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Pediatric unipolar depression: Psychotherapy

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INTRODUCTION

Psychotherapy is usually recommended for pediatric unipolar depression. These interventions attempt to improve symptoms and functioning by teaching patients and their families social and self-management skills, and how to effectively handle relationships and life stressors associated with depression. In addition, psychosocial interventions can help patients understand themselves and the nature of depression, and increase self-confidence.

Psychotherapies available for pediatric unipolar depression include cognitive-behavioral therapy (CBT), interpersonal therapy for adolescents (IPT-A), family therapy, problem-solving therapy, and supportive psychotherapy. CBT, IPT-A, and family therapy have been more widely studied than the others, and the best established psychotherapy is CBT [1,2]. Most psychotherapies for youth were adapted from therapies initially developed for adults [3,4].

Psychotherapy for treating adolescent depression is discussed below. Other topics provide an overview of treating pediatric depression and discuss choosing pharmacotherapy for adolescent depression. (See "Overview of prevention and treatment for pediatric depression" and "Pediatric unipolar depression and pharmacotherapy: Choosing a medication".)

GENERAL PRINCIPLES

For children and adolescents with unipolar depression, we suggest that treatment include psychotherapy. Evidence supporting this approach is described below in each of the sections

that discuss specific therapies: cognitive-behavioral therapy (CBT), interpersonal psychotherapy for adolescents (IPT-A), family therapy, problem-solving therapy, supportive therapy, and behavioral therapy.

General principles for using psychotherapy to treat pediatric depression include the following:

- Individualize care by identifying specific targets for the intervention, including cognitive, behavioral, emotional, interpersonal, and family problems that are maintaining the depressive syndrome. This often include issues such as parent-youth conflict, separation and individuation concerns, peer pressure, sexual identity, dating, substance use, and school performance.
- Incorporate the parents/caregivers in therapy.
- Evaluate patients for comorbid disorders; the benefit of psychotherapy is less established for youth with comorbidities such as anxiety disorders or substance-related and addictive disorders [1]. Comorbidity is common in adolescent depression and often requires treatment. (See "Pediatric unipolar depression: Epidemiology, clinical features, assessment, and diagnosis", section on 'Comorbidity'.)
- Engage the patient and family by establishing a therapeutic working alliance and collaborative framework that is based upon trust, genuineness, respect, and understanding.
- Collectively discuss that psychotherapy is most effective for patients who are motivated and can engage in treatment.
- The early stages of treatment need to instill hope that intervention can be effective, depression can remit, and problems are not insurmountable. Instilling hope activates the adolescent's motivation to engage in treatment. Addressing hopelessness early in therapy is important because hopelessness predicts dropout and poor response to treatment.
- Utilize measurement based care, which entails systematically monitoring depressive symptoms with self-report instruments (table 1), to engage patients and guide treatment.
- Include psychoeducation regarding relapse prevention and make "booster sessions" (maintenance therapy) available as needed.

It is not clear whether the benefit of psychotherapy varies by age. One review and one meta-analysis each found that psychotherapy was less established or less effective for children (age

≤12 years) than adolescents [1,2]; however, another meta-analysis found that age did not moderate the effect of therapy [3].

Contraindications — Contraindications to individual psychotherapies such as CBT and IPT-A include cognitive and language disabilities that limit understanding and engagement in the treatment [5]. If significant psychosocial issues are present in patients with intellectual disabilities, family therapy and/or parent education and guidance is more likely to be productive than individual therapy [6]. Given that psychotherapy targeted for depression is time limited, it is also not recommended for patients with a long-standing history of severe interpersonal dysfunction (eg, personality disorders). Other contraindications are psychotic features, suicidal thoughts with a plan and intent, and primary substance-related and addictive disorders [5].

Individual psychotherapy is also not suitable for patients who will not engage in treatment. If an adolescent is resistant to psychotherapy, the initial portion of treatment focuses on building rapport and working to find common objectives to use as a basis for developing a treatment plan and working alliance. This process may be aided by motivational interviewing, which consists of an empathic, nonjudgmental, and nonconfrontational exploration of the advantages and disadvantages of staying the same versus changing [7]. The clinician aims to help patients recognize their reasons to change and increase self-awareness and readiness for change. If motivation to actively engage in treatment is not present and cannot be instilled early in treatment, the prognosis is poor. Motivational interviewing is discussed further elsewhere. (See "Overview of psychotherapies", section on 'Motivational interviewing'.)

Dropout from therapy — Many patients drop out of psychotherapy [8]. As an example, in a randomized trial that included 406 adolescents with unipolar major depression who were treated with psychotherapy, the rate of dropout (ending treatment without the therapist's agreement) occurred in 42 percent [9].

CHOOSING A THERAPY

Among the major psychotherapies that are used to treat pediatric unipolar depression, there are no compelling data that one is superior to the others; thus, the choice usually rests upon availability and patient preference. Cognitive-behavioral therapy (CBT), interpersonal psychotherapy for adolescents (IPT-A), and family therapy are frequently selected for the initial treatment of unipolar depression because they have been more widely studied than other types of psychotherapies. However, other reasonable choices include problem-solving therapy and supportive psychotherapy.

Evidence regarding the comparative efficacy of psychotherapies for pediatric unipolar depression includes a network meta-analysis of 52 randomized trials of psychotherapies in approximately 3800 children and adolescents with depressive syndromes [1]. Efficacy was examined by using results from direct comparisons between the therapies, as well as indirectly comparing therapies through their relative effect with a common comparator, typically a control condition such as usual care or a waiting list. The trials included CBT, IPT-A, family therapy, problem-solving therapy, and supportive psychotherapy; duration of treatment lasted 4 to 16 weeks. The primary findings were as follows:

- Improvement posttreatment was greater with each of the five psychotherapies than the control conditions, and the clinical effect was moderate to large.
- The benefit of each therapy was comparable to that of the others.

Subsequent randomized trials also suggest that the benefit of different psychotherapies is comparable [10].

CHOOSING A THERAPIST

Psychotherapy is typically administered on an outpatient basis by various licensed mental health clinicians (eg, psychologists, clinical social workers, and psychiatrists). The first steps in choosing a therapist involve determining:

- The therapist's approach to treatment
- Training in evidence-based approaches
- Experience treating pediatric depression

Most psychologists receive formal training in cognitive-behavioral therapy (CBT), and many therapists outside of psychology have training in CBT as well. Training in interpersonal therapy for adolescents and family therapy is less common than CBT. One way to find a cognitive-behaviorally oriented therapist is to consult the Association for Behavioral and Cognitive Therapies website.

Another consideration when choosing a therapist is whether family members are included in the treatment. Treatment typically is more effective when family members (particularly parents/caregivers) are included to support and maintain treatment gains. Useful questions to ask the therapist include:

- What is your approach to treatment? What type of psychotherapy do you practice?
- What is your training and experience in treating depression in adolescents?

- Are family members included in some aspects of the treatment? How?

Treatment plan — Treatment planning should be collaborative and involve the patient and family. Elements of the treatment plan include the number, frequency, and duration of sessions, which are based upon clinical factors such as the severity of symptoms, the age and developmental status of the patient, and the degree of current exposure to negative life events. Multiple sessions per week may be needed during the initial treatment phase.

COGNITIVE-BEHAVIORAL THERAPY

Overview — Cognitive-behavioral therapy (CBT) is a time-limited, manualized intervention for depressive syndromes in adolescents that combines cognitive therapy and behavioral therapy [11,12]. Cognitive therapy attempts to modify dysfunctional thoughts about oneself (eg, "I'm no good because I'm stupid"), the world, or the future, using techniques such as examining the evidence, cognitive restructuring, and disengagement from unproductive thoughts. Behavioral therapy focuses upon modifying maladaptive behaviors (eg, social isolation), as well as increasing goal directed behaviors and mood enhancing activities. Patients learn cognitive and behavioral skills within the therapy setting and practice them in between sessions. The cognitive-behavioral treatment model, initially developed for depressive disorders, has been adapted for a wide range of psychopathology, including anxiety disorders, body dysmorphic disorder, eating disorders, insomnia, obsessive-compulsive disorder, posttraumatic stress disorder, schizophrenia, somatic symptom and related disorders, and substance-related and addictive disorders, as well as several general medical conditions such as chronic noncancer pain and tinnitus.

Although CBT is generally provided face-to-face with an individual patient, randomized trials suggest that group CBT or self-guided digital formats using a mobile telephone or computer may be reasonable alternatives, particularly if the standard format is not available or is declined [11,13-17]:

- A meta-analysis of 23 randomized trials in depressed adolescents (n >5400) found that group CBT was superior to control conditions such as bibliotherapy or waiting list [18].

- A randomized noninferiority trial compared computerized CBT with usual care in 187 adolescents who sought treatment for mild to moderate depression in primary care settings [19]. Computerized CBT consisted of an interactive fantasy game comprising seven modules which were delivered over four to seven weeks; usual care primarily

consisted of face-to-face counseling (mean number of sessions was five). Three months after the interventions, improvement of symptoms was comparable in the two groups.

Course of treatment — A standard course of acute CBT consists of 12 to 16 weekly sessions, but the schedule is flexible depending upon what is clinically indicated and varies among studies [11,12]. A longer duration of treatment (eg, six months) may be indicated for patients with comorbidities such as anxiety disorders or substance-related and addictive disorders. Treatment typically includes homework assignments (eg, self-monitoring or activity scheduling) between sessions. Throughout treatment, the therapist monitors depressive symptoms and mastery of CBT skills.

Initial phase — The initial phase of CBT includes [11,12]:

- Establishing parents/caregivers as part of the treatment team and engaging their support for early behavioral treatment goals
- Educating the family about the depressive disorder and CBT model/treatment rationale
- Developing a therapeutic relationship and instilling hope
- Collaboratively identifying problems to target, including distorted or maladaptive assumptions, automatic thoughts, beliefs, communication skills, problem solving, rumination, social skills, and standards (eg, perfectionism)
- Implementing behavioral techniques (eg, activity scheduling) to counteract withdrawal and increase involvement in constructive, mood enhancing activities

Goals in CBT for depression include:

- Increasing participation and mastery of pleasurable activities
- Improving social engagement
- Identifying, modifying, and disengaging from depressogenic thinking patterns (eg, maladaptive thoughts)
- Increasing goal directed (rather than mood-directed) behaviors
- Developing skills for communication, relationships, problem solving, and coping with negative life events

Middle phase — In the middle phase, CBT involves learning and practicing skills within and between sessions and building efficacy for self-management. The treatment components and

techniques include [11,12]:

- Continued activity scheduling and approach (rather than avoidance) behaviors
- Behavioral experiments and rehearsal
- Cognitive restructuring
- Self-monitoring
- Skills training:
  - Assertiveness
  - Conflict management
  - Relaxation
  - Social relationships
- Socratic questioning (examining the evidence)
- Family communication/interaction patterns
- Practicing new ways of coping with stressors and social situations
- Problem-solving (eg, addressing barriers to completing assignments between sessions)

Final phase — The final portion of treatment (termination phase) involves psychoeducation and planning for relapse prevention [12]. Discontinuation typically is based upon resolution of depressive symptoms and the patient's sense of efficacy to maintain gains and manage setbacks. Most treatment protocols provide for a continuation phase (eg, monthly booster treatment sessions) to maintain and/or extend gains. Once acute CBT is discontinued, the patient, family, and primary care clinician should monitor for recurrence of depression.

Efficacy

Acute phase — The efficacy of CBT for treating acute adolescent depression has been established through multiple meta-analyses of randomized trials that compared CBT with pharmacotherapy and other psychotherapies, as well as control conditions (usual care, pill and psychological placebo, and waiting list) [3,20]. As an example:

- A network meta-analysis of 52 randomized trials evaluated the efficacy of psychotherapies in approximately 3800 children and adolescents with depressive syndromes, including 1149 who were treated with CBT in trials lasting 4 to 18 weeks [1]. Improvement from baseline was determined from direct comparisons of psychotherapies in head-to-head

trials and from indirectly comparing psychotherapies through their relative effect with a common comparator, typically a control condition such as usual care or waiting list. The primary findings included the following:

- Improvement posttreatment was greater with CBT than control conditions, and the clinical effect was moderate to large.
- Improvement was greater with CBT than play therapy, and the clinical advantage was large.
- The benefit of CBT was comparable to that of IPT-A, as well as family therapy, problem-solving therapy, and supportive psychotherapy. This is consistent with a conventional meta-analysis (45 randomized trails), which found that after controlling for potential confounding factors such as patient age, sex, and type of control group, the efficacy of CBT and IPT-A were comparable [3].

- In the Treatment of Resistant Depression In Adolescents trial, 344 adolescents with unipolar major depression unresponsive to initial treatment with selective serotonin reuptake inhibitors (SSRIs) were randomly assigned to treatment with another SSRI, another SSRI plus CBT, venlafaxine, or venlafaxine plus CBT [21]. The response rate was greater in patients whose switch included CBT than in those whose who underwent medication switch alone (55 versus 41 percent).

  For adolescents with depression that includes prominent insomnia, CBT programs that explicitly address both conditions may be helpful [22]. Other subgroups that can benefit from CBT include youth who decline or quickly discontinue initial treatment with an antidepressant drug [23].

Maintenance phase and prevention — There are fewer randomized trials of CBT for treating adolescent depression during the continuation and maintenance phase than the acute phase; most studies indicate that continuation and maintenance treatment is beneficial. As an example [24]:

- A 33-month randomized trial compared CBT plus usual care with usual care alone in 316 adolescents with current subsyndromal depressive symptoms or a prior history of a depressive disorder [25]. At study entry, none of the patients met criteria for a major depressive episode. The format for the intervention was group therapy, consisting of eight weekly sessions followed by six monthly continuation sessions, each lasting 90 minutes. Depressive syndromes occurred in fewer patients who received active treatment than usual care alone (37 versus 48 percent).

- Subsequently, patients were followed for up to six years after treatment [26]. Fewer depressive episodes occurred in patients who received CBT plus usual care, compared with usual care alone (hazard ratio 0.71, 95% CI 0.53-0.96). The benefit of CBT occurred primarily in the first nine months of the study, when the intervention was administered; this suggests that monthly booster sessions beyond six months may extend the duration of the effect. However, the benefit of CBT on the risk of depression was observed only in patients whose parent/caretaker was not depressed at the time of the intervention, indicating the importance of co-treatment of parental depression in preventing adolescent depression.

The efficacy of continuation treatment with CBT plus pharmacotherapy in patients with acute major depression who respond to pharmacotherapy alone is discussed separately. (See "Overview of prevention and treatment for pediatric depression", section on 'Sequential treatment'.)

INTERPERSONAL PSYCHOTHERAPY FOR ADOLESCENTS

Overview — Interpersonal psychotherapy for adolescents (IPT-A) is a time-limited, manualized intervention for depressive syndromes in adolescents [5]. The therapy was adapted from the version of interpersonal psychotherapy developed for depressed adults. According to the treatment model, there are many possible etiologies of depression, but independent of the cause, depression disrupts relationships. Thus, IPT-A focuses on current relationship problems associated with the adolescent's depression and is well suited to patients who have an identifiable interpersonal event that precipitated or exacerbated a depressive episode. The treatment accounts for developmental issues relevant for adolescents such as establishing autonomy, negotiating romantic relationships, resolving questions about sexual orientation, managing parent-adolescent tensions, and coping with peer pressures. IPT-A can be effective for depressed patients with comorbid anxiety disorders, attention deficit hyperactivity disorder, and/or oppositional defiant disorder [5].

Although IPT-A is usually administered face-to-face with an individual patient, other formats include group therapy.

Course of treatment — A standard course of acute treatment consists of 12 weekly sessions, but the schedule is flexible depending upon what is clinically indicated and varies among studies [5]. Throughout treatment, the therapist monitors depressive symptoms and interpersonal functioning.

One of the adaptations for using interpersonal psychotherapy in adolescents is parental/caregiver involvement [27]. At a minimum, this component occurs in the beginning and includes education about depression as an illness and its treatment. Parents may also be involved in the middle and termination phases of treatment.

- **Initial phase** – Initially, treatment explores the patient's relationships by conducting an interpersonal inventory to identify problem areas that will be the focus of treatment [5,27]. IPT-A theorizes that there are four categories of interpersonal problems that are associated with the onset or maintenance of depression: grief due to death (prolonged grief disorder), role disputes, role transitions, and interpersonal deficits. Therapy focuses on one or two of these problem areas; in many cases, the therapist and patient decide to address interpersonal conflicts such as parent-child disputes or peer conflicts, or role transitions related to changes in family structure due to separation, divorce, remarriage, incarceration, or death.

- **Middle phase** – In the middle phase of treatment, therapists help patients identify specific strategies to successfully manage interpersonal difficulties related to their depression. General IPT-A techniques include promoting effective expression of affect, clarifying and reframing expectations for relationships, communication analysis, problem solving, and role playing to learn and practice effective methods of interaction [5,27]. Between sessions, patients are encouraged to practice the skills they are learning, and telephone contact may also be utilized. If patients have not demonstrated at least a 20 percent reduction in depression rating scale scores after four weekly sessions, it may be helpful to temporarily increase the frequency of treatment to two sessions/week, thereby increasing the total number of sessions [28].

- **Final phase** – During the termination phase, the therapist and patient review symptomatic changes and the skills that the patient has learned, address what difficult interpersonal situations may arise in the future and how to manage them, and discuss the patient's feelings about ending therapy [5]. The possibility that the depressive syndrome will recur is also discussed, including warning signs and how recurrences should be managed.

Following termination of acute treatment, monthly follow-up or maintenance treatment may be provided as clinically indicated, based upon the adolescent's mood and management of relationships. The patient, family, and primary care clinician should all be involved in monitoring for recurrence of depression.

Additional information about interpersonal psychotherapy is discussed in the context of adult depression. (See "Interpersonal Psychotherapy (IPT) for depressed adults: Indications,

theoretical foundation, general concepts, and efficacy" and "Interpersonal Psychotherapy (IPT) for depressed adults: Specific interventions and techniques".)

Efficacy — IPT-A has not been as widely studied as cognitive-behavioral therapy (CBT), but is nevertheless well established for treating adolescent depression:

A network meta-analysis of 52 randomized trials evaluated the efficacy of psychotherapies in approximately 3800 children and adolescents with depressive syndromes, including 344 who were treated with IPT-A in trials lasting 6 to 16 weeks [1]. Improvement from baseline was determined from direct comparisons of psychotherapies in head-to-head trials, and from indirectly comparing psychotherapies through their relative effect with a common comparator, typically a control condition such as usual care or waiting list. The primary findings included the following:

- Improvement posttreatment was greater with IPT-A than control conditions, and the clinical effect was moderate to large.
- Improvement was greater with IPT-A than play therapy, and the clinical advantage was large.
- The benefit of IPT-A was comparable to that of CBT, as well as family therapy, problem-solving therapy, and supportive psychotherapy. This is consistent with a conventional meta-analysis (45 randomized trails), which found that after controlling for potential confounding factors, such as patient age, sex, and type of control group, the efficacy of IPT-A and CBT were comparable [3].

FAMILY THERAPY

Family therapy for pediatric unipolar depression involves treating the depressed youth, the “identified patient,” as well as other family members residing with the patient [29,30]. The basis for this approach is that depression occurs in a social context (family system) and usually affects the patient’s significant others. The way in which family members and significant others respond to the depressed patient, in turn, influences the course and outcome of the depressive syndrome. Treatment is usually manualized and time limited.

Evidence regarding the efficacy of family therapy for pediatric unipolar depression includes a network meta-analysis of 52 randomized trials of psychotherapies in approximately 3800 children and adolescents with depressive syndromes, including 134 who were treated with family therapy in trials lasting 12 to 16 weeks [1]. Efficacy was examined by using results from

direct comparisons between the therapies, as well as indirectly comparing therapies through their relative effect with a common comparator, typically a control condition such as usual care or waiting list. The primary findings were as follows:

- Improvement posttreatment was greater with family therapy than the waiting list control condition, and the clinical effect was moderate to large.
- The benefit of family therapy was comparable to that of cognitive-behavioral therapy (CBT), interpersonal psychotherapy for adolescents, problem-solving therapy, and supportive psychotherapy.

Specific types of family therapy for pediatric unipolar depression include the following:

- **Family-based interpersonal psychotherapy** – Interpersonal psychotherapy for adolescents has been adapted for preadolescents as a therapy called family-based interpersonal psychotherapy, which focuses upon parent-child conflicts and peer relationship problems. Evidence for the efficacy of this adaptation includes a 14-week randomized trial that compared family-based interpersonal psychotherapy with child-centered therapy in children with a depressive syndrome (age 7 to 12 years; n = 38) [31]. Child-centered therapy attempts to treat depression through a therapeutic relationship marked by positive regard and empathic understanding, and thus resembles supportive psychotherapy. Remission occurred in twice as many patients who received family-based interpersonal psychotherapy than child-centered therapy (64 versus 31 percent). In addition, anxiety and interpersonal impairment improved more with family-based interpersonal psychotherapy.

  Interpersonal psychotherapy for adolescents is discussed elsewhere in this topic. (See 'Interpersonal psychotherapy for adolescents' above.)

- **Family-focused treatment** – Family-focused treatment for childhood depression is rooted in family treatment approaches and CBT, and emphasizes the interpersonal factors that precipitate and maintain youth depression. Evidence supporting this approach includes a 15-session randomized trial that compared family-focused treatment with individual supportive psychotherapy in youth with depressive disorders (n = 134, aged 7 to 14 years) [32]. Response, defined as reduction of baseline symptoms ≥50 percent, occurred in more patients who received family-focused therapy than supportive psychotherapy (78 versus 60 percent). In addition, families receiving family-focused therapy reported greater skills for managing depression.

- **Parent-child interaction therapy** – Parent-child interaction therapy is administered to a parent-child dyad and teaches parents how to interact with their child. The therapy, which has demonstrated efficacy for treating disruptive behavior disorders during early childhood (preschool), has been adapted for depression and other disorders [33]. Evidence supporting the use of parent-child interaction therapy includes an 18-week randomized trial that compared the therapy with a waiting list control condition in children with unipolar major depression (n = 229; mean age 5 years) [34]. Parent-child interaction therapy was modified to include a module that emphasized helping children to recognize and regulate emotions, and targeted reactivity to negative and positive stimuli. Therapy was delivered by master's level clinicians; use of antidepressants during the study was not allowed. Remission occurred in three times as many children who received parent-child interaction therapy as controls (73 versus 23 percent). In addition, active treatment led to greater improvement of comorbid anxiety disorders and oppositional defiant disorder in the children, as well as greater improvement of stress and depression in the parents. However, the waitlist control did not account for the attention received by patients in active treatment.

Other types of family therapy include [30]:

- Behavioral family therapy
- Psychoeducational family therapy
- Solution-focused therapy
- Strategic family therapy
- Structural family therapy

Information about family therapy for unipolar depression in adults is discussed separately. (See "Unipolar depression in adults: Family and couples therapy".)

PROBLEM-SOLVING THERAPY

Problem-solving therapy attempts to ameliorate unipolar depression by helping patients develop rational and effective problem-solving skills. Patients learn to identify and define their problems, and for each problem, consider the barriers to its resolution, set an achievable goal, list and evaluate the advantages and disadvantages for all available solutions (brainstorming), choose one option, develop an action plan, implement it, and evaluate the outcome.

Evidence regarding the efficacy of problem-solving therapy for pediatric unipolar depression includes a network meta-analysis of 52 randomized trials of psychotherapies in approximately

3800 children and adolescents with depressive syndromes, including 44 who were treated with problem-solving therapy in trials lasting five or six weeks [1]. Efficacy was examined by using results from direct comparisons between the therapies, as well as indirectly comparing therapies through their relative effect with a common comparator, typically a control condition such as a waiting list. The primary findings were as follows:

- Improvement posttreatment was greater with problem-solving therapy than the waiting list control condition, and the clinical effect was moderate to large.
- The benefit of problem-solving therapy was comparable to that of cognitive-behavioral therapy, interpersonal psychotherapy for adolescents, family therapy, and supportive psychotherapy.

SUPPORTIVE PSYCHOTHERAPY

Supportive psychotherapy is used to treat depression by improving self-esteem, psychological functioning, and adaptive skills [35]. Therapy focuses upon current, problematic relationships and maladaptive patterns of behavior and emotional responses.

Evidence regarding the efficacy of supportive psychotherapy for pediatric unipolar depression includes a network meta-analysis of 52 randomized trials of psychotherapies in approximately 3800 children and adolescents with depressive syndromes, including 244 who were treated with supportive psychotherapy in trials lasting 6 to 16 weeks [1]. Efficacy was examined by using results from direct comparisons between the therapies, as well as indirectly comparing therapies through their relative effect with a common comparator, typically a control condition such as a waiting list. The primary findings were as follows:

- Improvement posttreatment was greater with supportive psychotherapy than the waiting list control condition, and the clinical effect was large.
- The benefit of supportive psychotherapy was comparable to that of cognitive-behavioral therapy, interpersonal psychotherapy for adolescents, family therapy, and problem-solving therapy.

BEHAVIORAL THERAPY

Behavioral therapy, which is a component of cognitive-behavioral therapy (CBT) (see 'Cognitive-behavioral therapy' above), focuses upon increasing desirable behaviors (eg, socializing) and

decreasing the patient's problematic behavioral responses (eg, social isolation) to environmental stimuli [36,37]. Therapy begins with a behavior analysis to identify behaviors to change and the antecedents and consequences that are associated with the behaviors. Techniques used in behavior therapy include activity scheduling, assertiveness training, behavioral rehearsal, fading, graded task assignments, modeling, relaxation training, and stimulus control (also called contingency management). Patients learn behavioral skills and practice them within and outside of the therapy setting.

Different behavior therapies have been developed for treating pediatric unipolar depression, including behavioral activation and brief behavioral therapy, which are described in the subsections immediately below.

Behavioral activation — Behavioral activation is a type of behavior therapy that was originally developed for adults with depression. The therapy consists of specific clinical strategies such as self-monitoring, structuring and scheduling activities, problem solving, and skills training, which are intended to increase positive reinforcement. Repeated application of these strategies, in a structured format and with a prescribed style, can help depressed patients increase activities that are adaptive and rewarding and decrease withdrawal and avoidance behaviors that maintain or exacerbate depression.

Several qualities beyond efficacy make behavioral activation an appealing choice for treatment. The therapy is readily understood by patients and clinicians, does not require complex training or skills, can thus be administered by nonspecialists, and is time limited and cost effective. The therapy was initially developed for treating unipolar depression in adults but is also used for other psychiatric disorders, as well as promoting well-being in nonclinical populations.

Behavioral activation has been adapted for pediatric unipolar depression and initial studies suggest it may be beneficial [38]. As an example, a 12-week, 14 session randomized trial compared behavioral activation with standard psychotherapy (CBT or interpersonal psychotherapy for adolescents) in 60 adolescents with a depressive disorder [39]. Improvement of depression and functioning was comparable in both groups. The results from this rigorous trial are promising; nevertheless, lack of an inactive control limits interpretation of the results.

Additional information about behavioral activation is discussed separately in the context of adult depression. (See "Behavioral activation therapy for treating unipolar major depression".)

Brief behavioral therapy — Brief behavioral therapy attempts to treat pediatric anxiety and depression by combining exposure therapy and behavioral activation to progressively promote engagement in avoided activities; relaxation training and problem-solving skills are incorporated as well [40]. Evidence suggesting that brief behavioral therapy may be helpful

includes a 16-week randomized trial, sited in primary care clinics, which compared brief behavioral therapy with assisted referral to care in youths who met full or probable criteria for anxiety and/or depressive disorders (n = 185) [40]. Active treatment consisted of 8 to 12 sessions, each lasting 45 minutes, delivered by master's level clinicians; the control condition was delivered by master's level coordinators who referred patients for psychiatric care and called at least every two weeks to assist in the referral process. Clinically significant improvement occurred in twice as many patients who received active treatment than controls (57 versus 28 percent).

OTHER PSYCHOTHERAPIES

Other psychotherapies that may perhaps help pediatric patients with unipolar depression include:

- Acceptance and Commitment Therapy [41]
- Attention bias modification treatment [42]
- Dialectical behavior therapy [12] (see "Overview of psychotherapies", section on 'Dialectical behavior therapy')
- Group therapy [43]
- Mindfulness-based stress reduction [44] (see "Unipolar major depression: Treatment with mindfulness-based cognitive therapy")
- Psychodynamic psychotherapy [45] (see "Unipolar depression in adults: Psychodynamic psychotherapy")

In addition, interventions directed primarily towards the parents, such as counseling, psychoeducation, and support groups, may possibly be useful [46].

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Depressive disorders".)

INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, "The Basics" and "Beyond the Basics." The Basics patient education pieces are written in plain language, at the 5th to 6th grade reading level, and they answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or email these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on "patient info" and the keyword(s) of interest.)

- Basics topics (see "Patient education: Depression in children and teens (The Basics)" and "Patient education: Depression in adults (The Basics)")
- Beyond the Basics topics (see "Patient education: Depression in children and adolescents (Beyond the Basics)" and "Patient education: Depression treatment options for children and adolescents (Beyond the Basics)")

SUMMARY AND RECOMMENDATIONS

- **General principles** – For children and adolescents with unipolar depression, we suggest treatment that includes psychotherapy (**Grade 2C**). General principles for using psychotherapy to treat pediatric depression include identifying specific targets for the intervention, incorporating the parents/caregivers in therapy, and evaluating patients for comorbidities. (See 'General principles' above.)
- **Choosing a therapy** – Among the major psychotherapies that are used to treat pediatric unipolar depression, there are no compelling data that one is superior to the others; thus, the choice usually rests upon availability and patient preference. Cognitive-behavioral therapy (CBT), interpersonal psychotherapy for adolescents (IPT-A), and family therapy are frequently selected for the initial treatment of unipolar depression because they have been more widely studied than other types of psychotherapies. However, other reasonable choices include problem-solving therapy and supportive psychotherapy. (See 'Choosing a therapy' above.)
- **Cognitive-behavioral therapy** – CBT is a time-limited, manualized intervention for depressive syndromes in adolescents that combines cognitive therapy and behavioral

therapy. Cognitive therapy attempts to modify dysfunctional thoughts about oneself, the world, or the future. Behavioral therapy focuses upon modifying the patient's problematic behavioral responses (eg, social isolation) and increasing more effective, mood enhancing behaviors. (See 'Overview' above.)

A standard course of acute treatment consists of 12 to 16 weekly sessions. The initial phase of CBT includes education about the depressive disorder and treatment, and an assessment to identify targets for treatment, including problematic thoughts and behaviors. In the middle phase, therapists foster the development of cognitive and behavioral skills such as examining the evidence and cognitive restructuring, activity scheduling, behavioral experiments and rehearsal, and problem solving. The final portion of treatment includes planning for relapse prevention. Most treatment protocols provide for a maintenance phase to prevent relapse. (See 'Course of treatment' above.)

- **Interpersonal psychotherapy for adolescents** – Another time-limited, manualized intervention for adolescent depression is IPT-A, which focuses on current relationship problems. A standard course of acute treatment consists of 12 weekly sessions. Initially, treatment explores the patient's relationships by conducting an interpersonal inventory to identify problem areas that will be the focus of treatment, such as role disputes or role transitions.

  In the middle phase of treatment, therapists help patients identify specific strategies to successfully manage interpersonal difficulties related to their depression. General IPT-A techniques include promoting effective expression of affect, clarifying and reframing expectations for relationships, and communication analysis.

  During the termination phase, the therapist and patient review the skills that the patient has learned, address what difficult interpersonal situations may arise in the future and how to handle them, and managing recurrence of depression. Following termination of acute treatment, monthly maintenance treatment may be provided as clinically indicated.

(See 'Interpersonal psychotherapy for adolescents' above.)

- **Family therapy** – Family therapy for pediatric unipolar depression involves treating the depressed youth and other family members residing with the patient. The basis for this approach is that depression occurs in a social context (family system) and usually affects the patient's significant others. The way in which family members and significant others respond to the depressed patient, in turn, influences the course and outcome of the depressive syndrome. Treatment is usually manualized and time limited. (See 'Family therapy' above.)

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