



WHAT WE KNOW

AD/HD and Coexisting Conditions: Depression

Attention-deficit/hyperactivity disorder (AD/HD) is a common neurobiological condition affecting 5-8 percent of school age children^{1,2,3,4,5,6,7} with symptoms persisting into adulthood in as many as 60 percent of cases (i.e. approximately 4% of adults).^{8,9}

In addition, nearly two thirds of these children with AD/HD suffer from another condition such as depression or anxiety disorders in addition to their AD/HD.¹⁰ Any disorder can coexist with AD/HD, but certain disorders like depression seem to occur more commonly.¹¹

HOW ARE COEXISTING CONDITIONS IDENTIFIED?

It is essential to determine whether there are other psychiatric or physical disorders affecting the child with AD/HD. A thorough physical exam should be incorporated into a comprehensive evaluation for AD/HD. As part of the diagnostic process, the clinician must decide whether a symptom is associated with AD/HD, to a different disorder, or to both disorders at the same time. For some children, the overlap of symptoms among the various disorders makes multiple diagnoses possible.

Using a combination of symptom questionnaires and interviews with the child, the parents and significant others, the clinician determines if the child exhibits the characteristic symptoms of a disorder. In addition to listing the symptoms, the clinician will also ask when the symptoms began, how long they have

lasted, how severe they are, how they affect day-to-day functioning, as well as whether or not other family members have had these symptoms. As a result of this questioning, the clinician is able to determine if a child meets the criteria for diagnosis of AD/HD and/or another coexisting disorder.

This *What We Know* sheet deals with the diagnosis and treatment of AD/HD and coexisting depression. The diagnosis and treatment of AD/HD are discussed extensively in *What We Know #1: The Disorder Named AD/HD*.

WHAT IS DEPRESSION AND HOW IS IT DIAGNOSED?

According to the manual used by mental health professionals to diagnose mental disorders (DSM-IV-TR, 2000), either a depressed mood for most of the day or diminished interest or pleasure in activities must be present for a diagnosis of depression. In addition, at least four of the following symptoms must also be present:

- weight loss or weight gain
- insomnia or excessive sleeping
- hyperexcitability (greater than seen with AD/HD)
- lack of motivation
- fatigue or loss of energy
- feelings of worthlessness
- lack of concentration
- recurring thoughts of suicide or death.

These symptoms must be present for at least two weeks and represent a change from previous functioning before a diagnosis of depression can be made.¹²

It should be noted, however, that these criteria for the diagnosis of depression are based on symptoms as seen in adults and that children may not exhibit depression in quite the same way. Clinicians more often observe irritability or hyperactivity as major symptoms in young children who are suffering from depression, so a careful evaluation should be conducted.

TREATMENT OF DEPRESSION

Once the severity of symptoms and cause for the depression are established, the clinician can determine an appropriate course of action. Treatment of depression in children usually involves therapy. In addition, antidepressant medication may be helpful.

Therapy involves talking to a psychiatrist, counselor or mental health professional about things that are occurring in a person's life and family. The aim of therapy is to decrease suffering and to return a person to more normal functioning.

Therapies used in cases of depression include: behavioral therapy, cognitive therapy, interpersonal or family therapy or school-based mental health interventions. Behavioral therapy focuses on current behaviors and ways to change them, cognitive therapy focuses on changing negative thoughts and thinking patterns and interpersonal (family) therapy focuses on current family issues and relationships.¹³

If it is determined that a child also needs medication for depression, this step should be taken only after weighing all the pluses and minuses of antidepressant therapy. If parents are unsure about pursuing this avenue of

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treatment, they may conclude that they want a second opinion before proceeding and should not be hesitant to seek one.

At present, there are over 20 antidepressants available to treat this condition. Some antidepressants are not recommended for children under 18 years of age. Others carry a black box warning because of increasing suicidal thinking that has been seen in some children. It is important that your child be followed closely as he or she begins taking any medication, and antidepressants are no exception. Any worsening of symptoms or emergence of new symptoms should be reported immediately to your prescribing physician.

AD/HD AND DEPRESSION: INCIDENCE

Over time, children with AD/HD may become frustrated and demoralized because of their symptoms. They may develop feelings of a lack of control over what happens in their environment or become depressed as they experience repeated failures or negative interactions in school, at home, and in other settings. As these negative experiences accumulate, the child with AD/HD may begin to feel discouraged. Typically, in these situations AD/HD symptoms appear first and the depression comes later. These negative reactions are common in individuals with AD/HD and some experts claim that up to 70 percent of those with AD/HD will be treated for depression at some point in their lives.¹⁴

In addition to being saddened or demoralized as a result of AD/HD, children may also experience a true depressive illness. To date, studies indicate that

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between 10-30 percent of children with AD/HD may have a separate serious mood disorder like major depression.^{15,16,17} However, overlap of symptoms often makes the mood disorder (major depression) more difficult to diagnose.

For instance, physical agitation (or hyperactivity) and poor concentration are symptoms of both AD/HD and depression. If a child has these symptoms and appears to also be sad, hopeless, or suicidal, the clinician may consider a diagnosis of major depression. In such complex situations, it is important to see a psychologist or psychiatrist to diagnose and manage the conditions.

The incidence of depression in children with AD/HD can also be affected by the presence of other coexisting conditions. In children with AD/HD and oppositional defiant disorder or conduct disorder (ODD/CD) depression rates are substantially higher.¹⁸

AD/HD AND DEPRESSION: TREATMENT

Treatment of children with AD/HD and depression involves treating the symptoms of AD/HD and minimizing environmental traumas that take a heavy toll on self-esteem. Individual psychotherapy for the child with AD/HD and depression helps him articulate and deal with his feelings and teaches him appropriate coping skills. Cognitive therapy may also help reframe negative thoughts and result in a more positive outlook and reaction to situations. Additional family counseling sessions often result in everyone having a better understanding of the child's AD/HD symptoms and resulting behaviors, as well as providing an opportunity to address parenting or marital concerns. Behavioral intervention programs with positive reinforcement of appropriate behaviors may also impact the child's feelings of self-worth.

It is extremely important to make sure that you engage a therapist who is familiar with both AD/HD and depression when seeking a course of treatment for your child. In addition to these various therapies, the use of medication may be necessary to reduce symptoms of either AD/HD or depression or, at times, to treat both disorders. When medications are used, however, they should always be part of a total treatment plan and in conjunction with therapy.

When initiating treatment, the clinician must first attempt to determine which symptoms are more prominent and are having the greatest impact before prescribing medication. If symptoms of AD/HD are more impairing, treatment guidelines recommend that medication for this disorder be prescribed first.¹⁹ If symptoms of depression are of greater concern, these may need to be addressed as well. In some cases, antidepressants may be prescribed in addition to the medication used to treat AD/HD. In these cases, antidepressants should be used with caution and strict follow-up during the first few months, especially in children and adolescents.

Finally, AD/HD medications and antidepressants may be prescribed together to treat both conditions under the close supervision of the physician or therapist. Usually, the clinician will start with one medication only to treat the most serious condition and, only after establishing efficacy, will proceed to treat the other condition with the appropriate medication, if necessary. (See *What We Know #3: Managing Medication for Children and Adolescents with AD/HD* for more information.).

CONCLUSION

Being a parent of a child with AD/HD can be confusing. Keeping open lines of communication with your child and observing your child's behaviors can help identify problems with depression. Identifying and treating children with coexisting depression and AD/HD can be extremely complex and difficult; many factors need to be taken into consideration.

Parents who find themselves in the situation of seeking help for their child with AD/HD and depression may benefit from the following simple advice:

- Find a mental health professional, such as a psychologist or psychiatrist, for your child
- Be sure to seek out two opinions if you are unsure what path to take in choosing a treatment for your child
- Engage a therapist who is familiar with diagnosing and treating both conditions in children
- Be aware that depression that includes suicidal thoughts or plans should be taken very seriously
- Read all you can about both disorders and their treatment.

Parents may find the following books and videos to be particularly helpful.

MORE INFORMATION FOR PARENTS

Faraone, Steven (2003). *Straight talk about your child's mental health: What to do when something seems wrong*. New York, NY: Guilford Press.

Goldstein, Sam and Brooks, Robert (2001). *Raising resilient children*. Lincolnwood, IL: Contemporary Books. Also available in video as *Tough Times, Resilient Kids* by Robert Brooks and Sam Goldstein from www.addwarehouse.com.

Goldstein, Sam. *Why isn't my child happy: A video guide about childhood depression*. Video. Available through www.addwarehouse.com.

Ingersoll, Barbara and Goldstein, Sam (2001). *Lonely, sad and angry: A parent's guide to depression in children and adolescents*. Plantation, FL: Specialty Press.

Koplewicz, Harold (2002). *More than moody: recognizing and treating adolescent depression*. New York, NY: Berkley Publishing Group.

Wilens, Timothy (2004). *Straight talk about psychiatric medications for kids* (revised edition). New York, NY: Guilford Press.

REFERENCES

1. American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders: DSM IV* (4th ed., text, revision), Washington, D.C.: American Psychiatric Association.
2. Mayo Clinic. (2002). How Common is Attention-Deficit/Hyperactivity Disorder? *Archives of Pediatrics and Adolescent Medicine* 156(3): 209-210.
3. Mayo Clinic (2001). Utilization and Costs of Medical Care for Children and Adolescents with and without Attention-Deficit/Hyperactivity Disorder. *Journal of the American Medical Association* 285(1): 60-66.
4. Surgeon General of the United States (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services.
5. American Academy of Pediatrics (2000). Clinical practice guidelines: Diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. *Pediatrics*, 105, 1158-1170.
6. Centers for Disease Control and Prevention (2003). Prevalence of diagnosis and medication treatment for attention-deficit/hyperactivity disorder. *Morbidity and Mortality Weekly Report* 54: 842-847.
7. Froehlich, T.E., Lanphear, B.P., Epstein, J.N., et al. Prevalence, recognition, and treatment of attention-deficit/hyperactivity disorder in a national sample of US children. *Archives of Pediatric and Adolescent Medicine* (2007), 161:857-864.
8. Faraone, S.V., Biederman, J., & Mick, E. (2006) The age-dependent decline of attention-deficit hyperactivity disorder: A meta-analysis of follow-up studies. *Psychol Med* (2006), 36: 159-65.
9. Kessler, R.C., Adler, L., Barkley, R., Biederman, J., et al. The prevalence and correlates of adult ADHD in the United States: Results from the National Comorbidity Survey Replication. *Am Journal of Psychiatry* (2006), 163:724-732.
10. J. Biederman, S.V. Faraone, & K. Lapey (1992). Comorbidity of diagnosis in attention-deficit hyperactivity disorder. In G. Weiss (Ed.), *Attention-deficit hyperactivity disorder, child & adolescent clinics of North America*. Philadelphia: Sanders.
11. A. Adesman A (2003). A diagnosis of AD/HD? Don't overlook the probability of comorbidity! *Contemporary Pediatrics*.
12. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, fourth edition*. Washington, DC: American Psychiatric Association; 1994.
13. J. Maccley (2005). Learn about Depression, Health News OnLine http://www.dental.am/articles_more.php?id=3396_0_2_0_M.
14. R.A. Barkley, ed. (1998) *Attention-Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment*, second ed. (New York, NY: Guilford Press).
15. J.C. Anderson, S. Williams, R. McGee, et al (1987). DSM-III disorders in preadolescent children. Prevalence in a large sample from the general population. *Archives of General Psychiatry* 44: 69-76.

16. H.R. Bird, M.S. Gould, and B. Staghezza (1993). Patterns of diagnostic comorbidity in a community sample of children aged 9 through 16 years. *Journal of the American Academy of Child and Adolescent Psychiatry* 32: 361-36.
17. J. Biederman, S.V. Faraone, K. Keenan et al (1992). Further evidence for family-genetic risk factors in attention deficit hyperactivity disorder: Patterns of comorbidity in probands and relatives in psychiatrically and pediatrically referred samples. *Archives of General Psychiatry* 49: 728-738.
18. G.J. August, G.M. Realmuto, A.W. MacDonald et al (1996). Prevalence of AD/HD and comorbid disorders among elementary school children screened for disruptive behavior, *J. of Abnormal Child Psychology*, 24, 571-595.
19. Practice parameters for the assessment and treatment of attention-deficit hyperactivity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*. 1997;36(suppl 10):85S-121S.

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