Treating Depression in Children and Adolescents

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Chapter 48: Treating Depression in Children and Adolescents

- 456
- 457
- 464
- 467

- 470

Page 456 | Top of Article

Section 48.1: Nearly Two Thirds of America's Adolescents with Depression Do Not Get Treatment

From "Nearly Two-Thirds of America's 2 Million Adolescents Suffering from Major Depressive Episodes in the Past Year Did Not Receive Treatment," by the Substance Abuse and Mental Health Services Administration (SAMHSA, www.samhsa.gov), part of the U.S. Department of Health and Human Services, April 28, 2011.

A national report indicates that 8.1 percent of America's adolescents aged 12 to 17 (2 million youth) experienced at least one major depressive episode (MDE) in the past year. The report by the Substance Abuse and Mental Health Services Administration (SAMHSA) also shows that only 34.7 percent of these adolescents suffering from major depressive episodes received treatment during this period.

An MDE is defined as a period of two weeks or longer during which there is either depressed mood or loss of interest or pleasure and at least four other symptoms that reflect a change in functioning, including problems with sleep, eating, energy, concentration, and self-image.

“Depression among adolescents is a serious public health problem that is all too often overlooked and the consequences can be devastating,” said SAMHSA Administrator, Pamela S. Hyde, J.D. “If depression among young people is identified and treated early we can turn a life around and reduce the impact of mental illness and substance abuse on America's communities.”

One of the study's most notable findings was that adolescents who had suffered from an MDE in the past year were more than three times as likely as those without a past year MDE to have had a substance use disorder in the past year (18.9 percent versus 6 percent).

The study also found significant differences in the rates of past year MDE experiences among subgroups of adolescents. For example, adolescent females were twice as likely as their male counterparts to have experienced a past year MDE (11.7 percent versus 4.7 percent). Rates of past year MDE experience also rose as adolescents grew older

Page 457 | *Top of Article*

with rates increasing from 3.6 percent of adolescents aged 12 to 10.4 percent of adolescents aged 15.

Among the nearly 700,000 adolescents who suffered from MDE and received treatment, more than half (58.5 percent) saw or met with a medical doctor or other health professional only—without being prescribed medication.

The next largest segment of adolescents receiving treatment—34.7 percent—met with a medical doctor or other heath professional and were also prescribed medication. The remaining 6.7 percent receiving treatment used prescription medication only.

Section 48.2: Taking Your Child to a Therapist

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Sometimes kids, like adults, can benefit from therapy. Therapy can help kids develop problem-solving skills and also teach them the value of seeking help. Therapists can help kids and families cope with stress and a variety of emotional and behavioral issues.

Many kids need help dealing with school stress, such as homework, test anxiety, bullying, or peer pressure. Others need help to discuss their feelings about family issues, particularly if there's a major transition, such as a divorce, move, or serious illness.

Should My Child See a Therapist?

Significant life events—such as the death of a family member, friend, or pet; divorce or a move; abuse; trauma; a parent leaving on military deployment; or a major illness in the family—can cause stress that might lead to problems with behavior, mood, sleep, appetite, and academic or social functioning.

Page 458 | *Top of Article*

In some cases, it's not as clear what's caused a child to suddenly seem withdrawn, worried, stressed, sulky, or tearful. But if you feel your child might have an emotional or behavioral problem or needs help coping with a difficult life event, trust your instincts.

Signs that a child may benefit from seeing a psychologist or licensed therapist include:

- developmental delay in speech, language, or toilet training;

- learning or attention problems (such as ADHD [attention deficit hyperactivity disorder]);
- behavioral problems (such as excessive anger, acting out, bedwetting, or eating disorders);
- maintains high grades;
- episodes of sadness, tearfulness, or depression;
- social withdrawal or isolation;
- being the victim of bullying or bullying other children;
- decreased interest in previously enjoyed activities;
- overly aggressive behavior (such as biting, kicking, or hitting);
- sudden changes in appetite (particularly in adolescents);
- insomnia or increased sleepiness;
- excessive school absenteeism or tardiness;
- mood swings (e.g., happy one minute, upset the next);
- development of or an increase in physical complaints (such as headache, stomachache, or not feeling well) despite a normal physical exam by your doctor;
- management of a serious, acute, or chronic illness;
- signs of alcohol, drug, or other substance use (such as solvents or prescription drug abuse);
- problems in transitions (following separation, divorce, or relocation);
- bereavement issues;
- custody evaluations;
- therapy following sexual, physical, or emotional abuse or other traumatic events.

Page 459 | *Top of Article*

Kids who aren't yet school-age could benefit from seeing a developmental or clinical psychologist if there's a significant delay in achieving developmental milestones such as walking, talking, and potty training, and if there are concerns regarding autism or other developmental disorders.

Talk to Caregivers, Teachers, and the Doctor

It's also helpful to speak to caregivers and teachers who interact regularly with your child. Is your child paying attention in class and turning in assignments on time? What's his or her behavior like at recess and with peers? Gather as much information as possible to determine the best course of action.

Discuss your concerns with your child's doctor, who can offer perspective and evaluate your child to rule out any medical conditions that could be having an effect. The doctor also may be able to refer you to a qualified therapist for the help your child needs.

Finding the Right Therapist

How do you find a qualified clinician who has experience working with kids and teens? While experience and education are important, it's also important to find a counselor your child feels comfortable talking to. Look for one who not only has the right experience, but also the best approach to help your child in the current circumstances.

Your doctor can be a good source of a referral. Most doctors have working relationships with mental health specialists such as child psychologists or clinical social workers. Friends, colleagues, or family members might also be able to recommend someone.

Consider a number of factors when searching for the right therapist for your child. A good first step is to ask if the therapist is willing to meet with you for a brief consultation or to talk with you during a phone interview before you commit to regular visits. Not all therapists are able to do this, given their busy schedules. Most therapists charge a fee for this type of service; others consider it a complimentary visit.

Factors to Consider

Consider the following factors when evaluating a potential therapist:

- Is the therapist licensed to practice in your state? (You can check with the state board for that profession or check to see if the license is displayed in the office.)

- Is the therapist covered by your health insurance plan's mental health benefits? If so, how many sessions are covered by your plan? What will your co-pay be?
- What are his or her credentials?
- What type of experience does the therapist have?
- How long has the therapist worked with children and adolescents?
- Would your child find the therapist friendly?
- What is the cancellation policy if you're unable to keep an appointment?
- Is the therapist available by phone during an emergency?
- Who will be available to your child during the therapist's vacation or illness or during off-hours?
- What types of therapy does the therapist specialize in?
- Is the therapist willing to meet with you in addition to working with your child?

The right therapist-client match is critical, so you might need to meet with a few before you find one who clicks with both you and your child.

As with other medical professionals, therapists may have a variety of credentials and specific degrees. As a general rule, your child's therapist should hold a professional degree in the field of mental health (psychology, social work, or psychiatry) and be licensed by your state. Psychologists, social workers, and psychiatrists all diagnose and treat mental health disorders.

It's also a good idea to know what those letters that follow a therapist's name mean:

Psychiatrists

Psychiatrists (MDs or DOs) are medical doctors who have advanced training and experience in psychotherapy and pharmacology. They can also prescribe medications.

Clinical Psychologists

Clinical psychologists (PhDs, PsyDs, or EdDs) are therapists who have a doctorate degree that includes advanced training in the practice of psychology, and many specialize in treating children and teens and

their families. Psychologists may help clients manage medications but do not prescribe medication.

Clinical Social Workers

A licensed clinical social worker (LCSW) has a master's degree, specializes in clinical social work, and is licensed in the state in which he or she practices. An LICSW is also a licensed clinical social worker. A CSW is a certified social worker. Many social workers are trained in psychotherapy, but the credentials vary from state to state. Likewise, the designations (i.e., LCSW, LICSW, CSW) can vary from state to state.

Different Types of Therapy

There are many types of therapy. Therapists choose the strategies that are most appropriate for a particular problem and for the individual child and family. Therapists will often spend a portion of each session with the parents alone, with the child alone, and with the family together.

Any one therapist may use a variety of strategies, including Cognitive Behavioral Therapy (CBT). This type of therapy is often helpful with kids and teens who are depressed, anxious, or having problems coping with stress.

Cognitive behavioral therapy restructures negative thoughts into more positive, effective ways of thinking. It can include work on stress management strategies, relaxation training, practicing coping skills, and other forms of treatment.

Psychoanalytic therapy is less commonly used with children but can be used with older kids and teens who may benefit from more in-depth analysis of their problems. This is the quintessential “talk therapy” and does not focus on short-term problem-solving in the same way as CBT and behavioral therapies.

In some cases, kids benefit from individual therapy, one-on-one work with the therapist on issues they need guidance on, such as depression, social difficulties, or worry. In other cases, the right option is group therapy, where kids meet in groups of six to 12 to solve problems and learn new skills (such as social skills or anger management).

Family therapy can be helpful in many cases, such as when family members aren't getting along; disagree or argue often; or when a child or teen is having behavior problems. Family therapy involves counseling sessions with some, or all, family members, helping to improve communication skills among them. Treatment focuses on problem-solving techniques and can help parents re-establish their role as authority figures.

Page 462 | *Top of Article*

Preparing for the First Visit

You may be concerned that your child will become upset when told of an upcoming visit with a therapist. Although this is sometimes the case, it's essential to be honest about the session and why your child (or family) will be going. The issue will come up during the session, but it's important for you to prepare your child for it.

Explain to young kids that this type of visit to the doctor doesn't involve a physical exam or shots. You may also want to stress that this type of doctor talks and plays with kids and families to help them solve problems and feel better. Kids might feel reassured to learn that the therapist will be helping the parents and other family members too.

Older kids and teens may be reassured to hear that anything they say to the therapist is confidential and cannot be shared with anyone else, including parents or other doctors, without their permission—the exception is if they indicate that they're having thoughts of suicide or otherwise hurting themselves or others.

Giving kids this kind of information before the first appointment can help set the tone, prevent your child from feeling singled out or isolated, and provide reassurance that the family will be working together on the problem.

Providing Additional Support

While your child copes with emotional issues, be there to listen and care, and offer support without judgment. Patience is critical, too, as many young children are unable to verbalize their fears and emotions.

Try to set aside some time to discuss your child's worries or concerns. To minimize distractions, turn off the TV and let voice mail answer your phone calls. This will let your child know that he or she is your first priority.

Other ways to communicate openly and problem-solve include:

- Talk openly and as frequently with your child as you can.
- Show love and affection to your child, especially during troubled times.
- Set a good example by taking care of your own physical and emotional needs.
- Enlist the support of your partner, immediate family members, your child's doctor, and teachers.

Page 463 | *Top of Article*

- Improve communication at home by having family meetings that end with a fun activity (e.g., playing a game, making ice-cream sundaes).
- No matter how hard it is, set limits on inappropriate or problematic behaviors. Ask the therapist for some strategies to encourage your child's cooperation.
- Communicate frequently with the therapist.
- Be open to all types of feedback from your child and from the therapist.
- Respect the relationship between your child and the therapist. If you feel threatened by it, discuss this with the therapist (it's nothing to be embarrassed about).
- Enjoy favorite activities or hobbies with your child.

By recognizing problems and seeking help early on, you can help your child—and your entire family—move through the tough times toward happier, healthier times ahead.

Page 464 | Top of Article

Section 48.3: Antidepressant Medications for Children and Adolescents: Information for Parents

Excerpted from "Antidepressant Medications for Children and Adolescents: Information for Parents and Caregivers," by the National Institute of Mental Health (NIMH, www.nimh.nih.gov), part of the National Institutes of Health, June 13, 2011.

Depression is a serious disorder that can cause significant problems in mood, thinking, and behavior at home, in school, and with peers. It is estimated that major depressive disorder (MDD) affects about 5 percent of adolescents.

Research has shown that, as in adults, depression in children and adolescents is treatable. Certain antidepressant medications, called selective serotonin reuptake inhibitors (SSRIs), can be beneficial to children and adolescents with MDD. Certain types of psychological therapies also have been shown to be effective. However, our knowledge of antidepressant treatments in youth, though growing substantially, is limited compared to what we know about treating depression in adults.

Recently, there has been some concern that the use of antidepressant medications themselves may induce suicidal behavior in youths. Following a thorough and comprehensive review of all the available published and unpublished controlled clinical trials of antidepressants in children and adolescents, the U.S. Food and Drug Administration (FDA) issued a public warning in October 2004 about an increased risk of suicidal thoughts or behavior (suicidality) in children and adolescents treated with SSRI antidepressant medications. In 2006, an advisory committee to the FDA recommended that the agency extend the warning to include young adults up to age 25.

More recently, results of a comprehensive review of pediatric trials conducted between 1988 and 2006 suggested that the benefits of antidepressant medications likely outweigh their risks to children and adolescents with major depression and anxiety disorders. The study, partially funded by NIMH, was published in the

What did the FDA review find?

In the FDA review, no completed suicides occurred among nearly 2,200 children treated with SSRI medications. However, about 4 percent of those taking SSRI medications experienced suicidal thinking or behavior, including actual suicide attempts—twice the rate of those taking placebo, or sugar pills.

In response, the FDA adopted a “black box” label warning indicating that antidepressants may increase the risk of suicidal thinking and behavior in some children and adolescents with MDD. A black-box warning is the most serious type of warning in prescription drug labeling.

The warning also notes that children and adolescents taking SSRI medications should be closely monitored for any worsening in depression, emergence of suicidal thinking or behavior, or unusual changes in behavior, such as sleeplessness, agitation, or withdrawal from normal social situations. Close monitoring is especially important during the first 4 weeks of treatment. SSRI medications usually have few side effects in children and adolescents, but for unknown reasons, they may trigger agitation and abnormal behavior in certain individuals.

What do we know about antidepressant medications?

The SSRIs include:

- fluoxetine (Prozac);
- sertraline (Zoloft);
- paroxetine (Paxil);
- citalopram (Celexa);
- escitalopram (Lexapro);
- fluvoxamine (Luvox).

Another antidepressant medication, venlafaxine (Effexor), is not an SSRI but is closely related.

SSRI medications are considered an improvement over older antidepressant medications because they have fewer side effects and are less likely to be harmful if taken in an overdose, which is an issue for patients with depression already at risk for suicide. They have been shown to be safe and effective for adults.

However, use of SSRI medications among children and adolescents ages 10 to 19 has risen dramatically in the past several years. Fluoxetine (Prozac) is the only medication approved by the FDA for use in

treating depression in children ages eight and older. The other SSRI medications and the SSRI-related antidepressant venlafaxine have not been approved for treatment of depression in children or adolescents, but doctors still sometimes prescribe them to children on an "off-label" basis. In June 2003, however, the FDA recommended that paroxetine not be used in children and adolescents for treating MDD.

Fluoxetine can be helpful in treating childhood depression, and can lead to significant improvement of depression overall. However, it may increase the risk for suicidal behaviors in a small subset of adolescents. As with all medical decisions, doctors and families should weigh the risks and benefits of treatment for each individual patient.

What should you do for a child with depression?

A child or adolescent with MDD should be carefully and thoroughly evaluated by a doctor to determine if medication is appropriate. Psychotherapy often is tried as an initial treatment for mild depression. Psychotherapy may help to determine the severity and persistence of the depression and whether antidepressant medications may be warranted. Types of psychotherapies include cognitive behavioral therapy, which helps people learn new ways of thinking and behaving, and interpersonal therapy, which helps people understand and work through troubled personal relationships.

Those who are prescribed an SSRI medication should receive ongoing medical monitoring. Children already taking an SSRI medication should remain on the medication if it has been helpful, but should be carefully monitored by a doctor for side effects. Parents should promptly seek medical advice and evaluation if their child or adolescent experiences suicidal thinking or behavior, nervousness, agitation, irritability, mood instability, or sleeplessness that either emerges or worsens during treatment with SSRI medications.

Once started, treatment with these medications should not be abruptly stopped. Although they are not habit-forming or addictive, abruptly ending an antidepressant can cause withdrawal symptoms or lead to a relapse. Families should not discontinue treatment without consulting their doctor.

All treatments can be associated with side effects. Families and doctors should carefully weigh the risks and benefits, and maintain appropriate follow-up and monitoring to help control for the risks.

Page 467 | *Top of Article*

Section 48.4: Substance Use Associated with Low Response to Depression Treatment among Teens

From "Substance Use Associated with Low Response

to Depression Treatment Among Teens," by the National Institute of Mental Health (NIMH, www.nimh.nih.gov), part of the National Institutes of Health, December 9, 2009.

Depressed teens who report low levels of impairment related to drug or alcohol use tended to respond better to depression treatment than depressed teens with higher levels of substance-related impairment, according to an analysis of data from the NIMH-funded Treatment of SSRI-Resistant Depression in Adolescents (TORDIA) study. However, it is unclear whether less substance-related impairment allowed for better response to depression treatment, or if better treatment response led to less substance-related impairment. The study was published in the December 2009 issue of the *Journal of the American Academy of Child and Adolescent Psychiatry* .

Background

Substance use is more common among teens with depression than among those without depression. Researchers have also found that depression can inhibit teens' response to treatment of substance abuse, and substance abuse is associated with a poorer response to treatment of depression. Still, few trials have examined how coexisting depression and substance use among teens may affect treatment outcomes for both.

In the TORDIA study, 334 teens who did not respond to a type of antidepressant called a selective serotonin reuptake inhibitor (SSRI) before the trial were randomly assigned to one of four treatments for 12 weeks:

- Switch to another SSRI
- Switch to venlafaxine (Effexor), a different type of antidepressant

Page 468 | *Top of Article*

- Switch to another SSRI and add cognitive behavioral therapy (CBT), a type of psychotherapy
- Switch to venlafaxine and add CBT

Results of the trial were previously reported in February 2008. They showed that teens who received combination therapy, with either type of antidepressant, were more likely to improve than those on medication alone.

In this new analysis, Benjamin Goldstein, MD, of the University of Toronto, and colleagues examined TORDIA data to determine the relationship, if any, between substance use, major depression, and response to depression treatment.

Substance use was defined as using alcohol or drugs without meeting criteria for having a full-blown substance abuse disorder. Teens who were diagnosed with a substance abuse disorder were excluded from the TORDIA study.

Results of the Study

Substance use was fairly common among TORDIA participants. At baseline, about 28 percent reported experimenting with drugs or alcohol. Those who showed more substance-related impairment were older, felt more hopeless, had greater family conflict, developed depression at an earlier age, were more likely to have a history of physical or sexual abuse, and were more likely to have coexisting oppositional defiant disorder (ODD) or conduct disorder (CD). Substance-related impairment included certain attitudes and behaviors such as craving the substance, feeling hooked on it, accidentally hurting oneself or others while using it, and other similar effects.

Participants with low levels of substance use and substance-related impairment throughout the study tended to respond better to depression treatment than those who showed persistently high or increasing levels of substance-related impairment. There were no significant differences in rates of substance use and impairment among the treatment groups.

Significance

This study is one of the first to examine the association between substance use and depression treatment among depressed teens. The findings are consistent with other studies that found depression severity to be associated with a history of physical or sexual abuse, coexisting

ODD or CD, and substance-related impairment. However, the direction of the association is uncertain. The data could not determine whether low substance-related impairment facilitates improvement in depression symptoms, or whether improvement in depressed mood leads to a decrease in substance-related impairment.

What's Next?

The authors caution that the study does not provide definitive conclusions about depression treatment and substance use. However, they do suggest that clinicians treating teens for depression screen for signs of substance use and address those issues as well, even if the teen does not meet criteria for a full-blown substance abuse disorder.

Reference

Goldstein BI, Shamseddeen W, Spirito A, Emslie G, Clarke G, Wagner KD, Asarnow JR, Vitiello B, Ryan N, Birmaher B, Mayes T, Onorato M, Zelazny J, Brent D. Substance use and the treatment of resistant depression in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry* . 2009 Dec. 48(12):1182–1192.

Section 48.5: Teens Who Recover from Hard-to-Treat Depression Still at Risk for Relapse

From the National Institute of Mental Health (NIMH, www.nimh.nih.gov), part of the National Institutes of Health, December 3, 2010.

Teens with hard-to-treat depression who reach remission after 24 weeks of treatment are still at a significant risk for relapse, according to long-term, follow-up data from an NIMH-funded study published online November 16, 2010, in the *Journal of Clinical Psychiatry* . The long-term data reiterate the need for aggressive treatment decisions for teens with stubborn depression.

Background

In the Treatment of Resistant Depression in Adolescents (TORDIA) study, teens whose depression had not improved after an initial course of selective serotonin reuptake inhibitor (SSRI) antidepressant treatment were randomly assigned to one of four interventions for 12 weeks:

- Switch to another SSRI-paroxetine (Paxil), citalopram (Celexa), or fluoxetine (Prozac)