Thriving
children • youth • families
Growing Edge Training online journal

Evidence-Based Treatments for Depressed Youth: Under the Microscope

Robert Foltz, Psy.D.

A mental health crisis blankets the United States. From children through adulthood, people are facing more stress, more disrupted relationships, and more adversity than before. Yet, for the last generation, we have been busy creating, writing about, and implementing evidence-based treatments. One may then feel reassured that we have reliable, effective interventions capable of addressing these mental health needs across the lifespan. The following discussion explores our established treatments for depression in adolescents. It emanates from a chapter entitled, Rethinking the Treatment of Adolescent Depression, which is now available as an "early access chapter" from the forthcoming book, *No Method to the Madness: Making Sense of the Psychiatric Treatment of Our Youth*.

Many youth across the country face loneliness, failure, hopelessness, and deep sadness: Depression. While these thoughts and feelings are not new to adolescence, they are having a profound impact on their well-being. Suicide rates are at alarmingly high levels and have steadily increased over the last decade. In fact, as of 2020, suicide is the 2nd leading cause of death for those aged 10-14 and the 3rd leading cause of death for those 15-24 years old.[1] In 2021, the U.S. Centers for Disease Control and Prevention (CDC) reported that 20% of high school students seriously considered attempting suicide.[2] Visits to Emergency Departments and hospitalizations to maintain safety are also surging.

As we review the treatments for depression, we should also outline a typical process in our mental health system. Step one: We have to identify the problem. This basically refers to our diagnosis of a disorder. Step two: Once we identify what we're dealing with, we reach into the evidence-based treatment recommendations to use a strategy that has proven its effectiveness in treating the problem. These recommendations are typically generated by professional organizations and called Practice Guidelines or Practice Parameters. Step three: We monitor our outcomes.

1 Center for Disease Control. 10 Leading Causes of Death, United States. https://wisqars.cdc.gov/data/lcd/home

2 U.S. Center for Disease Control and Prevention. Youth Risk Behavior Survey. Data Summary & Trends Report, 2011–2021. https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf

Step One: Diagnostic Evolution

Unfortunately, the stress on our young people is not new. One could argue that it's become more complicated, though. For example, years ago, we didn't have to worry about social media as such a catalyst for feelings of inadequacy, loneliness, and rejection. But with the release of our newest diagnostic manual in 2022 (the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision—DSM-5-TR), we can sigh with relief of at least having an accurate framework to identify the clinical disorders that may impact adolescents. Or can we?

Unfortunately, the stress on our young people is not new. One could argue that it's become more complicated, though.

Let's briefly reflect on an earlier era in our diagnosing. I've been working in the mental health field for a little over 35 years. But in the years during my childhood, mental health professionals paid little attention to mood problems in youth. During that time, "physicians doubted the existence of significant depressive disorders in children."[3] Fast forward to our current situation, and now over a third of adolescents worldwide are at risk for diagnosable depression.[4]

Again, a sigh of relief. With our modern science, learning from our mistakes over time, recognition of traumatic experiences, and improvements in the development of the DSM, we're in better hands. Right? Well, one troubling aspect of this is that only 5% of clinical psychology graduate programs accredited by the American Psychological Association require a course in trauma.[5] But our diagnostic processes must have improved from those earlier days of ignoring mood problems in our young people.

3 Son, S. and Kirchner, J. (2000). Depression in Children and Adolescents. *American Family Physician, 62*(10).

4 Shorey, S., Ng, E., Wong, C. (2021). Global prevalence of depression and elevated depressive symptoms among adolescents: A systematic review and meta-analysis. *British Journal of Clinical Psychology, 61*(2).

5 Foltz, R., Kaeley, A., Kupchan, J., Mills, A., Murray, K., Pope, A., Rahman, H., & Rubright, C. (2023). Trauma-informed care? Identifying training deficits in accredited doctoral programs. *Psychological Trauma: Theory, Research, Practice, and Policy.* Advance online publication. https://doi.org/10.1037/tra0001461

Our latest diagnostic framework to identify Major Depression hasn't changed in a decade. And in 2013, the ability to accurately identify Major Depression fell into a category of "questionable agreement." Here's how this works: There is a measure called "inter-rater reliability" that results in a Kappa score. This examines the level of agreement among trained clinicians to accurately diagnose a person within a diagnostic interview, using the proposed diagnostic criteria. Studies called "Field Trials" are carried out in the development of the DSMs to determine the accuracy and utility of diagnostic criteria. For Major Depression, the field trial inter-rater reliability only achieved a 0.28 level of agreement.[6] This is embarrassing.

Think of it this way, based on our current diagnostic criteria, nearly 70% of sample evaluations in the field trials were *wrong*. "This is the reason that many texts recommend 80% agreement as the minimum acceptable interrater agreement…any Kappa below 0.60 indicates inadequate agreement among the raters and little confidence should be placed in the study results" (p. 277).[7] So how do we make sense of this? Simply put, our ability to accurately identify depression, based on our most advanced strategy, is unreliable.

One more aspect we should recognize here, is that our diagnostic framework falls short anyway. The DSM gives little attention to experiences that create depressed, hopeless feelings. Unmet needs create distress, and indeed, symptoms. Honestly, being unable to effectively cope with unmet needs should not always equate to, or be considered, a mental disorder, chemical imbalance, or brain problem. These symptoms can take many forms, but as depression has been a part of the human experience since our beginning, our goal should be to understand what needs are unmet, frustrated, or defeated. We also need to appreciate the reality that distress—in all its forms—affects our physiology, our relationships, our sense of self, our goals, and our perception of the world around us. When our needs continue to go unmet, our reactions can become more desperate, more intense, or more self-defeating. Focusing on an unreliable checklist of symptoms fails to appreciate the experience of the person sitting with you. In my training, it wasn't enough to simply diagnose a condition. The goal was to understand the experience. Symptoms have meaning and are signals of distress.

6 American Journal of Psychiatry, Editorial. (2013). The Initial Field Trials of DSM-5: New Blooms and Old Thorns. *American Journal of Psychiatry, 170*(1).

7 McHugh, M. (2012). Interrater Reliability: The kappa statistic. *Biochemical Medicine, 22*(3). 276-282.

Step Two: Treatment Dilemma

We are a society that relies heavily on medications. Indeed, these chemical compounds save lives every day. Able to resolve infections, control symptoms, and manage physiological processes, among a myriad of other potentials. But for depression, things are a little different. Particularly for young people. Since the 1980s, we've been accumulating evidence for treatments. That is, we have been accumulating "evidence-based" interventions. We have data.

Our goal should be to understand what needs are unmet, frustrated, or defeated.

We have recent Practice Guidelines. In recent years, the authorities in mental health have given us recommendations for effective care. The American Academy of Child & Adolescent Psychiatry (AACAP) and the American Psychological Association have evaluated the data. When we are faced with a young person diagnosed with depression, we know what to do. But I may be overstating this.

"Rethinking the Treatment for Adolescent Depression," the early access chapter from the forthcoming *No Method to the Madness,* provides a deep dive into these Practice Guidelines. I believe knowing the weaknesses in our positions can actually strengthen them. Rest assured, I have spent decades studying medication treatments in youth, and getting this right, matters.

Every day across our country, young people are taking antidepressant medications to alleviate these feelings of sadness, hopelessness, frustration, emptiness, and isolation. Based on the Practice Guidelines, a drug called fluoxetine (Prozac) is the preferred medication. In fact, no other antidepressant medications have reliably demonstrated any effectiveness in reducing symptoms of depression in young people. This may be surprising. You may be working with youth on different medications. But wait. What about the evidence?

We want to believe that for medications used in young people, there must be extensive studies, with thousands of participants, for years, to arrive at conclusions about effectiveness and safety. This is far from the reality. You'd be surprised to learn that the Guidelines that recommend our medication

strategies for youth are based on not years, not months, but weeks. There is one study, called the Treatment for Adolescents with Depression Study (TADS).[8] This trial is often touted as "the proof" for Prozac. But a close look at this research only shows a short-term advantage from Prozac. And, indeed, those youth that received therapy alone ended up with the same outcomes in the long term. Able to avoid side-effects, outcome measures converged to virtually identical points over time.

Knowing that there are *not* thousands of adolescents participating in studies to understand medication effectiveness, we begin to realize that size matters. Smaller samples in research create problems in our ability to generalize those results to a larger population. For example, if we only test a drug on four people, and three respond positively, we'd be foolish to assume that 75% of people will receive benefits across the entire population. Given this, how would you feel knowing that there are *fewer* young people that have responded positively to fluoxetine than those who haven't? The preponderance of the evidence suggests that placebos are as effective (in some cases more effective) as antidepressant medications. We have the data. Our practices just don't reflect it.

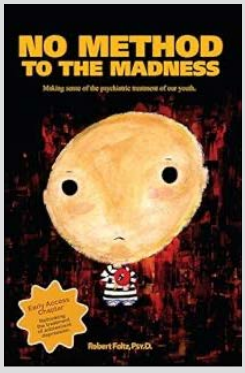
Health is not the absence of symptoms. Health must be pursued.

Step Three: The Outcomes

The experience of depression is painful. It's lonely, angry, desperate, frightening, helpless, and empty. These are signals of distress. This distress is not from a "chemical imbalance," nor is it from an elusive abnormality in the brain. This distress emerges from unmet needs. Many of the assessments used for outcomes in research look to measure the reduction of symptoms. It is assumed that if symptoms are reduced, this translates to health. Health is not the absence of symptoms. Health must be pursued. And in this case, as symptoms are signals of unmet needs, simply reducing or eliminating them is like taking the batteries out of a smoke detector.

I've always believed that these emotional and behavioral challenges occur within the context of relationships. And those of us connected with Reclaiming Youth, Growing Edge, and readers of Thriving know what works. We need to continue reminding ourselves that the Circle of Courage is evidence-based. It's easy to be distracted by new techniques or commercials for new medications. What is time-tested is that creating a world that supports Belonging, Mastery, Independence, and Generosity does meet the needs of youth in distress. And it doesn't assume that feelings of depression will disappear. Indeed, they are part of being human. But embracing them and walking through those dark times with someone who cares, supports your goals, helps strengthen your resiliency, and empowers you to live a fulfilling life, is the positive outcome we are seeking to achieve.

Robert Foltz, Psy.D., *is a clinical psychologist with over 30 years of experience in the field working with at-risk youth and their families. He has worked across residential, inpatient, and outpatient settings and has consulted with Illinois DCFS, school districts, residential treatment programs, and the Office of Refugee Resettlement in his role with Reclaiming Youth At Risk. Throughout this work, Foltz has focused on optimizing outcomes of these youth through the effective recognition and treatment of trauma exposure, utilization of evidence-based strategies, and coordinating services with multidisciplinary resources. He is now an Associate Professor in the Department of Clinical Psychology at the Chicago School, where his courses focus on Trauma-Informed Care, Pediatric Psychopharmacology, evidence-based interventions, and models for understanding psychiatric disorders. He is also the Vice President of Child Welfare at Multi-Dimensional Education, Inc. (MDed).*



This article was derived from an early access chapter of No Method to the Madness—Rethinking the Treatment of Adolescent Depression *by Robert Foltz. This Kindle edition chapter may be purchased on Amazon here. Look for the complete book later this year!*

8 TADS Team. (2004). Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents With Depression. Treatment for Adolescents with Depression Study (TADS) Randomized Controlled Trial. *Journal of the American Medical Association (JAMA), 292*(7).