SECTION 1

Children and Adolescents with Depressive Disorder:

Summary of Findings

from the Literature and Clinical Consultation in Ontario

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SUMMARY

Depressive disorders can have very significant effects on the functioning and adjustment of young people. They contribute to increased risk of illness and long-lasting interpersonal and psychosocial problems, including substance abuse and suicidal behaviour. Serious (clinical) depression often goes unnoticed by both families and physicians. Early identification, accurate assessment, and effective treatment allow children suffering from depression and their families to lead happy and fulfilling lives.

EPIDEMIOLOGY

Depressive disorders in children and adolescents are among the most common and more disabling disorders, affecting approximately 2% of children and 4% to 8% of adolescents. Depression in children manifests itself differently from depression in adults, and many questions remain about the course and outcome of serious depression in young people.

CLINICAL CHARACTERISTICS

Depression contains features associated with mood changes such as sadness, feelings of worthlessness, suicidal thoughts and behaviour. In serious depression, the depressed mood is present nearly all day long for at least two weeks. The symptoms of serious depression are somewhat different in younger children and adolescents than in adults.

Unlike adults or adolescents, younger children are less likely to make serious suicide attempts. Signs that may indicate depression in children, particularly if they reflect a change from the child's usual state, include:

- Depressed appearance
- Vague physical complaints (e.g., headaches, stomachaches, tiredness)
- Irritability and frustration, accompanied by tantrums and behavioural problems
- Apathy and disinterest
- Lack of cooperation
- Anxiety (particularly separation anxiety)
- Withdrawal from family and friends
- Auditory "hallucinations"

In contrast to younger children, adolescents are more likely to show symptoms of:

- Sleep and appetite disturbances
- Weight loss/gain
- Refusing to attend school or poor school performance
- Extreme sensitivity to rejection or failure
- Social isolation, poor communication
- Reckless behaviour
- Alcohol or substance abuse
- Fear of death, or suicidal thoughts or suicide attempts
- Delusions

RISK FACTORS FOR SERIOUS DEPRESSION

The presence of depression in parents is a signal that their children may also be depressed and in need of treatment. Serious depression is up to four times more common among the children of depressed parents, especially the mother, than among the general population. Serious depression is associated with other risk factors, in particular:

- Family history of depression
- Gender (adolescent females are at greater risk of depression)
- Child of teenaged mother

ASSESSMENT

Since symptoms vary with developmental level, the key defining features of serious depression may be more difficult to recognize in children and adolescents. Children and youth may have difficulty describing their mood states. For example, when they misbehave or are irritable with others, they may be perceived as disobedient rather than depressed. When a young person appears to be experiencing serious depression, a comprehensive assessment is warranted.

A thorough assessment is necessary to accurately diagnose serious depression in children and adolescents. It is essential that the assessment process take into account functioning relative to the child's developmental stage and social context (family, school, peers, community). During assessment, depressed children and adolescents may be uncooperative, withdrawn, irritable or have difficulty expressing their feelings. It may take time to build trust over several interviews before sensitive topics can be discussed.

A diagnosis of major depressive disorder is made when DSM-IV-TR target symptoms are present or reported in the history, and other disorders have been eliminated.

Mental health professionals should be aware that several disorders may imitate depression or occur at the same time (that is, they are comorbid with depression). A physical exam may be needed to rule out common medical conditions that mimic depression (anemia, hypothyroidism, infectious mononucleosis), as well as to check physical complaints (headaches, stomachaches, fatigue) and overall health. Psychiatric and/or psychological assessments may be required to rule out non-mood disorders with symptoms similar to depression (anxiety disorders, learning disabilities, conduct and disruptive disorders, and substance abuse disorders) and to determine if there are disorders comorbid with depression.

DISORDERS COMORBID WITH DEPRESSION

The majority of adolescents suffering from depression also suffer from two or more other disorders at the same time. The most frequent of these comorbid disorders are anxiety disorders (including separation anxiety in younger children), dysthymia (chronic depressed or irritable mood -- usually at least for one year), conduct and disruptive behaviour disorders, obsessive-compulsive disorder, and substance abuse disorders. A thorough assessment should check for comorbid disorders, since their presence affects the choice and sequence of therapeutic interventions.

TREATMENT

There is relatively little evidence-based research on the treatment of depression in children. Since most of the treatment recommendations are derived from clinical experience or research in adults, care should be taken when applying the results to children. Research and clinical experience indicates that treatment for depression may be discussed in terms of four phases:

- Phase 1: Preparation for Treatment
- Phase 2: Acute Treatment Phase
- Phase 3: Continuation Treatment Phase
- Phase 4: Maintenance Treatment Phase

Phase 1: Preparation for Treatment. Preparation for treatment is vitally important. Preparation includes forming a therapeutic alliance early in treatment to maintain child and family involvement over the course of treatment. The therapeutic alliance process is facilitated by psychoeducation -- the education of the parents, child, other family members, and teachers about the disorder and its treatment. Psychoeducation drastically reduces treatment dropout. It allows treatment to proceed with less blame of the child or self-blame on the part of parents or caregivers.

Phase 2: Acute Treatment Phase. It is important to recognize that child and adolescent depression occurs in episodes. The length of an acute episode is about 8 months. Up to 90% of children and adolescents will recover within 1 to 2 years from onset of an acute episode.

There is a wide range of views about which therapies or components of therapies are effective during the acute phase of child and adolescent depression. Evidence from clinical and controlled studies shows that interpersonal and cognitive-behavioural therapies are effective for treating serious depression in children and adolescents. **Interpersonal therapy** is based on the strong association between interpersonal problems and depression. Interpersonal therapy is a way to address issues of grief, interpersonal roles, role transitions, and interpersonal difficulties. **Cognitive-behavioural therapy** is based on the premise derived from cognitive theory that depressed children have distorted views of themselves and their environment that contribute to their depression and that these views can be modified. Themes addressed in therapy sessions include distinguishing different emotions and linking them to precipitating events, self-monitoring thoughts and feelings, self-rewarding positive behaviours, strengthening social skills, problem-solving, and modifying thinking patterns.

Therapist reports indicate that the principles of **psychodynamic therapy** are useful for the treatment of children and adolescents with mild and moderate levels of depression and also when they are integrated with structured forms of therapy, such as interpersonal and cognitive-behavioural approaches. Psychodynamic approaches are used to help youth understand themselves, identify feelings, improve self-esteem, change maladaptive patterns of behaviour, interact more effectively with others, and cope with ongoing and past conflicts.

There is a strong relationship between family factors and depression in children. There is little evidence, however, that **parent counselling** and **family therapy** <u>alone</u> are effective

in treating child and adolescent depression. With younger children **parent co-therapists** may be involved in delivering structured treatment such as cognitive-behavioural therapy. **Home-based interventions** may involve the family in developing a supportive home environment or in reducing the stress at home. **Social work interventions** involving the parents and family may be helpful in dealing with issues related to poverty and psychosocial stress (unemployment, homelessness, access to social supports). There also is an emerging recognition that children and adolescents benefit from an **integrative approach** that combines elements of psychodynamic therapy, interpersonal therapy, cognitive-behavioural therapy and family therapy.

Given the developmental and psychosocial context of child and adolescent depression, treatment with **antidepressant drugs** alone is not sufficient. If medication is prescribed, it should be used in conjunction with psychoeducation and the psychotherapeutic treatments described above.

Overall, there have been very few studies about the use of medications for children and adolescents with depression. The limited research evidence indicates that antidepressant medications, however, may be useful for treating children and adolescents with certain forms of serious depression that impedes psychological treatment or where the child or adolescent does not respond to psychotherapy. A major concern is the practice of prescribing combinations of medications ("drug cocktails") without sufficient evidence for their efficacy or adequate monitoring and review. Although selective serotonin reuptake inhibitors (SSRIs) have been shown to be effective for the treatment of adolescents with serious depression, additional research is needed to determine their long-term efficacy and effects in children and adolescents.

Phase 3: Continuation Treatment Phase. Given the high rates of relapse and recurrence of depression, once treatment outcomes have been attained, therapy should be continued for at least 6 to 12 months and it may be needed periodically to prevent recurrence. Monthly "booster sessions" have been found useful either in preventing relapses of depression in adolescents or in accelerating the recovery of those who were still depressed at the end of the acute phase. If medication is employed, it is usually continued at the same dose as prescribed in the acute treatment phase, unless there are significant side effects or dose-related negative effects.

Phase 4: Maintenance Treatment Phase. Children and adolescents with multiple or severe episodes of depression and those with a high risk for recurrence may need ongoing therapy to prevent relapse. The maintenance phase usually extends from one year onwards and includes monthly or quarterly sessions, depending on the severity of illness and availability of social supports. Children and adolescents who have suffered from two or more episodes of depression may also require long-term maintenance drug therapy under the care of a qualified child psychiatrist or physician.

DEPRESSION WITH SUICIDAL THOUGHTS AND BEHAVIOUR

Depression with suicidal thoughts and behaviour is more likely to occur in adolescents rather than younger children. Treatment for youth with suicidal thoughts and behaviour is similar to that for other severely depressed youth, but more attention is given to assessment, monitoring and reduction of suicide risk.

Assessment of suicide risk should be an integral component of any assessment of depression. Assessment of suicide risk considers functional impairment, degree of hopelessness, presence of psychosis, stability of family environment, access to supports, and availability of methods for suicide.

Risk factors for suicide include:

- Feelings of hopelessness and isolation
- Family history of suicide or suicide attempts
- Close friend or acquaintance who commits suicide ("contagion effect")
- Recent loss of a friend or loved one
- Shameful event (especially for adolescents)
- Reaction of others to gay/lesbian sexual orientation
- Impulsive behaviour
- Substance abuse
- History of physical or sexual abuse
- Unstable family environment
- Few supports
- Availability of methods for suicide

After assessment, the next step is developing a safety plan in conjunction with the parents that addresses safety, supervision, and removing the methods for committing suicide from the home.

If parent-child conflict, criticism, and/or family dysfunction are identified in the assessment, they should be treated right away to reduce or eliminate factors that often precipitate self-harm in children and adolescents.

If an adequate safety plan can be developed, then outpatient treatment is an option. If risk remains high, treatment in a more restrictive setting may be necessary.

Signs of high risk include plans for suicide, hopelessness, lack of a reason to continue living, previous suicide attempts (particularly those using active methods, rather than overdoses or cutting), and alcohol or drug abuse (especially for adolescent males).

ADDITIONAL RESOURCES:

See the CMHO website at **http://www.cmho.org** for the full paper "Children and Adolescents with Depressive Disorder: Findings from the Literature and Clinical Consultation in Ontario" and for links to other helpful resources regarding child and adolescent depression.