



DEPRESSIVE DISORDERS

OVERVIEW

Like adults, children and adolescents experience depression with the accompanying feelings of hopelessness, guilt, or sadness. However, depression in children and adolescents can manifest in different ways than it does in adults. For instance, in adolescents, an irritable mood rather than a sad or dejected mood often predominates.

Approximately 60 percent of adolescents with depression have recurrences throughout adulthood.

The emotional and behavioral dysfunction associated with these mood disorders can cause impairments across areas of functioning, including academic and social arenas.

There are three major categories of depressive disorders: disruptive mood dysregulation disorder, major depressive disorder, and persistent depressive disorder (dysthymia). Common symptoms are listed in Table 1.

Because depressive disorders can result in suicide, depression among children and adolescents is of grave concern. Information about suicide is provided in the “Youth Suicide” section of the *Collection*.

KEY POINTS

- Characterized by persistent sadness, hopelessness, guilt, apathy, and/or irritability.
- Associated with an increased risk of suicide. For this reason, early intervention is critical.
- A combination of cognitive behavioral therapy and medication therapy, (fluoxetine) usually offers maximum therapeutic benefits.

Disruptive Mood Dysregulation Disorder

This diagnosis is new to the *Diagnostic and Statistical Manual for Mental Disorders (DSM-5)*. It was created to reduce the risk of overdiagnosis and treatment of bipolar disorder in children.

The core feature of disruptive mood dysregulation disorder is chronic, severe, persistent irritability, which can include frequent temper outbursts. This irritable or angry mood must be characteristic of the child, be present most of the day, nearly every day, and noticeable by others in the child’s environment. Symptoms begin between age six and ten, are present for at least one year, and occur in more than one place (at home, school, and/or with peers). Disruptive mood dysregulation disorder often co-occurs with oppositional defiance disorder (ODD), and frequently occurs with other disorders as well, including behavior, mood, anxiety, and autism spectrum disorder diagnoses.

Table 1
Types and General Symptoms of Depressive Disorders

Major Depressive Disorder
<p>Experiences symptoms most of the time for at least two weeks.</p> <ul style="list-style-type: none"> • Sadness • Hopelessness • Feelings of worthlessness • Loss of feelings of pleasure • Guilt (preschool feature) • Loss of interest in enjoyable activities (preschool feature) • Irritability (adolescent feature) • Change in weight/failure to gain as expected (preschool feature) • Sleep disturbance (preschool feature) • Unintentional or purposeless motions • Fatigue and/or excess sleeping (adolescent feature) • Difficulty thinking or concentrating (preschool feature) • Recurrent thoughts of death or suicide (adolescent feature) • Deterioration in school or home functioning • Persistent physical complaints (age 6-9 feature) • Abusing substances (adolescent feature) • More accident prone than usual (preschool feature) • Develops phobias (preschool feature) • Increased aggression (age 6-9 feature) • Clings to parents or avoids new events and people (age 6-9 feature)
Persistent Depressive Disorder (Dysthymia)
<p>Experiences symptoms for most of the day, for more days than not, for at least one year. Symptoms are not as severe as those seen in major depression.</p> <ul style="list-style-type: none"> • Altered appetite (eating too much or too little) • Sleep disturbance • Fatigue • Low self-esteem • Hopelessness
Disruptive Mood Dysregulation Disorder
<p>Symptoms begin between age six and ten, are present for at least one year, and occur in more than one place (at home, school, and/or with peers).</p> <ul style="list-style-type: none"> • Severe temper outbursts at least three times per week • Sad, irritable, or angry mood almost daily • Reactions to adverse events is bigger than expected

Major Depressive Disorder

Major depressive disorder is characterized by a period of at least two weeks during which the youth experiences sadness, hopelessness, guilt, loss of interest in activities that are usually enjoyable, and/or irritability most of the time. Insomnia or fatigue is often the first noticeable and complained of symptom.

It is important to note that the youth's mood must differ from his or her usual mood and cannot be attributable to bereavement, a general medical condition, and/or substance abuse, although those conditions may co-occur and even contribute to depression.

About 40 to 90 percent of youth with major depressive disorder have at least one other psychiatric disorder. The most commonly co-occurring disorders are persistent depressive disorder (dysthymia), anxiety disorders, disruptive disorders, and substance abuse disorders. Depression is more likely to begin after the onset of the comorbid disorder, with the exception of substance abuse, which tends to occur after the onset of depression.

Persistent Depressive Disorder (Dysthymia)

Persistent depressive disorder (dysthymia) is a depressive disorder in which the symptoms are chronic and persistent but less severe than major depressive disorder. The disorder occurs when youth experience a sustained depressed mood for most of the day, for more days than not, for at least one year.

Because persistent depressive disorder is a chronic disorder, youth often consider their symptoms a part of who they are and do not report them unless asked directly.

CAUSES AND RISK FACTORS

The exact causes of depressive disorders are not known. There is evidence, however, that genetics contributes to a child's vulnerability to a depressive disorder. Other contributing factors are environment and biology (neurotransmitters, hormones, and brain structure).

EVIDENCE-BASED TREATMENTS

This section will focus on treatments that can apply to the most commonly diagnosed forms of depression among children adolescents: major depressive disorder and persistent depressive disorder (dysthymia). Research has shown a combination of the psychosocial and pharmaceutical treatments offers maximum therapeutic benefits.

Because youth who experience the onset of depressive disorders at a younger age typically have a worse prognosis, early intervention is critical to prevent additional functional breakdown, relapse, and suicidal behavior. Tables 2 and 3 summarizes the treatments for depressive disorders in children and adolescents.

Table 2
Summary of Treatments for Children with Depression

What Works	
Stark’s cognitive behavioral therapy (CBT)	Stark’s CBT (child only or child plus parent) includes mood monitoring, mood education, increasing positive activities and positive self-statements, and problem solving.
Fluoxetine in combination with CBT	Fluoxetine, a selective serotonin reuptake inhibitor (SSRI), is the only antidepressant approved by the FDA for use in children (eight years old or older) for depression. For moderate to severe depression, fluoxetine in combination with psychosocial therapy may be warranted. However, because SSRIs can increase suicidal behavior in youth, children taking fluoxetine must be closely monitored by a mental health professional.
What Seems to Work	
Penn prevention program (PPP)	PPP is a CBT-based program that targets pre-adolescents and early adolescents who are at risk for depression.
Self-control therapy	Self-control therapy is a school-based CBT that focuses on self-monitoring, self-evaluating, and causal attributions.
Behavioral therapy	Behavioral therapy includes pleasant activity monitoring, social skills training, and relaxation.

Psychosocial Treatments

The evidence-based psychological treatments for depressive disorders are cognitive behavioral therapy (CBT) and interpersonal therapy (IPT). Research indicates that treatment can be effective regardless of where it is provided (school, community clinics, primary care clinics, hospitals, or research settings).

Pharmacological Treatments

Currently, only one pharmacological treatment has been approved for use with youth with depressive disorders by the Food and Drug Administration (FDA). This medication, fluoxetine (a selective serotonin reuptake inhibitor [SSRI]), has been approved by the FDA for treating children eight years of age or older. More research has been completed on fluoxetine than any other SSRI.

There has been considerable debate about the use of antidepressants to treat youth with depression, specifically whether their use increases the risk of suicidal behaviors. U.S. manufacturers are now required by the FDA to place a “black box” warning label on antidepressant medications prescribed for youth. A more detailed discussion of the use of antidepressants to treat children and adolescents is provided in the “Antidepressants and the Risk of Suicidal Behavior” section of the *Collection*.

Table 3
Summary of Treatments for Adolescents with Depression

What Works	
Cognitive behavioral therapy (CBT) provided in a group setting	CBT for depression focuses on identifying thought and behavioral patterns that lead to or maintain the problematic symptoms.
Interpersonal therapy (IPT)	In IPT, the therapist and patient address the patient’s interpersonal communication skills, interpersonal conflicts, and family relationship problems.
Fluoxetine in combination with CBT	Fluoxetine, a selective serotonin reuptake inhibitor (SSRI), is the only antidepressant approved by the FDA for use in children (eight years old or older) for depression. For moderate to severe depression, fluoxetine in combination with psychosocial therapy may be warranted. However, because SSRIs can increase suicidal behavior in youth, children taking fluoxetine must be closely monitored by a mental health professional.
What Seems to Work	
CBT in a group or individual setting with a parent/family component	CBT for depression focuses on identifying thought and behavioral patterns that lead to or maintain the problematic symptoms.
Adolescent coping with depression (CWD-A)	CWD-A includes practicing relaxation and addressing maladaptive patterns in thinking, as well as scheduling pleasant activities, and learning communication and conflict resolution skills.
Interpersonal psychotherapy for depressed adolescents (IPT-A)	IPT-A addresses the adolescent’s specific interpersonal relationships and conflicts, and helps the adolescent be more effective in their relationships with others.
Physical exercise	Physical exercise has shown promise in improving symptoms of depression in adolescents. Group-based and supervised light- or moderate-intensity exercise activities 3 times a week for a period of between 6 to 11 or 12 weeks may bring about an improvement in depression.
Not Adequately Tested	
Dietary supplements	Supplements such as St. John’s Wort, SAM-e, and Omega-3 have not been adequately tested and may have harmful side effects or interact with other medications. Parents should discuss supplement use with a mental health care professional.
What Does Not Work	
Tricyclic antidepressants	These antidepressants can have problematic side effects and are not recommended for children or adolescents with depression.

RESOURCES AND ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry

Depression Resource Center

http://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Depression_Resource_Center/Home.aspx

American Psychiatric Association

<https://www.psychiatry.org/>

American Psychological Association

<http://www.apa.org/>

Anxiety and Depression Association of America (ADAA)

<https://adaa.org/>

Association for Behavior and Cognitive Therapies (ABCT)

<http://www.abct.org>

Mental Health America

Depression in Teens

<http://www.mentalhealthamerica.net/conditions/depression-teens>

Society of Clinical Child and Adolescent Psychology

<https://sccap53.org/>

Virginia Tech

Child Study Center

<http://childstudycenter.wixsite.com/childstudycenter>

Psychological Services Center

<https://www.psyc.vt.edu/outreach/psc>