1 Difficult, Temperamental, Impossible

THE CHALLENGE OF RAISING A MOODY CHILD

Kevin is ten. Although the past ten years have been mostly happy and uneventful, his parents say Kevin has always had a hard time handling disappointments and unexpected events. They've learned to warn him about schedule changes to avoid brief, but sometimes explosive, tantrums. The entire family has gotten used to tiptoeing around Kevin whenever things don't go his way.

Academic success has usually come easily to Kevin, although he has always worried a lot about doing well. Kevin tends to be a worrier in general. His parents have learned to keep the television off during the early evening news so that Keving won't worry about things he hears on the broadcast and have trouble falling asleep. He has lots of good friends at school, in the neighborhood, and on his sports teams.

Starting a couple of months ago, Kevin's parents, Bob and Cindy, noticed that their strategies for helping Kevin cope with changes and disappointments (such as giving him advance warning and providing lots of time and space) have not been enough. He cries easily at the slightest disappointment and has been having more frequent and longer tantrums in response to things not going his way. Although he typically enjoys playing games and spending time with the family, lately they have needed to coax him out of his room during the evenings to join the fam-

ily in watching a movie or playing a favorite game. He has been complaining about stomachaches almost daily. His teacher sent a note home because she was worried about him; her previously eager and efficient student had not been finishing his work. Kevin's parents have tried asking him what's wrong—whether he feels sick, or whether something happened at school or with one of his friends—but he just grunts and seems to be irritated by the questions.

Over the past couple of weeks, Kevin has gone from staying by himself in his room and mumbling sullenly to snapping at everyone, from Mom and Dad to his eight-year-old sister, Abby, and even his beloved dog, Max, who has slept with Kevin since Max was a puppy. One morning when Max jumped up on Kevin to greet him, Cindy was shocked when Kevin pushed Max away and cursed at him.

Kevin has also begun isolating himself on weekends, reluctant to go to baseball practices and games that formerly he had considered the best parts of his week. He also started turning down invitations to play with his friends. Kevin has started worrying so much about doing well at school that he recently begged his mother to let him stay home—he was convinced that he would fail his social studies quiz if he went to school that day.

Bob and Cindy feel paralyzed. For the last couple of months they have tried everything they could think of, from reading the latest self-help books and magazine articles to doing Internet searches, taking a parenting course through their church, and comparing notes with relatives and friends who have kids. Nothing has helped. In fact, things just seem to be getting worse. Bob was distraught when Abby began complaining that her parents favored her big brother over her. Cindy secretly worries that the family tension will cause her husband, who has not touched alcohol in five years, to begin drinking again—a problem that she does not want to recur.

Kevin's parents have always thought of Kevin as "moody," but they're starting to realize that this seemingly benign term that everyone seems to use does not fully capture what they and their son are experiencing. What could they have done to make Kevin so unhappy? What's really wrong with Kevin?

Feeling at the end of her rope, Cindy made an appointment with Kevin's pediatrician, who ruled out medical problems and referred them to a psychologist. The psychologist did a thorough evaluation and diagnosed Kevin with depression. Knowing what was really wrong was a considerable relief for Bob, Cindy, and even Kevin. Kevin wasn't just

"moody," and his parents were neither incompetent nor cruel. Like hundreds of thousands of other American children today, Kevin is depressed. Now he is taking Zoloft, an antidepressant, and attending a combination of individual and family therapy focused on helping Kevin and his parents understand depression, how to manage its symptoms, and how to work together to combat the illness. Things are starting to get better.

Kevin has depression, a mental illness. Reading this book will help you get comfortable with the term *mental illness* and recognize that mood disorders are treatable illnesses. The more comfortable you are with using this and other technical words we introduce in this book, the more you will be able to conquer stigma and to be the best advocate possible for your child.

But what are mood disorders? When we refer to mood disorders, we are talking about two sets of related illnesses: depressive disorders and bipolar disorders. Depressive disorders involve a sad or irritable mood that may last anywhere from a couple of weeks to several years. Bipolar disorders involve alternations between depression and mania, an extremely high mood that can be angry or euphoric. Switches between mania and depression can occur infrequently (e.g., one manic episode during a two-year period) or extremely frequently (e.g., multiple cycles from manic to depressed during a single day). We describe the different depressive and bipolar illnesses in detail in Chapter 2.

Treatment for mood disorders is not, unfortunately, always as straightforward as in Kevin's case. Mood disorders in children are complicated problems. They are not easy to diagnose, in part because the symptoms that children display can look so different from those of adults with mood disorders. For example, children with depression are more often cranky and irritable, whereas adults tend to be melancholy or sad. Adults with bipolar disorder more often experience discrete periods of mania lasting for two to three weeks, followed by a period of depression that might last for several months, whereas children more frequently cycle several times each day between rage, euphoria, and desperate sadness. In addition, in many cases, it can be very difficult to make a diagnosis because the illness is still in the process of developing when an evaluation is completed. For example, if Kevin had been seen three months earlier, when he was struggling to handle changes and disappointments but was generally doing fairly well, depression would not have been an accurate diagnosis. Also, children with mood disorders often have accompanying problems, such as anxiety and behavioral disorders. Kevin is a good example. In addition to depression, he becomes

overly anxious and worries excessively about his school performance, as well as about problems and situations that are unrelated to him (such as news items).

Even with treatment, life with a mood-disordered child can feel like a constant challenge—they can be difficult to get along with, seem "impossible" to handle, and generally wreak havoc with domestic tranquility. Their unstable emotional states can disrupt their schoolwork, their friendships, and their sibling bonds. They often need a lot of help to get along in the world, even when they are receiving good treatment.

Thirteen-year-old Caitlyn "never seems happy," according to her parents, and this emotional state is damaging every facet of her life—from her increasingly hostile relationship with her brother to alienation from her classmates (who mock her "Goth" outfits and her matching attitude). Out-and-out exhaustion has started to make her loving parents feel more and more distant from their daughter.

Tanisha, age fifteen, is so sad that she has difficulty speaking above a whisper and getting out of bed. She spends a lot of time crying and can't even pick up the clarinet that she plays with virtuoso skills. The former A student can't complete even short reading assignments. Though she feels guilty for feeling so sad despite what she calls a "great life," Tanisha lashes out in anger or irritation at her parents' constant attempts to comfort her. Her parents are feeling increasingly powerless and helpless.

Six-year-old Jeremiah's parents describe him as "Dr. Jekyll and Mr. Hyde" and then ruefully correct themselves: "He's more like Mr. Hyde and Mr. Hyde," alternating between restless, agitated harangues punctuated by outbursts of rage and slumps of hopelessness and profound sorrow. Their little boy has hit, kicked, and thrown things at his parents, and he has alarmed them several times by gyrating his hips provocatively toward his mother while telling her that he wants to "kiss with you, like in the movies."

Eleven-year-old Anya has shocked family and visitors to her house, running through the house naked, shifting in an instant from hysterical giggling to sobbing, and announcing to everyone who will listen that she can run faster than the cars on the street (and that she has done so) and that she can get 100 percent on all her tests because she can read her teacher's mind.

If any of the children we have described sound at all like your child, you are probably well acquainted with the term *moody.* You have probably felt lost, confused, powerless, and at times hopeless. The many hurdles you have encountered, some of which have seemed insurmount-

able, have probably overwhelmed you at times. Feeling blamed for your child's problems is exceedingly painful, yet you see blame in the eyes of family members, as well as strangers in the grocery store. Chances are you've felt anger—at your child, yourself, your spouse, your family pet, the person in the car in front of you, or God. The anxiety of not knowing where to turn and not knowing how to help your child can be almost unbearable.

If the children we've described and the feelings of confusion, powerlessness, and hopelessness sound familiar, this book is for you. You may be concerned about your child's behavior, unsure how to make sense out of what doesn't seem "right" to you, and worried about how to *make* it right. If you're wondering where to turn and don't know how to begin, or if you're getting conflicting advice, this book will help you understand what childhood mood disorders are all about—what they look like, how professionals diagnose and treat them, what you need to know about working with your child's school, and how you can manage better at home. In short, we hope that reading this book will help you become a better consumer of mental health care and will empower you to help your son or daughter and your family. Let's begin by replacing some "mood myths" with facts.

Facts versus Myths: Clearing Up the Misconceptions That Keep Moody Kids from Getting Help

Mood disorders in children—depression and bipolar disorder—are widespread, yet they frequently go undiagnosed and are significantly undertreated. Only about one-fourth of the nineteen million American adults with depression seek help. The statistics for children are worse. Additionally, a startling number of teenagers and children with depression are either undiagnosed or misdiagnosed or do not have access to treatment. The failure to identify and treat bipolar disorder in youth is also a significant problem. In a study of the frequency of bipolar disorder in adolescents by Peter Lewinsohn and his colleagues at the Oregon Research Institute, less than half of the teens with bipolar disorder had received any treatment. Current estimates suggest that approximately one-half of 1 percent of all children have bipolar disorder, and we know that one-fourth to one-half of children and adolescents with depression will develop bipolar disorder.

Depression is among the most common of psychiatric disorders,

with 10 to 25 percent of women and 5 to 12 percent of men experiencing depression at some point in their lifetimes. At any point in time, conservative estimates reveal that approximately 6 percent of adolescents and 2 percent of preadolescent children are depressed. Depression occurs among people of all ages, income levels, ethnic groups, and cultures (even animals can get depressed). Bipolar spectrum disorders (we define the different types of bipolar disorder in Chapter 2) occur in 3 to 6 percent of the population and occur at equal rates among men and women. Bipolar disorder also occurs in about 1 percent of older adolescents. Approximately 5 percent of older adolescents have enough manic symptoms to cause problems, although not enough to be diagnosed with the full-blown disorder. Prior to adolescence, the rates of bipolar disorder are lower, although Janet Wozniak and Joseph Biederman and their colleagues at Massachusetts General Hospital have found that up to 16 percent of children seen in psychiatric clinics have bipolar disorder. These figures translate as up to 1.8 million teenagers and 600,000 children with depression *at any point in time* and at least 300,000 teenagers and unknown numbers of children with bipolar disorder.[1]

For hundreds of thousands of mood-disordered children and their families, the costs—monetary and otherwise—associated with these disorders are significant. For children, the social price is sky high. If a child is irritable, lacks energy, or behaves unpredictably, other children may dislike her, avoid her, or just ignore her, which leads to many lost play opportunities. Over time these lost opportunities result in the child's falling further behind socially and becoming more and more lonely. Treatment can be expensive and can result in major financial strains for families; even for families with good health care coverage, co-payments for treatment and medication costs can add up quickly. Disagreement between parents about what treatments are necessary or how to discipline their challenging child can lead to marital discord. Tension created by trying to avoid the next crisis can lead to strained relationships and to siblings' feeling that their needs are secondary. Unpredictable or disruptive behavior such as the behavior exhibited by Anya can result in isolation, as the family avoids social gatherings with family and friends for fear of embarrassment.

This raises an important question: If childhood mood disorders are

[1] Calculated using 1990 census data and based on data suggesting that 6 percent of adolescents are depressed, 2 percent of children are depressed, and 1 percent of adolescents have bipolar disorder.

so widespread and their impact so great, why don't more people seek help? In addition to the complex nature of childhood mood disorders, these disorders are surrounded by many misconceptions that further impede access to treatment.

One primary misconception is that children do not get depressed. Children have no big cares and concerns as adults do, so what could possibly bother them to such a degree that they would get depressed, right? *Wrong!* Mood disorders in children have been recognized only recently—depression beginning in the 1970s and 1980s and bipolar disorder in the mid-1980s. The misconception that mental illnesses are always caused by psychological or environmental factors perpetuated the belief that children could not become depressed or manic. As the understanding of the role of biology, especially genetics, became better understood, childhood mood disorders have been recognized, studied, and treated.

Another myth is the belief that depression will go away quickly and on its own. However, a single episode can last from seven to nine months, an entire school year. And 40 percent of children who have had a single depressive episode will have another one within two years, 70 percent within five years. A single episode can wreak havoc with the life of a child and his family. Repeated episodes result in exponentially more damage. Just to make things more complicated, the course of depression and bipolar disorders is often unpredictable. Treatment can be helpful in reducing the frequency and severity of episodes, but families need to be on the lookout for signs of recurrence. It is clear that symptoms tend to worsen over time, making early and effective treatment particularly important.

The myth that "everybody gets that way" is common. Although we all have our good days and bad days, we don't all reach clinical highs and lows as a response to positive and negative life events. In Chapter 2, we provide a pictorial view of the different patterns mood disorders can take—that picture gives some perspective on the difference between normal variations in mood and the distinctly unhealthy vacillations that children with mood disorders experience. Take ten-year-old Kevin as an example. It is typical for kids to get upset in response to disappointment, but Kevin struggles excessively to recover and is unable to handle even minor disappointments. All kids can be silly and sometimes even claim superpowers as part of their play, but Anya's hysterical giggling punctu-

ated by sobbing and her outlandish claims are outside the bounds of normal childhood behavior.

Yet another myth is the belief that those with depression should "just snap out of it." No one would ever dream of telling a child with strep throat or an ear infection to just "snap out" of the discomfort he or she was experiencing. Instead, children who are sick are taken to the doctor and prescribed treatment. Mood disorders are also illnesses and require specialized treatment. In some cases the treatment will involve medication. However, finding the optimal medication or combination of medications for a particular set of mood symptoms is not always easy. In many cases, medication will help, but only partially. Therapy is also an important part of treatment for mood disorders. Therapy comes in many variations; deciding whom to see and what to try can be complicated. In Part II of this book we discuss the specifics of different types of treatment and help you begin to develop a road map for accessing the treatment your child needs.

One of the most damaging myths is that getting treatment is a sign of weakness or failure. Many adults avoid getting treatment for themselves because they fear appearing weak. This is also true of teenagers or older children, who feel that they should be able to "pull it together" themselves. Parents sometimes avoid seeking treatment for their children for fear they will be seen as having failed in parenting. This myth leads many to delay seeking treatment or, worse yet, not to seek help at all.

Another myth is that all adolescents are moody and that, therefore, there is no need to focus attention on their condition. Although teenagers, in particular, have their ups and downs as they develop their own personas, "normal" fluctuations in mood are less frequent, less intense, and less long lasting than the types of mood changes we see in clinical depression or bipolar disorder. For example, at first glance Caitlyn might seem like a normal teenager. She is "making a statement" with the way she dresses, although her statement is alienating her from many of her peers. She spends a lot of time in her own room, but she has shut herself off completely from her family and is irritable and rude in her interactions at home. Most important, she never seems happy. Healthy teenagers find enjoyment: They might not look forward to family game night with eagerness, but there should be signs that they are having fun at least some of the time. It's not uncommon for teenagers to pare down their interests and activities and to begin to pursue a few interests at a

greater level of depth. Dropping out of all or most activities and seeming uninterested in anything is not part of adolescence.

Finally, mood-impaired children and adolescents are often considered "bad" or "lazy" because of their frequently disruptive, surly, or even enraged behavior, as well as their lethargy, lack of interest, and difficulty concentrating. These pejorative interpretations of symptoms contribute to negative interactions between them and their parents, teachers, and others. When symptoms are perceived to be negative traits rather than signs of significant problems and a need for help, a major barrier to seeking treatment is erected.

What Can I Expect to Gain from Reading This Book?

In addition to the myths about mood disorders that pervade our society, parents who are seeking help for a child with any kind of psychological problem run into some common roadblocks along the way. The very first one, to which few parents seem impervious, is self-blame. Self-blame is all too common among parents of children with mood disorders. Parents of children with mood disorders frequently ruminate over what they have done to make their child so unhappy or to have provoked such interminably long and severe tantrums. Tanisha's parents, like many parents of depressed children, ask themselves what they have done wrong, and six-year-old Jeremiah's parents have frequently wondered how they allowed his behavior to get so out of control. The reality is that neither Tanisha's nor Jeremiah's parents caused their children's problems. Both Jeremiah and Tanisha have biological illnesses, their parents are in no way to blame. Unfortunately, self-blame only increases the pain that parents face.

The corollary to self-blame is blaming each other. Caitlyn's father has accused his wife of catering to her too much, whereas Caitlyn's mother feels that her husband has been too hard on Caitlyn and has alienated her. Blaming each other only increases tension, making it more difficult to get treatment and, ultimately, to solve the problem of managing symptoms.

Beyond self-blame there are some practical challenges that many families face. Insurance coverage is often limited to only a few providers within a community, and those providers may not have specific expertise

in childhood mood disorders. In addition, good providers often have long waiting lists. It is not uncommon for families to wait two to three months for an initial evaluation. Two or three months (or even one week) can seem like an eternity when your child is having daily rages, is not falling asleep until 1:00 or 2:00 A.M., and is so irritable that having a conversation has become impossible.

The evaluation process can sometimes be frustrating and time-consuming. Childhood mood disorders can be especially difficult to separate from such behavioral problems as poor attention, hyperactivity, impulsivity, and oppositional and defiant behavior. Although many providers are well versed in childhood problems, only a small subset are experts in childhood mood disorders. You may find yourself needing a second opinion following that first evaluation for which you waited so long.

Once you find a provider you trust, and once he or she has completed a thorough evaluation and has made a diagnosis with which you feel comfortable, determining how to proceed can still be a challenge. One question that many parents face is whether or not to medicate. Weighing the pros and cons of medications can be difficult—medications often have side effects, but they may improve quality of life overall. There are also many types of therapy and many different characteristics of therapists. Many different combinations of family members could potentially participate in therapy, ranging from the child alone to the whole family and even including extended family when relevant. Chapters 6 and 7 provide details about negotiating decisions on medications and therapy.

The steps required to get the right help sometimes occur swiftly and smoothly, but often some impediments occur along the way. If you feel unsure of how to proceed, you aren't alone. In this book, we walk you through the steps you need to take to get past these roadblocks and get on your way to helping your child.

The primary goal of this book is to help you find the assistance your child needs. We begin by helping you understand what you're seeing in your child, then we provide you with strategies to manage the challenges and frustrations that come with raising a moody child. Above all, we hope to help you become the best possible advocate for your child. You know your child best, and you spend far more time with your child than anyone else. Thus you are ultimately the most important member of your child's mental health team. With the information and advice in this book, we hope you will gain the confidence to make good decisions for your child, using the recommendations of the professionals on your team.

How Is This Book Organized?

Part I of this book describes mood symptoms and syndromes. You will learn about the evaluation and diagnosis process and about depression and bipolar disorder (manic–depression) in children. You will become familiar with different mood symptoms and how they fit into each diagnostic category. As you read (and as you work with treatment providers) you will be asked about a variety of symptoms that you have noticed in your child. Your treatment providers (and you, as you read) will start to notice particular clusters of symptoms in your child and will begin to label them in psychiatric terms. This is an important early step in getting good treatment. Developing a better overall understanding of mood disorders and a better specific understanding of your child's problem will equip you to find good treatment, reduce sources of conflict, and improve life for your child, yourself, and your family. Part I shows you how to become the best possible consumer of mental health services. Some of the most important decisions you will make for your child will involve choosing the professionals on your treatment team. You'll also learn how to find appropriate services and know what to expect from each of them. Before you can choose among professionals, you need to know what kind to look for, and you need to have an understanding of what to expect.

In Part II you'll learn about the different types of treatments available for children with mood disorders and their families. As you learn about the different medications and types of therapy available, you will come to understand the *biopsychosocial* model of treatment. Mood disorders are biological illnesses and therefore often require biological treatments such as medications. They are also psychological conditions, meaning that they result in problems with thoughts, feelings, and behavior, and therefore children and families typically require some sort of therapy to develop healthier patterns of thinking and behavior that ultimately help improve mood. And children with mood disorders function in a variety of social settings—mostly at home and at school—and therefore often need to have some temporary adjustments made in these settings. You'll learn about the different goals for each type of treatment and about how to complete a cost–benefit analysis to help you choose the appropriate treatment components for your child.

Part III focuses on how you can help your child. You'll learn coping skills for you and your child to use. Some of these skills, such as communication and problem-solving strategies, are good for families in general. We anticipate that you'll find them particularly beneficial as you work to-

gether to manage your child's mood symptoms. Information and suggestions on how to work with your school system and how to manage crises are also provided.

Finally, Part IV focuses on how you can help your family. Reading this section will help you recognize and break negative cycles that can occur within families stressed by the presence of a mood disorder. You will learn how to create a balance for your family, how to help siblings, and how to take care of yourself. We hope your journey through this book provides you the support, knowledge, and skill building you need to move forward productively.

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