National Alliance on Mental Illness

Children and Adolescents and Depression FACT SHEET

How common is depression in children and adolescents?

Studies have shown that on any single day (called "point prevalence" by epidemiologists) about 2 percent of school-aged children and about 8 percent of adolescents meet the criteria for major depression. Taking a longitudinal view, the numbers are higher—for instance, one in five teens have had a history of depression at some time. In primary care settings the rates of depression are higher still —as many as 28 percent for adolescents. Preschool depression has begun to attract interest in the literature but much more needs to be learned about this age group and mood disorders.

Which youth get depression?

During childhood, the number of boys and girls affected are almost equal. In adolescence, twice as many girls as boys are diagnosed. Well over half of depressed adolescents have a recurrence within seven years. Several factors increase the risk of depression, including a family history of mood disorders and stressful life events.

Repeated episodes of depression can take a great toll on a young mind. Therefore, getting an evaluation followed by thoughtful treatment is prudent to prevent the social isolation and self-esteem consequences and safety risk of persistent depression.

Do youth with depression need treatment? Will they just "grow out of it"?

Episodes of depression in children appear to last six to nine months on average, but in some children they may last for years at a time. When children are experiencing an episode they do less well at school, have impaired relationships with their friends and family, internalize their feelings and have an increased risk for suicide. To ignore these warning signs and hope for the best while the child tries to cope is a risky decision. There are effective treatments for youth depression.

How can you tell if your child is depressed?

Signs that frequently help parents or others know that a child or teen should be evaluated for depression include:

- feeling persistently sad or blue;
- talking about suicide or being better off dead;
- becoming suddenly much more irritable;
- having a marked deterioration in school or home functioning;
- reporting persistent physical complaints and/or making many visits to school nurses;
- failing to engage in previously pleasurable activities or interactions with friends; and
- abusing substances.

Because the child or teen experiencing depression may not show significant behavioral disturbance—a child who shows signs of internal effects but not disrupting the family—parents sometimes "hope for the best" or fail to get a child evaluated.

What are the treatments for children and adolescents with depression?

There are two main groups of treatments for children with depression with well- demonstrated evidence of efficacy:

- Psychotherapy (talk therapy)
- Pharmacotherapy (medications)

Additionally, in Sept. 2009, a study was published demonstrating that family psychoeducation was beneficial for children with depression ages 8-12. This is a key area for further investigation.

All treatment options have risks and benefits. The best strategy is to educate yourself about the choices you can make, share the decision with your child or teen and evaluate what is best for your child. Untreated depression confers a major risk of suicide, and so it is useful to consider that no treatment also carries risks.

Exercise and social support are also necessary elements of any good treatment plan to address depression. These interventions may fail to address more serious symptoms but remain important throughout the course of treatment.

Both talk therapy and medications have been shown to be useful in rigorous studies. Both treatments were more effective than when a placebo alone was given in the NIMH-funded Treatment for Adolescents with Depression Study (TADS https://trialweb.dcri.duke.edu/tads/index.html). This landmark study also demonstrated that combination of the two interventions is likely to create even better results than either one alone.

The two different specific psychotherapies which show efficacy in studies of children and/or adolescents are cognitive behavioral therapy (CBT) and interpersonal therapy (IPT). CBT concentrates on changing the negative attributional bias (seeing every cup as half-empty) associated with major depression. The focus in IPT is on a patient's relationships with peers and family members and the way they see themselves. More unstructured therapy with a supportive person may also be helpful but is more difficult to study. Ask the therapist about the kind of psychotherapy they do and why they feel it might help.

Antidepressant therapy has improved the outlook for the medication treatment of child and adolescent depression, but also carries risks. Fluoxetine (Prozac) has been approved by the FDA for the treatment of depression in children 8 and older. Doctors can prescribe other antidepressant medications "off label" (not specifically approved by the FDA for that condition). If that is the recommendation from your doctor, then it is a good idea to ask more questions.

There are three important considerations with the use of antidepressants in children and adolescents:

1. In 2004, the FDA issued a strong "black box" warning about the risk of increased suicidal thoughts and actions in a small percentage of persons who take antidepressants. It is important to have regular care assessments and monitoring and follow-up particularly in the first months of medication treatment. Please visit the FDA Web site (www.fda.gov) for more detail. All treatment options have risks and benefits. The best strategy is to educate yourself about the choices you can make, to share the decision with your child or teen and to evaluate what is best.

2. Children and adolescents who present with a major depressive episode may, over time, be predisposed to bipolar disorder. Reviewing any family history of bipolar disorder and being mindful of this possibility is a good idea when treating a child or adolescent experiencing a major depressive episode.

3. Research is ongoing in this important area, and more needs to be learned. Ask your caregiver about how the latest research studies have influenced their thinking. Look through the NIMH Web site (www.nimh.nih.gov) for a summary of the latest research. Of future interest are NIMH-funded studies TORDIA (Treatment of SSRI-Resistant Depression in), TASA (Treatment of Adolescent Suicidal Attempters) and ASK (Antidepressant Safety in Kids).

What is the right treatment for my depressed child?

First, be sure that a good assessment that looks at the whole person—their environment, medical and family history and current living situation—has been completed. It is important to have a real understanding of the stresses and strengths a youth brings to the equation. It is also essential to have the youth be a part of the emerging plan. There is no "one size fits all": mental health interventions need to be tailored to the individual.

Once the diagnosis is made, ask the clinician to collaboratively develop a treatment plan with your child and family. Target symptoms that you and your child are hoping will improve (*e.g.*, sleep problems, self harming statements, school attendance or performance) that will help track your child's progress. Treatment needs to be specific to your child and his or her world. For example, if there is a co-occuring alcohol problem that must also be addressed. If there is a learning disability or bullying problem at school, that needs attention. Family stresses or conflict may also need attention as part of helping the youth.

If you have concerns about your child's safety, be sure to have a plan to address that. This should include how to access resources after hours and on weekends.

In general, the youth, family and clinician should together choose a first treatment or treatments that seem best for that individual and give that treatment an adequate trial (*e.g.*, 8-12 weeks). The treatment should be reevaluated at the end of that time if it is not working.

How long should my child stay on treatment?

This is an important area of judgment and should be driven by how the treatment efforts progress. Assuming a simple and positive treatment response, medications are typically continued at least six months after response before tapering off. Many therapists will decrease the frequency of sessions but continue some maintenance therapy longer than the initial 8-12 weeks of treatment. Treatment for a first episode of depression is likely to last at least 6-12 months with either treatment but may be longer.

For recurring depression, many clinicians will keep a person on medication to prevent a recurrence for considerably longer periods, sometimes years. In that case, one key is to help the youth recognize when their symptoms are worsening so that additional supports can be activated.

References

Kessler et al. (2001). "Mood Disorders in Children and Adolescents: An Epidemiological Perspective," Biological Psychiatry. Volume 49.

Cheung et al. (2007). "Guidelines for Adolescent Depression: Treatment and Ongoing Management," Pediatrics, Vol. 120.

Luby, J. (2009). "Early Childhood Depression," American Journal of Psychiatry. 166, 974-979.

The TADS team (2007). "Treatment of Adolescent Depression Study: Long-term Effectiveness and Safety Outcomes," archives of General Psychiatry. 64(10) 1132-1143.

Fristad et al. (2009). "Impact of Multifamily Psychoeducational Psychotherapy in Treating Children Aged 8 to 12 with Mood Disorders," archives of General Psychiatry. 66 (9) 1013-1021.

www.fda.gov for all medication and antidepressant warnings and indications.

www.clinicaltrials.gov for up-to-date information on relevant research studies.

www.nimh.nih.gov for National Institute of Mental Health summary of research studies.

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