• Correspondence•

Antidepressants for children with depression

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The Forum about treating depressed children presented in the previous issue of the journal[1,2] highlighted several important issues about this controversial topic. Depression in children is a devastating disorder that effects psychosocial development and has long-term negative outcomes for both the patients and their families.[3-5] It has a relatively high prevalence of 1 to 2% in children and 3 to 8% in adolescents[3], but there are few randomized controlled trials on the efficacy of pharmacotherapy and other treatments for the disorder.[3-9]

After the FDA's 'black box' warning about the potential suicide risk of antidepressant use in children in 2004, the diagnosis of pediatric depression in the United States decreased from 5 per 1000 managed care enrollees to 3 per 1000 and the prescription of antidepressants among treatment-naive patients with depression who were 5 to 21 years of age decreased by approximately 50%.[6] These changes following the FDA warning suggest that many children with depression were not being treated with appropriate medication. This hypothesis is supported by the increase in the suicide rates of children and adolescents – by 14% in the United States[10] and 25% in Canada[6]—in the years following the FDA warning compared to increasing antidepressant prescription use and a decline in suicide rates among children and youth in the years prior to the warning.[6,7]

The results of several reviews about the association between the treatment of pediatric depression with antidepressants and suicidality have questioned the appropriateness of the FDA warning.[5-11] Ecological studies have reported a beneficial effect of antidepressant prescription in children and adolescents. In the United States, suicide rates among children and adolescents decreased from 4.4 per 100,000 to 2.8 per 100,000 between 1999 and 2003, a period during which there was a substantial increase in the rates of prescription of selective serotonin reuptake inhibitor (SSRI) antidepressants for pediatric depression.[6] The Treatment for Adolescents with Depression Study (TADS) found that adolescents with major depressive disorder (MDD) show significant decreases in suicidality in all treatment arms but no significant difference in between those treated with fluoxetine and those treated with CBT.[12] More recent studies also indicate that antidepressants are modestly effective for the treatment of pediatric MDD and that the benefits outweigh the risks of suicidalilty.[11] Finally, the FDA's warning applied to all antidepressants, but it appears that the relationship between antidepressant use and suicidality in children and adolescents varies for the different types of antidepressants.[4]

Despite the limited number of randomized controlled trials of pharmacotherapy for children with depressive disorders and the inconsistency of the results,[5] several studies found that SSRIs were significantly superior to placebo.[5,6,9-11] But some studies report antidepressants of limited use in children with depression.[9] Psychotherapy, especially CBT, and manipulation of the psychosocial context (including treatment of parental psychopathology) is considered effective for most children with mild or moderate depression,[7,10] but usually needs to be augmented with antidepressants in those with severe depression.[9] Based on scientific reviews and expert consensus statements, several practice guidelines recommend using fluoxetine or escitalopram – both of which are approved by the FDA – as the first-line pharmacological treatment for children and adolescents with MDD if medication is indicated.[5-11] With appropriate monitoring for suicidality and other potential adverse events, patients with severe forms of pediatric MDD or with less severe MDD that does not respond to psychosocial interventions alone will often benefit from combined psychosocial and psychopharmacological interventions.

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