

## **Depression in Children and Adolescents Fact Sheet**

### **What is depression?**

Depression is a disorder characterized by persistent depressed (sad) mood which may last months or even years. It can occur at any age through the lifespan. We do not yet completely understand the processes in the brain and the mind that lead to or sustain a depression. Some people seem to be a greater genetic risk for depression than others, just like some people are at greater genetic risk for hypertension, obesity, adult-onset diabetes and other "complex" genetic disorders (disorders where the risk is associated with a number of genes each of which somewhat increase the risk rather than diseases associated with a single gene which "causes" the disease). Environmental factors on average have about as much influence on who gets a depression as do genetic factors. Again, this makes depression almost exactly like other similar "complex" genetic disorders with strong environmental contributions (e.g. hypertension, obesity, adult-onset diabetes). Adverse life stresses, perhaps particularly interpersonal "loss" events (e.g. death of a parent) increase the hazard for a depression.

### **What are the different kinds of depression?**

Many classification systems have been proposed for depression. However, there is overwhelming evidence for at least two distinct type of depression:

1. Unipolar Depression
2. Bipolar Disorder or Manic Depressive Disorder

Unipolar depression consists of one or more episodes of moderate to severe depression with persistent depressed mood and other symptoms of depression including suicidal ideation, suicide attempts, inability to experience pleasure when doing normally pleasurable activities, impaired concentration, change in appetite, change in weight, difficulty sleeping, and/or increased sleep. The disorder is usually recurrent - if you get it once you are likely to get it again in the future.

Bipolar disorder is characterized by periods of depression essentially identical to that seen in unipolar depression and periods of euphoric (too happy) or extremely irritable mood at the same time as the person has other symptoms of mania including much less need for sleep, very rapid speech, dramatic increase in activities, hypersexuality, and/or "racing" (very rapid and confused) thoughts.

### **How often do children get depression?**

About 2% of school-age children (i.e. children 6-12 years of age) appear to have a major depression at any one time. With puberty, the rate of depression increase to about 4% major depression overall. With adolescence, girls, for the first time, have a higher rate of depression than boys. This greater risk for depression in women persists for the rest of life. Depression is diagnosable before school age (e.g. ages 2-5) where it is somewhat more rare but definitely occurs. Overall, approximately 20% of youth will have one or more episodes of major depression by the time they become adults.

## **Do children with depression need treatment? Will they just "grow out of it"?**

Episodes of depression in children appear to last 6-9 months on average but in some children they last for years at a time. When children are in an episode they do less well at school, have impaired relationships with their friends and family, suffer inside, and have an increased risk for attempted and completed suicide. Because there are effective treatments, to ignore it and hope for the best while the child suffers is not a reasonable approach.

### **How can you tell if your child is depressed?**

Signs that frequently help parents or others know that a child should be evaluated for depression include: the child talking about feeling persistently sad or blue, the child who talks about suicide or being better off dead, the child who is suddenly much more irritable, has a marked deterioration in school or home functioning, or no longer engages in previously pleasurable social interactions with friends.

Because the depressed child may not show significant behavioral disturbance, sometimes parents "hope for the best" or fail to get a child evaluated who shows signs of suffering internally but not disrupting the family.

### **What are the treatments for depressed children and adolescents?**

There are two main groups of treatments for the depressed child with demonstrated evidence of efficacy:

1. Psychotherapy
2. Pharmacotherapy

Because the course of major depression is fluctuating and because there is a general positive effect on the child (or adult) with depression just from the process of seeing and talking with another caring individual about their depression, to say that a treatment is effective we require that it work better than non-specific psychotherapy (e.g. talking to a nice and empathic person) in the case of psychotherapies or placebo medication pills given by a warm and friendly person in the case of pharmacotherapies. Thus, the treatments described below have an additional specific effect as well as all the benefit of the human contact and non-specific discussion of the depression. These are the best we know how to do at present.

The two different specific psychotherapies which show efficacy in 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.

Despite a number of studies, there is essentially no evidence to suggest that older-generation tricyclic antidepressants (e.g. Tofranil, Elavil) work for depression in children or adolescents. There are published studies finding efficacy for two SSRIs, fluoxetine (Prozac) and sertraline (Zoloft), in child and adolescent depression. There are ongoing studies and studies which are completed and have been presented at national meetings but not yet published for other antidepressants in child and adolescent major depression. Some of

these studies are positive and others have failed to show efficacy (though individual studies frequently fail to find evidence of efficacy even for known effective treatments because of simple bad luck-studies are mathematically much more informative if positive than if negative).

In the middle of 2003 there were FDA (for paroxetine) and pharmaceutical company (for venlafaxine) reports of low but increased rates of impulsive/suicidal behaviors in depressed youth randomized to those active compounds when compared to depressed youth randomized to placebo in the same studies. While there were no completed suicides in these studies in any group, these findings are worrisome and demand increased attention to the question of whether or not some antidepressants may increase the hazard of suicide. At present, the data necessary to understand these studies has not been published or released to the field.

### **OK, what is the right treatment for my depressed child?**

Given that both psychotherapeutic and pharmacological approaches have demonstrated efficacy, what is the right treatment for a particular child?

Ultimately, we don't have the answer to that question yet though there are two large ongoing multi-site studies which will help us. When considering monotherapy with either talking or pharmacological approaches we do know that all of these approaches have something like a 60% good to excellent clinical response rate which means that many youth do not respond or do not respond adequately to the first treatment and will require augmentation or change of treatment.

Therefore, the youth, family, and clinician should together choose a first treatment that seems best for that individual and give that treatment an adequate trial (e.g. 8-12 weeks). At the end of that time if the treatment isn't working, it should be changed-try the treatment for at least two to three months but no longer before evaluating it and modifying or completely scrapping as indicated by the progress.

### **How long should my child stay on treatment?**

Medications are typically continued at least 6 months after response before tapering off. Many therapists will decrease the frequency of session but continue some maintenance therapy longer than the initial 8 to 12 weeks of treatment. Treatment for a first episode of depression is likely to last at least 6 to 12 months with either treatment.

For recurring depression, many clinicians will maintain prophylactic treatment for considerably longer periods (e.g. years).

*Reviewed by Neal Ryan, MD September 2003  
Information from the NAMI website ([www.nami.org](http://www.nami.org))*