

An Update on Mood Disorders in Children and Adolescents

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Major Depressive Disorder (MDD) & Dysthymia (DD) - Epidemiology

- **MDD Prevalence**
 - 2% in children (M:F = 1:1)
 - 4-8% in adolescents (M:F = 1:2)
- In community samples cumulative incidence of approximately 20% by age 18
- **DD Prevalence**
 - 1.7% in children
 - 1.6-8.0% in adolescents

Clinical Presentation of Depressive Disorders

- Irritable mood and dysphoria (vs. sadness in adult depression)
- Inability to enjoy favorite activities (“bored”)
- Social withdrawal
- Blame/worthlessness/ guilt
- Suicidal preoccupation
- “Mood reactive” similar to atypical adult depression
- Abnormal sleep patterns (ie, nightmares)
- Fatigue
- Diminished ability to concentrate

Clinical Course of Pediatric MDD

- **Average Duration:**
 - Clinically referred youth 8 months
 - Community Samples 1-2 months
- In two years approximately 90% have achieved remission
- **BUT,**
 - Relapse 50%
 - Recurrences 20-60% in two years; 70% in five years
 - 6-10% with a chronic course

40-90% of Pediatric Patients with MDD have Comorbidity with

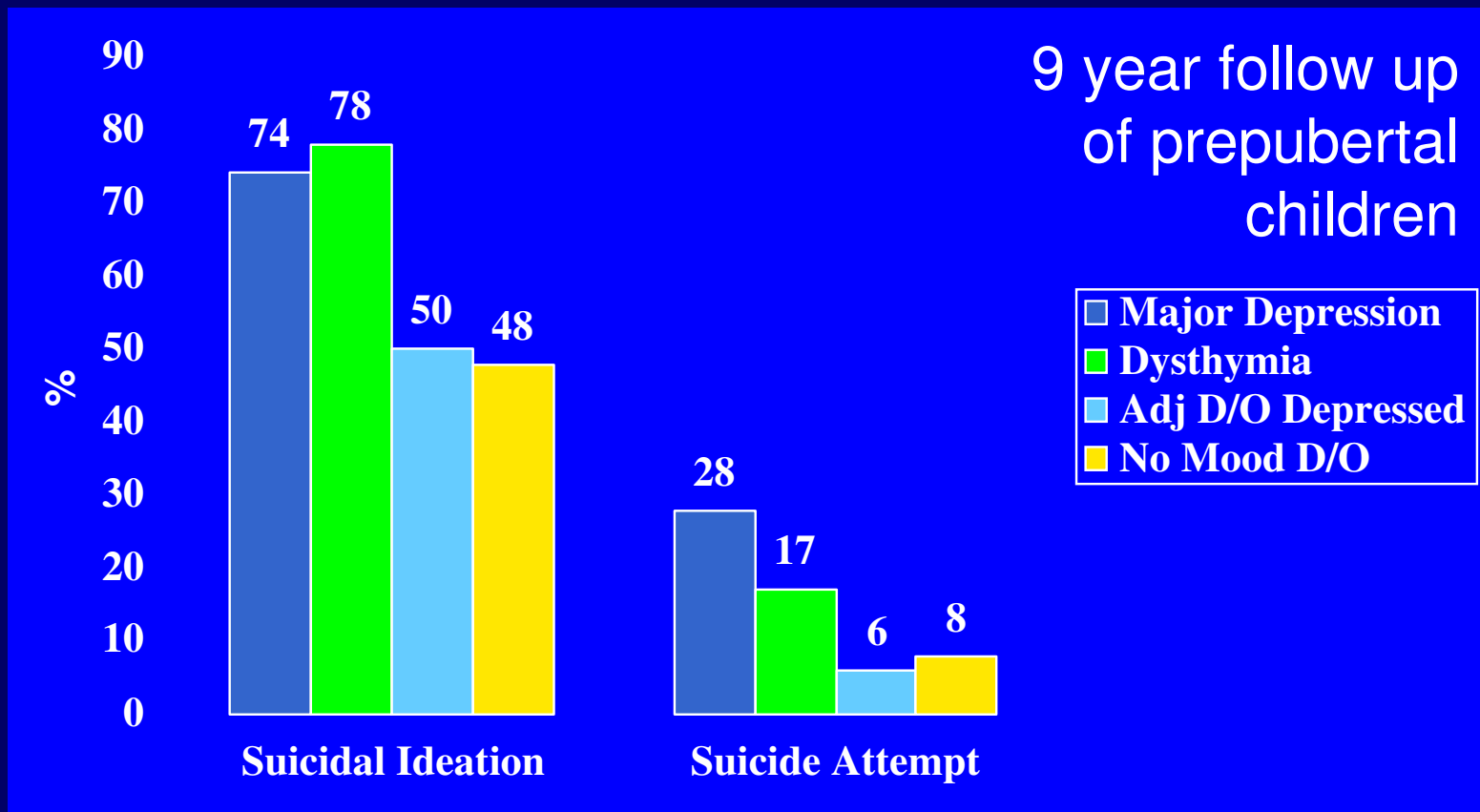
- Anxiety Disorders
- ADHD, ODD and/or Conduct Disorder
- Substance use, misuse, abuse
- Eating Disorders
- Personality Disorders

**Up to 50% have two or more
comorbid disorders**

Complications of Depressive Disorders

- Academic, interpersonal, and family difficulties
- Increased risk for suicide and other psychiatric problems (e.g., conduct problems, use/abuse of nicotine, alcohol and drugs)
- Increased risk for suicidal behaviors 10- to 50-fold
- 80% of attempters and 60% of completers are depressed

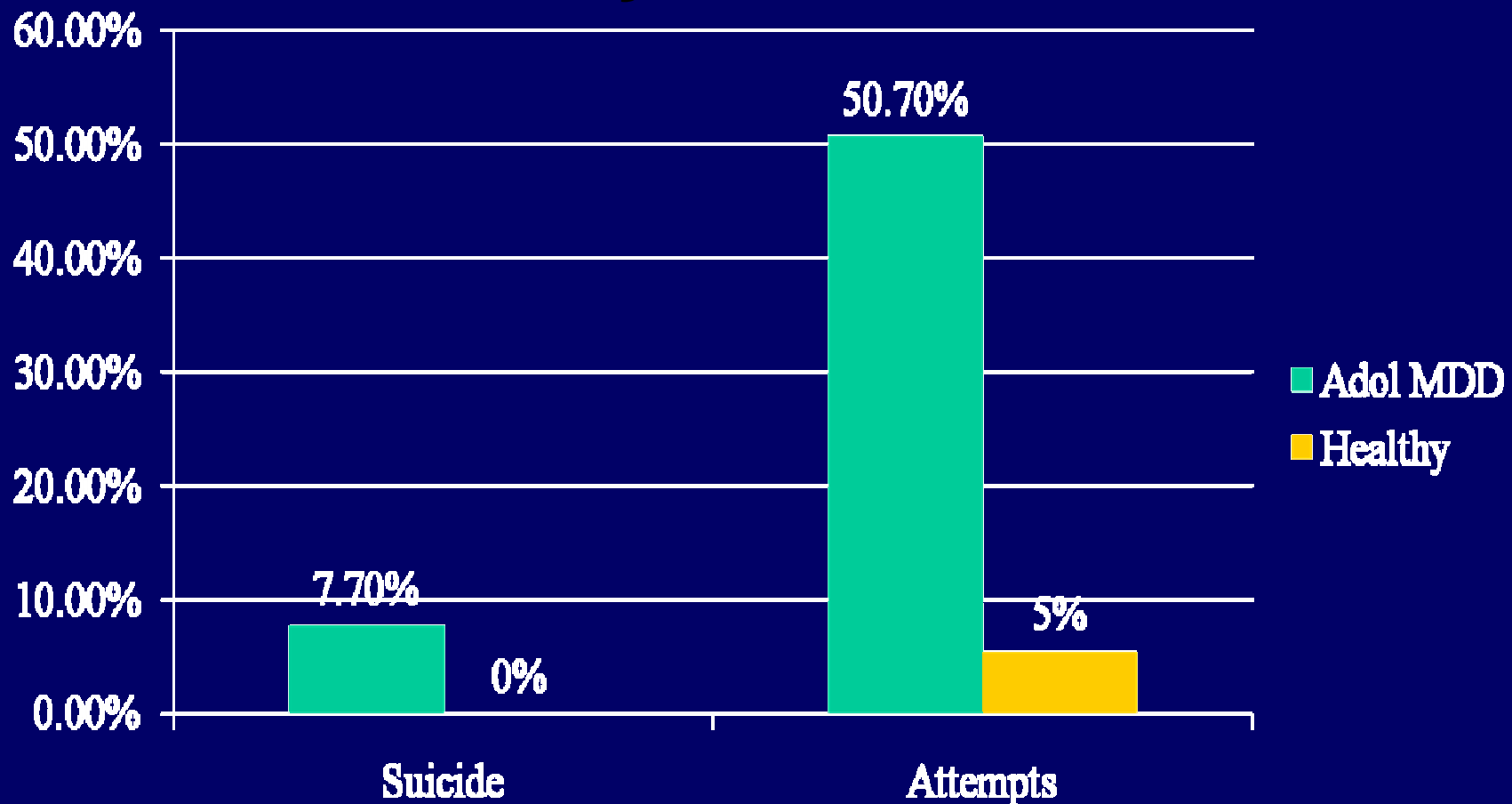
Pediatric Depression: Associated With High Risk of Suicidality



Kovacs et al. J Am Acad Child Adolesc Psychiatry 1993

38% of depressed youths had made attempt by age 17

Elevated Rates of Suicide & Suicide Attempts in Adolescent-Onset MDD by Early Adulthood

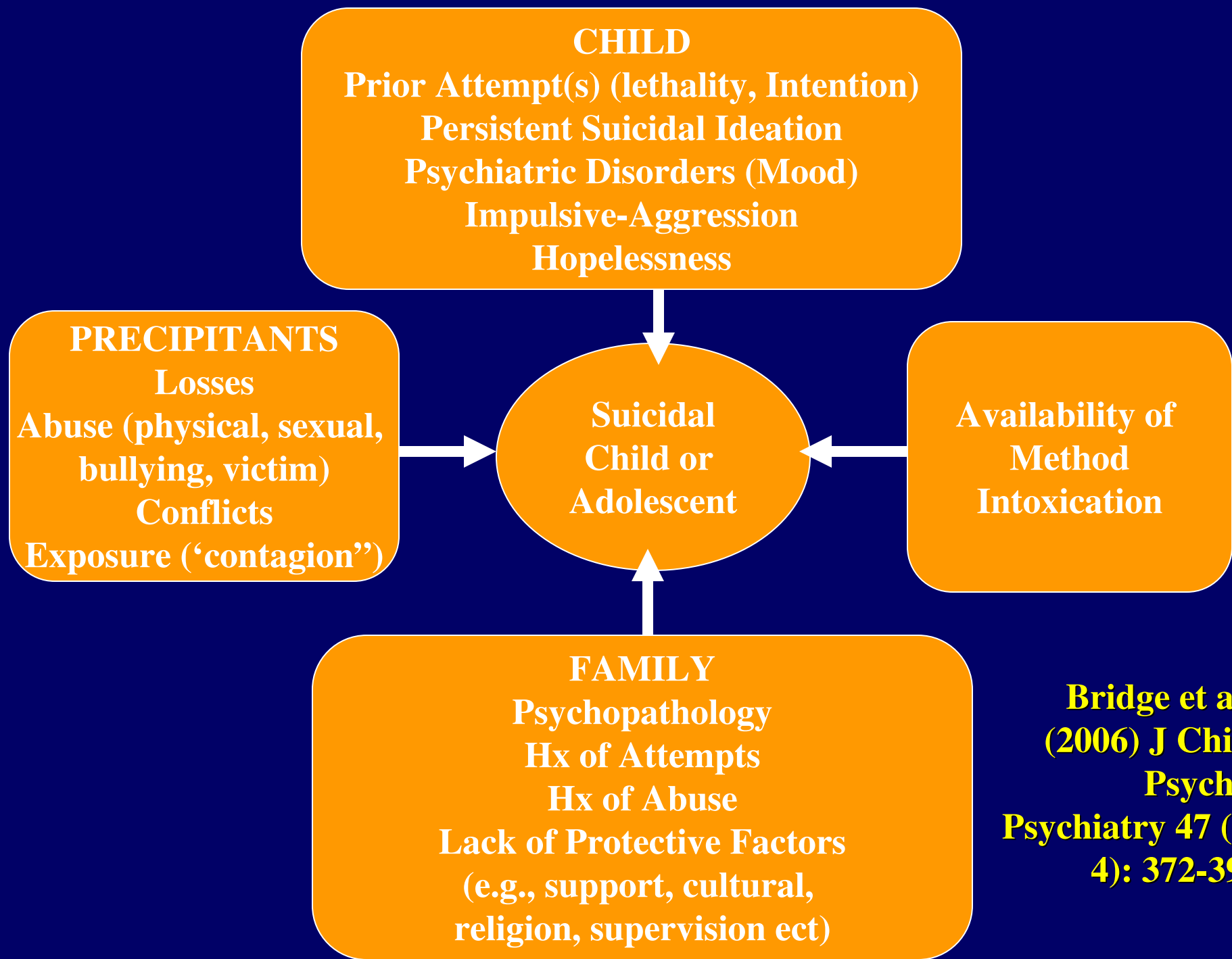


From Weissman et al. (1999). Depressed Adolescents Grown Up. JAMA
Mean age at follow-up 26 yrs, follow-up period ≈10 years

Leading causes of death for selected age groups – United States, 2004

Rank	10-14 years	15-19 years	20-29 years	30-39 years	40-49 years	50-59 years
1	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	Malignant Neoplasms	Malignant Neoplasms
2	Malignant Neoplasms	Homicide	Homicide	Malignant Neoplasms	Heart Disease	Heart Disease
3	Suicide	Suicide	Suicide	Heart Disease	Unintentional Injuries	Unintentional Injuries
4	Homicide	Malignant Neoplasms	Malignant Neoplasms	Suicide	Suicide	Diabetes Mellitus
5	Congenital Malformations	Heart Disease	Heart Disease	Homicide	HIV	Cerebro-vascular
6	Heart Disease	Congenital Malformations	HIV	HIV	Liver Disease	Liver Disease
7	Chronic Lower Respiratory Ds	Chronic Lower Respiratory Ds	Congenital Malformations	Diabetes Mellitus	Cerebro-vascular	Chronic Lower Respiratory Ds
8	Influenza & pneumonia	Cerebro-vascular	Cerebro-vascular	Cerebro-vascular	Diabetes Mellitus	Suicide

Source: CDC vital statistics



**Bridge et al.,
(2006) J Child
Psychol
Psychiatry 47 (3-
4): 372-394**

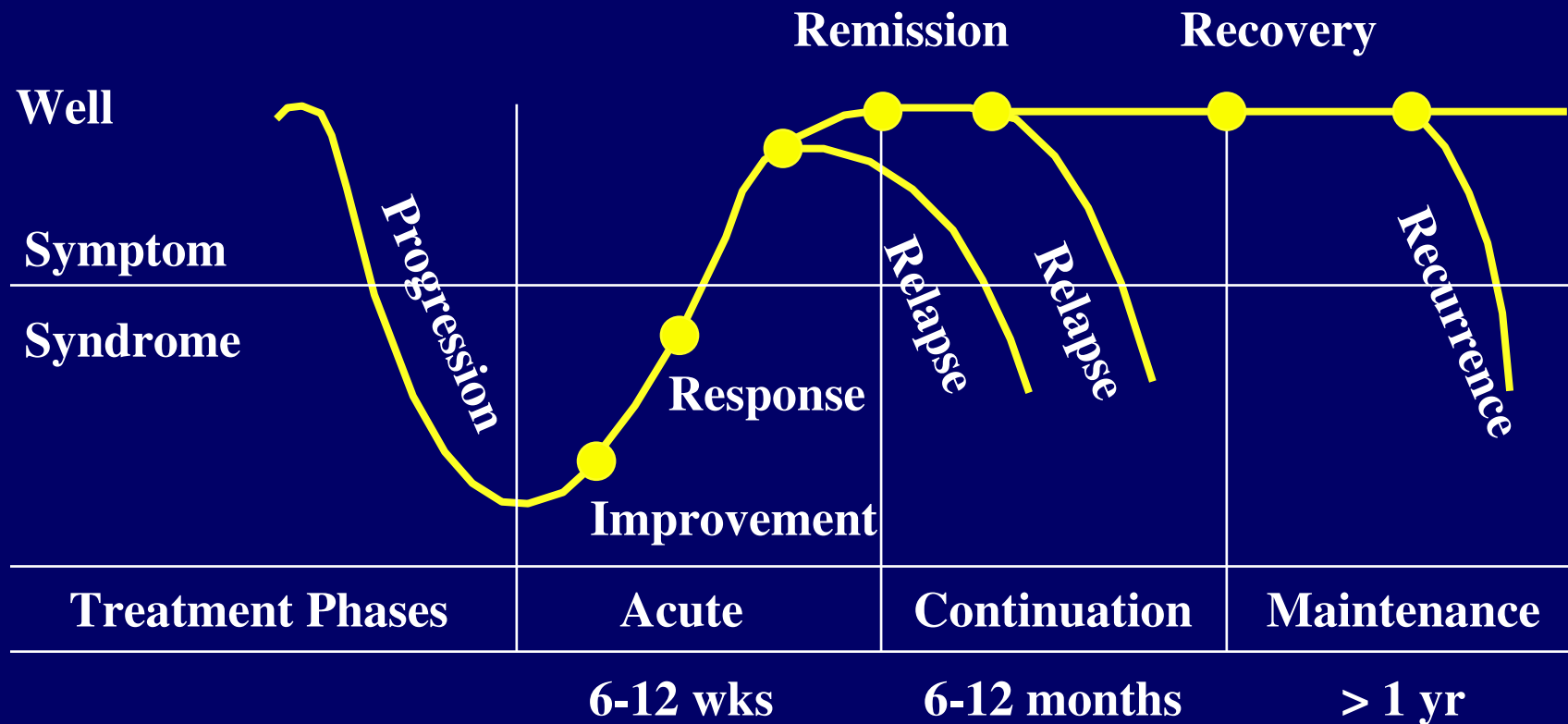
Example of Adolescent Support Card

- Safety Plan (write together and rehearse)
- Doctor's Number
- Therapist's Number
- ER/Hospital Numbers
- Identified Support Network (Family, Pets, Friends, Church)
- **National Adolescent Suicide Hotline**
800-621-4000
- www.suicidelines.com/national.html

Tools for Treatment of Pediatric Depressive Disorders

- Psychoeducation
- Psychotherapy
- Pharmacotherapy

Course of Depressive Disorders



Kupfer DJ. *J Clin Psychiatry* 1991

Education is the Foundation of Successful Treatment

- **Education**
 - Clinical manifestations
 - Course, Duration and Prognosis
 - Treatment Options: Importance of Adherence
 - <http://www.nimh.nih.gov/health/topics/depression/index.shtml>
 - www.wordscanwork.com/
- **Secure GUNS and other means**
- **Identify available supports and how to access**
 - Adolescent Support Card
- **Agree on a treatment plan (including a safety plan; consider practicing it)**

Discuss wellness/lifestyle changes

- **Strengths**
- **Diet (Food and Media)**
- **Breathe and Laugh and Smile**
- **Exercise**
- **Sleep**
- **Participation in School/Learning Supports**
- **Substances (e.g., caffeine, nicotine, alcohol, marijuana, others)**
- **Motivation, goals, values & mindset**
- **Practice Relaxation Response and/or Stress Reduction**

Psychological Treatments for Children & Adolescents with Depression

- Supportive
- Cognitive Behavioral Therapy (CBT)
- Psychodynamic
- Dialectical Behavioral Therapy (DBT)
- Interpersonal Psychotherapy (IPT)
- Family
- Group Psychotherapy
- Self Help Resources

http://depressionbookstore.com/depression_people/teens

FDA Approved Medications to Treat MDD

Name of Medication	Pediatric	Adults
Fluoxetine (Prozac)	✓ (7-17 yrs)	✓
Sertraline (Zoloft)	✗	✓
Paroxetine (Paxil)	✗	✓
Fluvoxamine(Luvox)	✗	✓
Citalopram (Celexa)	✗	✓
Escitalopram (Lexapro)	✓ (12-17 yrs)	✓
Venlafaxine (Effexor)	✗	✓
Duloxetine (Cymbalta)	✗	✓
Bupropion (Wellbutrin)	✗	✓
Mirtazapine (Remeron)	✗	✓
TCAs	✗	✓
MAOIs	✗	✓

FDA Approved Medications for Major Depressive Disorders in Children and Adolescents

Medication for Major Depressive Disorders	FDA Approved for	My Usual Starting Dose Children	My Usual Starting Dose Adolescent	My Usual Target Dose (titrate in 1-2 week intervals)
Fluoxetine (Prozac)	MDD \geq 7	5 mg	10 mg	5-40 mg (children) 20-80 mg (adol)
Escitalopram (Lexapro)	MDD \geq 12	2.5 mg	5 mg	25-200 mg

Other medications that are not FDA approved for treatment of Pediatric Depressive Disorders but may be clinically appropriate include:

Medication for Major Depressive Disorders	My Usual Starting Dose Children	My Usual Starting Dose Adolescent	My Usual Target Dose (titrate in 1-2 week intervals)	Comments
Citalopram (Celexa)	5 mg	10 mg	5-30 mg (children) 10-60 mg (adol)	
Bupropion (Wellbutrin)	37.5 mg IR	100 mg SR	37.5 mg BID to 300 mg XL	Do not use in pts with Sz or Eating D/o
Sertraline (Zoloft)	12.5 mg	25 mg IR	25-150 mg	

A variety of other antidepressant medications that are not FDA approved but may be clinically appropriate

Treatment of Depressive Disorders in Adolescents and Young Adults

- Start low, go slow
- After initiation of pharmacotherapy make plan for regular follow-up & emergency access
- Educate patient and usually family about:
 - Delay in onset of action
 - Possible worsening depression/anxiety/sleep
 - Negative behavior change
 - Discontinuation Syndrome
 - Potential for increase in ‘Suicidality’
 - Symptoms of mania, hypomania & mixed episodes
 - www.parentsmedguide.org

Possible Complications of Treatment with an Antidepressant Medication

- Activation
- Bipolar Switching
- Celebration
- Dimensional Issues/Comorbid Disorders
- Evolving Psychopathology
- Frontal Lobe Symptoms
- Gastrointestinal Side Effects (? Growth)
- Hey! And Hematological
- Suicidality

Walkup & Labellarte, J Child Adol Psychopharmacology 11: 1-4, 2001
Updated 2009

Black Box Warning

Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major Depressive Disorder (MDD) and other psychiatric disorders. Anyone considering the use of [Drug Name] or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. [Drug Name] is not approved for use in pediatric patients....

The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. No suicides occurred in these trials.

Meta-Analysis of Overall Rate of Emergent Suicidality All Types of Antidepressants

Diagnosis	Number Needed to 'Harm' (NNH)
MDD	112
OCD	200
Anxiety	143

Bridge, J. A. et al. JAMA 2007;297:1683-1696.

How Long to Treat?

- Medications help decrease feelings and physical symptoms of Anxiety/Depression
- When ill, kids think that is who they are...
- When they are better, need to 'relearn' who they are
- If they have been ill for XX years, then how long will it take to relearn?
- Sometimes they don't want to come off
- Sometimes the MDs 'forget'
- It is never 'for the rest of your natural life'

How to taper off

- Establish that there is a solid response and return to function for long enough...
- Trial of CBT and/or self-regulation (relaxation response, Biofeedback, MBSR)
- Pick a 'best time' for possible relapse
- Did they experience discontinuation syndrome during treatment?
- Take it down slowly
- Watch like a hawk for a year, educate about early symptoms of relapse

Complementary & Alternative Treatments for Depression

- **Omega-3 Fatty Acids**

- Overall, the data support using omega-3 fatty acids as adjunctive treatment for depression, but appropriate dosage levels and effective omega-3 components or ratios of components need to be established.

- **Folate**

- Folate monotherapy may benefit certain depressed adults, and augmentation with folate may enhance antidepressant efficacy from treatment initiation or may convert partial and nonresponders into responders or even into remitters. Ultimately, many patients with depression may safely benefit from folate supplementation, whether or not they have abnormal folate levels, although more information is needed about using folate in depression. Get Vitamin B-12 too

Complementary & Alternative Treatments for Depression

- **SAM-e**

- Overall, evidence supports the use of intravenous, intramuscular, and oral SAM-e in the treatment of adults with depression, with adjunctive therapy being possibly the most advantageous use. However, additional studies are needed to support its clinical relevance.

- **St. John's Wort**

- Current evidence does not support the efficacy of St John's wort in adults with major depression, and the evidence in mild/minor depression is insufficient to draw conclusions.

Freeman MP., et al., J Clin Psychiatry. 2010 Jun;71(6):669-81 Complementary and alternative medicine in major depressive disorder: the American Psychiatric Association Task Force report.

Light Therapy

- Blue Light Spectrum

Check out www.CET.org

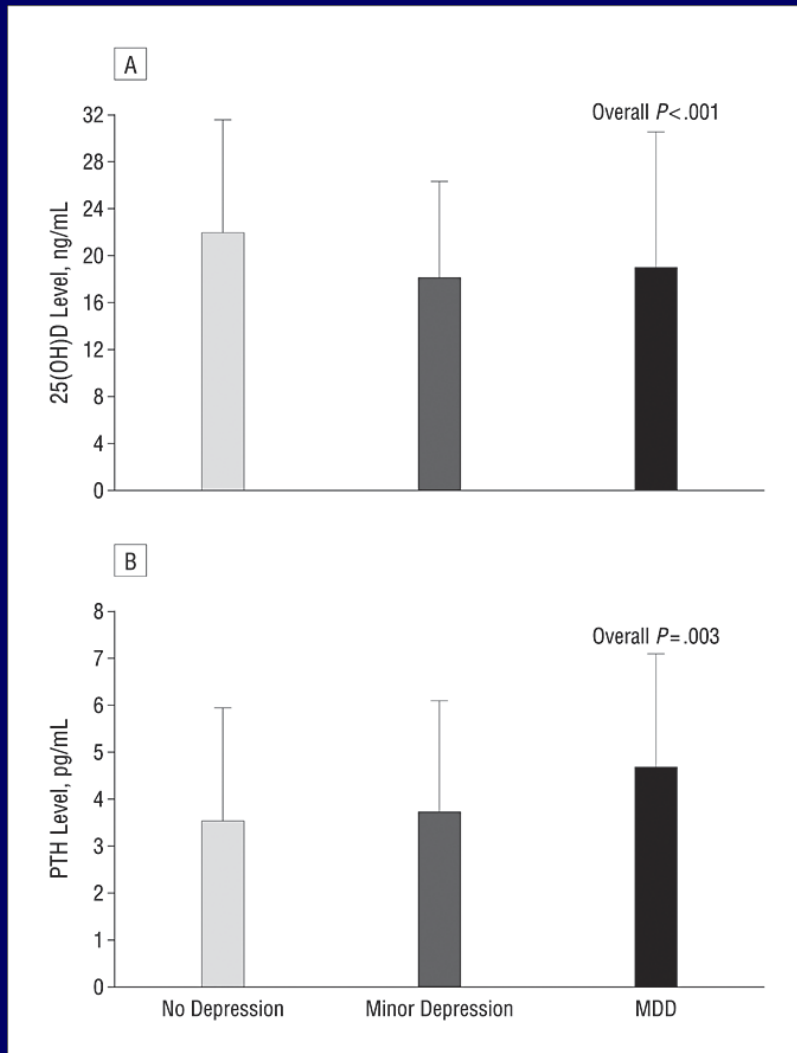
Terman and Terman CNS Spectr. 2005;10(8):647-663

Can Exercise Alleviate Symptoms of Depression

- YES! Exercise reduces patient-perceived symptoms of depression
- As monotherapy
- Relieves symptoms as effectively as cognitive behavioral therapy (CBT) or pharmacologic anti-depressant therapy (SOR: B, meta-analysis) and more effectively than bright light therapy (SOR: B, meta-analysis).
- Resistance exercise and mixed exercise (resistance and aerobic) work better than aerobic exercise alone (SOR: B, meta-analysis). High-frequency exercise is more effective than low-frequency exercise (SOR: B, small RCT).
- "Mindful" exercise, which has a meditative focus, such as tai chi and yoga, also reduces symptoms of depression (SOR: B, systematic review of RCTs).

Gill A., et al., J Fam Pract. 2010 Sep;59(9):530-1.

Vitamin D and Depression



- **Mixed Results**
- Zhao G., et al., British Journal of Nutrition (2010) results did not show significant associations between serum concentrations of 25(OH)D and PTH and the presence of moderate-to-severe depression, major depression or minor depression among US adults.
- Hoogendijk, W. J. G. et al. Arch Gen Psychiatry 2008;65:508-512

Putting It All Together

Child or Adolescent Patient

Medical

ADs
SSRIs
SNRIs
Others
AAP

Psychological

CBT
IPT
DBT

Self

Sleep
Subs
Diet
Exercise
Laugh
Stress
Reduction

Educational

Clarify
LD
504
IEP
Advocate

Supports for Children and Adolescents with Depression

- American Academy of Child and Adolescent Psychiatry
www.aacap.org
- American Psychiatric Association www.psych.org
- Education about Depression and use of antidepressants in adolescents available at www.parentsmedguide.org
- Screening Tools available at www.schoolpsychiatry.org
- The National Alliance on Mental Illness www.nami.org
- A Family Guide: What Families Should Know About Adolescent Depression and Treatment Options
www.nami.org/Content/ContentGroups/CAAC/Family_Guide_final.pdf
- The Depression Sourcebook By Brian P. Quinn, C.S.W., Ph.D.

Risk of Converting to Bipolar Disorder

- 20-40% of youth with MDD convert to Bipolar Disorder if they have:
 - Psychosis
 - Family History of Bipolar Disorder
 - Pharmacologically induced hypomania/mania
- **BUT,**
 - Not all youth who are activated by antidepressants have bipolar disorder

Switching Predictors

- Family history of bipolar disorder
- Psychomotor retardation rather than agitation
- Psychosis
- Hypersomnia
- Rapid onset of depression

“This is the story of an extraordinary boy
with a brilliant mind, a heart of gold,
and a tortured soul. It is the story of an
illness, a fight to live, and a race
against death.”

Danielle Steele,
His Bright Light: The Story of Nick Traina

“There's a tremendous amount
of progress in understanding
bipolar disorder.

It's a bad illness to have,
but a good time to have it.”

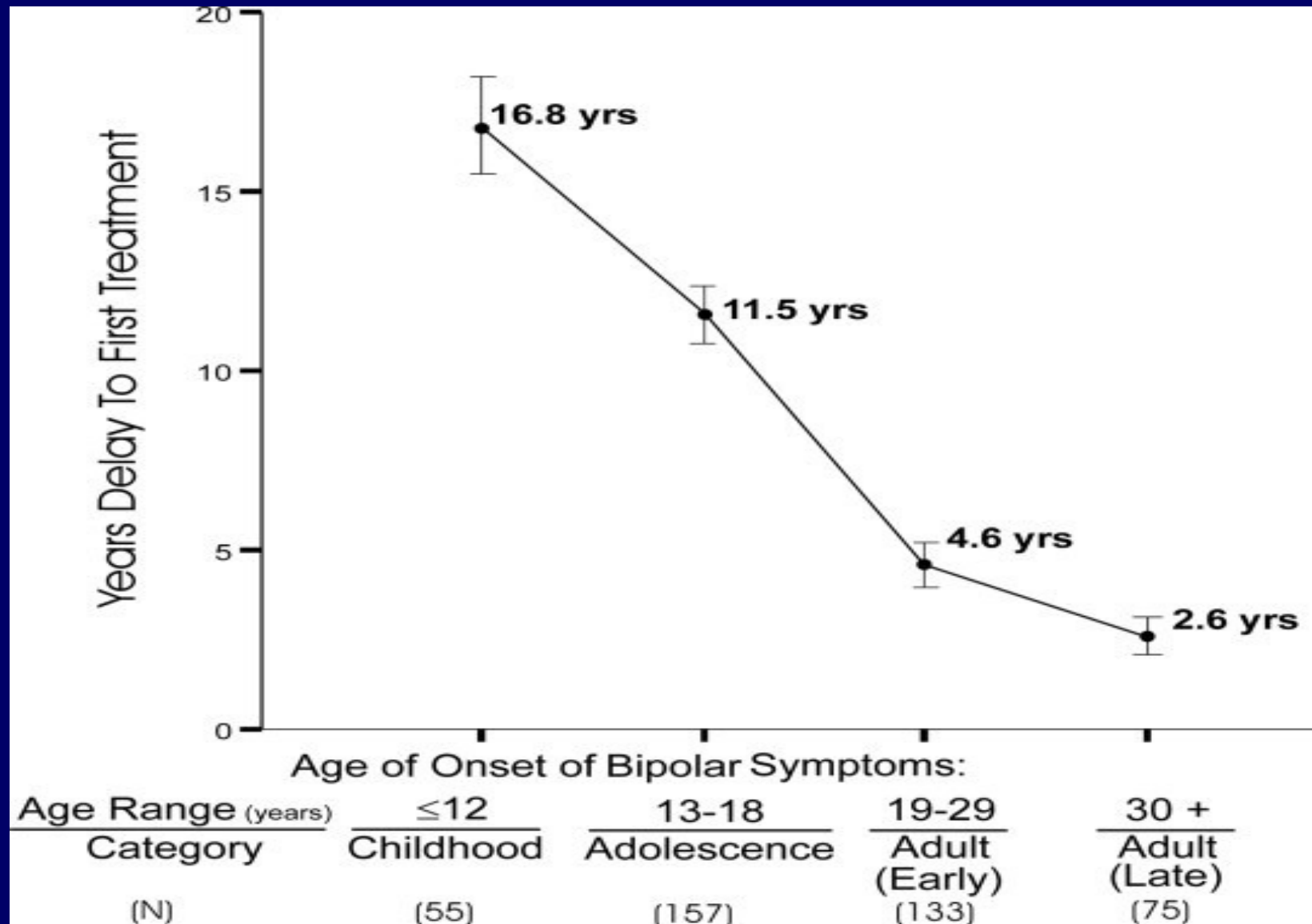
Kay Redfield Jamison, Ph.D.

<http://www.bpkids.org/learn/library/about-pediatric-bipolar-disorder>

Pediatric Bipolar Disorder

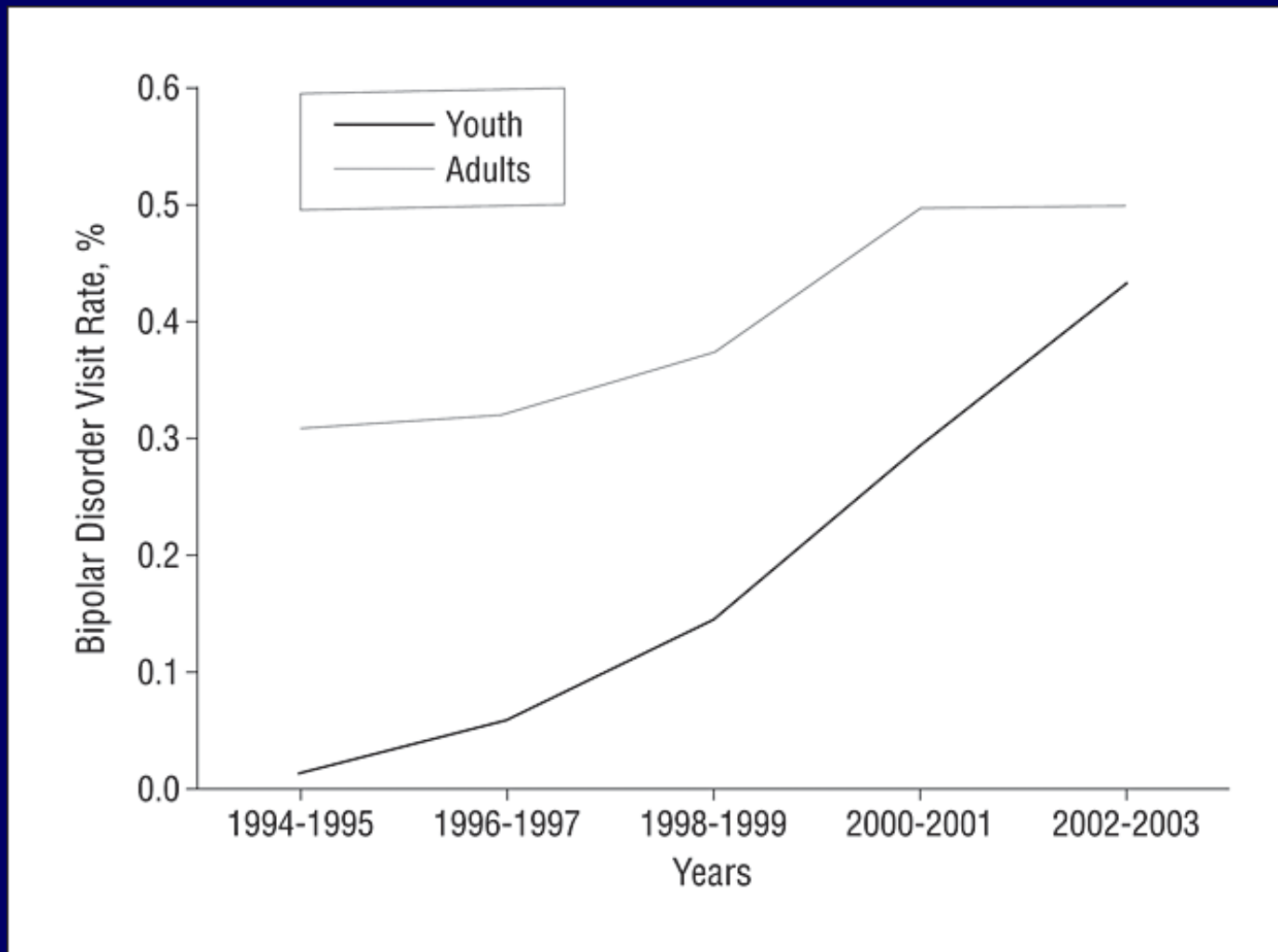
Diagnosis is common,
Impairment is severe,
Treatment is difficult

Delay in Onset of First Treatment



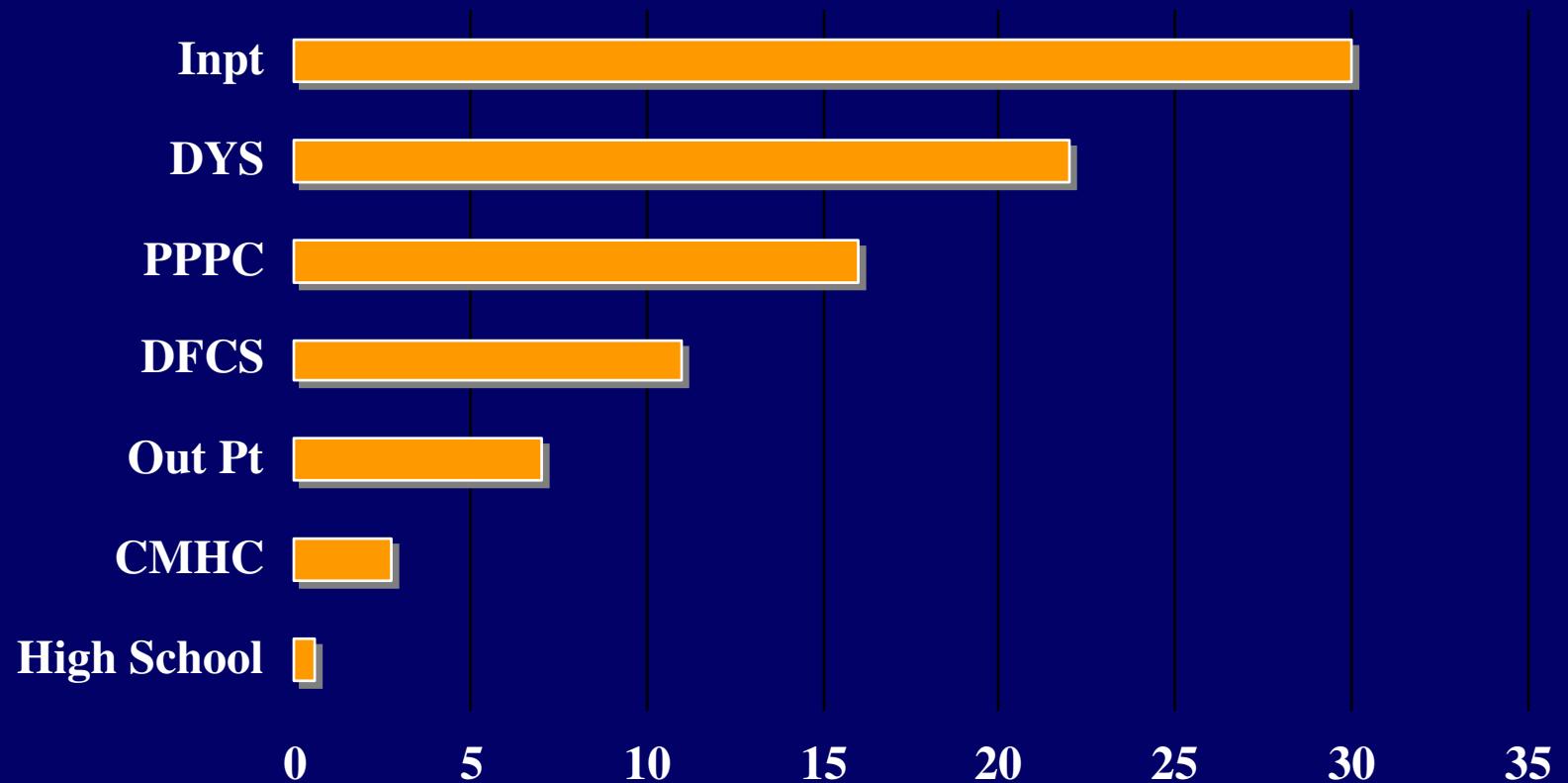
Leverich GS et al., J Pediatrics 2007 150 (5): 485-490

National trends in visits with a diagnosis of bipolar disorder as a percentage of total office-based visits by youth (aged 0-19 yrs) and adults (aged ≥ 20 yrs)



Geller B et al., (2008) AGP 65 (10): 1125-1133

Base Rates of Pediatric Bipolar in Different Clinical Settings



Youngstrom et al., (2005) J Clinical Child and Adolescent Psychology 34 (3): 433-448

DSM-IV-TR Criteria for Bipolar Disorder/Mania

- A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood >1 week
- B. At least 3/7 (4/7 if mood is irritable)
 - D Distractibility
 - I Injudicious actions
 - G Grandiosity or Inflated Self-esteem
 - F Flight of Ideas/Racing Thoughts
 - A Increased Goal-directed Activity
 - S Decreased need for Sleep
 - T Pressure to keep Talking

DSM-IV-TR, APA, 2000

Symptom Domains of Bipolar Disorder

Manic mood and behavior

- Euphoria
- Grandiosity
- Pressured speech
- Flight of Ideas
- Impulsivity
- Excessive libido
- Recklessness
- Social intrusiveness
- Diminished need for sleep
- Racing thoughts

Psychotic symptoms

- Delusions
- Hallucinations
- Formal thought disorder

Bipolar Disorder

Dysphoric or negative mood and behavior

- Depression
- Anxiety
- Irritability
- Hostility
- Violence or suicide

Cognitive symptoms

- Attention deficits
- Distractibility
- Executive functions
- Memory deficits

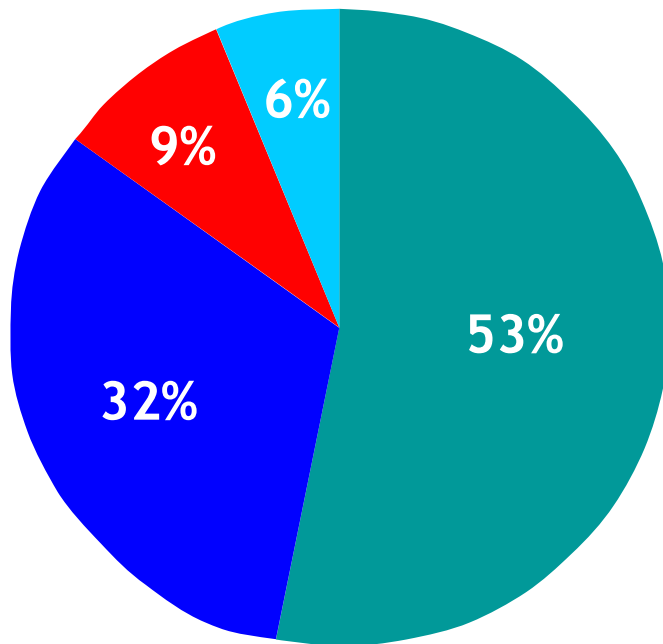
Pediatric Bipolar Phenotypes

- Bipolar Type I
- Bipolar Type II
- Bipolar NOS (not otherwise specified)
- Severe Mood Dysregulation (SMD) or
- ADHD + Conduct Disorder

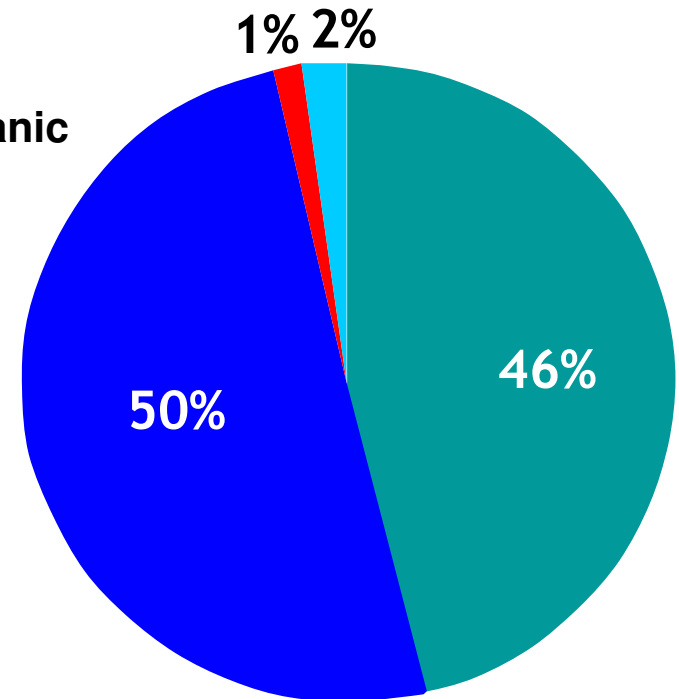
Bipolar Disorder Symptoms Are Chronic and Predominantly Depressive

Weeks:

- Asymptomatic
- Depressed
- Manic or hypomanic
- Cycling/mixed



146 bipolar I patients followed up for a mean of 12.8 years¹



86 bipolar II patients followed up for a mean of 13.4 years²

1. Judd LL et al. *Arch Gen Psychiatry*. 2002;59:530-537.

2. Judd LL et al. *Arch Gen Psychiatry*. 2003;60:261-269.

Comorbidity of Prepubertal & Early Adolescent Bipolar Disorder

<u>Comorbidity</u>	<u>Total N=93</u>	<u>Prepubertal N=53</u>	<u>Pu berta l N=40</u>
ADHD	87% (81 /93)	98% (52 /53)	73%(29 /40)
ODD /CD	76% (71 /93)	79% (42 /53)	73%(29 /40)
Psychosis	60% (56 /93)	55% (29 /53)	68% (27 /40)
Su icidality	25% (23 /93)	26% (14 /53)	23% (9 /40)

43% of sample displayed hypersexual behaviors

Geller, et al., JCAP, 2000 10 (3) 157-164

Four-Year Longitudinal Course of Children and Adolescents With Bipolar Spectrum Disorders: The Course and Outcome of Bipolar Youth (COBY) Study

Corroborating prior COBY findings, this study showed that bipolar spectrum disorders in youths are episodic disorders characterized most often by subsyndromal episodes and less frequently by syndromal episodes, with mainly depressive and mixed symptoms and rapid mood changes.

Birmaher, B et al., Am J Psychiatry 2009; 166:795-804

Longitudinal Assessment of Manic Symptoms (LAMS) study

- NIMH sponsored study of differences in
 - psychiatric symptomatology,
 - diagnoses,
 - demographics,
 - functioning, and
 - psychotropic medication exposure
- in children with elevated symptoms of mania (ESM) compared to youth without ESM.

Findling, RL et al., (2010) J Clin Psych

Is Irritability/Moodiness Excessive for this child/adolescent?

- Mood Disorder Questionnaire Parent/Adolescent Version (**MDQ-A**)
- Short form of the Parent General Behavior Inventory (**SF-PGBI**)
- Young Mania Rating Scale for Parents (**P-YMRS**)

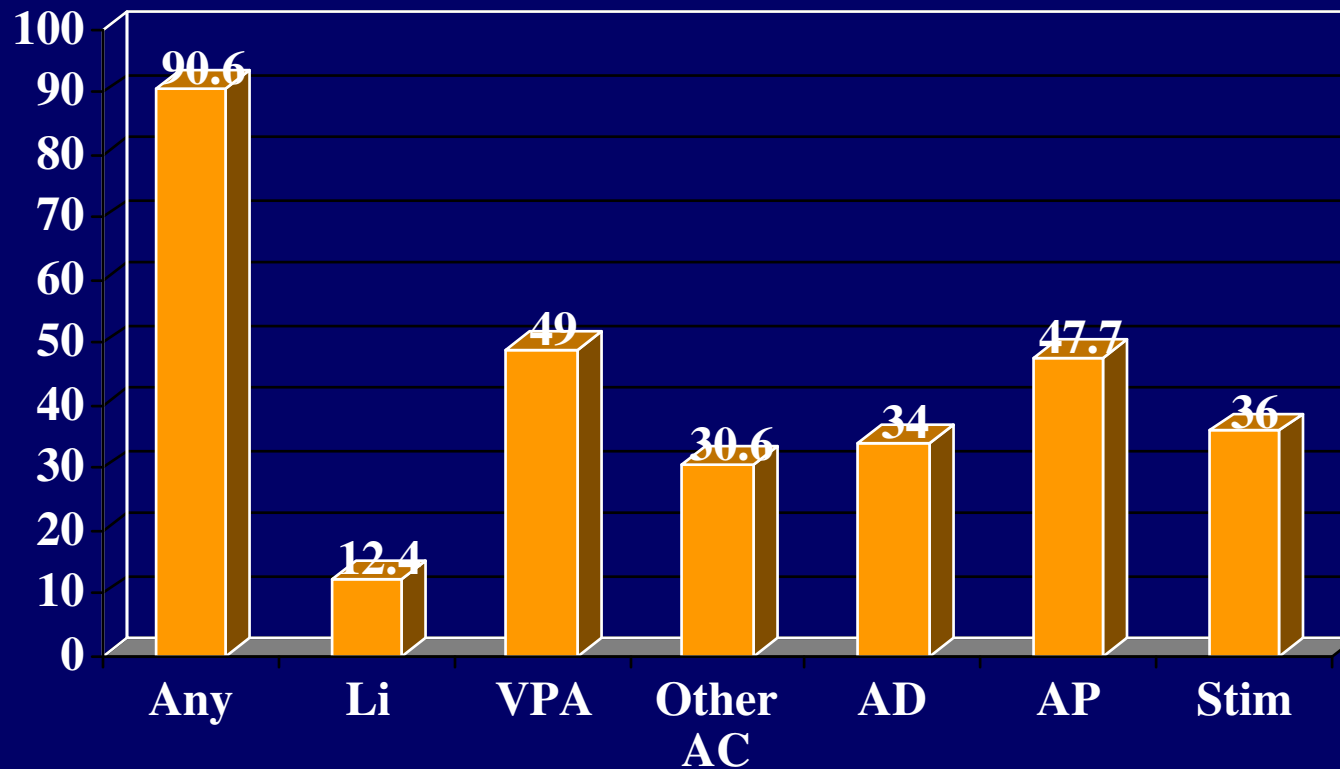
List of Available resources can be found at

www.schoolpsychiatry.org

Pediatric Bipolar Disorder

**No Data linking the controversial
Bipolar Sub-types or their
imitators to effective treatment**

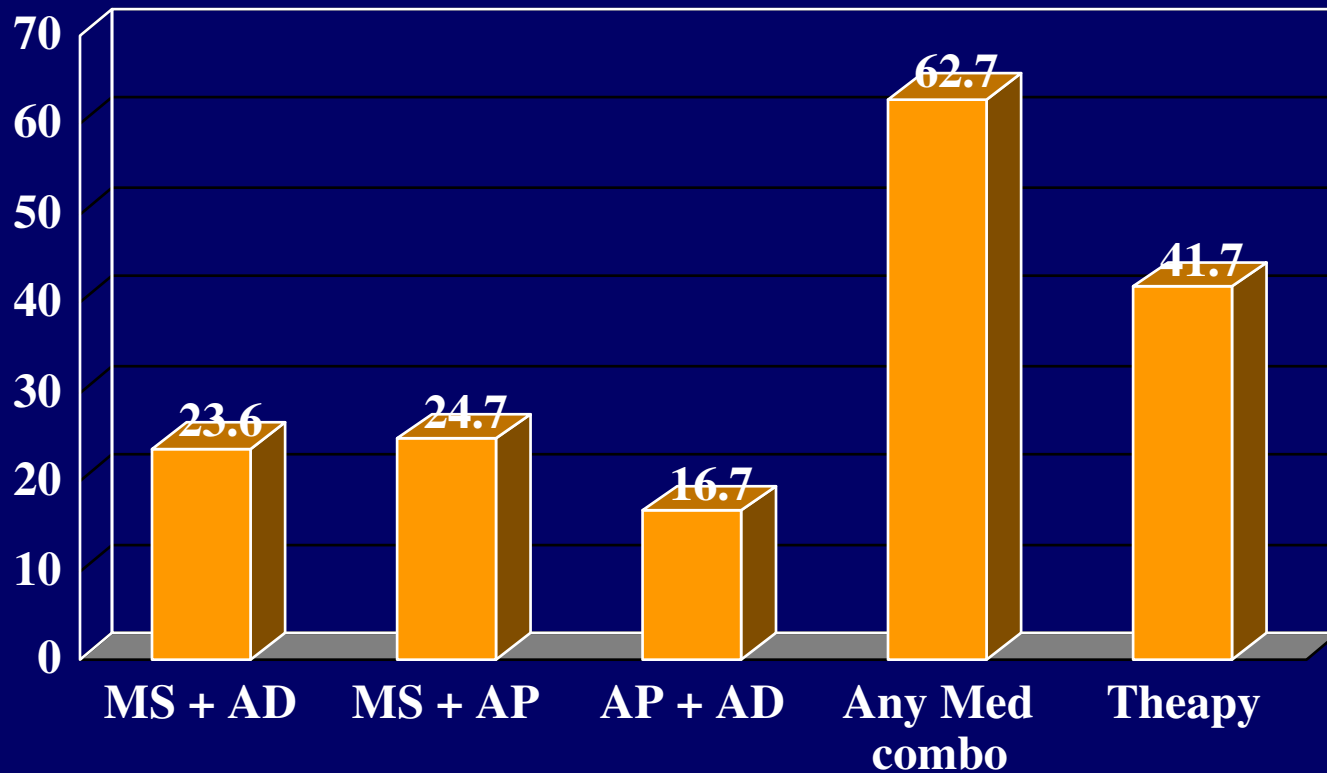
Treatment For Youth with Bipolar Disorder 1999-2003



MS = Mood Stabilizer; AP = Antipsychotic; AD = Antidepressant; AC = Anticonvulsant; Stim = Stimulant

Geller B et al., (2008) AGP 65 (10): 1125-1133

Treatment For Youth with Bipolar Disorder 1999-2003



MS = Mood Stabilizer; AP = Antipsychotic; AD = Antidepressant

Geller B et al., (2008) AGP 65 (10): 1125-1133

Guidelines for Pediatric BPD I Disorder

- **Without Psychosis** (Mixed, Manic)
 - Monotherapy-First Line
 - Traditional Mood Stabilizers
 - Atypical Antipsychotics
 - If moderate or minimal improvement
 - Add a second mood stabilizer or an atypical antipsychotic
 - May Consider Lithium and Valproate prior to adding an atypical
- **With Psychosis**
 - Combined traditional mood stabilizer and atypical
 - If minimal improvement, a combination of 3

Kowatch R et al., (2005) JAACAP 44:213-235

Medications FDA Approved for Pediatric Bipolar Disorder

Medication	Starting daily dose	Usual Therapeutic range*(mg)	Usual daily dosing
Lithium	150-300 mg	300-2100 mg	2-3
Depakote, Depakene	125-250 mg	250-2000 mg	2-3
Lamictal	5-12.5 mg	50-400 mg	2
Risperidone (Risperdal)	0.25-0.5 mg	Usually < 4 mg/day	2-3
Aripiprazole (Abilify)	2-5 mg	2-30 mg	1-2
Quetiapine (Seroquel)	50 mg	100-600 mg	1-2

Anticonvulsants & Lithium: Dosing Guidelines

Available Agents

Lithium (ESKALITH, LITHOBID)

Valproic Acid (DEPAKOTE,
DEPAKENE)

Carbamazepine (TEGRETOL,
CARBATROL, TEGRETOL-XR)

Oxcarbazepine (TRILEPTAL)

Gabapentin (NEURONTIN)

Topiramate (TOPAMAX)

Lamotrigine (LAMICTAL)

Initial & Max Doses

75-150 mg & 1800 mg/day

10-15 mg/kg/d & 60 mg/kg/d

100 mg & 200-400 mg bid-qid

8-10 mg/kg/d & 1800 mg/day

100 mg & 3600 mg/day

25 mg & 400 mg/d

2.5-12.5 MG & 400 MG

Alternative Anticonvulsants: Levetiracetam (KEPPRA)

Zonisamide (ZONEGRAN); Tiagabine (GABITRIL)

Atypical Antipsychotics: Dosing Guidelines

<u>Available Agents</u>	<u>Initial & Max Doses</u>
Clozapine (CLOZARIL)	12.5-25 mg & 400 mg/day
Olanzapine (ZYPREXA)	2.5-5mg & 20 mg/day
Quetiapine (SEROQUEL)	12.5-25 mg & 800 mg/day
Risperidone (RISPERDAL)	0.125-0.5 mg & 6 mg/day (liquid)
Zispraside (GEODON)	10-20 mg & 140 mg/day
Aripiprazole (ABILIFY)	5-10 mg & 30 mg/d

Alternative Antipsychotics: **Low Potency:** Thioridazine (MELLARIL); Chlorpromazine (THROAZINE); **Medium Potency:** Trifluoperazine (TRILAFON); **High Potency:** Molindone (MOBAN); Haloperidol (HALDOL)

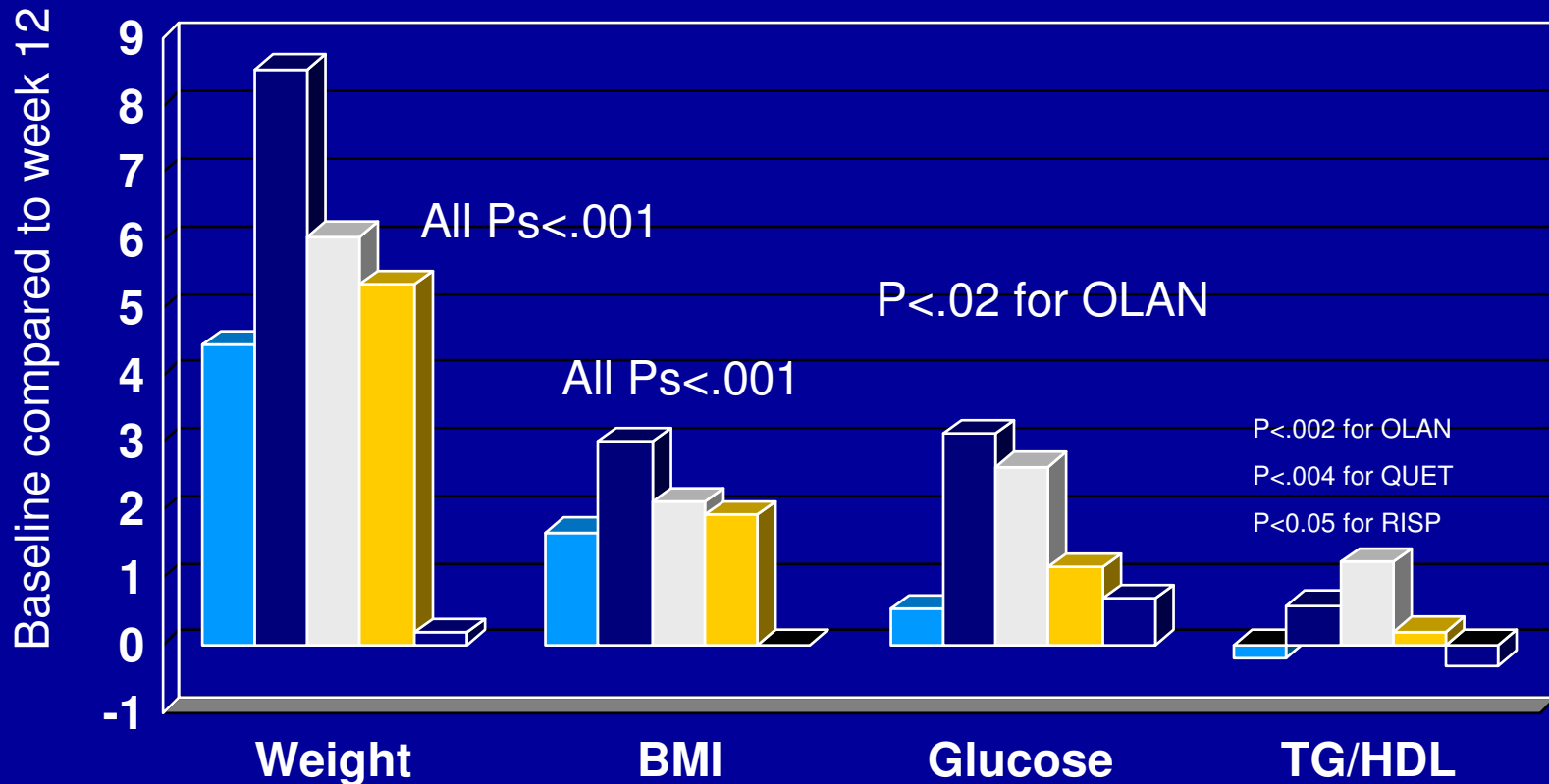
Antipsychotic: Side Effects

Often more prevalent and severe in youth than adults

- Sedation
- Extrapyramidal symptoms
- Akathisia
- Increased appetite and weight gain
- Elevated Prolactin
- Glucose and lipid changes
- ??? Cardiac Arrhythmias: Black Box Warnings in Elderly
- Monitor with Abnormal Involuntary Movement Scale (AIMS)

Cardiometabolic risk of second-generation antipsychotic medications during first-time use in children and adolescents

ARI OLAN QUET RISP UNTX



Correll, C. U. et al. JAMA 2009;302:1765-1773.

ADA Consensus Guidelines: Antipsychotics and Obesity and Diabetes

	B	4wk	8wk	12wk	Q3m	Ann	5 yr
FH _x	X					X	
BMI	X	X	X	X	X		
Waist circum	X					X	
BP	X			X		X	
Fasting BG	X			X		X	
Fasting Lipid	X			X			X

ADA et al., Diabetes Care (2004) 27 (2) : 596-601

Strategies to (Possibly) Reduce Weight Gain, Lower Triglycerides, Support Glucose Regulation

- Lifestyle Changes
 - Diet, Regular Physical Activity
- Metformin
- Sibutramine
- Topiramate
- ? Naltrexone

**For recent review see Miller LJ. Pharmacotherapy.
(2009) Jun;29(6):725-35.**

In this 12-week study, we found statistically significant decreases in mean weight, BMI, waist circumference, insulin, and IRI among patients in the lifestyle-plus-metformin, metformin-alone, and lifestyle-plus-placebo groups but not among those in the placebo-alone group whose measurements continued to increase.

Wu, R.-R. et al. JAMA 2008;299:185-193.

Complementary and Alternative Treatments in Youth with Bipolar Disorder

- Omega-3-fatty acids
- Inositol
- St. John's wort
- SAMe
- Melatonin
- Lecithin
- Acupuncture
- Light Box for Depression
- Folate, Leucovorin, L-Methylfolate
- Micronutrients
- Vitamin D

**For Review of some of these treatments see Potter M et al.,
Child Adolesc Psychiatr Clin N Am. 2009 Apr;18(2):483-514**

“If substantiated in controlled trials, the normalization of the mentally ill via nutrient supplementation would be the most significant breakthrough in the field of mental illness since the beginning of time.”

Bonnie Kaplan, Ph.D

Pediatric Bipolar Disorder

Proposed Solutions

1. Include both 'classic' phenotypes and BP-NOS, SMD (or Conduct with ADHD) in treatment studies
2. Increased NIMH funding for practical comparative clinical trials
3. Formation of a treatment outcomes network

Post, RM Psychiatric Annals (2009) 39 (10): 879-886

Putting It All Together

Child or Adolescent Patient

Medical

AAP
AC
Li
ADHD
Others

Psychological

CBT
IPT
DBT

Self

Sleep
Subs
Diet
Exercise
Laugh
Stress
Reduction

Educational

Clarify
LD
504
IEP
Advocate

Supports for Families & Clinicians with Bipolar Children

- Bipolar Disorder Support Group
 - **1130-1 First Wednesday of Every Month**
 - Basement NSCH
- MassGeneral Hospital for Children at NSMC **Family Resource Center** (Marguerite Roberts or Ivette Tompson 978-354-2660)
- Mood and Anxiety Disorder Institute at MGH
 - www.schoolpsychiatry.com

Supports for Families & Clinicians with Bipolar Children

- Manic Depressive Disorder Association (MDDA)
- STEP

www.Manicdepressive.org

– Download pathways, mood charts, ec

- *Child & Adolescent Bipolar Foundation*

www.bpkids.org

- Medline Plus (A service of the U.S. National Library of Medicine and the National Institute of Health)

www.nlm.nih.gov/medlineplus/druginformation.html

Proposed Changes to DSM V

- Temper Dysregulation Disorder with Dysphoria
- Comes out of the researchers/clinicians articulating Severe Mood Dysregulation (SMD)
- See www.dsm5.org for more information

Temper Dysregulation Disorder with Dysphoria (TDD)

- 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.

Temper Dysregulation Disorder with Dysphoria (TDD)

- **B. Frequency:** The temper outbursts occur, on average, three or more times per week.
- **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 in one setting.**
- **F. Chronological age is at least 6 years (or equivalent developmental level).**
- **G. The onset is before age 10 years.**

So why did the DSM-V decide that TDD is not simply bipolar disorder of childhood?

- Outcome
- Biological Markers
- Treatment response
- Gender Differences
- **You** can participate in the discussion at
- www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=397