

A FAMILY GUIDE

*W*hat Families Should Know about Adolescent Depression and Treatment Options



A FAMILY GUIDE

*W*hat Families Should Know about Adolescent Depression and Treatment Options



*Kenneth Duckworth, M.D., NAMI Medical Director, ABPN Board-Certified,
Child and Adolescent Psychiatry*

Darcy Gruttadaro, J.D., Director, NAMI Child & Adolescent Action Center

May 2005

What is adolescent depression?

Adolescence is a time of many changes and challenges. Developing bodies and social and academic stresses make for a difficult period for many teens. Yet most teens get through these years with only short-term feelings of sadness or irritability. While people sometimes use the word “depressed” to describe how they feel, there is also a psychiatric disorder known as “clinical depression” or “major depression.” Some medical conditions need to be ruled out before a diagnosis of depression is made. Your child should be assessed for alcohol and drug use, which can cloud the picture as well as raise safety concerns. Depression in adolescents is a major public health concern. If you are concerned that your child may have depression, you need to obtain an accurate diagnosis for your child that includes a comprehensive understanding of your child’s needs in multiple settings, including home, school, and in peer relationships. You will also need to make sure that your child is assessed for suicide risk.

Causes of Depression.

No one knows for sure what causes depression. Research suggests that depression is a common condition that can result from stress in individuals who are vulnerable because of their genetic or biological makeup. Some individuals develop depression because of a chemical imbalance in their brain started by stress from loss, humiliation, or failure. A relationship breakup may make one teen unsettled for a few days, but send another teen with biological risk into depression. We simply do not currently know how best to determine an individual’s risk for depression. This is an area that requires further research.

Symptoms of Depression.

Clinical depression involves at least two weeks’ duration (and usually more) of five of the nine symptoms listed below:

- sleep problems (*commonly more sleeping*)
- a loss of interest or pleasure in formerly fun activities (*loss of interest in friends*)
- appetite changes
- energy loss
- sadness or irritability
- concentration problems
- hopeless or guilty thoughts
- body movement changes — feeling edgy or slowed down
- suicidal thoughts or preoccupation with death

ALL CONCERNS ABOUT SUICIDE REQUIRE IMMEDIATE ATTENTION.

All statements about suicide need to be taken seriously and are a reason to immediately alert a treating provider or seek emergency help.

Suicidal thoughts are, for many teens, part of the disorder and must be assessed. A treatment plan must be developed to ensure “safety first.” Suicide is a permanent “solution” to what may be a temporary problem. Although teenage girls are at greater risk of depression, boys have a higher risk of suicide if they are depressed. But if diagnosed and treated promptly, almost everyone — children, adolescents, and adults — recovers from depression.

Psychiatric disorders like depression often co-occur with other disorders. Anxiety commonly co-occurs with depression. Sometimes, especially for girls, eating disorders such as anorexia nervosa or bulimia co-occur with depression. Learning disabilities and attention-deficit/hyperactivity disorder (ADHD) also raise the risk of depression.

Depression may also be the first sign of what later turns out to be bipolar disorder (manic-depressive illness). Bipolar disorder has important and additional symptoms that often include periods of feeling irritable, high, or powerful; needing little sleep but still feeling full of energy; and grandiosity, euphoria, and hypersexuality. Adolescents with bipolar disorder may also talk loudly and fast. Risk-taking can be a symptom of both depression and bipolar disorder.

What are the treatment options for depression?

The most common treatments for depression are talk therapy (or psychotherapy), medication, or the two used in combination. Depression is a serious disorder that, when left untreated, can have devastating and life-threatening consequences. Families must weigh the risks and benefits of all treatment options for their child, including the risk of waiting while their child may be suffering from depression. The reality is that depression often gets better with treatment.

The first step in treatment is to obtain an accurate diagnosis. The second is to develop an effective treatment plan. A treatment plan must address the adolescent's unique and individual needs. Ask your doctor about the latest studies on depression and educate yourself about the latest research findings by using the resources listed at the end of this guide. It is vital that you and your family become educated consumers. When you are seeking a provider, ask about his or her training and experience in treating adolescent depression and the research that supports the recommended form of treatment. Follow your instincts about whether your child would connect with the treating provider, whether it is a therapist or psychiatrist, and then check in with your child about the treatment relationship.

If your child is prescribed medication and is receiving talk therapy or psychotherapy, make sure that there is a plan for the psychiatrist to communicate with the therapist (if the psychiatrist is not also providing the therapy for your child). Clear lines of communication, with you as the parent facilitating that communication, will improve the treatment results. Also, you should talk with the treating provider (therapist and/or psychiatrist) about the need to protect the teen's privacy, whenever possible, with the understanding that thoughts of hurting self or others will be shared with the family.

Having a connection to family members is a protection against depression, and keeping the lines of communication open can help to make treatment decisions more collaborative. A sense of connection at school and with peers is also helpful for adolescents who are at risk of depression.



What is talk therapy?

There is an ancient expression, “pain shared is pain halved.” When an adolescent is depressed, feeling alone and isolated makes it much harder for him or her to cope. There are several types of talk therapy that are designed to reduce or eliminate depressive symptoms.

Cognitive Behavioral Therapy (CBT).

One form of talk therapy shown to be effective for adolescents with depression is Cognitive Behavioral Therapy (CBT). CBT looks at thoughts and the impact that they have on an individual’s feelings. CBT breaks down negative thinking patterns and attempts to change them. For example, if an adolescent did poorly on a test and is thinking “I’m dumb and worthless,” CBT helps her to think about what she could have done differently to do better on the test, rather than focusing on negative thoughts about herself. There is good evidence to show that CBT helps to reduce symptoms of depression in adolescents; however, the best treatment outcomes are found when CBT is combined with antidepressant medication.

Interpersonal Psychotherapy (IPT).

Interpersonal Psychotherapy (IPT) is another form of talk therapy that looks at relationships and how they affect a person’s feelings and thinking. Because relationships are key in adolescence, IPT makes sense as an appropriate treatment intervention for adolescent depression. However, IPT needs further study in adolescents to better understand its full effectiveness in treating depression. It is, however, well established as an effective treatment for adults with depression.

It is not known how well a relationship with one therapist is helpful outside of these techniques — it is hard to study something as unique as a relationship. Some adolescents feel the relationship alone is helpful — the therapist is a safe person outside of their family with whom they can share their thoughts and concerns.

Family therapy has not been well studied for the treatment of depression. However, if there are specific family-related stresses in an adolescent’s life (like divorce, serious illness, or financial strains) or a lack of communication within the family, family therapy may prove beneficial. Also, family therapy can be helpful because it gets the whole family involved in and supportive of treatment. Without that level of family support, adolescents may not comply with their treatment plan.

Addressing substance use is a key part of the treatment plan because it compounds risks associated with depression, especially the risk of suicide. Also, alcohol is a depressant, and substance use impacts the effectiveness of medication. Ask your child’s provider if she or he feels comfortable asking your child about substance use or if the provider can suggest an effective intervention for the substance use. Alcoholics or Narcotics Anonymous (AA or NA) groups that are tailored to young people can be extremely helpful for adolescents with depression and substance-use disorders.

In developing an appropriate treatment plan, it is important to keep the whole picture of your child’s life in mind. Talk therapy can often help in exploring stressful circumstances in your child’s life (such as issues related to sexuality or a poor school match).

Aerobic exercise has positive antidepressant effects in adults with mild to moderate depression and can be a useful part of the treatment plan for an adolescent as well. An individualized treatment plan should be developed to take the whole picture of your child’s life into account.



What about medications?

Many providers prescribe antidepressant medications to treat adolescent depression. You should approach the decision about whether antidepressant medications are appropriate for your child with caution and care. This is true for all decisions related to the use of medications, and antidepressants are no exception.

Here are some recommended questions to ask your child's treating provider:

- What are the potential risks and benefits of the medication and other treatment options?
- What are the anticipated side effects of the medication?
- How are the other elements of the treatment plan (such as psychotherapy or school and family interventions) integrated with the decision about medication?
- What can the provider do to help you get a good sense of what to look for, and who should be called with questions related to the medication or changes in behavior or symptoms?
- How will you, your child, and your doctor monitor progress, behavior changes, symptoms, and safety concerns?
- How can we best ensure that your child is actively involved in the discussion and decision-making related to the use of medications (whenever possible)?
- Is there a clear communication plan for the family and the treating providers (therapist and psychiatrist) to ensure open lines of communication between all of them?
- How does any family history of mental disorders (especially a history of bipolar disorder) factor into the decision to use medication?
- How might you know when it is appropriate for your child to discontinue medication?

What is a black-box warning?



You may be aware of the recent decision by the Food and Drug Administration (FDA) to attach a cautionary label or “black-box warning” to all antidepressant medications used to treat depression and other disorders in children and adolescents.

A “black box” is a form of alert used by the FDA to warn the public that special care must be taken in certain uses of a medication. The FDA directed the manufacturers of all antidepressant medications to add a “black-box” warning to their products. It is important to understand the potential risks of antidepressant medications in order to make an informed decision about your child's treatment.

What does the warning say?

The following text box includes the complete black-box warning that the FDA is requiring that manufacturers include on their antidepressant medication products:

SUICIDALITY IN CHILDREN AND ADOLESCENTS

Antidepressants increase the risk of suicidal thinking and behavior (suicidality) in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of [Drug Name] or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. [Drug Name] is not approved for use in pediatric patients except for patients with [Any approved pediatric claims here]. (See Warnings and Precautions: Pediatric Use)

Pooled analyses of short-term (4 to 16 weeks) placebo-controlled trials of nine antidepressant drugs (SSRIs and others) in children and adolescents with MDD, obsessive compulsive disorder (OCD), or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal thinking or behavior (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events on drug was 4%, twice the placebo risk of 2%. No suicides occurred in these trials.

The greatest risks exist in the first few months of treatment. Anyone considering the use of these medications in children or adolescents must balance this risk with the clinical need for the medication. The warning also states that anyone using these medications should be observed closely for a worsening of the symptoms, signs of suicidal thoughts or behavior, or unusual changes in behavior.

The FDA did not prohibit use of the medications for children and adolescents.

Are any antidepressants approved for use in children?

Among the antidepressants, only one — Prozac (fluoxetine) — is approved by the FDA for treating depression in children and adolescents. Prozac and three other medications — Zoloft (sertraline), Ludiomil (fluvoxamine), and Anafranil (clomipramine) — are approved by the FDA for treating obsessive-compulsive disorder (OCD) in children and adolescents. However, all physicians have the option of prescribing medications for “off-label” use based on their clinical judgment of an individual’s treatment needs. Off-label use, which consists of using a medication for medical conditions that are not recognized on the FDA-approved labeling for that medication, is a common practice.

Also, the FDA is requiring that Prozac include the black-box warning despite the fact that it is approved by the FDA for treating depression in children and adolescents.



What prompted the FDA warning?

During 2004, a FDA advisory committee reviewed data related to the safety and effectiveness of antidepressant medications. As part of this process, the FDA analyzed data from 24 clinical trials involving more than 4,400 children and adolescents who had been prescribed antidepressant medications for the treatment of major depression, anxiety, or obsessive-compulsive disorder. This review showed that a small number of trial participants who were given antidepressant medications experienced a heightened rate of suicidal thinking or behavior. Most often, this occurred soon after an individual started the medication. It is important to note that there were no suicides in any of these clinical trials.

Although no suicides occurred in the trials, 78 (or 1.7 percent) of the 4,400 trial participants receiving antidepressant medications experienced suicidal thoughts or engaged in some form of suicidal behavior. Based on this analysis, about 2 children out of 100 might be expected to experience these symptoms when taking antidepressant medications.

Although only nine medications were re-examined in the FDA analysis, the FDA applied the black-box warning requirement to all antidepressant medications. This was done because the FDA advisory committee was concerned that currently available research data would not allow them to exclude any single antidepressant medication from being potentially associated with an increased risk of suicidality.

Finally, clinicians have long known (even before medications were available) that as people recover from depression, their risk of suicide is increased. This is true because people often have more energy but still have hopeless thoughts during this time.

What evidence exists to show that these medications are effective in treating adolescent depression?

A recent study funded by the U.S. National Institute of Mental Health (NIMH) provides important information about effective treatment for adolescent depression. This study, the “Treatment for Adolescents with Depression Study” (TADS), is looking at treatment outcomes for adolescents receiving treatment in one of three groups described below:

- 1 Group one received medication only (Prozac);
- 2 Group two received medication combined with CBT (Prozac + CBT); and
- 3 Group three received CBT only.

The treatment outcomes for the individuals in the three groups described above are being compared with participants that are receiving placebo treatment (a sugar pill).

The results show that for the initial 12 weeks of the yearlong study, 71 percent of the adolescents receiving medication combined with CBT (group two) improved measurably with the combination treatment. Those adolescents receiving medication only (group one) showed improvement in slightly more than 60 percent of those participating, and adolescents receiving CBT treatment only (group three) had slightly more improvement than those adolescents receiving a placebo or sugar pill.

So what does TADS tell us? The TADS study shows that the combined treatment intervention of psychotherapy and medication offers advantages over either treatment intervention used alone. This finding is consistent with the studies that have been done on adults with depression that show the best treatment outcomes with combined psychotherapy and medication.

What precautions should be taken to minimize any risks associated with antidepressant medications?

Certainly if your child voices new or more frequent thoughts of wanting to die or to hurt himself or herself, or takes steps to do so, you should immediately contact your child’s provider. You should also know that when starting a new medication or changing the dosage, your child may show signs of increased anxiety or even panic, agitation, aggressiveness, or impulsivity.

Families should be aware of “akathisia,” a rare side effect that may exist in a small percentage of youth taking medications. Akathisia is an internal sense of restlessness coupled with a strong need to move about for no reason that the youth may be able to identify. To the youth, this may feel like a sense of agitation and nervousness. Families should immediately contact their treating provider or should seek immediate help if they are concerned that their child may be experiencing this rare side effect.

Your child may experience involuntary restlessness, or an extreme degree of unwarranted elation or energy accompanied by fast, driven speech and unrealistic plans or goals. If you see any of these symptoms, consult your doctor. It may be appropriate to adjust your child’s medication dosage, change to a different medication, or stop using medication. Research has shown that 30 percent to 40 percent of children and adolescents will not respond to an initial medication, but many of these individuals will respond to an alternate medication.



Does thinking or talking about suicide signal an increased likelihood that an adolescent will hurt himself or herself?

Psychiatrists and other mental health providers have found that when an adolescent talks about suicidal thoughts, it opens the door to communication that increases the likelihood that special safety or protective measures can and will be taken. Therefore, any treatment intervention that increases discussion of hidden suicidal thoughts or impulses is helpful.

Also, research shows that individuals with a prior history of suicide attempts have an increased risk of suicide.

Should my child continue on medication now being prescribed?

If your child is currently taking antidepressant medication and doing well, your child should continue with that treatment. Still, you should talk with your child about the possibility of rare and serious side effects, including suicidal thoughts and behaviors. Also, you, your child, and your child's physician should discuss a safety plan. This plan should indicate whom the child should contact immediately if thoughts of suicide or self-harm occur.

More critically, no individual should abruptly stop taking antidepressants. Parents contemplating changing or terminating their child's antidepressant medication should always consult with their child's treating physician before taking such action.

Does the FDA warning mean that antidepressant medications are not safe and effective for my child?

No. Researchers and clinicians have found that antidepressant medications, often in combination with research-based therapy (like CBT), are safe and effective for most adolescents. However, all treatment decisions must be made on an individual basis and in close consultation with a trained and qualified professional. Also, the FDA warning is an important reminder about the critical need for close monitoring.

Many medications routinely used for children and adolescents, including insulin used to treat children with diabetes and chemotherapy to treat children with cancer, have rare and tragic side effects. However, like antidepressants, these medications also have positive treatment results for many children and adolescents.

What is a good monitoring system?

First, parents and caregivers should make sure that the adolescent understands whom to talk with about concerns related to his or her treatment and understands the potential side effects of medications. They should also make sure that the adolescent understands the impact of not taking medications once they are prescribed.

Families must understand that medication may promote "activation," a phase in which an adolescent may begin to improve from treatment and begin to feel more energy to act on continued negative thoughts, leading to a heightened risk of self-harm. This often exists in the first few weeks of treatment and is the reason that treating providers and families must be particularly vigilant in observing changes in a teen's behavior and symptoms during this time period.



The FDA is recommending the following general guidelines for the close monitoring of children and adolescents being treated with antidepressant medications:

- During the first four weeks of treatment, a child or adolescent should be seen by the provider prescribing the medication at least once a week, with face-to-face contact with the family (weeks 1-4);
- In weeks five through eight of treatment, a child or adolescent should be seen every other week by the treating provider, with face-to-face contact (weeks 5-8);
- A child or adolescent should then be seen again by the treating provider at week 12, with face-to-face contact (weeks 9-12); and
- A child or adolescent should be seen by the treating provider as clinically indicated after 12 weeks of treatment (weeks 13+).

The close monitoring should involve closely observing the child or adolescent for a worsening of symptoms, suicidality, and unusual changes in behavior, especially during the initial few months of medication treatment. **A prescription for an antidepressant medication without close follow-up is not a good treatment plan.**

Providers prescribing antidepressant medication should give families the contact information necessary to reach the provider 24 hours a day and seven days per week should their child exhibit serious or concerning side effects, like agitation or akathisia. The family should also understand when to take their child to an emergency room for safety-related concerns.

Whenever possible, families should make the home environment open to communicating about depression. Talk about what is working and what is not, make suggestions for additional supports, and take action to minimize risks for self-injurious or harmful behaviors. You need to agree with your child that there can be no secrets when it comes to safety. The key is to keep the conversation going, because isolation is a risk factor for suicide.



What is the risk of no treatment?

Depression is a leading cause of suicide in America today. It is estimated that about 3,000 youth die each year from suicide in our nation. Research shows that 90 percent of those individuals have a diagnosable and treatable mental disorder, often depression. Yet, the vast majority of youth with depression go undiagnosed and untreated. Untreated depression — not treated depression — is the single most significant risk factor for suicide.

Depression tends to be an episodic illness, with some youth spontaneously improving. Yet it also tends to be recurrent, with one episode of depression raising the risk for another. Without treatment, the consequences of childhood and adolescent depression are extremely serious (this can also be true for some adolescents even with treatment). Children and adolescents are likely to have ongoing problems in school, at home, and with their friends. Four out of ten will have a second episode of depression within two years. They are also at increased risk for substance abuse, eating disorders, and adolescent pregnancy. Research indicates that over half of depressed youth will eventually attempt suicide, and at least 7 percent will ultimately die as a result. Getting an accurate diagnosis and developing an effective treatment plan for a child who suffers from depression is an essential first step to minimizing the risk of suicide.



Is safety really a concern with adolescent depression?

Yes. Depression causes negative thinking, and teens with depression often think about death.

It is critical to develop a safety plan given the risk of suicide in teens with depression. Talk with a qualified and trained mental health or primary care professional about what should be in the safety plan. These plans should be specific and individualized to address the unique needs of your child.

A safety plan must include your removing any objects from the house that might be used to commit suicide. Guns should be removed from the house at least temporarily, or at a minimum, kept under lock and key and not accessible by the youth. If locked guns are kept in the house, all ammunition should be removed. Other items, such as poisons and prescription and over-the-counter medications, should be temporarily removed or made inaccessible to the teen, along with all sharp knives. It is important to note that, like all medications, antidepressant medications can be lethal if ingested in massive quantities or in combination with other medications or substances (such as illegal drugs or alcohol). Therefore, families should treat antidepressant medications as they would any other potentially harmful substance. The family caregiver should be responsible for securing and administering the correct dosages to the individual at the right times. Also, the safety plan should include trying not to leave your child home alone during the first few weeks of treatment with medication.

“Self-medication” (using alcohol or street drugs to change how one feels) is a concern, as it increases the risks of suicide and other self-harming behaviors. Alcohol and drug use can be both a cause of, and a consequence of, depression. It is important to talk with adolescents about getting support for sobriety during the depression if substance abuse is suspected.

Families sometimes must make extremely difficult decisions, including — as a last resort — the decision to hospitalize a child against his or her wishes. Taking this step may be the most painful thing that a parent or caregiver ever does. Be sure to get good input about safety-related concerns from a professional who is trusted and trained to treat adolescents with depression.

How is adolescent depression different from adult depression?

Adolescents are thought to differ from adults with depression because they often experience symptoms of irritability, anger, and self-criticism more commonly than feelings of sadness and a loss of energy. Also, school performance frequently drops off for adolescents struggling with depression — sometimes dramatically. Adolescents with depression often visit the school nurse more frequently with vague body complaints like headaches and stomachaches. They may also get more involved in physical fights with their peers, take more risks, and even shoplift or engage in sex. Loss of interest in peers is a “red flag” for adolescent depression, as these relationships are key to normal development.

Adolescence is a time when peer relationships are central to the task of becoming an adult. When adolescents are depressed, talk with them about how to use their peers and other important people in their life to support them.

How does my family history play into decisions about treatment?

Family history is a clue to genetic risk for depression, but it is not enough on which to base a diagnosis or treatment plan.

A family with individuals with bipolar disorder should be cautious about using antidepressant medications and may want to talk with their child’s provider about the appropriateness of combining antidepressant medication with a mood stabilizer. The chance that an adolescent could have undetected bipolar illness is real, because the first episode of bipolar disorder can be depression.

A family history of depression or suicide may indicate the need for more aggressive treatment because these factors may lead to a heightened risk of suicide in your child. This is part of the risk-benefit analysis that should be discussed with your treating provider.

How can I be an effective advocate for my child?

You are your child's strongest advocate. You have a right to any and all information available about the nature of your child's illness, the treatment options, and the risks and benefits of treatment. You should ensure that your child receives a comprehensive evaluation and an appropriate diagnosis, and you should have no qualms about seeking a second opinion if you have questions or concerns. Ask a lot of questions about any proposed diagnosis or treatment. Help your child learn, in an age-appropriate way, about his or her illness so that he or she can be an active partner in treatment.

Having a child with depression can be a frightening experience for family and loved ones, especially if a child has had a suicide attempt or engaged in self-injurious behaviors. It may be helpful to find a trusted friend, family member, or professional for support and guidance. This will help parents and caregivers to cope with their child's illness and to provide the child with the support and advocacy that he or she may need.

NAMI has developed a Web site for families that will include updated information and resources on the treatment of adolescent depression. Please visit our Web site at www.nami.org/adolescentdepression.

NAMI and other family advocacy organizations stand ready to help families with a loved one living with depression and other mental disorders. Together, we can make a positive difference in the lives of our loved ones and friends.



FAMILY ADVOCACY ORGANIZATIONS

NAMI

- www.nami.org

Child and Adolescent Bipolar Foundation

- www.bpkids.org

CHADD (Children and Adults with Attention-Deficit/Hyperactivity Disorder)

- www.chadd.org

Depression and Bipolar Support Alliance

- www.dbsalliance.org

Depression and Related Affective Disorders Association

- www.drada.org

Families for Depression Awareness

- www.familyaware.org

Federation of Families for Children's Mental Health

- www.ffcmh.org

National Mental Health Association

- www.nmha.org

Suicide Prevention Action Networks

- www.span.org

PROVIDER ORGANIZATIONS AND CHILDREN'S MENTAL HEALTH CENTERS

American Academy of Child and Adolescent Psychiatry

- www.aacap.org

American Academy of Pediatrics

- www.aap.org

American Psychiatric Association

- www.psych.org

American Psychological Association

- www.apa.org

Center for the Advancement of Children's Mental Health

- www.kidsmentalhealth.org

FEDERAL AGENCIES

Centers for Disease Control and Prevention

- www.cdc.gov

Food and Drug Administration (FDA)

- www.fda.gov

National Institute of Mental Health (NIMH)

- www.nimh.nih.gov

Center for Mental Health Services (CMHS)

- www.mentalhealth.org

OTHER HELPFUL RESOURCES

ParentsMedGuide.org (a Web site developed by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry)



The Nation's Voice on Mental Illness

Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
PH: 703-524-7600 • FAX: 703-524-9094
Web site: www.nami.org