CORRESPONDENCE

The Treatment of Depressive Disorders in Children and Adolescents

by Dipl.-Psych. Kathrin Dolle, Prof. Dr. med. Gerd Schulte-Körne
in volume 50/2013

Dr. med. Rainer Frick

Neurology, psychiatry and pediatric neuropsychiatry
Malchin, frick.malchin@web.de

Strong Empathy a Must

The paper says nothing about the critical role strong empathy plays when dealing with these children and adolescents. Whether this empathy is genuine or just evidence-based is something they are particularly sensitive about. The algorithm is too complex to be useful, especially in a statutory health insurance setting. It is unfortunate that fluoxetine is the only approved medicine. Of all selective serotonin reuptake inhibitors (SSRIs), it has the longest half-life and is thus the most difficult to control. As it contains only the active enantiomer, escitalopram can be recommended.

DOI: 10.3238/arztebl.2014.0330a

REFERENCES

1. Dolle K, Schulte-Körne G: The treatment of depressive disorders in children and adolescents. Dtsch Arztebl Int 2013; 110(50): 854–60.

Dr. med. Franz-Ulrich Beutner

Burgdorf, fub_bu@me.com

A Poor Soloist in Most Cases

As an office-based neurologist, I came to believe that an antidepressant is generally a poor soloist in an antidepressant strategy. Correction of sleep and, where necessary, anxiolysis during the day are indispensable to ensure adequate response to antidepressants. You can give patients with significant sleep problems antidepressants by the bucketful without any success. To publish papers evaluating psychotherapy versus fluoxetine (or another antidepressant) without taking sleep problems and their semi-quantitatively equal distribution in the compared groups into consideration is an approach I have difficulties with.

Any treatment of depression requires sleep optimization and the same holds true for addressing restlessness/worrying during the day; only then the antidepressant's value can be determined. Targeted investigations to identify superficial sleep patterns must be undertaken.

ADHS also falls into the category of depressive disorders and the treatment approach described above works well for this condition, without adding Ritalin or its analogues. My preference is side effect-guided combination treatment with gradually increased doses, also in comparison with psychotherapy.

DOI: 10.3238/arztebl.2014.0330b

REFERENCES

1. Dolle K, Schulte-Körne G: The treatment of depressive disorders in children and adolescents. Dtsch Arztebl Int 2013; 110(50): 854–60.

In Reply

The overall goal of a guideline is to improve medical care. To achieve this goal it needs to be built on scientifically proven systematic evidence-based data. On the other hand, its legitimacy for implementation has to be ensured by a representative guideline developer group and a structured consensus building approach (1). Consequently, when preparing this guideline we did not stop at collecting relevant studies, but also critically evaluated their validity, taking into consideration both the methodical aspects and their practical value for the German health system. The recommendations were laid down after discussions with representatives of the 23 professional societies and associations involved. Some of the arguments and concerns raised in the correspondence were also raised in the guideline panel. To some critical questions, the answers could not be found based on evidence, either because no relevant studies were available or the available studies were not sufficiently valid. Thus, the recommendations are based on the current state of research and the clinical consensus reached by the panel members. In the long version of the guideline (2), the recommendations are discussed in more detail.

The work on the guidelines is far from being completed. Some important tasks, such as preparing a version that a lay person will understand, distributing the guideline, and collecting important user feedback, are only starting now. At the same time, efforts should be made to prompt the conduction of more valid, clinically relevant studies free of any conflict of interest. Moreover, it would be desirable to extend the guideline to include recommendations for the diagnosis of depressive disorders in children and adolescents which could not be addressed before. We look forward to a critical dialogue to ensure continuous improvement of the guideline. The next update of this guideline should be completed by June 2018.

DOI: 10.3238/arztebl.2014.0330c

REFERENCES

1. Selbmann HK, Kopp IB: Leitlinien im Gesundheitswesen: Kompetenzen und Zuständigkeiten der AWMF. Forum DKG 2006; 5: 5–8.
2. Dolle K, Schulte-Körne G: The treatment of depressive disorders in children and adolescents. Dtsch Arztebl Int 2013; 110(50): 854–60.

Prof. Dr. med. Gerd Schulte-Körne

Dr. hum. Biol. Kathrin Krick

Department of Child and Adolescent Psychiatry, Psychosomatics, and Psychotherapy
Hospital of the University of Munich
Gerd.Schulte-Koerne@med.uni-muenchen.de

Conflict of interest statement

The authors of all contributions declare that no conflict of interest exists.