

The **A B C s** of Children's Mental Health



A guide for children and youth,
parents and professionals



from **Project LIFE**

ABCs of Children's Mental Health

A Project LIFE publication

edited by

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with research assistance from

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Dedicated to Our Children

Project LIFE is a cooperative program supported by the Missouri Dept. of Mental Health, Division of Comprehensive Psychiatric Services with the Department of Parks, Recreation and Tourism, School of Natural Resources, College of Agriculture, Food and Natural Resources; and University Extension at the University of Missouri.

Our mission is to advocate for the quality of life of people with mental illnesses and to advance their independence in leisure pursuits and community programs.

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— *Kristen Heitkamp, Editor*

Note to Readers

Until recently, professionals and the public assumed that many mental illnesses (such as anxiety disorders, depression and bipolar disorder) began after childhood. Yet these can begin much earlier.

What are commonly called “mental illnesses” are neurological disorders of the brain, that is, disorders of the brain's nervous system that affect mood, perceptions and behavior. Today, thanks to advances in the mental health field, brain disorders can be managed, much like juvenile onset diabetes.

According to the National Institute of Mental Health:

An estimated one in ten children and adolescents in the United States suffers from a mental illness severe enough to cause some level of impairment. Fewer than one in five of these children receives treatment. Perhaps the most studied, diagnosed, and treated childhood-onset mental disorder is attention deficit hyperactivity disorder (ADHD), but even with this disorder there is a need for further research in very young children. Children rapidly change during their developmental years. Diagnosis and therapy of brain disorders must be viewed with these changes in mind. While some problems are short-lived, others are persistent and respond best to early intervention.

Some disorders can be alleviated by medication. Some will respond to behavioral therapy. A combination of both therapies are necessary and integral to healing.

In this book, you'll find strategies for promoting the mental health of children and youth, as well as information about neurobiological brain disorders, some developmental disabilities, and serious emotional disturbances that may occur in childhood. These are clinically defined in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. (DSM-IV)*, which is the “trade bible” for assessment and diagnosis.

What's in a name?

In this book, you'll find words that are used interchangeably to describe mental illnesses. Definitions of these words, found below, will help you understand each term and its context.

Behavioral disorder

"Behavioral disorder" invariably refers to serious emotional disturbance or mental illness. This term may be used most frequently in the schools.

Brain disorder

Brain disorders are biologically inherent, and impair mental performance. Many people use the phrase "brain disorder" in reference to a mental illness. This is entirely appropriate, however, many insurers will cover treatment only if the diagnosis is categorized as a "serious emotional disturbance."

Developmental disability

These are neurobiological disorders of the brain, such as Down's syndrome and autistic disorders, in which a child does not fully achieve developmental functioning.

Individualized Education Plan (IEP)

Federal law mandates that public schools accommodate all children. A component of accommodation is an individualized education plan (IEP). Using input from parents, teachers, and other professionals, the plan is designed to maximize a child's school performance. Depending on a child's diagnosis, the IEP includes strategies such as "taking verbal, rather than written tests" or "giving the student extra time to finish tests."

Mental illness

Children who have mental illnesses are faced with a double whammy—the illness itself and the stigma attached to it. Sometimes the stigma is worse than the illness itself. Parents are reluctant to have their children "labeled" with a mental illness, knowing that the label will define their children for life. Some parents (and kids) are more comfortable with the

term “serious emotional disturbance.” Others, like the advocacy group National Alliance for the Mentally Ill (NAMI), use “brain disorder.”

Regardless, having a mental illness is no different than having diabetes or cancer. The illness can be managed with medication and there is hope of recovery.

Neurological disorder

Some disorders are rooted in the nervous system, thus the term “neurological.” These may or may not impair mental functioning. Examples are migraines, Tourette Syndrome (which has a DSM-IV classification), and epilepsy.

Neurobiological brain disorder

We don't know all the causes of mental health problems in young people. We do know that both environment and biology can be involved.

Examples of biological causes are genetics, chemical imbalances, and damage to the central nervous system. The medical profession refers to these as neurobiological brain disorders.

—from The Center for Mental Health Services (CMHS) pamphlet, “Your Child's Mental Health: What every family should know”

Serious emotional disturbance (SED)

The phrase “serious emotional disturbance” for children and adolescents refers to mental health problems that are severely disrupting daily life and functioning at home, at school, or in the community. “Serious emotional disturbance” (SED) is federal-defined language which, when applied to a diagnosis, can make it easier for a child to receive mental health services. What determines a SED? The classification varies, for instance, although it has a DSM-IV classification, conduct disorder is not a SED.

What Is Mental Health?

Mental health is a term for how we think, feel and act, in order to face life's situations. It is how we look at ourselves, our lives, and the people we know and care about. It also helps determine how we handle stress, relate to others, evaluate our options, and make choices. Everyone has mental health. (National Institute of Mental Health)

Like physical health, mental health is important at every stage of life. Caring for and protecting a child's mental health plays a major part in helping children grow to become the best they can be.

Nurturing Your Child's Mental Health

The best medicine is a positive attitude. Many children respond to a nutritional diet, sleep and exercise, and learning new skills. Outdoor recreation has been shown to be a strong component of recovery. For instance, practitioners note that therapy for childhood depression includes active experiences—hiking and biking, swimming, sports, martial arts and dance. Art and music help develop ways to express emotions.

Support groups offer both children and parents timely information and validation. Parental advocacy, community education and clinical research are equally important components of support.

Parents and other caregivers are responsible for children's physical safety and emotional well being. Parenting styles vary; there is no "right way" to raise a child. Clear and consistent expectations for each child (by all caregivers) are important. Many good books and videos are available in libraries and bookstores on subjects such as child development, constructive problem-solving, discipline styles, and other parenting skills. The following suggestions are not meant to be complete, but offer a place to start.

- Take care of basics: nutritious meals, regular health checkups, immunizations and exercise.
- Be aware of stages in child development so you don't expect too much or too little from your child.
- Encourage your child to express feelings; respect those feelings. Let your child know that everyone experiences negative feelings such as pain, fear, anger and anxiety.
- Try to learn the source of these feelings. Help your child express anger positively, without resorting to violence.

- Promote mutual respect and trust. Keep your voice level down—even when you don't agree. Keep communication channels open.
 - Listen to your child. Use words and examples your child can understand. Encourage questions.
 - Provide comfort and assurance. Be honest. Focus on the positives. Express your willingness to talk about any subject.
 - Look at your own problem-solving and coping skills. Do you turn to alcohol or drugs? Are you setting a good example? Seek help if you are overwhelmed by your child's feelings or behaviors, or if you are unable to control your own frustration or anger.
 - Encourage your child's talents and accept limitations.
 - Set goals based on the child's abilities and interests—not someone else's expectations. Celebrate accomplishments. Don't compare your child's abilities to those of other children; appreciate the uniqueness of your child.
 - Spend time regularly with your child.
 - Foster your child's independence and self-worth.
 - Help your child deal with life's ups and downs. Show confidence in your child's ability to handle problems and tackle new experiences.
 - Discipline constructively, fairly and consistently. (Discipline is a form of teaching, not physical punishment.) All children and families are different; learn what is effective for your child. Show approval for positive behaviors. Help your child learn from his mistakes.
 - Love unconditionally. Teach the value of apologies, cooperation, patience, forgiveness, and consideration for others. Do not expect to be perfect; parenting is a difficult job.
- reprinted with permission from *The Girl Power! Campaign*, under the leadership of the Center for Substance Abuse Prevention (CSAP), Substance Abuse and Mental Health Services Administration (SAMHSA), collaborating with the Center for Mental Health Services (CMHS).

Leisure as a Positive Experience for Children with Attention Deficit/Hyperactivity Disorder

by Geoff Lanham, Project LIFE

Attention Deficit/Hyperactivity Disorder (ADHD) is one of the most frequently diagnosed behavioral disorders of children. Between 5% and 10% of the children in the United States are affected with this syndrome. Many may also have a learning disability (difficulty in writing or processing information) or coexisting disorders (e.g. Oppositional Defiant Disorder). Many children with ADHD also tend to have problems with self-esteem and self-concept, anger control and relationships.

Children with ADHD easily get bored and distracted (attention deficit), acting without thinking first of the consequences (impulsivity), and constantly fidgeting with their hands, feet, or entire body. Sometimes they act as if they are being driven by a motor burning high-octane fuel (hyperactivity). ADHD children are thrill seekers and can be highly emotional.

Children with ADHD also have spunk, resilience, persistence, charm, creativity and a hidden intellectual talent. There is a link between ADHD and giftedness. These children have vivid imaginations and quickly can generate new and different ideas. They love to ask questions about why things work, and are wonderful assets in problem solving and brainstorming.

ADHD is not a disorder that is outgrown as the child grows into adulthood. Some of the symptoms lessen over time, because the adult learns coping skills through a lifetime of dealing with this disorder. So how can leisure help children with ADHD? Leisure and recreation will not make this disorder go away, but it can be used as a tool to help them with the struggles of every day life.

Preschool-Age Children

Preschool-aged children spend the majority of their day in play. Providing them with opportunities to be creative, to discharge large amounts of energy, and to move from one activity to the next can result in a positive play experience. During this time the parent (or caregiver) may be able to help the child develop social skills, academic skills, self-esteem and numerous talents that are useful throughout life.

It is important for young children to have several different activities in which they can participate at one time. Because they often become bored quickly, one activity may not hold their attention for an extended period of time. For the child who is alone with the caregiver, there may be few problems. But for the caregiver with more than one child, there must be set rules during play time. The ADHD child (and other children, as well) must be taught that possession of a piece of equipment is determined by its use—whoever is using it can keep it until finished with it. Pushing or hurting each other is forbidden. They should be asked to share.

Play Activities

Children with ADHD are often very creative, therefore, toys that encourage them to be creative and use their imagination may hold their attention and provide more than just a few minutes of play. Large puzzles work well with the ADHD child. Putting the pieces together takes time to figure out exactly where the piece will fit and will allow the child to see the picture come together, right in front of their eyes.

LEGOS AND LINCOLN LOGS are toys that encourage imagination and creativity. They can be used to build castles, houses, trucks and cars. The bright and different colors stimulate the senses and promote creativity. As the parent or caregiver, help them use their imagination by offering suggestions, and *always* provide positive feedback no matter what they build. When they get frustrated during play, it is important to build on their strengths (or what they have accomplished), rather than to criticize them for something “negative” that may have occurred during play.

BUBBLE BLOWING is another activity that can keep kids entertained for an extended period of time. When you give them the opportunity to create bubbles with different bubble-blowing wands, they may go back and forth from one wand to another. They will also enjoy watching the parent (or caregiver) blow bubbles. You can talk about the different sizes and shapes, where the wind is carrying the bubbles, how long they last, and how many bubbles a particular wand can produce. Use imagination and let the kids laugh and have fun. Let them run around the yard with the wand; they may get a little soapy and sticky, but the time spent will be well worth it.

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SIDEWALK CHALK is fun without making a mess inside the house. Children can draw whatever they want and will probably ask you to help. To show how big they are, have them lie down on the sidewalk and trace a chalk line around them. Fill in the silhouette with what they are wearing or draw some funny eyes and a mouth on it. Have them trace around you.

Work together to fill in what you look like. Draw pictures of their favorite activity or toy. Have children use their imagination and allow them to use their favorite colors. Who said that clouds always have to be white? Purple clouds can work, too. After all, there is a purple dinosaur, isn't there?

CARDBOARD BOXES and blankets are great for building a tent or fortress. Kids can camp in the "outdoors" and not leave their bedroom. Have you ever given kids an expensive toy that comes in a big box, only to see them play with the box for a much longer time than the toy? They may become bored with the toy because it is limited in its use, but the box or blanket promotes their imagination. Children with ADHD may use the box as a train one minute, and the next, they will be climbing through the clouds aboard a jumbo jet.

Contact an appliance store to see if they have any large boxes available. The wonderful thing about boxes is that they are inexpensive, abundant, and can be recycled when they are no longer usable. You can also create a wonderful playground with these boxes. Creating tunnels or caves will provide kids with countless minutes (or if you are lucky, countless hours) of play time.

SINGING AND DANCING give children with ADHD the chance to have some active fun. Younger children love to sing songs, and you can have fun with them in a number of ways. They have remarkable memories, and you can play games as you sing the songs. Have them fill in the last word as you sing a particular line of the song. Create your own funny songs, letting them fill in the last words as you make up the lyrics. Dance about with them as you listen to the words of their favorite songs. Act out the words as the song is being played. Let kids clap their hands and stomp their feet. Let them sing and dance and fill the room with laughter.

PLAYGROUNDS and parks are great places for kids to roam. Give children the chance to run from one apparatus to another. Provide them with the opportunity to use their imagination during play. They often act as if they are driven by a motor. This will give them the chance to

burn off some of that high-octane fuel. Try to find a park that has many different types of play equipment.

Sand pits, climbing tires, slides, swings and plenty of area to roam will keep them entertained. It is important to note that children with ADHD have little fear and are thrill seekers. They may climb to the top of the slide, and decide to jump instead of sliding down. The child with ADHD may also run to a different part of the playground, and be out of sight in the blink of an eye. Don't let yourself get distracted by other children and outside stimuli. Keep a watchful eye on your child.

It's Very Important to Play

It is very important that the parent (or caregiver) play with the child. The importance of the parent/child play time cannot be overemphasized. It is crucial for family harmony. At these times, permit your inner child to respond to them, so that a new and special bond can form, one that strengthens and expands the other loving and caring feelings that connect you. Parents who make a special place in their weekly schedule for a regular play time with their children usually find the experience surprisingly reassuring and fulfilling, even when other aspects of their relations with their child are less positive or pleasant.

Being able to have fun with your kids is essential to enjoying their company, regardless of any other feeling you may have towards them. A regular play time has a number of important rewards. It allows regularly available high-quality time for interacting and socializing. It can be a pleasant change from conflict-laden interactions, and can also counterbalance the less intense experiences that occur when parents have busy schedules.

By allowing yourself to become totally immersed in the play experience, you can temporarily abandon outside concerns, and can focus on your home and family, using the opportunity to train your kids in important skills.

Activities for Older Children

As the children get older, their leisure interests will change. The cardboard box and large puzzles may no longer hold their attention. When they start school, their interests will probably become similar to those of their classmates and friends. They will now have the opportunity to par-

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ticipate in team sports. They must interact with teammates, and learn that the games are often played with rules. This can be a trying time for them. With help from the parent and coaches, they can have a positive experience.

As with preschool children, it is very important to remember to always look for the positive in what they are doing and what they have accomplished. Children with ADHD (and other children as well) are constantly bombarded with negative comments from parents, siblings, teachers and friends. When they become disruptive, it is helpful not only to point out to them what they have done wrong, but also to provide them with constructive criticism and positive feedback at the same time. You may have to search very hard to find something positive to say, but with constant practice, you can get the job done.

Individual Activities

FISHING is a wonderful leisure activity that can provide them with a positive experience. Because ADHD children often experience difficulty staying still, fishing gives them the chance to move around while fishing the pond or lake, without being criticized.

Using different artificial baits will give kids the opportunity to cast and retrieve. The repetitive motion of casting and retrieving artificial baits and lures is not as boring as sitting in one place, and will make the experience more enjoyable. Finding a fishing spot that is abundant with pan fish (blue gill, sunfish, etc.) can provide the angler hours of fishing enjoyment. A simple fishing pole with a cork bobber, and a hook baited with worms, can give them the chance to catch many fish.

Take your child to a local bait and tackle shop. Find out what lures and live bait work for a particular species of fish. Subscribe to fishing magazines or go to the local library and check out books on fishing. To increase the chances of bringing home your dinner, find out what fish are abundant in your area. Catching the fish can be only the first step in the leisure experience. If you plan on eating what you have caught, then planning a menu, inviting friends over for a fish fry, and cooking the fish can be part of the fishing experience.

BICYCLING/TRAIL RIDING. Riding a bike on a trail can be an activity that is done with the entire family. Trail riding can provide them with exercise to combat their hyperactivity, the chance to view nature, an opportunity for a family picnic, and a time to just have some fun.

You can also make it an educational experience by researching the different wild flowers and trees that may be blooming. Have your children point out the various plant life as they ride the trail. This will help them focus as they trail ride and make the trip more enjoyable.

Children with ADHD soak up information like a sponge. You will be amazed at the amount of information they retain and the joy you will have as they share this with family and friends.

Leisure Activities and Education

As the child grows older, the parent (or caregiver) can use each recreational experience as an opportunity to teach children with ADHD something new. This experience also can incorporate what they are learning in school with the leisure experience. If they are learning about ecology in school, then the fishing trip can be a lesson in ecology. Talk to children about the importance of clean water, removing litter from the fishing site, the food chain and the role that fish and aquatic life play in the process.

Recreational activities also can help children who have learning disabilities. As stated before, many children with ADHD are also very intelligent or gifted, but they may have test anxiety, or problems with reading, writing or processing information. They may feel they aren't intelligent, because they have to stay in during recess (or after school) to get assigned work completed. Using a recreational activity as an example may help them have a better understanding of their schoolwork.

A student may be struggling in the classroom with math. Using examples from a football game can help them with their math skills. By removing them from the "school setting" and placing them in an environment that is more comfortable, they will be able to answer the questions. Offering positive reinforcement after each question will help them feel better about their math skills and may help in the classroom next time they take a test.

Baseball is another sporting event with numbers. Calculating batting averages, earned run averages, slugging percentages, and on-base percentages are just a few examples you can use to help them work on their math skills.

Individual/Team Sports

As children with ADHD get older, they may want to participate in team sports. Because of their hyperactivity and inability to stay focused, this can present a problem. However, with advanced planning and help from the parents and coaches, these obstacles can be overcome.

BASKETBALL. Children with ADHD may have trouble remembering a particular play in basketball, or have difficulty staying focused during a baseball game. Provide them with opportunities to participate without worrying about making mistakes. This can be a big boost to self-esteem, and help them develop into team players.

Many youth basketball leagues do not allow the opposing team to press during the game. Provide them with a positive experience and allow them to pass the ball in after the opposing team makes a basket. There is no pressure, it is a task that is easily accomplished, and they are directly involved in the game. This will make them feel as if they are an integral part of the team.

BASEBALL is a game in which (even for children with a great attention span) it can be hard to concentrate while playing. For children with ADHD, this can be an even more difficult task. Use verbal cues or hand gestures to remind them to stay focused. You may tell them before the game that when they see you give them the "THUMBS UP" sign and call their name, it is time to pay attention.

Always follow up with some type of positive reinforcement. It also may help to play them in a position that requires concentration or remaining focused. Catching is a position that will allow them to be involved on each pitch. When they are not playing in the field, you may have them keep score, warm up the next pitcher, or take care of the bat after a player has hit. This will keep them involved. Keeping the same batting order each game will help them remember their place in the lineup. Have the players sit on the bench in that order when they are off the field. This will be a reminder of what order they are to bat, and will also help the other players too.

SOCCER is a game that involves constant motion. Children with ADHD can play an important role in the team's success. They get to run a lot in a controlled environment, burning off excess energy, and end up having great fun. They never seem to tire, so they may be able to play the entire game. Once again, providing verbal cues and gestures can help them stay focused throughout the game.

WRESTLING is a sport at which children with ADHD can excel. Wrestling requires that they are active, but for only a short period of time. Wrestling matches consist of three periods, lasting two minutes each. They only need to focus on their opponent and the clock.

COMPUTER/VIDEO GAMES will keep them entertained for hours on end. Unfortunately, it is easy to use these games as baby-sitters, so you will need to encourage the child to learn while they are playing. For example, they can learn different football defensive schemes or different basketball plays by playing these games. They will amaze you with how well they pick up these plays and relate them to games they watch on TV. There are also many educational games that can teach the child to spell, write, and learn math. Often, they will be learning without realizing it.

Summary

Leisure activities can breathe fresh air into the life of children with ADHD. A positive experience will provide them with the chance to share their successes with you and their friends. They will learn about teamwork, discipline, and perhaps learn new ways to do their schoolwork. They will amaze you with their knowledge, and the joy they receive from a job well done. Leisure is not the end-all for children with ADHD. Proper behavior modification, medication, and positive reinforcement from family and friends will go a long way to help them.

It is vital for parents of children with ADHD to become involved. Volunteer to become coaches or assistant coaches. Constantly look for ways to use recreation and leisure as a learning opportunity for your children, and to turn this time together with the ADHD child into a positive and enjoyable experience.

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Passive Lifestyle Stress

While the forgoing article targets children with ADHD, the suggestions for leisure activities apply to all. Every child will benefit from an active life-style. The deficits of sitting around have been reported by the U.S. Surgeon General: there are more obese children today than forty years ago. And there are more depressed children. What's do these statistics have in common? TV.

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A growing number of proponents argue that television plays a strong role in the development of ADD and ADHD symptoms. The effects of television watching are well-documented. Pediatrician Barry Brazelton has written that sitting in front of a television will cue a child's neurological system to turn on, thus making a child tense and irritable when the television is turned off. (T. Berry Brazelton; Chapter 41; "Television," *Touchpoints*; Addison Wesley; Reading, MA. 1992).

Television flickers at an average rate of about once every 3.5 seconds. The average American child in the crucial formative years of birth through age five watches over 5,000 hours of TV. That may be too much for a young child's neurological system. For background on the suggested relationship between TV and ADD, see the resources listed on the web site "TV, ADD & ADHD" at <http://www.limitv.org/tvaddadhd.htm>.

TV Usage Stats

Number of minutes per week that the average American child watches television: 1,680

Number of minutes per week that parents spend in meaningful conversation with their children: 38.5

Number of murders seen on TV by the time the average child finishes elementary school: 8,000

— from "The Boob Tube," *San Francisco School for Children web site* at <http://www.sfschool.org/student.htm>

The Family Dinner

Don't have family dinner time? Too busy running children around town? Ever think of retiring your children's daily schedule? Psychologist John Rosemund remarked that *not* granting your children extracurricular activities could be the best action you take as a parent! Instead of spending your time on the road, spend time at the dinner table. The family that eats together may stick around the table and talk with each other.

Children are happier when they feel that they make a contribution to the family. Teach your children how to shop, cook and clean the sink. Ten-year-old kids can make dinner, even if it's hot dogs! After all, where will they learn these important life skills if they don't learn from you?

Neurobiological brain disorders A to Z

Anorexia Nervosa

“Lose Weight. Feel Great. Be Happy.” You could say that this sums up the thought pattern of a person with anorexia. The features of Anorexia Nervosa are that the person “refuses to maintain minimal body weight [for age and height], is intensely afraid of gaining weight,” and has “significant” misperceptions of body image. People who have Anorexia Nervosa will typically deny reality and think that their bodies are too fat. Often they strive for perfection or accomplishments, and yet never feel rewarded. Underlying stress, depression or anxiety may cause the initial negative body image. Calorie-counting is a way to gain control over one's life, thus the emphasis on diet and exercise.

While the average age of onset is 17, it has been noted in individuals (90% are females) as young as 13. Research suggests that about one percent (1%) of female adolescents have anorexia. That means that about one out of every 100 young women, between ten and twenty years of age, is starving herself, sometimes to death.

The primary medical deficits of anorexia are those associated with starvation, such as osteoporosis, laguna (fine hair growth on the body), hair loss, anemia, memory deficiencies, gum disease, chronic fatigue and lack of motivation.

It is important to note that anorexia can be reversed, and that there are many survivors of this disorder. Behavioral motivation therapy, nutritional therapy and group therapy may help reverse this condition. Therapy includes building self-esteem, behavior modification, and/or administration of a selective serotonin reuptake inhibitor medication (SSRI).

Anorexia Nervosa Resources

See *Eating Disorders*

Anorexia Nervosa Support

American Anorexia/Bulimia Association, Inc.; 239 Central Park West,
Suite 1R; New York, NY 10024; (212)501-8351

ANRED: Anorexia Nervosa and Related Eating Disorders
(web site) <http://www.anred.com>

National Association of Anorexia Nervosa and Associated Disorders;
P.O. Box 7; Highland Park, IL. 60035; (847)831-3438;
FAX (847)433-4632; info@anad.org

Anxiety Disorders

Anxiety disorders include eating disorders (Anorexia Nervosa and Bulimia Nervosa), obsessive-compulsive disorder (OCD), phobias, pica (eating clay, dirt or sand), panic disorder and posttraumatic stress disorder (PTSD). *See individual entries for descriptions of each disorder.*

Anxiety disorders are typified by behavior that attempts to avoid a traumatic situation or to alleviate the anxiety surrounding a traumatic event. An anxiety disorder is diagnosed if the behavior limits a person's ability to function at school or at work, or in social interactions.

In general, anxiety disorders are caused by neurological deficiencies, that is, lack of certain chemicals that work in the nervous system. Just as diabetes is associated with levels of glucose and insulin, anxiety disorders are related to levels of neurochemicals such as serotonin and dopamine.

A number of medications that were originally approved for treatment of depression have been found to be effective for anxiety disorders. Some of the newest antidepressants are called selective serotonin reuptake inhibitors, or SSRIs. SSRIs are often used to treat people who have panic disorder in combination with OCD, social phobia or depression. These medications slow the depletion of serotonin, a brain chemical that affects emotions, particularly feelings of well being and comfort. Usually it takes several weeks for an SSRI to have the desired effect.

Anxiety Disorders Support

Anxiety Disorders Association of America ; 11900 Parklawn Drive, Suite 100; Rockville, MD 20852; (301)231-9350; www.adaa.org
Freedom From Fear; 308 Seaview Ave.; Staten Island, NY 10305;
(718) 351-1717; www.freedomfromfear.com
National Anxiety Foundation; 3135 Custer Drive, Lexington, KY
40517-4001; (606) 272-7166

Asperger's Syndrome

Asperger's syndrome (AS) is a developmental disability similar to autism. Unlike autism, Asperger's syndrome may affect only minimal aspects of people's lives, and people who have this disorder can often function well in the outside world. AS does impact the ability to relate to others, feel empathy, or anticipate others' feelings. More common in males, Asperger's is associated with severe impairment of social interaction and "the development of restrictive, repetitive patterns of behavior, interests and activities" (DSM-IV). Language and cognitive abilities are unaffected, although motor clumsiness may be observed at an early age. Asperger's syndrome may be associated with vocal or facial tics. Behavior therapy is often very effective.

Asperger Syndrome Resources

Asperger Syndrome and Difficult Moments: Practical Solutions for Tantrums, Rage and Meltdowns, Brenda Smith Myles and Jack Southwick, Autism Asperger Publishing Company, 1999.

Asperger Syndrome: A Guide for Parents and Professionals, Tony Attwood, Taylor and Francis, Inc., 1997.

Asperger Syndrome Support

MPACT (Missouri Parents ACT) 1 West Armour, Suite 301, Kansas City, MO 64111; (816)531-7070; FAX (816) 531-4777

Easter Seals; 230 West Monroe Street, Suite 1800, Chicago, IL. 60606; (312)726-6200; 1-800-221-6827; TTY (312)726-4258; FAX (312)726-1494; info@easter-seals.org

Attention Deficit Disorder (ADD) Attention Deficit/Hyperactivity Disorder (ADHD) Hyperactivity Disorder (HD)

ADD, HD and ADHD, the most common brain disorders in children and adolescents, usually appear in preschool or early elementary years, and frequently persist into adulthood.

A growing number of children, especially boys, are diagnosed with attention-deficit or hyperactivity disorders. Not all children (or adults) will exhibit both disorders, although a significant number do. For diagnosis, a person must exhibit characteristics of ADD or ADHD in more than one setting—in both school and home, for instance.

Typically, a person diagnosed with **attention-deficit disorder**

- fails to pay attention to details;
- has difficulty sustaining interest in tasks or play;
- will not listen when spoken to directly;
- will not follow through on instructions;
- procrastinates;
- is easily distracted; and
- is forgetful.

With **hyperactivity disorder**, a person typically

- fidgets or squirms;
- cannot remain seated;
- has difficulty playing quietly;
- often talks excessively;
- often interrupts or intrudes on others.

What causes ADD and ADHD?

Researchers have yet to find an answer. Many have suggested links to environmental stress or genetics (often a parent will exhibit similar behavior). Other factors may cause behaviors similar to those of ADD or ADHD; these include allergies, child abuse, drug use, prolonged deprivation, disorganized or limited home or school environments, and other developmental problems, as well as bipolar disorders or posttraumatic stress disorder.

Please note:

If your child has been diagnosed by a family physician with ADHD, and prescribed a stimulant medication such as Ritalin® or Adderal,™ it is very important to seek the opinion of a child psychiatrist. Sometimes bipolar mood disorders can be mistaken for ADHD; unfortunately, the results of giving stimulants to a child with bipolar disorder can be devastating. Stimulants can trigger a manic reaction and increased rapid cycling moods. See *Bipolar Disorders*, page 22, for more information.

ADD, ADHD Resources

ADHD: A Path to Success, Lawrence Weathers, Ponderosa Press, 1998.
Driven to Distraction, Edward M. Hallowell, MD and John J. Ratey, MD, Pantheon Books, 1995.

Helping Your Hyperactive/Attention Deficit Child, John F. Taylor, Prima Publishing, 2001.

How to Reach and Teach ADD/ADHD Children, Sandra F. Rief, The Center for Applied Research In Education, 1993.

"Leisure as a Positive Experience for Children with ADHD," Geoffrey Lanham, ATTENTION!, Vol. 7, No. 5, April 2001.

Parenting a Child with Attention Deficit/Hyperactivity Disorder, Nancy S. Boyles, and Darlene Contadino, Lowell House, 1999.

Taking Charge of ADHD, Russell A. Barkley, The Guilford Press, 2000.
Television and Child Development, Judith Van Evra, Lawrence Earlbaum Associates, 1998.

The ADD Hyperactivity Workbook, Harvey C. Parker, Specialty Press, 1995.

"Your Child's Brain," *Newsweek*, February 19, 1996, pp. 55-62.

ADD, ADHD Support

CHADD; 8181 Professional Place, Suite 201, Landover, MD 20785;
1-800-233-4050; (301)306-7070; FAX (301)306-7090; www.chad.org
National ADDA; 1788 Second Street, Suite 200, Highland Park, IL 60035;
(847)432-2332; FAX (847)432-5874; www.adda.org

Autism (Autistic Disorder)

See *Rett's disorder* and *Asperger's Syndrome*.

Autistic disorder affects an estimated 1 to 2 per 1,000 people. Autism and related disorders (also called autism spectrum disorders or pervasive developmental disorders) develop in childhood and generally appear by the age of three. Autism is about four times more common in boys than girls.

Isolated in worlds of their own, children with autism appear indifferent and remote and are unable to form emotional bonds with other people. Although children with this baffling brain [neurological] disorder can display a wide range of symptoms and disability, many kids are incapable of understanding other people's thoughts, feelings and needs. Often, language and intelligence fail to fully develop, making communication and social relationships difficult.

— from National Institute of Mental Health

A child with autism may engage in repetitive activities, like rocking, or rigidly following familiar patterns in everyday routine. He or she may be painfully sensitive to sound, touch, sight or smell, and most likely didn't follow typical patterns of development. Between the ages of 18 and 36 months, the child may suddenly reject people and lose language and social skills already acquired. In most cases, problems become more noticeable as a child slips further behind other children the same age.

The communication abilities of people with autism vary, depending upon the intellectual and social development of the individual. Some may be unable to speak, whereas others may have rich vocabularies and are able to talk about topics of interest in great depth. Despite this variation, most children with autism can master pronunciation, but have difficulty using language effectively. Many also cannot understand word and sentence meaning, intonation, and rhythm.

For many children, speech and language develop unevenly, for example, vocabulary development in areas of interest may be accelerated. A child may have a good memory for information just heard or seen. A child may be able to read words well before the age of five, but may not be able to demonstrate understanding of what is read. Another child may have musical talent or advanced ability to count and perform mathematical calculations. Approximately one in ten children with autism also has "savant" skills, that is, detailed abilities in specific areas such as calendar calculation, musical ability or math.

Several therapies have been found to successfully improve communication for children who have autism. Effective parental and school response begins early in the preschool years, is individually tailored, targets both behavior and communication, and involves parents and all primary caregivers. The goal of therapy is to improve useful communication—for some, verbal communication, for others, gestured communication. Still others may use a symbol system such as picture boards. Some children respond well to highly structured behavior modification programs, and others respond better at home.

Working dogs have been trained as companions for children who have autism. Therapeutic horseback riding (hippotherapy) is recognized as an effective way to engage a child's response to an animal, and thus to the outside world. Music therapy and sensory integration therapy (designed to improve a child's sensory response) appear to have helped some children, although research on these approaches is limited.

Autism Resource

Missouri Autism Resource Guide, 1998. Request a copy from the Center for Innovations in Special Education, Parkade Center, Suite 152, 601 Business Loop 70 West, Columbia, MO 65211; 1-800-976-2473.

Autism Support

Autism Society of America Foundation; 7910 Woodmont Avenue, Suite 300, Bethesda, MD. 20814-3067; 1-800-328-8476, ext. 127 or call (301)657-0881 ext 127; FAX (301)657-0869; asaf@autism-society.org
Cure Autism Now (CAN) Foundation; 5225 Wilshire Boulevard, Suite 226, Los Angeles, CA 90036; (323)549-0500; www.canfoundation.org
Judevine Centers. St. Louis (314)849-4440; Columbia (573)874-3777; Southeast (573)339-9300; Southwest 1-800-420-7410.

Missouri Families for Effective Autism Treatment (MO-FEAT); P.O. Box 410305, St. Louis, MO 63141; (314)645-6877; MO-FEAT@bigfoot.com; www.MO-FEAT.org

North American Riding for the Handicapped Association (NARHA); P.O. Box 33150, Denver, CO 80233; 1-800-369-7433; FAX (303)252-4610; www.narha.org; (see feature on autism)

Project ACCESS, 901 South National, Springfield, MO 65804; (417)836-6755.

Bipolar Disorders

Bipolar disorders are mood disorders. This means that among other things, there is a major change in mood—from depression to elation (mania).

All bipolar disorders are a combination of mania with depression. The clinical criteria of mania follows:

Mania is indicated by an elevated, expansive, or irritable mood, lasting at least one week. This mood is also accompanied by at least three (four if the mood is only irritable) of the following:

- Inflated self-esteem or grandiosity
- Decreased need for sleep
- Increased talkativeness or pressure to keep talking
- Racing thoughts or flight of ideas
- Distractibility
- Increased activity or psychomotor agitation
- Excessive involvement in pleasurable activities that have a high potential for painful consequences.

For years, bipolar disorders were not considered childhood syndromes. A child who has bipolar disorder most likely will be misdiagnosed—commonly as ADHD or oppositional defiant disorder. As a parent explained, “Depression in a kid may be misinterpreted as a bad attitude and uncooperative behavior. It can also be observed as low energy, inability to concentrate and low self-esteem. Even small assignments can be overwhelming. Everything seems difficult.” Each individual with a bipolar disorder is unique; in fact, siblings with mood disorders may have very different symptoms. Warren A. Weinberg, MD and others note that bipolar disorder covers a wide range of symptoms:

Hypomania (hypo=“low”). This may appear in a child who has been an overly alert, irritable, colicky infant with poor sleep habits or as a “supermarket toddler” requiring restrictions in the grocery store. The hypomanic child progresses through preschool years with significant hyperactivity, excessive cheerfulness, inappropriate silliness, giddiness and elation, and “night owl” insomnia. As the child ages, periodic rants, rages, hostile anger and threats limit the child’s ability to function socially.

Hypomania is not severe enough to cause a marked disability; it can last only a few days, and does not require hospitalization. Or it can be present most of the time, depending on the person. In pediatric mania and hypomania, the mood is more likely interpreted as irritability.

Less severe mood swings are diagnosed as cyclothymia. **Cyclothymia** is defined as chronic hypomania with moments per day of both depressive moods and “mini” moments of significant anger. Most of the days are “mixed days” with an occasional all “bad” day, but rarely an “all good day.” These features come and go throughout the day, week or month, and are not as persistent. The cyclothymic disorder begins in the toddler or preschool years and progresses during late childhood and early adolescent years to periods of major depression or manic episodes.

Juvenile Rapid Cycling Bipolar Disorder. This term is applied to children and youth who have moment-to-moment, day-to-day (“all mixed days”) depressive moods, actions and feelings interspersed with hostile anger, rantings or rages. Juvenile rapid cycling bipolar disorder most often is evident during preschool years, changing to classic bipolar symptoms with age. —from *Weinberg, et al.*

Some kids and youth “cycle” back and forth from depression to mania. Still others seem to be both manic and depressed at the same time. Over the course of a year, some people with bipolar disorders may have a few cycles of depression and mania. Others have many cycles in a year, a week or even in a day. Some people may start out the day in tears and feel on top of the world by nightfall, or vice versa. Shifts in mood that occur within a 24-hour period are termed **Ultradian Cycling Type of Bipolar Affective Illness.**

A diagnosis of bipolar disorder means the child has a significant health impairment (such as diabetes, epilepsy, or leukemia) that requires ongoing medical management. The child needs and is entitled to accommodations in school to benefit from his or her education. Bipolar disorder and the medications used to treat it can affect a child's school attendance, alertness and concentration, sensitivity to light, noise and stress, motivation, and energy available for learning. The child's functioning can vary greatly at different times throughout the day, season, and school year.

— from www.bipolarkids.org

Unfortunately, misdiagnosis as ADHD or as depression may worsen a bipolar condition, since the medications prescribed for those illnesses (both stimulants and antidepressants) may incite a manic episode. Researchers have noted, also, a “kindling effect” when medication or environmental effects apparently produce hypersensitivity to stimuli, and greater risk of ultradian cycling.

Also regarding medication, children cannot tolerate lithium (the most effective adult medication), "as it damages the growing kidneys. It may be used in very extreme cases when there is risk of suicide. Depakote,TM used for years to control seizures in children and considered safe, is effective in controlling mood swings in some kids." Today clinicians are working to improve drug therapy for kids with bipolar disorders, and to better diagnose this chronic neurological condition.

Bipolar Disorders Resources

"Depression," Jim Chandler, MD, FRCPC, at

<http://www.klis.com/chandler/home.htm#author>

"Depression and other affective illnesses as a cause of school failure and maladaptation in learning disabled children, adolescents, and young adults," Weinberg, et al., 1/27/2001 on <http://www.ldantl.org/>

Double-Dip Feelings: Stories to Help Children Understand Emotions, Barbara S. Cain, American Psychological Association, 1990.

DSM-IVTM Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, American Psychiatric Association, 1994.

"Nimodipine treatment of an adolescent with ultradian cycling bipolar affective illness," Davanzo, et al., *Journal of Child and Adolescent Psychopharmacology*, Vol. 9, Issue 1, 1999.

The Bipolar Child, The Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder, Demetri F., MD and Janice Papoulas, Broadway Books, 1997. (Indeed the definitive book on this subject. See www.bipolarchild.com.)

Bipolar Disorders Support

DMDA Columbia (Depressive and Manic-Depressive Association); c/o Services for Independent Living, 1301 Vandiver, Suite Q, Columbia, MO 65201; (573)874-1646

DMDA Fairway-Kansas City; 901 Tamoshanter, Kansas City, MO 64145; (816)942-5802; FAX 913-281-3977

DMDA-Greater St. Louis; Empowerment Center, 1905 S. Grand Blvd., St. Louis, MO 63104; (314)865-2112; FAX (314)776-7071; email: dmdastl@aol.com

Bulimia Nervosa

This eating disorder is characterized by binge eating and subsequent purging; bulimia occurs, on the average, at least twice a week for three months for diagnosis. Like Anorexia Nervosa, unrealistic feelings about body shape and weight are common. A person with bulimia usually is within normal body weight. A person may deny the bulimia; she (or he) may feel guilty and fear humiliation. The pattern of eating forbidden food, then feeling guilty, erodes a positive self-image.

Research suggests that about four percent (4%) college-aged women have bulimia. About 50% of people who have been anorexic develop bulimia or bulimic patterns. It should be noted that purging (vomiting) causes erosion of teeth enamel; medical deficits include osteoporosis, anemia and gum disease. This disorder generally appears in late adolescence and responds well to behavioral and/or medication therapy.

Bulimia Nervosa Resources

See *Eating Disorders Resources*

Bulimia Nervosa Support

American Anorexia/Bulimia Association, Inc.; 239 Central Park West, Suite 1R, New York, NY 10024; (212)501-8351
 BANA; 300 Cabana Road East, Windsor, Ontario, Canada N9G 1A3
 (519)969-2112; FAX (519)969-0227; info@bana.ca

Conduct Disorder

The “essential feature of conduct disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.” (DSM-IV)

Thirty years ago, conduct disorder was commonly called “juvenile delinquency.” Today we recognize it as a serious emotional disorder, with behavior usually seen in a variety of settings. Typically, a person with this disorder is aggressive, deceitful, and lacks empathy for the feelings of others.

Typically, children with conduct disorder:

- have frequent accidents,
- run away from home,
- play hooky from school, or
- engage in risky behavior such as vandalism and shoplifting.

The diagnosis of conduct disorder ranges in severity. "Mild" means few if any conduct problems are in excess of those required to make the diagnosis, and conduct problems cause only minor harm to others. "Moderate" means that the number of conduct problems and effect on others are intermediate. "Severe" indicates many conduct problems in excess of those required to make the diagnosis, or that conduct problems cause considerable harm to others. Associated features may be learning disabilities, depressed or dysthymic mood, hyperactivity, addiction, or dramatic, erratic or antisocial personalities.

Children may be diagnosed with co-occurring disorders such as ADHD, oppositional defiant disorder or personality disorders. Options for rehabilitation include behavioral therapy and medication.

Conduct Disorder Resources

Do They Grow out of It? Long-Term Outcomes of Childhood Disorders, Lily T. Hechtman, American Psychiatric Press, Inc., 1996.

DSM-IV™ Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, American Psychiatric Association. 1994.

When Acting Out Isn't Acting: Understanding Child and Adolescent Temper, Anger and Behavior Disorders, Lynn W. Weisburg and Rosalie Greenberg, PIA Press, 1988.

Conduct Disorder Support

See <http://www.conductdisorders.com> ... "A Place for Us."

Depression

Depression in children is very similar to depression in adults—with a few exceptions. Rather than having a depressed mood, children are much more likely to have an irritable mood. Adults often will not enjoy anything when they are depressed, but there are usually some activities children and adolescents will enjoy doing no matter how depressed they get. To say a child has clinically significant depression, he or she must

have five of the nine symptoms listed below to such a degree that they significantly interfere with the child's functioning, nearly every day, for at least a year.

- depressed or irritable mood most of the day
- markedly diminished interest or pleasure in all (or almost all) activities
- significant weight loss when not dieting, or failure to make appropriate weight gains
- trouble sleeping or too much sleeping
- restlessness or really slowed activity, which is obvious to others
- fatigue or loss of energy
- feelings of worthlessness or excessive guilt
- diminished ability to think or concentrate, or indecisiveness
- recurrent thoughts of death, suicidal thoughts or suicide attempts

Although it is not one of the criteria, some physical symptoms are very common in depression. Headaches are one of these. About 10% of children have severe headaches at least once a month, however 40% of girls with depression have severe headaches.

NOTE: If an adolescent who seems happy still complains of fatigue, is slow, and tends to be overweight, a simple blood test can rule out hypothyroidism (low thyroid hormonal level).

What can be done for childhood depression? According to psychiatrist Jim Chandler,

If a normal child did everything a depressed child did, he would probably start to feel depressed, too. Depressed children and adolescents spend a lot of time doing dull and uninteresting things. Others spend most of their time doing nothing or being alone. The essence of intervention is to get them doing more activities that are fun with others. What is fun? It depends on the person but the idea should incorporate one or two of the following: exercise, social contacts and accomplishments. Usually there is some element of this type of intervention in every treatment plan. Often it is combined with the other types of treatment such as medication.

Here are some ideas for kids, parents and professionals:

- swim at the YMCA with a friend or cousin
- go to a park with a friend
- go to a movie with a friend (do not watch a video at your house)
- get a model or craft you can do together
- go for walks

- go fishing, hunting, or biking with family or friend
- go to a concert
- camp overnight
- have friends over
- build something with friends
- join youth groups; sports teams; dance and music classes; scouts

Depression Resources

"Depression," Jim Chandler, MD, FRCPC;

<http://www.klis.com/chandler/pamphlet/dep>

Depression is the Pits, But I'm Getting Better: A Guide for Adolescents,
E. Jane Garland, American Psychological Association, 1997.

"Headaches and Psychopathology in Children and Adolescents." Egger,
Angold, et al., *Journal of the American Academy of Child and Adolescent Psychiatry* (1998) 37(9):951-958.

Help Me, I'm Sad: Recognizing, Treating and Preventing Childhood Depression, David G. Fassler and Lynn S. Dumas, Viking Penguin, 1997.

Depression Support

Depression and Related Affective Disorders Association (DRADA); Meyer
3-181, 600 N. Wolfe Street, Baltimore, MD. 21287-7381; (410)955-4647
National Foundation for Depressive Illness (NAFDI); P.O. Box 2257,
New York, NY 10116, 1-800-239-1265; www.depression.org

Depression and Accutane™ (isotretinoin)

Teenagers who are seeking treatment for acne should consider reports of depression, suicide and psychosis associated with the acne medication isotretinoin (Accutane™). The drug manufacturer Roche has noted reports of depression, including some cases in which symptoms resolved and then reemerged when the medication was stopped and restarted.

Revised FDA-approved labeling for Accutane™ elaborates on the seriousness and persistence of depression, and the possible occurrence of suicide. It warns that discontinuation of Accutane™ therapy may be insufficient to address the symptoms of depression, and that further evaluation and treatment may be necessary. — Kenneth J. Bender

Depression and Accutane™ Resource

“New Warning of Depression with Accutane Could Apply to Other Medications,” Kenneth J. Bender, Pharm.D, *Psychiatric Times* (May 1998), Vol. XV, 5.

Dysthymia

A lowered expectation of outcomes, lack of real enjoyment, and mild irritation are common indications of dysthymia. This is a “milder” depression that goes on for years at a time. Children and adolescents with dysthymia often have been depressed so long that they can not recall what not being depressed is like. People think it is part of their personality. Typically they are irritable, hard to please, unhappy with nearly everything and very trying to be around. They tend to have fewer problems with sleep and appetite than do children with major depression. — Jim Chandler, MD

For diagnosis, a person must be depressed or irritable for **at least** a year straight with at least two of the following:

- poor appetite or overeating
- insomnia or excess sleeping
- low energy or fatigue
- low self-esteem
- poor concentration or difficulty making decisions
- feelings of hopelessness

Children with dysthymia often enjoy some activities. Yet, children with dysthymia are at a very high risk to get major depressive disorder. Over 70% of children with dysthymia will get severely depressed, and 12% will be diagnosed with bipolar disorder.

Dysthymia Resources

Growing up Sad: Childhood Depression and Its Treatments, Leon Cytryn and Donald H. McKnew, Norton and Company, Inc., 1998.

Is It Just A Phase? How To Tell Common Childhood Phases from More Serious Disorders; Susan Anderson Swedo and Henrietta Leonard, Western Publishing Company, Inc., 1998.

Jim Chandler, MD, at <http://www.klis.com/chandler/home.htm#author>

Dysthymia Support

The Children's Foundation; 725 Fifteenth Street, NW, Suite 505, Washington, DC 20005-2109; (202)347-3300; FAX (202)347-3382; email: info@childrensfoundation.net

Eating Disorders

See *Anorexia Nervosa* and *Bulimia Nervosa*

Eating disorders include Anorexia Nervosa and Bulimia Nervosa, as well as binge eating (without purging). These are invariably seen in young women. The disorders are linked to anxiety disorders, such as obsessive compulsive disorder, and respond well to behavioral and/or medication therapy.

A girl's independence is usually encouraged in childhood, and their strengths nurtured. Most girls become emotionally, mentally, and physically healthy young adults. Sometimes during the transition from childhood to adolescence, extra care is necessary, so that a girl's self-esteem and coping skills are not diminished.

Eating Disorders Resources

Anorexia and Bulimia, Paul R. Robbins, Enslow Publishers, Inc., 1998.
Anorexia and Bulimia: How to Help, Roger H. Slade, Taylor and Francis, Inc., 1998.

Eating Disorders: nutrition therapy in the recovery process, Dan W. Reiff and Kathleen Kim Lampson Reiff, Aspen Publishers, 1992.

Handbook of Eating Disorders: physiology, psychology, and treatment of obesity, anorexia, and bulimia, edited by Kelly Brownell and John Foreyt, Basic Books, 1986.

Nutrition & Eating Disorders: guidelines for the patient with anorexia Nervosa and bulimia nervosa, Catherine Patterson, PM, Inc., 1989.

Reviving Ophelia: Saving the Selves of Adolescent Girls, Mary Pipher Ballantine Reader's Circle, 1994.

Surviving an Eating Disorder: new perspectives and strategies for family and friends, Michele Siegel, et al., Harper & Row, 1988.

Mood Disorders in Childhood and Adolescence

See *Bipolar Disorders*, *Depression* and *Dysthymia*.

Can a child become seriously depressed? Certainly. The signs of depression or mania are similar for children and adults: a child or adolescent has recurring depression, with or without manic episodes, and has **not** been without symptoms for more than two months at a time, over the period of a **year**.

If a child talks about committing suicide, **BELIEVE IT**. Waste no time in contacting a psychiatrist who can prescribe an appropriate antidepressant. It is a matter of life and death. If you suspect that your child is suicidal, asking about it **will not** encourage the possibility; it may actually decrease the risk, because treatment and help can be obtained.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is characterized by anxious thoughts or rituals that cannot be controlled. Children with OCD may be plagued by persistent, unwelcome thoughts or images, or by the urgent need to engage in certain rituals such as hand-washing, checking, counting or ordering. The disturbing thoughts or images are called obsessions, and the rituals that are performed in an attempt to prevent or dispel them are called compulsions. There is no pleasure in carrying out the rituals, only temporary relief from the discomfort caused by the obsession.

Many healthy people can identify with having some of the symptoms of OCD, such as checking the stove several times before leaving the house. But the disorder is diagnosed when such activities

- consume at least an hour a day,
- are very distressing, and
- interfere with daily life.

The occurrence of OCD is approximately 2% of the population. It can appear in childhood, adolescence or adulthood, but on the average it first shows up in the teens or early adulthood. One-third of adults with OCD experienced their first symptoms as children. Children with OCD may not realize that their behavior is out of the ordinary. The course of the disease is variable—symptoms may come and go, they may ease over time, or they can grow progressively worse. Evidence suggests that OCD may run in families.

Depression, tics or anxiety disorders may accompany OCD. Some people with OCD have eating disorders. In addition, they may avoid situations in which they might have to confront their obsessions, or they may try unsuccessfully to self-medicate with alcohol or drugs.

Although the findings are preliminary, there is evidence that OCD which begins in childhood may be different than OCD which begins in adulthood. Individuals with childhood-onset OCD appear much more likely to have blood relatives who are affected with the disorder, than are those whose OCD first appears when they are adults. People with OCD benefit from a combination of medications and behavioral treatments. Some individuals respond best to one therapy, some to another.

Medications with U.S. Food and Drug Administration (FDA) approval for use in children and adolescents include clomipramine (Anafranil®) and fluvoxamine (Luvox®).

Behavioral therapy, specifically a type called exposure and response prevention, also has proven useful for treating OCD. It involves exposing the person to whatever triggers the problem, and then helping him or her forego the usual ritual—for instance, having the patient touch something dirty and then not wash his hands. This therapy is often successful in people who complete a behavioral therapy program, though results have been less favorable in some people who have both OCD and depression.

Obsessive Compulsive Disorder Resources

Brain Lock: Free Yourself from Obsessive-Compulsive Behavior, Jeffrey M. Schwartz and Beverly Beyette, Harper Trade, 1997.

Freeing Your Child from Obsessive-Compulsive Disorder: A Powerful, Practical Program for Parents of Children and Adolescents, Tamar E. Chansky, Times Books, 2000.

Getting Control: Overcoming Your Obsessions and Compulsions, Lee Baer and Judith L. Rapoport, Dutton/Plume, 2000.

How I Ran OCD Off MY Land, J. March and K. Mulle, Guilford Press, 1994.

Obsessive-Compulsive Disorder in Children and Adolescents—A Guide, Hugh F. Johnston, M.D. and J. Jay Frueling, Obsessive Compulsive Information Center, 1997.

Teaching the Tiger, Marilyn P. Dornbush and Sheryl K. Pruitt, Hope Press, 1995.

The Boy Who Couldn't Stop Washing, Judith Rapoport, M.D., Gefen Publishing House, Limited, 2000.

The Doubting Disease, Joseph W. Ciarrocchi, Paulist Press, 1996.

The Imp of the Mind: Exploring the Silent Epidemic of Obsessive Bad Thoughts, Lee Baer, Penguin Putnam, Inc., 2000.

The Touching Tree: A video about a young girl with OCD. Jim Cullner, Awareness Films, 1993.

Trichotillomania, Dan Stein, Eric Hollander and Gary Christensen, American Psychiatric Press, Inc., January 1999.

Obsessive-Compulsive Disorder Support

Association for the Advancement of Behavioral Therapy; 305 Seventh Avenue, 16th Floor, New York, NY 10001-6008; (212)647-1890

Kansas City OCD Support Group; Menocah Medical Center, 5721 W. 119th Street, Overland Park, KS 66209; (816)763-8174

St. Louis OCD Support Group; 7008 S. Rockhill, St. Louis, MO 63123; (314)842-7228; FAX (314)849-1134 web site: www.stlocd.org

Obsessive Compulsive Foundation at www.ocfoundation.org

Wonder if you have OCD? Take the Internet test at

<http://www.adaa.org/aboutanxietydisorders/ocd/ocdseltest>

Obsessive Compulsive Disorder and Strep Throat

Parents have suspected their child's strep throat caused subsequent development of obsessive compulsive (OCD) or tic disorders, and now research confirms this relationship. The mounting evidence pointing to a link between group A Beta-hemolytic streptococci and these disorders could eventually lead to a means of identifying children at risk and the use of preventive therapy.

In susceptible children, a strep infection triggers the autoimmune response, which affects the basal ganglia and can lead to symptoms of OCD or tic disorder (including Tourette Syndrome). In the United States, about 1% of children have OCD and up to 15% of elementary school children have some sort of tic disorder, according to Dr. S.E. Swedo of the National Institute of Mental Health.

Children with PANDAS (pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections) can display obsessive

symptoms including washing, checking, hoarding, arranging, symmetry rituals and various compulsive movements. They usually are “squirmy, fidgety” and unable to sit still, said Dr. Swedo.

One of the red flags for PANDAS is sudden onset, she said. “Nearly all the patients tell us that the symptoms have exploded in severity on a specific day or week. [Parents] say they went to bed fine and woke up the next morning and had (a compulsion) to check.” Yet it's sometimes difficult to make the connection between strep and onset of OC symptoms because the “dramatic explosion of symptoms” may not occur until one or two weeks after their strep throat, said Dr. Swedo.

Dr. Swedo said the determination of at risk status for OC following strep infections may involve several factors. These may include genetics (about 17% of the parents of children with PANDAS had one or both parents with OCD), neurodevelopment (a birth trauma that makes the basal ganglia more susceptible to another insult), immunological factors, or even a “mutated” strep bacteria.

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Obsessive Compulsive Disorder and Strep Throat Resources

<http://intramural.nimh.nih.gov/research/pdn/web.htm>

“A Case of Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections,” SJ Perlmutter, MA Garvey, et al., *American Journal of Psychiatry* (1998) 155(11):1592-98.

“Case Study: A New Infection-Triggered Autoimmune Subtype of Pediatric OCD and Tourette's Syndrome,” AJ Allen, H Leonard, SE Swedo, *Journal of the American Academy of Child and Adolescent Psychiatry*, (1995) 34(3):307-311.

“PANDAS: The Search for Environmental Triggers of Pediatric Neuropsychiatric Disorders. Lessons from Rheumatic Fever.” MA Garvey, J Giedd, SE Swedo, *Journal of Child Neurology* (1998) 13(9):413-423.

“Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections: Clinical Description of First 50 Cases.” SE Swedo, H Leonard, MA Garvey, et al., *American Journal of Psychiatry* (1998) 155(2):264-71.

Oppositional Defiant Disorder

Essentially, in this disorder there is a “recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least six months,” characterized by losing one’s temper, arguing, defiance, annoying others, blaming others, being angry and resentful, or spiteful and vindictive.

These behaviors usually appear (in both boys and girls) before the age of eight years, and no later than early adolescence. It appears to be more common in families in which at least one parent has mood or substance abuse disorders.

Oppositional Defiant Disorder Resources

Oppositional Defiant Disorder: Help for the Angry, Troubled Child, John F. Taylor and Jamie Miller, Prima Communications, Inc., 2001.

Winning Cooperation from Your Child: A Comprehensive Method to Stop Defiant and Aggressive Behavior in Children, Kenneth Wenning, Jason Aronson Publishers, 1996.

Panic Disorder

People with panic disorder experience frequent, unprovoked panic attacks that involve some or all of these symptoms:

- racing heartbeat or chest pains
- terror
- fear of dying
- dizziness or light-headedness
- nausea
- flushes or chills
- difficulty breathing
- tingling or numbness
- feelings of unreality
- fear of losing control or doing something embarrassing

Panic disorder can appear at any age—in children or in the elderly—but most often it begins in young adults. Not everyone who experiences panic attacks will develop panic disorder—for example, many people have one attack but never have another. Panic disorder is often accompanied by conditions such as depression, and may spawn phobias, which can develop toward places or situations where panic attacks have occurred.

A tendency toward panic disorder and agoraphobia (fear of people) runs in families. Studies have shown that proper treatment (cognitive behavioral therapy, medications, or a combination of the two) helps 70–90% of people with panic disorder.

—from NIMH web site on anxiety disorders

Panic Disorder Resource

Triumph over Fear: A Book of Help and Hope for People with Anxiety, Panic Attacks and Phobias, Jerilyn Ross and Rosalynn Carter, Bantam Doubleday Dell Publishing Group, 1995.

Panic Disorders Support

Anxiety Disorders Association of America; 11900 Parklawn Drive, Suite 100, Rockville, MD 20852; (301)231-9350; FAX (301)231-7392
National Institute of Mental Health Panic Information Line:
1-800-647-2642

Post-traumatic stress disorder (PTSD)

Post-traumatic stress disorder (PTSD) is an extremely debilitating condition that can occur after exposure to a terrifying event or ordeal in which grave physical harm was threatened or occurred. Traumatic events that can trigger PTSD include violent personal assaults such as rape or mugging, domestic abuse or neglect of the child or parent, natural or man-made disasters (fires, floods, the “Farm Crisis”) or accidents.

Symptoms of PTSD typically begin within three months following a traumatic event, although occasionally symptoms do not begin until years later. Once PTSD develops, the duration of the illness varies. Some people recover within six months, while others may suffer much longer.

Most people with PTSD try to avoid any reminders or thoughts of the ordeal. Despite this avoidant behavior, many people with PTSD repeatedly reexperience the ordeal in the form of flashback episodes, memories, nightmares, or frightening thoughts, especially when they are exposed to events or objects reminiscent of the trauma. Symptoms of PTSD also include emotional numbness and sleep disturbances (including insomnia), depression, and irritability or outbursts of anger. Feelings of intense guilt are also common.

PTSD is diagnosed only if these symptoms last more than one month. Yet symptoms of PTSD may not occur until years following the event. For instance, a child may lose a parent and be expected to “grow up” and care for younger siblings. The child may use denial or anger to deal with former trauma, may become emotionally numb, or may become depressed.

Treatment for PTSD includes cognitive-behavioral therapy, group therapy and medications (including antidepressants). Children and adolescents with PTSD may have other difficulties, particularly depression, substance abuse, or another anxiety disorder. The likelihood of treatment success is increased when these other conditions are appropriately diagnosed and treated as well.

Post Traumatic Stress Disorder Resource

When Nothing Makes Sense: Disaster, Crises and Their Effects on Children, Gerald Deskin and Greg Steckler, Fairview Press, 1996.

Post Traumatic Stress Disorder Support

Institute for Children and Families, LLC; 790 East Market Street, Suite 300, West Chester, PA 19382; (610)431-9508; FAX (610)431-3862

Rett's Disorder

Rett's Disorder is a pervasive developmental disorder that causes mental retardation and developmental degeneration. Inherited as an X-linked trait, it has been reported only in females.

Children with this disorder seem to develop normally for the first six to eight months of life. Parents may notice excess levels of hand patting, waving, and involuntary movements of the fingers, wrists and arms; however, these signs are subtle and may go unnoticed. There is a slowing of normal development and a failure to reach developmental milestones on time. Children undergo a rapid deterioration in behavior including loss of acquired speech, and purposeful use of hands. A lack of interest in social relationships, loss of expressive language and the development of stereotypies can cause this disorder to be confused with autism

—from Jayna-Girl at <http://www.bsc.net/jaynamom/rett2.html>

Rett's Disorder Resources

It's Nobody's Fault: New Hope and Help for Difficult Children and Their Parents, Harold S. Koplewicz, Random House, 1997.

Pathways to Learning in Rett Syndrome, Jackie Lewis and Debbie Wilson, David Fulton Publishers, LTD, 1998.

Rett Syndrome: Clinical and Biological Aspects, Bengt Hagberg, Jan Wahlstrom and Maria Anvret, Cambridge University Press, 1994.

Rett's Disorder Support

International Rett Syndrome Association; 9121 Piscataway Road, Suite 2B, Clinton, Maryland 20735; (301)856-3334; FAX (301)856-3336; www.rettsyndrome.org

Schizophrenia

While it is rarely diagnosed in children, schizophrenia is a neurological disorder of the brain that impacts a person in several ways. Schizophrenia can be treated with new psychiatric drugs that correct the balance of neurochemicals and their actions in the brain; this gives people with schizophrenia a new prospect for recovery.

Untreated, schizophrenia causes a distortion of reality; a person may have auditory or visual hallucinations, be fearful and withdrawn, or show behavior inappropriate for the circumstances.

The essential features of schizophrenic disorders are

- The presence of certain psychotic features (hallucinations, delusions) during the active phase of the illness.
- Characteristic symptoms involving multiple psychological processes.
- Deterioration from a previous level of functioning in such areas as work, social relations and self-care.
- Onset in adolescence or early adulthood.
- A duration of at least six months.

Characteristic symptoms always include disturbances in several areas (involving multiple psychological processes).

The major disturbance involves delusions that are often multiple, fragmented or bizarre. Examples include persecutory delusions involving the belief that others are spying on, spreading false rumors about, or planning harm to the individual; delusions of reference in which events, objects, or

other people are given particular and unusual significance; the belief that one's thoughts are not one's own and are inserted into one's mind; that one's feelings, impulses, thoughts, or actions are imposed by some external force.

Frequently there is a tendency to withdraw and become preoccupied with egocentric and illogical ideas and fantasies.

Schizophrenia Resources

Childhood Onset Schizophrenia, C.T. Gordon, Jossey-Bass, 1992.

Surviving Schizophrenia: For Families, Consumers and Providers, E. Fuller Torrey, Harper & Row, 1995.

Schizophrenia Support

National Institute of Mental Health Study of Childhood Onset Schizophrenia at <http://www.silk.nih.gov/silk/nimh/index.html>

Seasonal Affective Disorder (SAD)

Some children have depression only in one season, usually winter. A depressive episode may start in late October and reach its peak in January, after the holidays; then by March, things are usually on the mend. Unfortunately this can be extremely disabling for a child. Approximately 3–4% of school-age children have seasonal affective disorder (SAD).

Studies show that light boxes can help children, as well as adults, with this condition. The technique is to sit in front of a specially-made light box and do something (homework, for instance) for about 30 minutes, five times a week. These boxes are not hard to make or purchase, and they produce good results. Another technique is to use a “dawn stimulator” in the child's bedroom; this light gets steadily brighter, mimicking a spring or summer morning.

— from Jim Chandler, MD, FRCPC, at
<http://www.klis.com/chandler/home.htm#author>

Seasonal Affective Disorder (SAD) Resource

Winter Blues: Seasonal Affective Disorder: What It Is and How To Overcome It, Norman E. Rosenthal (The man that gave SAD its name), Guilford Publications, Inc., 1993.

Light Boxes and other supplies for light treatment for SAD

Bio-Brite; 7315 Wisconsin Avenue, Bethesda, MD. 200814-3202;
(301)961-8557; 1-800-621-5483

Sphere One, Inc.; Box 1013, Silver Plume, CO 80476; (212)208-4438;
light@sphereone.com

Sexual Abuse

Child sexual abuse has been reported up to 80,000 times a year, but the number of unreported instances is far greater, because the children are afraid to tell anyone what has happened, and the legal procedure for validating an episode is difficult. The problem should be identified, the abuse stopped, and the child should receive professional help. The long-term emotional and psychological damage of sexual abuse can be devastating to the child. When sexual abuse has occurred, a child can develop a variety of distressing feelings, thoughts and behaviors. Sexually abused children may develop the following:

- unusual interest in or avoidance of all things of a sexual nature
- sleep problems or nightmares
- anger
- depression or withdrawal from friends or family
- seductiveness
- statements that their bodies are dirty or damaged, or fear that there is something wrong with them in the genital area
- refusal to go to school
- delinquency/conduct problems
- secretiveness
- aspects of sexual molestation in drawings, games, fantasies
- unusual aggressiveness, or
- suicidal behavior

Child sexual abusers can make the child extremely fearful of telling, and only when a special effort has helped the child to feel safe, can the child talk freely. If a child says that he or she has been molested, try to remain calm and reassure the child that what happened was not their fault. Seek a medical examination and psychiatric consultation.

— *American Academy of Child and Adolescent Psychiatry. Reprinted with permission.*

Substance Abuse

Adolescence is typically a period of experimentation. Some youth will try smoking cigarettes or marijuana, or drinking alcohol, during their teen years. It is troubling when the child or teenager develops an addiction to any of these drugs. While there are many theories about controlling the use of recreational drugs, the fact is that of the three mentioned above, two are legal and one is widely available.

Drug use is a problem when it interferes with a person's work, school, home life, relationships and self-esteem. Potential health deficits associated with drug abuse are well known—AIDS, sexually transmitted diseases, and hepatitis C, among others. Prescription drug abuse targets drugs such as Ritalin, which is sold on the street and in school yards.

Many people with mental disorders have a “comorbid” disorder—drug abuse—which often exacerbates the symptoms of mental illness. Some kids with undiagnosed ADHD, depression, anxiety disorders or bipolar disorders will self-medicate with “street” drugs, alcohol, caffeine or nicotine. Often a youth with a mental disorder will show up in the system as a drug abuser. A person with a mental disorder can be helped by drugs, and *must* take them. Conversely, a substance abuser *must not* use drugs.

Substance Abuse Resource

Substance Abuse and Mental Health Statistics National Household Survey on Drug Abuse Report: “Obtaining Marijuana Easy for Youths.” August 2001.

Substance Abuse Support

Call the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse at 1-800-364-9687 for information.

Tourette Syndrome

Tourette Syndrome (TS) is a neurological disorder characterized by tics: “involuntary,” rapid, sudden movements that occur repeatedly in the same way. To receive a diagnosis of TS, a person must have both multiple motor and one or more vocal tics, not necessarily simultaneously, throughout a span of more than one year. The tics may occur many times a day (usually in bouts), nearly every day, or intermittently. Tics periodically change in the number, frequency, type and location, and wax and wane in their severity. Symptoms can sometimes disappear for weeks or months at a time.

While most persons with TS have some control over their symptoms from seconds to hours at a time, suppressing them may merely postpone more severe outbursts. Tics are experienced as irresistible and (like the urge to sneeze) eventually must be expressed. Tics increase as a result of tension or stress, and decrease with relaxation or concentration on an absorbing task. Behavioral and medication therapies offer relief from the symptoms of this disorder. Tourette Syndrome may co-occur with Obsessive Compulsive Disorder, ADHD, or bipolar disorder.

—*from University of Iowa College of Medicine, Department of Psychiatry, Becky Ottinger of the Joshua Child and Family Development Center, Grandview, Mo. May 2000.*

Tourette Syndrome Resources

Children with Tourette Syndrome: A Parent's Guide, Tracy Haerle, Woodbine House, 1992.

Icy Sparks: A Novel, Gwyn Hyman Rubio, Viking Penguin, 2001.

Living with Tourette Syndrome, Elaine Fantle Shimberg and Arthur K. Shapiro, Simon and Schuster Trade, 1995.

Tourette Syndrome Support

Missouri Tourette Syndrome Association (St. Louis); (314)821-2964

Tourette Syndrome Association. 1-800-237-0717; (718)224-2999; guide to Tic Disorders at <http://www.mentalhealth.com/book/p40-gtor.html>; tourette@ix.netcom.com

Medications

There has been public concern over reports that very young children are being prescribed psychotropic medications. The studies to date are incomplete, and much more needs to be learned about young children who are treated with medications for all kinds of illnesses. In the field of mental health, new studies are needed to tell us what the best treatments are for children with emotional and behavioral disturbances.

— from NIMH, *Treatment of Children with Mental Disorders*;
NIH Publication 00-4702 Sept. 2000

Major categories of psychotropic medications are stimulants, antidepressants, antianxiety agents, antipsychotics and mood stabilizers. For medications approved by the FDA for use in children, dosages depend on body weight and age. The NIMH Medications Chart in this booklet shows the most commonly prescribed medications for children.

Stimulant Medications

Four stimulant medications are approved for use in the treatment of attention deficit hyperactivity disorder (ADHD). These medications have all been extensively studied and are specifically labeled for pediatric use. **Stimulant medication should be prescribed only after a careful evaluation to establish the diagnosis of ADHD and to rule out other disorders or conditions.** Medication treatment should be administered and monitored in the context of the overall needs of the child and family, and consideration should be given to combining it with behavioral therapy. For school-aged children, collaboration with teachers is essential.

Antidepressant and Antianxiety Medications

Antidepressant and antianxiety medications are prescribed for depression, and for anxiety disorders including obsessive-compulsive disorder (OCD). The medications most widely prescribed for these disorders are the selective serotonin reuptake inhibitors (the SSRIs).

In the human brain, there are many “neurotransmitters” that affect the way we think, feel, and act. Three neurotransmitters that antidepressants influence are serotonin, dopamine and norepinephrine. SSRIs specifically target serotonin levels. These new medications are effective

in treating depression and anxiety, without the debilitating side effects associated with other antidepressants.

Antipsychotic Medications

Antipsychotic medications are used to treat children with schizophrenia, bipolar disorder, autism, Tourette syndrome, and severe conduct disorders. Some of the older antipsychotic medications have specific indications and dose guidelines for children. Some of the newer “atypical” antipsychotics, which have fewer side effects, are also being used for children, with close monitoring for side effects.

Mood Stabilizing Medications

Mood stabilizing medications are used to treat bipolar disorders. Because there is limited data on the safety and efficacy of most mood stabilizers in youth, treatment of children and adolescents is based mainly on experience with adults. In adults, the most typically-used mood stabilizers are lithium and valproate (Depakote®), which are often very effective for controlling mania and preventing recurrences of manic and depressive episodes. [Currently Depakote is the first choice for children.—Ed.] Research on the effectiveness of these and other medications in children and adolescents with bipolar disorder is ongoing.

Effective treatment depends on appropriate diagnosis of bipolar disorder in children and adolescents. There is some evidence that using antidepressant medication to treat depression in a person who has bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer. In addition, using stimulant medications to treat co-occurring ADHD or ADHD-like symptoms in a child with bipolar disorder may worsen or induce manic symptoms. While it can be hard to determine which young patients will become manic, there is a greater likelihood among children and adolescents who have a family history of bipolar disorder. If manic symptoms develop or markedly worsen during antidepressant or stimulant use, the physician should be consulted immediately, and diagnosis and treatment for bipolar disorder should be considered.

Medications Chart

— from NIMH, *Treatment of Children with Mental Disorders*;
NIH Publication 00-4702 Sept. 2000

Stimulant Medications

<u>Brand Name</u>	<u>Generic Name</u>	<u>Approved Age</u>
Adderall	dextroamphetamine	3 and older
Concerta	methylphenidate	6 and older
Cylert*	pemoline	6 and older
Dexedrine	dextroamphetamine	3 and older
Dextrostat	dextroamphetamine	3 and older
Ritalin	methylphenidate	6 and older

*Due to its potential for serious side effects affecting the liver, Cylert should not ordinarily be considered as first line drug therapy for ADHD.

Antidepressant and Antianxiety Medications

<u>Brand Name</u>	<u>Generic Name</u>	<u>Approved Age</u>
Anafranil	clomipramine	10 and older (for OCD)
BuSpar	bupirone	18 and older
Effexor	venlafaxine	18 and older
Luvox (SSRI)	fluvoxamine	8 and older (for OCD)
Paxil (SSRI)	paroxetine	18 and older
Prozac (SSRI)	fluoxetine	18 and older
Serzone (SSRI)	nefazodone	18 and older
Sinequan	doxepin	12 and older
Tofranil	imipramine	6 and older (for bed-wetting)
Wellbutrin	bupropion	18 and older
Zoloft (SSRI)	sertraline	6 and older (for OCD)

Antipsychotic Medications

<u>Brand Name</u>	<u>Generic Name</u>	<u>Approved Age</u>
Clozaril (atypical)	clozapine	18 and older
Risperdal (atypical)	risperidone	18 and older
Seroquel (atypical)	quetiapine	18 and older
Mellaril**	thioridazine	2 and older
Zyprexa (atypical)	olanzapine	18 and older
Orap	pimozide	12 and older (for Tourette syndrome)

****WARNING:** The FDA has established a risk for a potentially fatal arrhythmia, "torsades de pointes," from Mellaril. Use of this drug advised only in treatment-resistant schizophrenia.

Mood Stabilizing Medications

<u>Brand Name</u>	<u>Generic Name</u>	<u>Approved Age</u>
Cibalith-S	lithium citrate	12 and older
Depakote	divalproex sodium	2 and older (for seizures)
Eskalith	lithium carbonate	12 and older
Lithobid	lithium carbonate	12 and older
Tegretol	carbamazepine	any age *

*Doctors prescribe this anti-convulsant because of its anti-manic and anti-aggressive properties. It is useful in treating frequent rage attacks. (from www.bipolarkids.org)

Resources

Parenting Information

Missouri Parents Act (MPACT); 1 W. Armour Blvd., Suite 302, Kansas City, MO 64118; (816)531-7070; Call 1-800-743-7634 for information about regional offices; FAX (816)531-4777; www.ptimpact.com

“Vision for Tomorrow,” an indepth class about children's psychiatric illnesses, medications, treatments, etcetera for anyone who has an emotional bond with a child who has a brain disorder. Call NAMI of Missouri at 1-800-374-2138 for details.

General Resources

American Academy of Child and Adolescent Psychiatry; 3615 Wisconsin Avenue, N.W., Washington, DC 20016-3007; (202)966-7300

American Psychiatric Association; www.psych.org

Center for Mental Health Services' Knowledge Exchange Network (KEN); P.O. Box 42490, Washington, DC 20015; 1-800-789-2647;

TDD(301)443-9006; FAX (301)984-8796; www.mentalhealth.org

Child Help USA! National Abuse Hotline: 1-800-422-4453

Federation of Families for Children's Mental Health; 1021 Prince Street, Alexandria, VA 22314-2971; (703)684-7710; FAX (703)836-1040

Girl Power! For information, call 1-800-729-6686 or visit the web site at www.girlpower.gov

Missouri Department of Mental Health-CPS Children's Services; PO Box 687, Jefferson City, MO 65102; (573)751-3070; 1-800-364-9687 FAX (573)526-7926; www.modmh.state.mo.us

MO-SPAN; 580 S. Costello St., Florissant, MO 63031; (314)972-0600; FAX (314)972-0606; www.mo-span.org

National Alliance for the Mentally Ill (NAMI) of Missouri; 1001 Southwest Blvd., Suite E, Jefferson City, MO 65109; (573)634-7727; 1-800-374-2138; <http://mo.nami.org>

NAMI Help Line for Information and Referral Services: 1-800-950-6264

National Institute of Mental Health (NIMH), 600 Executive Blvd., Rm 8184 MSC9663, Bethesda, MD 20892-9663; (301)443-4513;

FAX (301)443-4279; www.nimh.nih.gov; nimhinfo@nih.gov

National Institute of Neurobiological Disorders and Stroke (NINDS)
P.O. Box 13050, Silver Springs, MD 20911; (301)496-5751;
1-800-352-9424; www.ninds.nih.gov
Parental Stress Help Line: 1-800-367-2543

Web Sites

www.aacap.org/publications/factsfam American Academy of Child and Adolescent Psychiatry. Facts for Families© is developed and distributed by the American Academy of Child and Adolescent Psychiatry (AACAP). Facts sheets may be reproduced for personal or educational use. To order, contact Public Information, 1-800-333-7636.

www.aecf.org Annie E. Casey Foundation, resources for children's and teens' health and mental health, annual *Kids Count* reports

www.bcpl.net/~sandyste/school_psych.html School Psychology Resources Online

www.bipolarchild.com Bipolar disorders resources and information

www.bpkids.org Child and Adolescent Bipolar Foundation

www.chadd.org Children & Adults with Attention Deficit/Hyperactivity Disorder home page

www.ffcmh.org Federation of Families for Children's Mental Health

www.girlpower.gov Girl Power!

www.klis.com/chandler/home.htm Pediatric Psychiatry Pamphlets

www.mentalhealth.org/kidsarea/govkids.htm Knowledge Exchange Network resources for and about children and youth

www.mokids.org Citizens for Missouri's Children

www.narha.org North American Riding for the Handicapped Organization; links to local equestrian therapy centers

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For More Information
call the Project LIFE Line
at 1-800-392-7348

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