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IN THIS ISSUE

Antidepressant Use in Children

- Diagnosing Depression in Children and Adolescents — 1
- Expert Q&A: — 1
John Walkup
Antidepressant Use in Children and Teenagers
- Table: Tips for Diagnosing Depression by Age Group — 3
- Antidepressants and Suicidal Ideation in Young People: A Practical Approach — 5
- CME Post-Test — 7

Learning Objectives

After reading these articles you should be able to:

1. List some of the general and age-specific characteristics of depression in children and adolescents.
2. Describe some of the challenges in diagnosing and treating children and adolescents with depression.
3. Evaluate the data on antidepressants and suicide risk and how this impacts clinical practice.

Diagnosing Depression in Children and Adolescents

Glen R. Elliott, MD, PhD is the editor-in-chief of The Carlat Child Psychiatry Report

Dr. Elliott has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Today, the idea that adolescents and children, even young children, can have a major depressive disorder is widely accepted, but that was not always the case. Debates about the age at which “true” depression could manifest itself were widespread in child and adolescent psychiatry through the late 70s and into the early 80s (Pataki CS and Carlson GA, *Harvard Rev Psychiatry* 1995;3(3):140–151). With the introduction of *DSM-III* and its emphasis on objective signs and symptoms, researchers began to survey adolescents and latency-age children and found that a subgroup of these young

In Summary

- Adolescents are more likely to present with atypical depressive signs and symptoms when compared to adults with depression.
- Although they often lack the words for describing their mood, depressive symptoms in children ages 6 to 12 tend to be fairly similar to adults.
- Parents may not consider depression as a possible cause for behavioral problems in children and adolescents.

patients indeed met criteria for major depression (Puig-Antich and Weston, *Annual Rev Med* 1983;34:231–245).

The prevalence of depression increases markedly with age (Manepalli et al, *Current Psychiatry* 2011; 10:20–24), with rates of about 0.3% of preschoolers, 0.5%–3% of prepubertal

Continued on page 2

Q&A With the Expert

Antidepressant Use in Children and Teenagers

John Walkup, MD

Dr. Walkup is the director of the Division of Child and Adolescent Psychiatry at Weill Cornell Medicine-New York Presbyterian Hospital in New York, NY

Dr. Walkup has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CCPR: Based on your experience treating kids with depression, how do you determine when a patient has the type of depression that is likely going to respond to medication?

Dr. Walkup: There are a few key things that I look for. One is a clearly defined episode onset that includes a change from prior functioning. Second, I look for diurnal variation in mood, which is a worse mood in the morning with an improved mood later in the day. Sometimes what this looks like is kids staying up late in an attempt to stay awake during the time the mood is good, or at least better. They recognize they are going to be tired and grumpy in the morning, and so they make the most of those late evening hours when their mood is slightly better than it is in the morning and they phase shift themselves. Some kids even do partial sleep deprivation, which may actually bump their mood the next day. The third thing that I look for is pervasive anhedonia.

CCPR: Why is pervasive anhedonia so important?

Dr. Walkup: Many children may meet criteria for



Continued on page 4

Diagnosing Depression in Children and Adolescents

Continued from page 1

children, 0.5%–6.5% of teenagers, and 10%–17% of adults. While adult depression is twice as common in women as in men, that ratio is nearly 1:1 in prepubertal children. In the early teen years, roughly correlating with the onset of puberty, though not necessarily associated with it, depression rates rise much more rapidly in females, so that the adult ratio of 1:2 is achieved by early-to-mid teens. While we don't understand why, the bottom line is

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that young boys are as likely to have depression as young girls, while teen girls are twice as likely to be depressed as teen boys.

Depression in adolescents

Aran was a 15-year-old Asian male whose parents came to the U.S. as young adults. He was academically gifted and committed to scholarly pursuits, and which his parents strongly encouraged. He was somewhat of a loner but had friends; his parents perceived him as being happy and eager to please. They were conservative about him spending time on social media and the Internet but he never complained, did expected household chores, and was involved in school-sponsored clubs.

The summer before his 10th grade year, Aran began to spend more time in his room, complained of being tired and started sleeping 10–12 hours a night. He seemed to be always hungry, gaining 12 pounds in 10 weeks, and became apathetic about previous interests such as video games. When school started, he took much longer doing his homework and had particular trouble with an advanced math class, getting his first-ever B+. He and his parents were both upset, and hired a tutor. However, when Aran took the final, he was convinced he failed it. That evening, he would not talk to his parents, did not eat supper, and went to his room. Worried, they entered his room, where they found him holding a sharp knife that he had taken from the kitchen. Aran began crying and tried to stab himself. His parents were able to wrest the knife from him and took him to the nearest emergency room, where he was assessed and hospitalized for suicidality.

One might assume that adolescents, being almost adults, would be most apt to present with adult-like signs and symptoms of depression. In fact, they are more likely to have atypical depressive symptoms such as increased appetite with weight gain and increased need for sleep (Pataki CS and Carlson GA, *Harvard Rev Psychiatry* 1995;3(3):140–151). In addition, their mood is less persistent and more reactive to environmental setting than is true for depressed adults. With friends and at school, they may seem happy and untroubled, only to appear deeply depressed when they are alone or at home, which can be particularly

baffling—and frustrating—for parents.

When evaluating adolescents for depression, I usually begin by meeting briefly with the whole family, and then with the patient alone. Adolescents are often angry about having been forced to come see me but generally calm once parents leave. I start by exploring neutral or positive aspects of their life such as interests, what they like most about school, and favorite shows or hobbies. I then ask why they think their parents brought them to see me. I ask specifically about mood, using a variety of terms such as “down,” “irritable,” “sad,” “upset,” and “moody” and sticking to whatever term the adolescent endorses. I also ask about a series of symptoms and experiences common in adolescent depression (See the “Tips for Diagnosing Depression” table on page 3). Equally important are questions about how the teen feels about the possibility of taking a medication to help with depression and discussing any concerns.

As with Aran's scenario, depressed adolescents are at high risk for suicidal ideation. Some estimates suggest that as many as 60% of all adolescents think about killing themselves or that their family would be better off without them at least once during adolescence, though obviously for the vast majority it is idle speculation (VanderStoep A et al, *Suicide Life Threat Behav* 2009;39(6):599–613). I ask specifically about self-injurious behaviors, suicidal thoughts, suicidal plans or past attempts, and risk factors in the household such as guns and other weapons, prescription medications, and poisons. I also ask about use or abuse of alcohol and drugs, as well as other risk-taking behaviors such as high-speed driving and unprotected sex.

Particularly important in terms of acute suicidal risk is any event that the adolescent perceives as life-changing and irreversible—for example, abrupt loss of a significant romantic relationship, failure to achieve a highly desired goal (such as high grades for Aran), or some form of humiliation such as being bullied or publicly shamed. The risk of suicide after such events typically is acute but short-lived, so in a depressed adolescent, awareness of the importance of such an occurrence can be life-saving.

Continued on page 3

Diagnosing Depression in Children and Adolescents Continued from page 2

I always interview parents or other informants about their take on the patient's mood and behaviors, usually separate from the adolescent. Parents can offer crucial details such as how much time a teen spends alone versus with friends or on other activities, and the progression of symptoms over time. It also is important to ask each parent about attitudes toward their child being on a medication and to address any expressed concerns. If parents describe a strikingly different presentation, I have everyone meet together to discuss those differences. This can also be a time to bring up issues that the adolescent and I agree parents need to know.

Depression in latency-age children

Amelia was a 10-year-old white female who came with her parents for evaluation because of falling grades and social withdrawal, worsening over the past 6 months. The parents initially denied any stressors in her life, but when she was out of earshot, confided that they were considering separation or divorce. Until recently, school had been easy and a source of pride for Amelia, but she now was less invested academically. She complained of not being able to sleep and of waking repeatedly throughout the night; she

often napped in the late afternoon, sometimes for several hours. She had also been eating less and was not gaining weight, and often declined opportunities to play with friends. Her parents also reported that she was angry with them, complaining alternately that they didn't care or were too intrusive. She had never talked about wanting to die; but sometimes, they found her crying in her room, and she never explained why.

On interview, Amelia presented as a thin, casually groomed child who insisted "everything is fine." She admitted that she sometimes got upset with her parents and yelled at them, explaining, "They are too bossy." She said her friends were often mean to her, which was why she got upset. She knew she was doing worse in school, stating, "The work is harder." She cried once when asked about friends and again when asked about home, but quickly recovered. She firmly insisted she was not "depressed"; however, when we looked at a list of synonyms for depression, she said she was often "blue."

Depressive symptoms in children from ages 6–12 tend to be fairly similar to adults. They are apt to appear sad, though they often lack words for

describing their mood. As with Amelia, one important clinical task with kids this age is to work with them to find a word or phrase that best matches their mood and then use that term with them. A clinical tip is to have a list of synonyms for depression such as "sad," "down," "blue," "moody," "off," and "irritated" that can study together. Kids this age can be quite concrete and may only endorse the term that "fits" them.

Like teens, children typically respond to their environment by being fine in some settings and distressed in others (CS Pataki and GA Carlson, *Harvard Rev Psychiatry* 1995;3(3):140–151). They are especially prone to somatic complaints and worries about their health and that of others. A depressed child might say things like "my stomach hurts when I think about school" or "sometimes my head hurts so bad I'm sure something is wrong with me." Sleeping may be disrupted, with trouble getting to sleep and increased likelihood of awakening during the night or early in the morning. This is not a decreased need for sleep but an inability to get enough sleep, and you will often hear about napping in the afternoon, like with Amelia, or on long rides. Mood-congruent auditory and visual hallucinations occur in 20–25% of

Continued on page 6

Tips for Diagnosing Depression by Age Group

| Preschool (under age 6) | Prepubertal school-age (age 6 to age 12) | Postpubertal (over age 12 to late teens) |
|--|---|--|
| <p>General features for all age groups:</p> <ul style="list-style-type: none"> • Social withdrawal • Variable mood, often with rapid changes • Irritability and anxiety may be more prominent than overt depression • Marked, persistent changes in appetite: increased appetite with accompanying weight gain or decreased appetite with weight loss or failure to gain weight appropriately • Changes in sleep patterns, with either increased need for sleep or decreased ability to get to sleep and stay asleep • Apathy and decreased interest in previously favored activities—often presents as "boredom" • Somatic symptoms such as headaches, stomach aches, and muscle pain may be prominent | <p>Possible abuse or neglect, or marital discord important factors that may require specific exploration</p> <p>Intense feelings of blame and guilt especially common</p> <p>General withdrawal and apathy highly prevalent</p> <p>Tantrums and meltdowns mixed with fears of rejection and abandonment</p> <p>Comorbid conditions of anxiety and oppositional behavior common.</p> | <p>More typical adult pattern of decreased appetite and problems sleeping</p> <p>Social isolation and withdrawal especially marked; may present as school phobia</p> <p>New onset of tantrums and meltdowns</p> <p>Highly variable mood, quite responsive to environment and social situation</p> <p>Comorbid conditions of separation anxiety, general increase in fears and phobias, and oppositional behavior common</p> <p>Outside stressors such as neglect or abuse, or marital discord common</p> <p>High likelihood of feeling parents "don't understand" or "hate" them</p> |
| | | <p>Increasing incidence in both boys and girls but especially in girls</p> <p>Increased risk of suicidal ideation, gestures, and self-harm, and of suicide attempts and completions</p> <p>Pattern of adult "atypical" depression fairly common, with increased sleep and appetite</p> <p>High environmental response to mood, with marked mood lability</p> <p>Comorbid conditions of anxiety, oppositional behavior, conduct disorder, and substance use or abuse common</p> <p>Outside stressors such as neglect or abuse or marital discord common and associated with self-harm</p> <p>High likelihood of feeling parents "don't understand" or "hate" them</p> |

Expert Interview

Continued from page 1

depression but are demoralized by life circumstances rather than being clinically depressed.

CCPR: How do I sort out whether a child meeting criteria for depression is demoralized or clinically depressed?

Dr. Walkup: I might ask my patient to tell me about some upcoming fun plans. The demoralized teen might brighten in anticipation of a future fun event. The clinically depressed teen might say something like, “Ah, I don’t think I’m gonna be doing anything fun. There’s supposed to be a trip with my family, but I don’t know. They tell me it will cheer me up, but nothing is going to cheer me up.” I could then follow up with a question about a past fun event. Again, the demoralized teen would brighten with remembering a fun event, but the clinically depressed child would not. I might say, “Tell me about something you did that was fun. Your parents told me you really enjoyed yourself a couple of years ago at Disneyland.” A kid with anhedonia might say something like, “Yeah, but I don’t know why they said that. They are trying to cheer me up, but the fact that they can’t makes me even more depressed.” Whereas if you posed that follow-up question to a typically developing kid, the response would be different: “Oh, man, that was so much fun I can hardly wait to go back.” It is very common clinically to see a demoralized young person unhappy and even suicidal in the ER, but look much better after admission in a structured, secure, and predictable environment.

CCPR: So you differentiate between “depressed” and “demoralized”?

Dr. Walkup: Yes, we see many, many kids who meet the diagnostic criteria for major depression, but largely their unhappiness and disturbed mood are related to life experiences: bad schools, troublesome families, poor peer relationships, poverty, and other kinds of adversity. And we preferentially call those kids “demoralized” rather than “clinically depressed.” I have much more confidence that medication is likely to be effective for kids with pervasive anhedonia and syndromic depression that appears “to have a life of its own.” With this sorting, the number of kids who actually suffer from clinical depression with anhedonia is pretty small compared to the numbers of kids who are demoralized.

CCPR: What kinds of treatments will the demoralized kids respond to?

Dr. Walkup: They are most likely going to respond to good problem-solving techniques since medication treatment is oriented towards a biological condition of depression. If teens are aware that their low mood is related to their life circumstances, a med trial might actually demoralize them further.

CCPR: In what way?

Dr. Walkup: Because it leads to an attitude of, “My life is tough, but they give me this stupid medicine that is supposed to help.” What these kids really want or need is somebody to talk to and help manage situations that cause specific distress, such as at school or home. So I think there are complications to medicating that demoralized state. You could also say that the children who met criteria for MDD that was caused by demoralization might be the reason our clinical trials of antidepressants have such high placebo response rates.

CCPR: I can see how that could happen. Getting back to determining medication-responsive depression, can you tell us a little bit more about defined onset and changes in functioning?

Dr. Walkup: Sure. As far as change in functioning, I look for psychomotor slowing—parents will tell you that the child is moving slowly and just sitting in one place for long periods of time. I also look for attention and concentration problems that had a pretty clear onset to everyone involved. I also make the determination by age. I more often see depressed kids in their teens, usually at ages 15–18 years—maybe an early episode at 14. These kids have been humming along doing pretty well, and then at age 14 or 15 suddenly they really slump. I have seen young patients with serious melancholia as early as 10–12 years of age, but that is very rare. If I see an unhappy 6- or 7-year-old, I don’t necessarily think depression but rather demoralization or anxiety—a child with an anxiety disorder whose life has gotten complicated, because of all the things he or she avoids, leads to unhappiness and demoralization rather than depression. Such kids are usually not anhedonic.

CCPR: From what you say, it sounds like we may be over-diagnosing depression in kids.

Dr. Walkup: Yes, one thing that’s happened in terms of our diagnostic criteria is that we’ve moved away from a concept of melancholia as a classic form of depression. We’ve broadened diagnostic boundaries to now include most forms of unhappiness. What’s interesting, though, is that most kids who are experiencing depression will not describe it as unhappiness. Instead, they’ll describe their mood as miserable, and say it’s harder for them to think and concentrate, that they can’t read stuff. They may report problems with focus and concentration more so than a disturbance of mood, much like what we tend to see in elderly people. Whereas the demoralized kids will really talk about how unhappy and difficult their lives are.

CCPR: Let’s say we diagnose a kid with something that we believe is a legitimate sort of melancholic depression or biologic depression with anhedonia and the other features we just discussed. We consider a medication, and many of us automatically think of either fluoxetine or escitalopram, because those are FDA-approved. Is there something particularly effective about these specific drugs with kids?

Dr. Walkup: I think when most people talk about evidence-based practice, they get kind of stuck on the idea of double-blind placebo-controlled trials. And in that sense, you really have the 2 drugs you mentioned: fluoxetine (approved for kids 8 and older) and escitalopram (approved for kids 12 and older). But keep in mind that FDA indication is really an artifact of government and pharmaceutical interaction; it doesn’t necessarily tell you much about what

“You could also say that the inclusion of children who met criteria for MDD that was caused by demoralization might be the reason our clinical trials of antidepressants have such high placebo response rates.”

John Walkup, MD

Antidepressants and Suicidal Ideation in Young People: A Practical Approach

Daniel Carlat, MD

Publisher, The Carlat Child Psychiatry Report

Many of you will remember that in October of 2004, the FDA announced to drug companies that they should add black-box warnings about the risk of suicidal behavior in children and adolescents started on antidepressants. This was based on an analysis of placebo-controlled, randomized trials (a total of 24 trials involving over 4,400 patients) showing that patients assigned to antidepressants had roughly double the risk of suicidal behavior [mostly suicidal ideation (SI)]—from 2% for the placebo group to 4% for the drug group (<http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm096352.htm>). A later meta-analysis found that while SI was more likely among those taking medications, this risk difference was only significant for the pooled sample of all clinical trials. The risk was not significantly greater for sub-groups of trials, including trials of meds for major depression, OCD, and the non-OCD anxiety disorders (Bridge JA et al, *JAMA* 2007;297(15):1683–1696).

A few years later, in May of 2007, the FDA determined that there was a similar risk for young adults (18–24 years old) and required black-box warnings for this population as well. The increased risk was smaller than for children (roughly 1.5x the risk vs. 2x the risk), and unlike the case for children, it was not statistically significant. Other independent meta-analyses found that as patients grew older, the antidepressant-induced risk of SI lessened progressively, so that for patients ages 25–64, antidepressants had no effect on suicidality, while for patients 65 and older, these drugs were actually protective, lowering the risk of suicidality by 61% (Leon A, *Am J Psychiatry* 2007;164:1786–1789).

How have these black-box warnings affected clinical practice over the past decade? Several studies have been published, and the consensus is that since the black-box warnings, the use of antidepressants in young people decreased significantly, and that suicide attempts increased (there was no increase in completed suicide) (Lu C et al, *BMJ* 2014;348). While this association cannot prove causation, given the tim-

ing it seems likely that the FDA actions caused these practice changes. Of course, just because decreased prescribing of antidepressants may lead to more suicide attempts does not mean that these medications are benign. It is possible that both antidepressant use and underuse lead to suicide risk, via different mechanisms.

Dr. John Walkup, this month's expert, sees two factors driving the apparent increase in SI in patients in clinical trials: artifacts of research design and real effects of medications.

Research artifacts and suicidal ideation

In clinical trials of antidepressants, SI as an adverse event has typically been established based on what subjects tell researchers in response to an open inquiry. One potential source of artifact is that as young participants get more deeply involved in a clinical study, they may become more open about their symptoms, including suicidal behavior, according to Dr. Walkup. "I've seen this both in the clinic and in my research. A young person will say, 'Thanks for sticking with me. I'm feeling much better. I am not suicidal now but did have those thoughts on and off since we started.'" While such comments could be discounted as pre-existing suicidal thoughts, well-trained investigators would likely conservatively report them as "new onset" SI. Ironically, this scenario might be more common when the medication is actually lifting mood and improving the patient's overall outlook.

Another potential artifact relates to patients who discontinue medications. Suppose a young person with depression is enrolled in a 12-week-long trial. If the medication leads to improvement after 6 weeks, the patient might stop taking the medication, reasoning that it is no longer needed. However, medication discontinuation can lead to re-emergence of both depression and SI, which would be reported as an adverse event even if it occurred in the context of medication discontinuation. "In the large FDA data set, we have very limited information on how many people developed new-onset suicidal behavior after discontinuing their antidepressant," says Dr. Walkup.

Effects of antidepressants on suicidality

Nonetheless, Dr. Walkup believes there are some pathways for the emergence or worsening of suicidal behavior during treatment with and without antidepressants. Two main mechanisms for antidepressant-induced SI in children are excessive activation/disinhibition and enhanced mood, leading to more peer group involvement.

"About 10%–15% of kids get activated by antidepressants; when that activation verges on disinhibition, one could imagine it might contribute to suicidal behavior," says Dr. Walkup. "Yet, even though a signal for activation was found by the FDA analysis, they couldn't identify whether it was associated with the observed suicidal behavior." How can clinicians recognize this activation? Dr. Walkup explains that antidepressant-induced activation can include symptoms such as insomnia, increased activity level, agitation, mental restlessness, worsening anxiety, and, at the most extreme end, behavioral disinhibition. "In my experience," says Dr. Walkup, "it's the young kids—under 10 or 12 years old—that are much more vulnerable to activation on SSRIs. Also kids who have some kind of neurodevelopmental disturbance, such as ADHD, tic disorders, or autism spectrum, combined with anxiety, are especially vulnerable to activation."

From a clinical perspective, Dr. Walkup starts most children who fit the risk profile on low doses of SSRIs. "Activation usually presents within the first 24–72 hours. If you start with a low dose, you may not see the activation until you get to the starting dose or the next dosage increase. If it occurs at the low dose, chances are slim that you will get to a full treatment dose. I haven't been able to do it, no matter how slowly I titrate, which is why I tell parents to discontinue the medication entirely if they see signs of activation."

Assuming that the medication must be discontinued because of activation, what should we do next? Psychotherapy is one option, as is trying another antidepressant, eg, a different SSRI or one of the SNRIs, such as venlafaxine or duloxetine. For children with depression and no anxiety, a dopaminergic antidepressant such as bupropion might be worth

Diagnosing Depression in Children and Adolescents

Continued from page 3

young children with severe depression (Carlson GA and Kashan JH, *Amer J Psychiatry* 1988;145(10):1222-1225). Tantrums and meltdowns also are common.

Children are highly sensitive to environmental strains and stresses, so I ask about the home environment. A remarkable number of parents who are having marital problems believe that their children are oblivious to the stress and uncertainty they are creating. Parents may not volunteer information about the marriage or other troubles within their family, such as chronic sibling squabbles, unless I ask. It's also important to inquire about bullying or abuse from peers or adults, past or present.

Persistent depressive disorder (dysthymia) is especially prevalent in latency-age children. Such children have a negative take on the world and tend to expect the worst. It can be tempting to write such attitudes off as "temperament," but research has shown that children with persistent depressive disorder have at least a 40% chance of developing a major depression within 2–3 years (Kovacs M et al, *Arch Gen Psychiatry*. 1984 41(7):643-9).

Depression in children under age 6

Juan was a 4-year-2-month old Hispanic male who came with his adoptive parents for assessment of chronic irritability, social withdrawal, poor appetite, and disrupted sleep. He had been separated from his biological mother at age 6 months and was in

foster care until adopted by his parents at age 2. The parents had been told that his biological mother was neglectful but not abusive. He talked little when he first came into their home but quickly caught up with all milestones and seemed fine until about age 3, when he began to display the above symptoms.

Juan did well in preschool, getting along with teachers and peers. Parents reported that he had a low frustration tolerance, reacting with tantrums if he did not get a toy he wanted, then expressing feelings of guilt and saying he was "bad" once the tantrum ended. Testing showed that his language and motor skills were at or above age level. With the examiner, he played readily, but themes of the play were negative with bad outcomes such as people being hit by cars or falling off cliffs. Also, he showed little enthusiasm with the play and was quiet and soft-spoken with a subdued affect.

In the 1940s, Rene Spitz coined the term "anaclitic depression" to describe the reaction of infants under 1 year of age who were separated from their primary caregiver and placed in institutional care with minimal adult interaction (Spitz, *Psychoanalytic Study Child* 1946;2:113–117). Over the course of several months, they deteriorated both physically and emotionally and, after 5 to 6 months of such neglect, would develop appetite loss, weight loss, and diminished reactions.

More recent research has confirmed that depressive symptoms do occur in very young children (Luby, *Amer*

J Psychiatry 2009;166(9):974–979), but there is some controversy about whether depression in the very young is the same disorder as that in older people. Key features include feeling and appearing sad most or all of the time, crying, being irritable and socially withdrawn, having somatic complaints with extreme fatigue, and feeling excessive guilt and shame. Parents are especially unlikely to consider depression as a problem in toddlers, so I ask specifically about these symptoms.

As with prepubertal children, environmental factors such as abuse or neglect or loss of a major caregiver may be key to the development of depression in very young children. In fact, for depressed children under age 6, abuse or neglect or both should be considered present until proven otherwise.

Summary

Assessing depression in children presents some challenges. It can take time to establish trust with the patient and gather vital information from other sources, children may lack the words to express their symptoms, and the symptoms themselves may be different from what one sees in adult depression. The table on page 3 provides a quick summary of key features of depression in young individuals. Because many parents may not consider depression as a cause for behavioral problems in children, it is crucial that clinicians ask questions of the youth and parents that will elicit symptoms, if present.

Antidepressants and Suicidal Ideation in Young People: A Practical Approach

Continued from page 5

a try. For anxious kids, while there are no actual data to support such a recommendation, you might start with a sedating antidepressant like mirtazapine.

Another potential mechanism for the association of antidepressant treatment and suicidality is *improvement* in mood and increased energy, which may put teens in more at-risk situations. For example, increased interaction with parents could in turn lead to more parent-child conflict. Such interpersonal conflict is commonly associated with suicidal behavior. In addition, improved mood can lead teens into peer situations that backfire on them, according to Dr. Walkup. "When kids first begin

to recover from depression, they seek out social interactions in a way that they hadn't been able to before. While often positive, it can also lead to risky situations—increased involvement in drugs and alcohol, and involvement in romantic relationships. This may create more opportunity for peer conflict or romantic disappointments." It is very important clinically to assess the patient's emotion and behavior control before starting medication so as to anticipate whether improvement might have this effect.

Clearly, the antidepressant/suicide connection is multifactorial. Some of this association is likely not "real," in the sense that artifacts of how research stud-

ies are conducted may yield apparent drug-induced symptoms that are actually caused by other factors. But you should be aware of ways in which medication effects may directly or indirectly complicate recovery.

CCPR VERDICT: Antidepressants and suicidality in kids: There's a connection, but it's not straightforward. Monitor closely for agitation as well as for mood improvement that can lead to more peer group involvement—with its attendant risks for disappointment and suicidality.

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CME Post-Test

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Below are the questions for this month's CME post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning objectives are listed on page 1.

- Which of the following statements about SSRIs and activation is true? (Learning Objective #3)
 - a. Activation usually occurs in fewer than 10% of patients
 - b. Activation at a low dose decreases the likelihood that a patient will tolerate a full dose without continued or worsening activation
 - c. Activation usually presents only after a patient reaches a full treatment dose
 - d. Even if activation occurs at a low dose, most patients will tolerate a full dose without continued or further activation
- When comparing girls to boys, which of the following statements characterizes the occurrence of depression in children and adolescents? (LO #2)
 - a. Teen girls are three times as likely to be depressed as teen boys
 - b. Teen girls are as likely to be depressed at the same rate as teen boys
 - c. Prepubertal school-age girls are twice as likely to be depressed as prepubertal school-age boys
 - d. Prepubertal school-age girls are as likely to be depressed as prepubertal school-age boys
- Mood-congruent auditory and visual hallucinations occur in what percentage of young children with severe depression? (LO #1)
 - a. 5%–10%
 - b. 10%–15%
 - c. 15%–20%
 - d. 20%–25%
- How have the black-box warnings affected clinical practice and suicide rates among young people over the past decade? (LO #3)
 - a. The use of antidepressants in young people decreased slightly, as did suicide attempts and completed suicides
 - b. The use of antidepressants in young people decreased significantly, while suicide attempts and completed suicides increased
 - c. The use of antidepressants in young people decreased slightly; suicide attempts and completed suicides remained the same
 - d. The use of antidepressants in young people decreased significantly; suicide attempts increased, while completed suicides remained the same
- A child diagnosed with persistent depressive disorder has at least a 40% chance of developing a major depression within which time frame? (LO #2)
 - a. 2–3 years
 - b. 3–5 years
 - c. Shortly after puberty is complete
 - d. Adult onset

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Expert Interview

Continued from page 4

the true evidence base is.

CCPR: Could you tell us a little bit more about that?

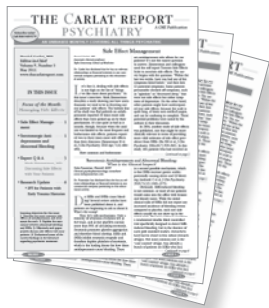
Dr. Walkup: Well, I would suggest that pharmaceutical companies have never really wanted to do studies in kids, and it took the Food and Drug Administration Modernization Act (FDAMA) in 1997 to get them to do that. This law encouraged companies to do studies on kids by awarding them an extra 6 months of marketing exclusivity if they did such studies. For companies, the upside is clear—they can make quite a bit more money over those 6 months. But they also incur some legal risks if their studies actually lead to a pediatric indication.

CCPR: How would that lead to a legal risk?

Dr. Walkup: A company is marketing an antidepressant that has an indication for kids 12 and older. If someone uses it properly within that indication and there's an adverse event or problem, the company could be liable in a lawsuit. Whereas if there is no pediatric indication, then doctors prescribe them off-label and use them at their own risk. If there's a bad outcome, the company may have less legal exposure without the labeling, but the clinician who prescribes off-label might. It's important for prescribers to understand what this means—namely, that there may well be other antidepressants that are effective in kids, but that because of financial and regulatory factors (or high placebo response rates), these potentially effective meds do not have official FDA approval. So in deciding which medication to use, I would not rely on FDA approval alone, but rather the evidence base—including efficacy data, of course, but drug-drug interactions, half-life, the activity of the primary metabolites and other metabolites, etc.

Continued on page 8

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This Issue's Focus:
Antidepressant Use in Children

Next Time in *The Carlat Child Psychiatry Report*: ADHD in Children

Expert Interview
Continued from page 7

CCPR: Let's discuss some of the factors you consider in making medication decisions, such as side effects.

Dr. Walkup: If I'm treating a kid with a history of side effects, I will choose a short acting drug and one that doesn't have drug-drug interactions. The reason for a short-acting drug is that I want it to leave the system quickly if there are side effects. And the absence of drug-drug interactions helps avoid unpredictability in case I want to switch or cross-taper.

CCPR: Do you have different drug preferences depending on the ages of the kids that you treat?

Dr. Walkup: Somewhat. Younger kids are often anxious and have problems falling asleep, so I tend to like the quieting or sedating SSRIs more. For teenagers that are lying on the couch, so to speak, I use the SSRIs that are more activating. And if I'm working with a depressed teen who is likely to be non-adherent a good percent of the time, I might use a longer half-life medication that would maintain more consistent blood levels despite missed doses. Keep in mind that these differences, however, can be quite subtle, and I think that as a class the SSRIs all work. They just don't all work for every patient. So sometimes you can pick one and it won't work very well for that child, and you move them to another and it works much better.

CCPR: Thank you, Dr. Walkup.

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