symptoms include:

- irritability, depressed mood, persistent sadness, frequent crying
- thoughts of death or suicide
- loss of enjoyment in favorite activities
- frequent complaints of physical illnesses such as headaches or stomach aches
- low energy level, fatigue, poor concentration, complaints of boredom

- major change in eating or sleeping patterns, such as oversleeping or overeating

Some of these signs are similar to those that occur in teenagers with other problems such as drug abuse, delinquency, attention-deficit hyperactivity disorder, or even schizophrenia. The diagnosis can only be made with careful observation over an extended period of time. A thorough evaluation by a child and adolescent psychiatrist can be helpful in identifying the problems and starting specific treatment. Teenagers with Bipolar Disorder can be effectively treated. Treatment for Bipolar Disorder usually includes education of the patient and the family about the illness, mood stabilizing medications such as lithium and valproic acid, and psychotherapy. Mood stabilizing medications often reduce the number and severity of manic episodes, and also help to prevent depression. Psychotherapy helps the teenager understand himself or herself, adapt to stresses, rebuild self-esteem and improve relationships.

PSYCHIATRIC MEDICATIONS FOR CHILDREN AND ADOLESCENTS PART III: QUESTIONS TO ASK

No. 51

(03/01)

Medication can be an important part of treatment for some psychiatric disorders in children and adolescents. Psychiatric medication should only be used as one part of a comprehensive treatment plan. Ongoing evaluation and monitoring by a physician is essential. Parents and guardians should be provided with complete information when psychiatric medication is recommended as part of their child's treatment plan. Children and adolescents should be included in the discussion about medications, using words they understand. By asking the following questions, children, adolescents, and their parents will gain a better understanding of psychiatric medications:

1. What is the name of the medication? Is it known by other names?
2. What is known about its helpfulness with other children who have a similar condition to my child?
3. How will the medication help my child? How long before I see improvement? When will it work?
4. What are the side effects which commonly occur with this medication?
5. What are the rare or serious side effects, if any, which can occur?
6. Is this medication addictive? Can it be abused?
7. What is the recommended dosage? How often will the medication be taken?
8. Are there any laboratory tests (e.g. heart tests, blood test, etc.) which need to be done before my child begins taking the medication? Will any tests need to be done while my child is taking the medication?
9. Will a child and adolescent psychiatrist be monitoring my child's response to medication and make dosage changes if necessary? How often will progress be checked and by whom?
10. Are there any other medications or foods which my child should avoid while taking the medication?
11. Are there interactions between this medication and other medications (prescription and/or over-the-counter) my child is taking?
12. Are there any activities that my child should avoid while taking the medication? Are any precautions recommended for other activities?
13. How long will my child need to take this medication? How will the decision be made to stop this medication?
14. What do I do if a problem develops (e.g. if my child becomes ill, doses are

missed, or side effects develop)?

15. What is the cost of the medication (generic vs. brand name)?

16. Does my child's school nurse need to be informed about this medication?

Treatment with psychiatric medications is a serious matter for parents, children and adolescents. Parents should ask these questions **before** their child or adolescent starts taking psychiatric medications. Parents and children/adolescents need to be fully informed about medications. If, after asking these questions, parents still have serious questions or doubts about medication treatment, they should feel free to ask for a second opinion by a child and adolescent psychiatrist.

PSYCHOTHERAPIES FOR CHILDREN AND ADOLESCENTS

No. 86

(01/03)

Psychotherapy is a form of treatment that can help children and families understand and resolve problems, modify behavior, and make positive changes in their lives. There are several types of psychotherapy that involve different approaches, techniques and interventions. At times, a combination of different psychotherapy approaches may be helpful. In some cases a combination of medication with psychotherapy may be more effective.

Different types of psychotherapy: (alphabetical order)

- **Cognitive Behavior Therapy (CBT)** helps improve a child's moods and behavior by examining confused or distorted patterns of thinking. During CBT the child learns that thoughts cause feelings and moods which can influence behavior. For example, if a child is experiencing unwanted feelings or has problematic behaviors, the therapist works to identify the underlying thinking that is causing them. The therapist then helps the child replace this thinking with thoughts that result in more appropriate feelings and behaviors. Research shows that CBT can be effective in treating depression and anxiety.
- **Dialectical Behavior Therapy (DBT)** can be used to treat older adolescents who have chronic suicidal feelings/thoughts, engage in intentional self-harm or have Borderline Personality Disorder. DBT emphasizes taking responsibility for one's problems and helps the person examine how they deal with conflict and negative feelings. This often involves a combination of group and individual sessions.
- **Family Therapy** focuses on helping the family function in more positive and constructive ways by exploring patterns of communication and providing support and education. Family therapy sessions can include the child or adolescent along with parents, siblings and grandparents. Couples therapy is a specific type of family therapy that focuses on a couple's communication and interactions (e.g. parents having marital problems).
- **Group Therapy** uses the power of group dynamics and peer interactions to increase understanding and improve social skills. There are many different types of group therapy (e.g. psychodynamic, social skills, substance abuse, multi-family, parent support, etc.)
- **Interpersonal Therapy (IPT)** is a brief treatment specifically developed and tested for depression. The goals of IPT are to improve interpersonal functioning by decreasing the symptoms of depression. IPT has been shown to be effective in adolescents with depression.
- **Play Therapy** involves the use of toys, blocks, dolls, puppets, drawings and games to help the child recognize, identify and verbalize feelings. The psychotherapist observes

how the child uses play materials and identifies themes or patterns to understand the child's problems. Through a combination of talk and play the child has an opportunity to better understand and manage their conflicts, feelings and behavior.

- **Psychodynamic Psychotherapy** emphasizes understanding the issues that motivate and influence a child's behavior, thoughts and feelings. It can help identify a child's typical behavior patterns, defenses and responses to inner conflicts and struggles. Psychoanalysis is a specialized, more intensive form of psychodynamic psychotherapy which usually involved several sessions per week. Psychodynamic psychotherapies are based on the assumption that a child's behavior and feelings will improve once the inner struggles are brought to light.

Psychotherapy is not a quick fix or an easy answer. It is a complex and rich process that can reduce symptoms, provide insight and improve a child or adolescent's functioning and quality of life. Child and adolescent psychiatrists are trained in different forms of psychotherapy and, if indicated, are able to combine these forms of treatment with medications to alleviate the child or adolescent's emotional and/or behavioral problems.

Working Together

- Agencies & health care community
- Child care staff & treatment team
- Caseworkers & foster parents
- Primary & specialty care providers
- Child, biological & foster parents

Laws and Regulations

- Federal Early Periodic Screening Diagnostic and Treatment (EPSDT) standards
- New York State Child/Teen Health Plan (C/THP)
- OCFS Social Services Law (SSL), Regulations and Administrative Directives

Health Services for Children in Foster Care

- Comprehensive assessments integrated into service plan
- Medical home
- Care Coordination
- Discharge planning

Comprehensive Assessments

- Medical
- Developmental
- Dental
- Mental Health
- Substance abuse

Health Services Treatment Plan

- Clinician for each assessment develops a problem list and plan of care
- Plan includes:
 - Diagnostic tests or referrals
 - Management or treatment recommendations
 - Follow-up appointments to review results and adjust plan
- All assessments coordinated into comprehensive plan of care

Integrating the Plan

- Comprehensive plan of care integrated into overall service plan
- Case planner reviews health services plan
- Include goals and activities in the UCR to address health needs

Care Coordination

- A series of activities that support oversight and responsibility for all aspects of health services
- Local discretion on how to implement
- Medical advice and technical assistance should be available
- Each child in foster care needs health care coordination

Summary

- Pay attention to health status
- Know child's needs (assessments!)
- Obtain the necessary services
- Know how and by whom child's health needs are being met
- Health services impact all aspects of the child welfare case
- Communicate, advocate, keep learning

http://www.ocfs.state.ny.us/main/sppd/health_services/

Risk Factors Contributing to Mental Illness in Children

- Biological
- Psychological
- Social/Environmental

Biological Risk Factors

- Family predisposition to psychiatric disorders
- Prenatal exposure to drugs, alcohol, infection
- Poor nutrition in infancy and early childhood
- Lead poisoning

Psychological Risk Factors

- Emotional deprivation
- Inexperienced, ineffective parenting
- Abandonment
- Physical or sexual abuse

Social & Environmental Risk Factors

- Chronic poverty
- Domestic violence
- Community violence
- Unemployment
- Poor education
- Homelessness

Emotions

- Responses evoked by significant environmental stimuli
- Can be positive or negative
- Varying degrees of intensity

Mood

- Longer lasting state than emotions
- Less likely to be evoked by environmental stimuli
- Change in mood can occur with a major life event (e.g. placement in foster care)

Caregiver Influence

- Relationship with caregivers is critical
- Caregiver support teaches child how to cope with stress
- Without support, child doesn't learn how to control emotions

What is Resilience?

- Ability to cope with adversity
- Resilience = Strengths
- Resilience results from a combination of positive factors

What Makes a Child Resilient?

- Temperament or innate character
- Social, cognitive, problem-solving skills
- Social support
 - Young children: primary caregiver
 - Older children: family, friends, teachers, other caring adults

Mental Health Assessment

- Review information on child
- Clinical interview with child
- Multiple interviews with child and collaterals
- Screening or testing

Information for Mental Health Assessment

- Prenatal condition
- Family history
- Developmental milestones
- Child's temperament
- Primary caregivers

Information for Mental Health Assessment

- School performance
- Relations with peers
- Interests & hobbies
- Removal circumstances
- Child's functioning in foster care placement
- Child's current problems

Sources of Information

- Biological and foster parents
- Other relatives
- Teachers
- Daycare providers
- Caseworkers and child care staff

Caseworker Role in Mental Health Assessments

- Identify & gather information on the child in a variety of settings
- Share known information on the family and child
- Facilitate attendance at assessment appointments

Benefits of Collaboration

- More complete and accurate assessments
- Appropriate treatment plan for child
- Practical guidance for caregivers

Common Mental Health Problems for Children in Foster Care

- Entry into foster care is a major life stress
- Adjustment disorder
- More serious psychiatric disorders
- Multiple diagnoses (co-morbid)

Symptoms of Depression Parents May Observe

- Irritability
- Moodiness, whining
- Disruptive behavior (fighting)
- Loss of interest in activities, such as school or sports

Symptoms of Depression All Children

- Depressed mood
- Suicidal ideation
- Sleep problems

Symptoms of Depression Young Children

- Depressed appearance
- Somatic complaints
- Agitation
- Separation anxiety
- Phobias

Symptoms of Depression Older Children and Adolescents

- Lack of pleasure
- Hypersomnia (an inability to stay awake)
- Hopelessness or worthlessness
- Weight gain or loss
- Possible drug abuse

Symptoms of Depression Clinical Presentation

- Sad, tearful
- Slow movements
- Monotone speech
- Hopelessness
- Negative self-image
- Self-endangering behavior
- Suicide attempts or gestures

Psychosocial Therapies

- Generally the initial approach to treatment
- Individual therapy (play or talk)
- Group therapy
- Family therapy

Therapy Guidelines

- Regular appointments
- Involve caregivers
- Continuity of therapist

Medication

- First line of treatment only if child is non-functional or suicidal
- Finding the right medication
- "Start Low & Go Slow"

Monitoring Children on Medication

- Caregivers must be alert for side effects
- Routine medication monitoring
- Communication among caregivers, child, and doctor on effects of medication

<http://www.aacap.org/publications/factsfam/index.htm>

To Evaluate Online (Intranet):
<http://sdssnet5/>



To Evaluate online (Internet):
<http://www.dfa.state.ny.us/>


