Depression in Children and Adolescents 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. Looking in the long term, the numbers are higher—for instance, one in five teens have experienced depression at some point. 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 how mood disorders may affect this age group.

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. It is prudent to get an evaluation followed by tailored treatment to prevent the social isolation, 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—that is, the depression may be taking an internal toll without 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:

1. Psychotherapy (talk therapy)
2. Pharmacotherapy (medications)

Additionally, in September 2009 a study was published by Fristad, *et al*. demonstrating that family psychoeducation was beneficial for children with depression ages 8–12. This is a key area for further study.

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 real risk of suicide, so it is important to consider that no treatment also carries risks.

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

Rigorous studies have shown both talk therapy and medications to be useful. Both treatments were more effective than when a placebo alone was given in the NIMH-funded Treatment for Adolescents with Depression Study (TADS). This landmark study also demonstrated that the combination of the two interventions is likely to create even better results than either one alone.

There are two different kinds of psychotherapy that studies have shown to be effective for children and/or adolescents—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. CBT attempts to challenge the automatic negative thinking that may contribute to depression. IPT focuses on a patient's self-concept and relationships with peers and family. More unstructured therapy with a supportive person may also be helpful but is more difficult to study. Ask potential therapists about the kind of psychotherapy they practice and why they feel it might help your child.

Antidepressant therapy can be an effective treatment option for child and adolescent depression, but it also carries risks. Fluoxetine (Prozac) is the only antidepressant specifically approved by the FDA for the treatment of depression in children ages 8 and older. Doctors can prescribe other antidepressant medications “off label” (not specifically approved by the FDA for that condition). If a doctor suggests another medication it is a good idea to ask more questions. Ask why he or she is not recommending the medication approved by the FDA for this condition, and what research and experience are the basis for the recommendation. You may ask for a second opinion from another doctor if you are not sure this is the best course of action.

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

1. **Suicidal thoughts.** In 2004, the FDA issued a strong “black box” warning about the risk of increased suicidal thoughts and actions in a small percentage of children and adolescents who take antidepressants. While none of the 2200 children and adolescents in antidepressant studies killed themselves, a review of the data determined that the rate of suicidal thoughts was about 4% for those taking the medication, double the rate expected. It is important to have regular care assessments, monitoring and follow-up, particularly in the first months of medication treatment. Please visit the FDA website for more detail.

   In addition, in 2006 the FDA expanded the warning about suicidal thoughts and antidepressants to include adults under the age of 25. 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 in the context of a comprehensive care plan.

2. **Bipolar disorder.** Children and adolescents who first experience 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 as antidepressants may increase the risk of mania in some youth.

3. **Research on depression in children and adolescents**. Research is ongoing in this important area, and more needs to be learned. Ask your caregiver about how the latest research studies have influenced the

treatment plan. Look through the **NIMH website** 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 the caregiver has performed an in-depth assessment that looks at the whole person—the environment, school life, medical and family history and current living situation. It is important to have a real understanding of the stresses and strengths a youth brings to the equation. It is also essential to make the youth a part of the emerging plan. There is no "one size fits all" in 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-occurring alcohol problem, that must also be addressed. If there is a learning disability or bullying problem at school, that needs attention. Addressing family stresses or conflict may also be part of helping the youth.

If you have concerns about your child's safety, be sure to have a plan for responding to these concerns. 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 and give that regimen an adequate trial determined in concert with the doctor (*e.g.*, eight to12 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?

Treatment duration should be driven by the improvement and severity of the symptoms. 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 psychotherapy sessions but continue some maintenance therapy longer than the initial eight to12 weeks of treatment. Treatment for a first episode of depression is likely to last at least six to 12 months with either treatment but may be longer.

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

The field of depression treatment for youth is continuously evolving and recent research may hold new information to better guide these decisions. The **NIMH** is a good source to summarize these recent findings. The **American Association of Child and Adolescent Psychiatry** is another good resource.

References

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

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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.

Reviewed by Ken Duckworth, M.D., July 2010