Children and Adolescents With Depression At A Glance*

Screen children and adolescents for key depressive symptoms including depressive or sad mood, irritability, and anhedonia. A diagnosis of a depressive disorder should be considered if these symptoms are present most of the time, affect the child's psychosocial functioning, and are above and beyond what is expected for the chronological and psychological age of the child.

Maintain a confidential relationship with the child or adolescent while developing collaborative relationships with parents, medical providers, other mental health professionals, and appropriate school personnel.

PRESENTING SYMPTOMS

Clinical depression manifests with symptoms ranging from subsyndromal to syndromal. To diagnose a syndromal disorder, Major Depressive Disorder (MDD), a child or adolescent must have at least 2 weeks of persistent change in mood manifested by either depressed or irritable mood and/or loss of interest and pleasure plus a group of other symptoms including persistent thoughts of death, suicidal ideation or attempts; increased or decreased appetite, weight, or sleep; and decreased activity, concentration, energy, or self-worth or exaggerated guilt. These symptoms must represent a change from previous functioning and produce impairment in relationships or in performance of activities and must not be attributable only to substance abuse, use of medications, other psychiatric illness, bereavement, or medical illness.

Children may have mood lability, irritability, low frustration tolerance, temper tantrums, somatic complaints, and/or social withdrawal instead of verbalizing feelings of depression. Also, children tend to have fewer melancholic symptoms, delusions, and suicide attempts than depressed adults.
Depressive disorder (DD) consists of a persistent, long-term change in mood that generally is less intense but more chronic than in MDD. As a consequence, DD is often overlooked or misdiagnosed. Although the symptoms of dysthymia are not as severe as in MDD, they cause as much or more psychosocial impairment.

Careful assessment of risk for suicide is crucial. An assessment of the presence of suicidal ideation is essential, including the degree to which the person served intends to act on any suicidal ideation and the extent to which the child or adolescent has made plans for or the availability of means for suicide should be determined and a judgment made concerning the lethality of those means. Because antidepressant use has been associated with new and heightened suicidal ideation and behavior, be alert for the emergence or worsening of suicidality.

Seasonal affective disorder (SAD)

Bright light therapy may be effective treatment for youths with SAD. It appears that youth may respond better during the morning hours, but morning hours may be difficult on school days and for youths who refuse to wake up early in the morning. Bright light therapy has been associated with some side effects, such as headaches and eye strain. Consider an ophthalmologic evaluation before initiating light therapy, but especially for youths with a history of eye illness. Treatment with light may induce episodes of hypomania or mania in vulnerable young people.

Antidepressant medications

Except for lower initial doses to avoid unwanted effects, the doses of the antidepressants in children and adolescents are similar to those used for adults. Some studies have reported that the half-lives of sertraline, citalopram, paroxetine, and bupropion SR are much shorter than reported in adults. Consequently the clinician should be alert to the possibility of suboptimal outcomes or withdrawal side effects when these medications are prescribed once daily. Also, to avoid side effects and improve adherence to treatment start with a low dose and increase it slowly until appropriate doses have been achieved. Persons served should be treated with adequate and tolerable doses for at least 4 weeks.

Clinical response should be assessed at 4-week intervals, and if the child has tolerated the antidepressant, the dose may be increased if a complete response has not been obtained. At each step, adequate time should be allowed for clinical response, and frequent, early dose adjustments should be avoided.

Failure to respond

Persons served displaying minimal or no response after 8 weeks of treatment are likely to need alternative treatments. Furthermore, by about 12 weeks of treatment, the goal should be remission of symptoms, and in youths who are not remitted by that time, alternative treatment options may be warranted.

Consider the following reasons for treatment failure: misdiagnosis, unrecognized or untreated comorbid psychiatric or medical disorders (e.g., anxiety, dysthymic, eating, substance use, personality, hypothyroidism), undetected bipolar disorder, inappropriate pharmacotherapy or psychotherapy, inadequate length of treatment or dose, lack of adherence to treatment, medication side effects, exposure to chronic or severe life events (e.g., sexual abuse, ongoing family conflicts), personal identity issues (e.g., concern about same-sex attraction), cultural/ethnic factors, and an inadequate fit with, or skill level of, the psychotherapist.

Moderate depression may respond to CBT or IPT alone. More severe depressive episodes will generally require treatment with antidepressants. Treatment with antidepressants may be administered alone until the child is amenable to psychotherapy or if appropriate, they can be combined with psychotherapy from the beginning of treatment. Finally, depressed youth who do not respond to prior monotherapy treatment, either psychotherapy or antidepressants, require a combination of these two treatment modalities.

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