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Pharmacological Treatment of Childhood and Adolescent Depression: What School Counselors and School Psychologists Need to Know

Paper based on a program presented at the 2007 Association for Counselor Education and Supervision Conference, October 11-14, Columbus, Ohio.

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Introduction

The National Institute of Mental Health (1999) has reported that as many as 3% of all children and 8% of all adolescents in the United States are classified as clinically depressed. School counselors, as the first line of mental health resource personnel in our public schools, can and should play a very active role in assisting these students (Evans, Van Velsor, & Schumacher, 2002). Students experiencing more severe clinical forms of depression are beyond the province of school counselors and are better served by specialized professionals such as psychiatrists and physicians (Abrams, Theberge & Karan, 2005). School counselors can work collaboratively with these clinicians to best meet the needs of these students.

Childhood and Adolescent Depression

The *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [APA], 2000) categorizes depression as a mood disorder and includes specific descriptors of the various types of depressive disorders. Typical behavioral and emotional indexes of depressive disorders displayed by children and adolescents include: decreased ability to experience pleasure; irritability and anger; sadness; changes in appetite and weight; somatic complaints such as headaches and stomachaches; a sense of worthlessness, excessive guilt, and hopelessness; psychomotor extremes of either lethargy, or agitation; exhaustion and lack of energy; trouble concentrating, thinking clearly or making decisions; insomnia or, less often, hypersomnia; suicidal ideation, threats, or behavior; and preoccupation with recurrent thoughts of death (Abrams et al., APA, 2000; 2005; Kauffman, 1997; Vernon, 1999).

Ryan (2005) reports that depressive disorders during youth occur frequently, are chronic and recurrent, and are associated with significant functional impairment, comorbidity, and mortality. There is substantial impairment in social functioning, including poor school achievement and problems with both family and peers. Depression

in children and adolescents is associated with increased risk of suicidal behavior. Adolescent boys in particular are at an increased risk, especially if accompanied by comorbid disorders or substance abuse (Angold, Costello, & Erkanlie, 1999). The National Institute of Mental Health (1999) found that among adolescents who develop major depressive disorder (MDD), as many as 7% may commit suicide in the young adult years. However, suicide rates are decreasing overall in adolescents, and there seems to be a correlation between the use of antidepressant medications and a decrease in completed suicide (Ryan, 2005). It is critical, though, to note that there has been an increase in suicidal ideation in patients on antidepressant medications (Ryan, 2005). This is the critical component of the current debate in determining the best treatment for this disorder in youths and will be further explored in the next section.

Current & Historical Pharmacological Treatments

Treatment studies of depression in children and adolescents have been sparse for reasons of patient availability, prevalence rates, funding and research concerns (Ryan, 2005). Some basic conclusions have been drawn from what information there is available. According to Cao and Annis (2004), children and adolescents with mild to moderate depression can benefit from psychotherapy and counseling as an initial treatment. Counseling is also an effective adjunct therapy to medications in pediatric populations with more severe depression. The only controlled study, to date, comparing psychotherapeutic and pharmacological approaches found the most effective treatment for childhood and adolescent depression to be a combination of cognitive behavioral therapy and fluoxetine (the SSRI Prozac) treatment (Treatment for Adolescents with Depression Study Team, 2004).

Pharmacologic treatment of depression began with the introduction of tricyclic antidepressants (TCAs). While studies showed TCAs efficacy with adults, they were not found to be more effective than placebo use in treating depressed youth (Cao & Annis, 2004). Because TCAs had a high prevalence of negative side effects, these medications were not widely used in the treatment of children with depression. Another class of antidepressants that have only been sparingly used in the treatment of pediatric depression is the monoamine oxidase inhibitors (MAOIs).

More recently, pharmacologic treatment has shifted to the use of selective serotonin reuptake inhibitors (SSRIs). In 2002, an estimated 1.4 million children received antidepressant medication (Vitiello, Zuvekas, & Norquist, 2006). For adult populations, SSRIs have contributed greatly to effective pharmacological treatment protocol, as the SSRIs address the major debilitating depressive symptoms without many of the more severe and negative side effects inherent to tricyclic antidepressant use. Proven efficacy of SSRIs in the treatment of childhood and adolescent depression has been more limited. Currently, the only SSRI with documented efficacy in the pediatric population is fluoxetine (Prozac) and it is currently the only SSRI approved by the Food and Drug Administration for the treatment of depression in children and adolescents. However, there has been much controversy in the press recently regarding recent research and the potential for significant negative side effects experienced by children and adolescents

being treated with SSRIs (Abrams, Flood, & Phelps, 2006; Cropper, 2004; Wachter, 2005). The controversy revolves around a reported increase in short-term risk, an extra 2% of patients who will either attempt suicide or exhibit suicidality because of the use of an SSRI, and the potentially decreased long-term risk of suicidal thoughts and behavior attributable to depression (Wachter, 2005).

On September 16, 2004, the Food and Drug Administration Center for Drug Evaluation and Research (2004) supported recommendations made that antidepressants should include warnings about increased risk of suicidal ideation and suicide attempts in children and adolescents. Specifically, it was recommended that: (1) Warnings about the increase risk of suicidality in pediatric patients be placed on all antidepressant drugs (including those not studied); (2) A black box warning related to an increase risk of suicidal ideation and suicide attempts in pediatric patients be included in the labeling for all antidepressant medications; (3) It be required for a medication guide to be given to patients and caregivers with antidepressant prescriptions; (4) These agents should not be contraindicated in the United States for use in the pediatric population because of their vital role in the benefit for some children; and (5) The labeling of antidepressant medications include the results of clinical trials that studied in the pediatric population. Additionally, it is recommended to patients currently taking antidepressant therapy that these medications should not be stopped abruptly because of the risks of withdrawal symptoms such as agitation, anorexia, confusion, and/or seizures.

There has been some suggestion (Brent, 2004) that the committee recommending this action overestimated the risk while underestimating the benefit of pediatric antidepressant drugs. The American Academy of Child and Adolescent Psychiatry (2004) concluded that the data do not support a warning that may be misinterpreted to mean that antidepressant medications cause children and adolescents to commit suicide. They further support research showing the effectiveness of fluoxetine (Prozac) in the treatment of pediatric depression, stating that fluoxetine was well tolerated and was associated with significantly greater reduction in acute depressive symptoms. Likewise, the Treatment for Adolescents with Depression Study Team (2004) found fluoxetine alone, as well as fluoxetine combined with cognitive behavior therapy, to be highly efficacious in the treatment of adolescent major depressive disorder.

Apter and King (2006) point out that SSRIs likely reduce suicide risk for the general population of depressed children but increase it for a subset of patients who react adversely. So, the question that remains is whether or not antidepressants should be prescribed for the treatment of childhood and adolescent depression. "For those who cannot afford therapy or gain access to it, [medications] may be a far better solution than not treating a depressed child at all" (Cropper, 2004). The recommendations by many in both the mental health and medical fields include a careful consideration of the risks and benefits of such treatment combined with diligent monitoring of the patients reaction to treatment (Dubicka & Goodyear, 2005; Wachter, 2005).

Implications for School Counselors and School Psychologists

In 2003, the President's New Freedom Commission on Mental Health noted that, "Recognizing that children receive more services through schools than any other public system, federal, state, and local agencies should more fully recognize and address the mental health needs of youth in the education system" (p. 4). Because most students do spend a majority of their day in school, it is not unreasonable to assume that school counselors and school psychologists need to play a role in helping such students (Evans et al., 2002). Abrams et al. (2006) highlight the critical role school psychologists and counselors play in medication management by monitoring behavioral, social-emotional, and academic outcomes. Additionally, they can serve as coordinators for the intervention team, interface with providing physicians and provide psychosocial interventions.

Further, school counselors and school psychologists can serve to educate the entire school community regarding the signs of depression and the warning signs to be aware of in students that may signal significant concern, so that they might refer the student to the school counselor (Abrams et al., 2005). Early identification of depression and suicidal ideation is most likely when people are more knowledgeable about early signs; early identification is most likely to lead to treatment that is more effective and the prevention of completed suicide attempts (Miller, 1998).

A collaborative system of care that comprehensively meets the mental health needs of students with depression requires that school mental health professionals and educators working with these students have a solid understanding of the medications used to treat these disorders (Davis, Kruczek, & McIntosh, 2006). School counselors and school psychologists are a "natural bridge" between schools, families, and medical personnel (Abrams et al., 2006). Parents may feel more comfortable and at ease in expressing concerns the school setting than in a physician's office. Therefore, it is imperative that we are aware of the research and can provide families with current, relevant resources that can assist them in best meeting the needs of their child. This can only be accomplished if we stay current and informed of the myriad of options utilized by the students within our system in addressing their mental health needs. By doing this, school counselors and school psychologists are meeting this challenge put forth to us by the President's New Freedom Commission on Mental Health (2003) to promote collaboration between schools, families, and communities.

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