are also required: changes in appetite; sleep difficulty, fatigue; low self-esteem; poor concentration or difficulty with making decisions; and feelings of hopelessness. About 70% of children and adolescents with dysthymic disorder eventually develop major depression. The development of MDD after dysthymia is often referred to as *double depression*.

Atypical depression is MDD characterized by hypersomnia, increased appetite with carbohydrate craving, weight gain, interpersonal rejection sensitivity, and mood reactivity.

Adjustment disorder with depressed mood is the most common depressive disorder in children and adolescents. Symptoms start within 3 months of an identifiable stressor (e.g., loss of a relationship), with distress in excess of what would be expected and interference with social, occupational, or school functioning. Symptoms should not meet criteria for another psychiatric disorder, should not be caused by bereavement, and should not last longer than 6 months after the stressor has stopped.

Seasonal affective disorder is a condition common in northern or extreme southern latitudes, in which depressive symptoms occur in the late fall and early winter when the hours of daylight are shortening.

Depressive disorder not otherwise specified is a diagnosis used when patients have functionally impairing depressive symptoms that do not meet criteria for another condition.

Treatment of depression involves psychopharmacy and psychotherapy. First line antidepressant selective serotonin reuptake inhibitors (SSRIs) have response rates of 50% to 70% despite high-placebo response rate. Fluoxetine is the only agent approved by the U.S. Food and Drug Administration (FDA) for treatment of youth. Citalopram, escitalopram, paroxetine, and venlafaxine have positive clinical trial results as well. An antidepressant should be given an adequate trial (6 weeks at therapeutic doses) before switching or discontinuing unless there are serious side effects. For a first episode of depression in children and adolescents, treatment for 6 to 9 months after remission of symptoms is recommended. Patients with recurrent or chronic depression may need to take antidepressants for extended periods (years or even a lifetime). If a patient does not respond to adequate trials of two or more antidepressants, a child psychiatrist should be consulted. The psychiatrist's evaluation should focus on diagnostic clarity and psychosocial issues that might be preventing a full response. The psychiatrist may use augmentation strategies that may include lithium, thyroid hormone, lamotrigine, or bupropion.

For acute depression, more frequent visits are indicated, and the risks of medication (including suicidal and self-destructive behavior) should be discussed with parents, guardians, and patients. Higher frequency of monitoring can include phone calls or collaborative care with a psychotherapist. Parents and patients should also be educated about warning signs and to call immediately if these new symptoms occur. Notable side effects are thoughts of suicide, increased agitation, or restlessness. Other side effects include headache, dizziness, gastrointestinal symptoms, sleep cycle disturbance, sexual dysfunction, akathisia, serotonin syndrome, and risk of increased bruising (due to platelet inhibition.) There is also a risk of SSRI-induced mania.

In 2004 the FDA issued warnings for all antidepressants regarding suicidal thinking or behavior. The data suggest that antidepressants pose a 4% risk, versus a 2% risk in placebo. An increase in suicides in children and adolescents since that year has many experts believing that it might be related to low prescription of antidepressants and resultant untreated depression. Substance use, concomitant conduct problems, and impulsivity increase the risk of suicide.

Psychotherapy appears to have good efficacy in mild to moderate depression. In moderate to severe depression, combined treatment with psychotherapy and medication has the greatest rate of response, although in severe cases the efficacy was equivalent to medication alone. Cognitive-behavioral therapy and interpersonal therapies are the empirically supported psychotherapies. Cognitive behavioral therapy and its derivative, dialectic behavioral therapy (for borderline personality disorder), involve techniques and skills-building to mitigate cognitive distortions and maladaptive processing; whereas interpersonal therapy focuses on collaborative decisions between the therapist and patient and is based on the exploration and recognition of precipitants of depression. Family therapy is often used as an adjunct to other treatments for depression.

Light therapy has been shown to be beneficial for seasonal affective disorder and in MDD with a seasonal component. Electroconvulsive therapy is used in refractory and life-threatening depression.

Depression is a chronic and debilitating illness that often starts in childhood or adolescence. It increases risk for future suicide, substance use, and other psychiatric sequelae. Adolescent depressive disorders are more likely to be recurrent into adulthood than childhood onset depression.

Suicide is a fatal complication of MDD and surpasses motor vehicle accidents as a **cause of death in adolescents**. It has high prevalence among high school students with 20% having contemplated suicide and 8% having attempted each year. While the risk of suicide during an MDD episode is high, it can be paradoxically higher during start of treatment as energy and motivation improve with cognitive recovery from depression.

Treatment is targeted toward decreasing morbidity and suicide. Along with treatments mentioned previously, modalities such as hospitalization, partial hospital, therapeutic after-school programs, or psychoeducation may be needed.

BIPOLAR DISORDERS

Bipolar disorder consists of distinct periods of mania (elevated, expansive, or irritable moods and distractibility) that may alternate with periods of severe depression (Table 18-2).

To diagnose mania associated with BD, euphoria (elevated or expansive mood) and three additional symptoms; or irritability and four additional manic symptoms are required. Children and adolescents with euphoric mood are bubbly, giggly, and "over-the-top" happy, to a degree that is socially unacceptable to others. Grandiosity in children is often dramatic. Children act as if they are superior even when it is obvious that it is not true, and they behave as if the laws of nature do not apply to them. Racing thoughts are common in BD. Periods of extreme rage also are common. Children with BD often present with rapid or ultra-rapid cycling with multiple shifts between euthymia, mania, and depression.

A decreased need for sleep is a hallmark of mania. There are no other diagnoses where a child has a greatly decreased amount of total sleep (compared with age-appropriate norms) and is not fatigued. Sleep deprivation, substance abuse, and antidepressants may trigger mania. BD onset often begins with an episode of depression. It is estimated that 33% of youth will develop BD