

**Please note: This guidance is based on the work of the World Health Organization ([www.who.int](http://www.who.int)) and may be updated annually. Check “Feedback & Updates” periodically.**

In the United States, it is estimated that up to 3% of children younger than 13 years and up to 6% of adolescents suffer from depression.<sup>1</sup> Estimates of lifetime prevalence of major depressive disorder are significantly higher at up to 20%.<sup>1</sup> Depression is associated with an increased risk of recurrence, suicide attempts, and suicide. Other associated problems include negative effects on school performance, early pregnancy, and impairment of function in the work, social, and family environments.<sup>1</sup> Because of the prevalence and clinical significance of depression and the potential effectiveness of primary care interventions, the American Academy of Pediatrics endorsed “Guidelines for Adolescent Depression in Primary Care”<sup>2,3</sup> and recommends that pediatric primary care clinicians achieve competence in the care of children and adolescents who are depressed.<sup>4</sup>

### Screening Results Suggesting Depression

**Pediatric Symptom Checklist (PSC)-35:** Total score  $\geq 24$  for children 5 years and younger;  $\geq 28$  for those 6 to 16 years; and  $\geq 30$  for those 17 years and older AND further discussion of items related to depressive symptoms confirms a concern in that area.

**PSC-17:** Internalizing subscale is  $\geq 5$  AND further discussion of items related to depressive symptoms confirms a concern in that area.

**Strengths and Difficulties Questionnaire (SDQ):** Total symptom score of  $>19$ ; emotional symptom score of 7 to 10; impact scale (back of form) score  $\geq 2$  indicates some degree of impairment; AND further discussion of items related to depression confirms a concern in that area.

### Symptoms and Clinical Findings Suggesting Depression

History from youth or parent suggests

- Low or sad mood is present most days.
- Loss of interest in school or other activities is present most days.
- Loss of pleasure in activities formerly enjoyed (When is last time he/you had fun?).

- Suicidal thoughts or acts.
- Irritability (especially in adolescents).
- Academic difficulties.
- Withdrawal from friends and family.
- Physical symptoms such as headaches, abdominal pain, trouble sleeping, fatigue, or poor control of a chronic illness.
- Hopelessness.
- Poor concentration.
- Poor or excessive sleep for developmental stage.
- Weight loss (or failure to gain weight normally) or excessive weight gain.
- Low self-esteem.
- Loss of energy.
- Agitation or slowing of movement or speech.

Risk factors increasing susceptibility

- Prior trauma or bereavement
- Family breakdown
- Shy personality
- Peer relationship problems
- Breakup of a relationship; setback or disappointment

## Conditions That May Mimic or Co-Occur With Depression

### Differentiate From Normal Behavior

All children may be sad or irritable at times, but for some children these symptoms limit their adaptability to normal peer and family situations, interfere with learning, or precipitate suicidal thoughts.

*Sleep deprivation.* Sleep problems can cause irritability and labile mood; conversely, depression may contribute to difficulty sleeping.

*Somatic complaints.* Depressed children may present with a variety of somatic complaints, (eg, gastrointestinal symptoms, headaches, chest pain). Conversely, acute or chronic medical conditions or pain syndromes may cause depression.

*Learning problems or disabilities.* If symptoms of depression are associated with problems of school performance, the child may be experiencing learning difficulties. (See Learning Difficulties guidance to explore this possibility.)

*Exposure to adverse childhood experiences (ACE).* Children who have experienced or witnessed trauma, violence, a natural disaster, separation from a parent, parental divorce or separation, parental substance use, neglect, or physical, emotional, or sexual abuse are at high risk of developing emotional difficulties such as adjustment disorder, post-traumatic stress disorder (PTSD), and depression. Denial of trauma symptoms does not mean trauma did not occur; questions about ACE should be repeated as a trusting relationship is established. See also Anxiety guidance.

*Maltreatment.* Children who have experienced neglect or physical, emotional, or sexual abuse are at high risk of developing emotional difficulties such as depression; this possibility should always be considered.

*Anxiety.* Depression often co-occurs with anxiety. See Anxiety guidance.

*Bereavement.* The vast majority of children will experience the death of a family member or friend sometime in their childhood. Other losses may also trigger grief responses—separation or divorce of parents, relocation, change of school, deployment of a parent in military service, breakup with a girlfriend or boyfriend, or remarriage of parent. Such losses are traumatic. They may result in feelings of sadness, despair, insecurity, or anxiety immediately following the loss and, in some instances, more persistent anxiety or mood symptoms or disorders. Furthermore, they may make the child more susceptible to impaired functioning at the time of subsequent losses. See also the discussion of PTSD in Anxiety guidance.

*Physical illness and medication side effects.* Medical issues that can mimic or provoke symptoms of depression include hypothyroidism, lupus, chronic fatigue syndrome, diabetes, and anemia. Children with any chronic medical condition are more likely to experience depression than their peers (and depression may contribute to poor management of the condition). Medications commonly used in adolescence can be associated with depression, eg, acne preparations, oral contraceptives, interferon, corticosteroids.

*Substance use.* Children with symptoms of depression may self-medicate with alcohol, nicotine, or other drugs. Conversely, children using substances may manifest depression and deteriorating school performance. See Substance Use and Abuse guidance.

*Conduct or oppositional disorders.* Oppositional children may manifest depressive symptoms. Children with conduct problems are at higher risk for suicide. See Disruptive Behavior and Aggression guidance.

*Psychosis.* Depression can be complicated by problems with thinking that go beyond the distortions or hopelessness of low mood. These problems include delusions (ie, strongly held and usually odd false beliefs about others, one's body, or one's self), paranoia (ie, strongly felt and unjustified concerns that others are following or intend harm), or hallucinations (ie, seeing or hearing things that others don't hear or see). Individuals often don't volunteer that they are having these sorts of thoughts; asking is important if the person's interactions seem unusual. (Do you ever feel your eyes or ears play tricks on you?)

*Bipolar disorder:* Adults with bipolar disorder may have markedly varying low mood (depression) or high mood (mania), cycling over weeks or months. Diagnosis of bipolar disorder in children and adolescents remains controversial. It may be considered in children who cycle through low and high moods very rapidly, and in children with explosive or destructive tantrums, dangerous or hypersexual behavior, aggression, irritability, bossiness with adults, driven creativity (sometimes depicting graphic violence), excessive talking, separation anxiety, chronic depression, sleep disturbance, delusions, hallucinations, psychosis, and talk of homicide or suicide. See also Inattention and Impulsivity, Disruptive Behavior and Aggression, and Anxiety guidance.

## Tools for Further Assessment of Depression

### Determine suicide risk.

*Are there others in the family (present or past generations) who have had depression or bipolar disorder, or who have attempted suicide?* Teens and parents may need opportunities to answer these questions confidentially because this is information that is not always shared among family members. Positive responses—especially a family history of suicide—increase concern.

The severity of suicidal thoughts can be assessed with several questions (eg, Bright Futures, page 276; **SAD PERSONS**; **GLAD-PC**).

- “Have you ever felt bad enough that you wished you were dead?”
- “Have you had any thoughts about wanting to kill yourself?”
- “Have you ever tried to hurt or kill yourself or come close to hurting or killing yourself?”
- “Do you have a plan?”
- “Do you have a way to carry out your plan?”

### Patient Health Questionnaire for Adolescents (PHQ-A) or PHQ-A Depression Screen

### Beck Depression Inventory-Primary Care (also known as Fast Screen)

**Modified Patient Health Questionnaire-9 (PHQ-9):** Score of >5 suggests depression; higher scores suggest higher severity, with score of >20 suggesting severe depression.

## Evidence-Based and Evidence-Informed Interventions for Depression (as of April 2010)

Updates are available at [www.aap.org/mentalhealth](http://www.aap.org/mentalhealth).

### Psychosocial Interventions for Depression<sup>5</sup>

- **Level 1 (best support):** cognitive behavior therapy (CBT), CBT and medication, CBT with parents (includes parent and child, focusing on the child’s concerns), family therapy
- **Level 2 (good support):** client-centered therapy, expressive writing/journaling/diary, interpersonal therapy, relaxation

### Psychosocial Interventions for Suicidality<sup>5</sup>

- **Level 1 (best support):** none
- **Level 2 (good support):** multisystemic therapy, social support team

## US Food and Drug Administration–Approved Psychopharmacologic Interventions (as of April 2010)

*For up-to-date information about Food and Drug Administration (FDA)-approved interventions, go to [www.fda.gov](http://www.fda.gov).*

- **Major depressive disorder (MDD):** selective serotonin reuptake inhibitor (SSRI) (fluoxetine and escitalopram are currently the only drugs approved by the FDA for treating MDD among youth). See the following links for guidelines addressing benefits, risks, dosage, and monitoring requirements. There are data that indicate superior efficacy of combination CBT and SSRI versus CBT or SSRI alone.

### Selected Informational Links

- American Academy of Pediatrics Children’s Mental Health in Primary Care Web site ([www.aap.org/mentalhealth](http://www.aap.org/mentalhealth)).

- American Academy of Child & Adolescent Psychiatry Web site ([www.aacap.org](http://www.aacap.org)).
- “Guidelines for Adolescent Depression in Primary Care (GLAD-PC): I. Identification, Assessment, and Initial Management” (<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;120/5/e1299.pdf>).
- “Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management” (<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;120/5/e1313.pdf>).
- GLAD-PC Toolkit ([www.thereachinstitute.org/files/documents/GLAD-PCToolkit.pdf](http://www.thereachinstitute.org/files/documents/GLAD-PCToolkit.pdf)).
- US Preventive Health Services Task Force. Major Depressive Disorder in Children and Adolescents ([www.ahrq.gov/CLINIC/uspstf/uspschdepr.htm](http://www.ahrq.gov/CLINIC/uspstf/uspschdepr.htm)).
- US FDA Web site ([www.fda.gov](http://www.fda.gov)).

## Plan of Care for Children With Depression

### Engage child and family in care.

#### Engaging Children and Families in Mental Health Care: A Process for Pediatric Primary Care Clinicians\*

Reinforce strengths of child and family. Follow the mnemonic HELP to

- Build trust and optimism.
- Reach agreement on incremental next steps and, ultimately, therapeutic goals.
- Develop plan of care (see the following clinical guidance).
- Collaboratively determine role of primary care clinician, eg, provide intervention(s); provide initial intervention while awaiting family's readiness for or access to specialty care; coordinate with specialist(s), child care, school, or agencies; monitor progress; encourage child and family's positive view of treatment.

*\*Without engagement, most families will not seek or persist in care. Process may require multiple primary care visits.*

### Encourage healthy habits.

Encourage exercise, outdoor play, healthy diet, sleep, limiting screen time, one-on-one time with parents, praise for positive behavior, and acknowledgment of child's strengths. Caring for oneself can be honestly presented as therapeutic.

### Reduce stress: consider the environment

(eg, family social history, parental depression screening, results of any family assessment tools administered, reports from child care or school).

*Are there grief and loss issues in the child or other family members?* Grief and loss are virtually universal childhood experiences. (See previous discussion of bereavement.) Children vary widely in their reactions to these events, depending on their developmental level, temperament, prior state of mental health, coping mechanisms, parental responses, and support system. Supportive counseling; explaining to children and adolescents what they might reasonably expect; inviting them to participate in the funeral or other ceremonies to the level they feel comfortable;

active listening while allowing the child or adolescent to express his or her grief; providing guidance about the grief process; and identifying and addressing feelings of guilt can all be helpful. When a parent is also grieving, children and adolescents may need time alone with the clinician because they may be reluctant to increase parental sadness. Providing follow-up to see how the child and family are coping with a loss can help gauge how the family is doing and provide opportunities to assess for more serious reactions such as complicated bereavement, depression, or PTSD. Providing referral to community resources may also be helpful.

The effects of profound losses, such as the death of a sibling or parent during childhood or removal from parents, last a lifetime. The clinician will need to view all future physical and mental health issues in the family through the prism of this loss. Overlooking such experiences and failing to follow up on the child and family's progress after a traumatic event are lost opportunities to connect with the child and family around important mental health issues. See "Enhancing Pediatric Mental Health Care: Strategies to Prepare a Primary Care Practice" for steps a clinician and practice can take to address these issues.

*Is the child or family experiencing unusual stress?* The family can work to try to reduce stresses and increase support for the adolescent. This may involve reasonable and short-term changes in demands and responsibilities, including negotiating extensions or other ways of reducing stress at school; it can also include seeking help for others in the family who are distressed. If a parent is grieving a loss or manifesting symptoms of depression, it is particularly important that the parent address his or her own needs and find additional support for the adolescent and other family members.

*Are there weapons or medications in the house?* Guns should be removed from the home; other weapons, medications (including over-the-counter preparations and acetaminophen), and alcohol should be removed from the home, destroyed, or secured.

Acknowledge and reinforce protective factors, eg, good relationships with at least one parent or important adult, pro-social peers, concerned or caring family, help-seeking, connection to positive organization(s).

**Offer initial intervention(s).****Educate the family.**

- The adolescent is not making the symptoms up.
- What looks like laziness or crossness can be symptoms of depression.
- There is often a family history of the condition; talking about this may reduce stigma and increase empathy and a willingness to seek care, but may also be met with resistance.
- Depression is very common and not the result of lack of coping ability or personal strength.
- The hopelessness of depression is a symptom, not an accurate reflection of reality. However, this negative view of the world and of future possibilities can be hard to penetrate.
- Treatment works, though it can take several weeks for improvement, and the affected individual is often the last person to recognize that it has taken place.
- Weapons and potentially lethal substances should be removed from the home.

**Help the youth to develop cognitive and coping skills.**

- Find agreement with the youth and family on a description of the problem.
- Many negative thoughts can be empathetically challenged and looked at from another perspective. Helpful metaphors include, “Long journeys start with a single step”; “The glass is half full, not half empty.”
- Relaxation techniques and visualization (eg, practicing relaxation cued by a pleasant memory, imagining being in a pleasant place) can be helpful for sleep and for anxiety-provoking situations.
- Ask the youth what he or she does to feel better or relax and if appropriate, prescribe more of that (*behavioral activation*). Encourage a focus on strengths rather than weaknesses. Encourage doing more of what the teen is good at.

**Help adolescent to develop problem-solving skills.**

- Determine what small achievable act would help the youth feel that he or she is on the way to overcoming his or her problems.
- Suggest that the adolescent list out difficulties, prioritize them, and concentrate efforts on one issue at a time.

**Rehearse behavior and social skills.**

- Reactions to particular situations or people often seem to trigger or maintain low mood. If these can be identified, assist adolescent in developing and practicing means of avoidance or alternative responses.
- Practice doing things and thinking thoughts that improve mood.

**Offer child and parents resources to educate and assist them with self-management.****Brochures**

*Your Child’s Mental Health: When to Seek Help and Where to Get Help*

*Help Stop Teenage Suicide*

*Teen Suicide, Mood Disorder, and Depression*

**Web Sites**

HealthyChildren.org Web site ([www.healthychildren.org](http://www.healthychildren.org)). Accessed April 28, 2010

National Alliance on Mental Illness ([www.nami.org](http://www.nami.org)). Accessed April 28, 2010

ParentsMedGuide.org ([www.parentsmedguide.org](http://www.parentsmedguide.org)). Accessed April 28, 2010

US Department of Health and Human Services, Food and Drug Administration. Medication Guide Web site. Available at: <http://www.fda.gov/Drugs/DrugSafety/ucm085729.htm>. Accessed April 28, 2010

**Monitor child’s progress toward therapeutic goals.**

- See report “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Primary Care Practice” for monitoring methods.
- Child care or preschool reports can be helpful in monitoring progress.
- SDQ (parent, teacher) and PSC can be helpful in monitoring progress with symptoms and functioning.



- Create a safety and emergency plan.
  - Treatment plan developed jointly with family should include listing of telephone numbers to call in the event of a sudden increase in distress.
  - Instruct family to proactively remove lethal means.
  - Instruct family to monitor for risk factors for suicide such as increased agitation, stressors, loss of rational thinking, expressed wishes to die, previous attempts, and comorbid conduct disorder or aggressive outbursts.
  - Plan specific monitoring schedule when initiating SSRIs.
  - Provide number for suicide or depression hotline, on-call telephone number for the practice, or area mental health crisis response team contact information according to community protocol.

**Involve specialist(s) if child does not respond to initial interventions or if indicated by the following clinical circumstances:**

- A preadolescent child manifests depression.
- An adolescent with depressive symptoms has made a prior suicide attempt, developed a plan (especially with means available), or known a friend or acquaintance who has committed suicide.
- An adolescent's functioning is significantly impaired.
- Symptoms are threatening the achievement of developmentally important goals, eg, attending school or spending time with friends.
- The adolescent has mental health comorbidities such as substance use or psychosis.
- The adolescent has symptoms of bipolar disorder.
- Primary care interventions have not improved symptom severity or functioning.
- Depressive symptoms were preceded by serious trauma.

√ **Primary care tasks may include the following:**

- Initiating medication or adjusting doses
- Monitoring response to treatment (Child may improve just knowing that primary care clinician is involved and interested.)
- Monitoring adverse effects
- Engaging and encouraging child's positive view of treatment
- Coordinating care provided by parents, school, medical home, and specialists

## Resources for Clinicians

### Toolkits

Cheung A, Ghalib K, Jensen PS, et al. *Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit*. 2007. Available at: <http://www.thereachinstitute.org/files/documents/GLAD-PCToolkit.pdf>. Accessed February 24, 2010

Laraque D, Jensen P, Schonfeld D. *Feelings Need Check Ups Too: Addressing the Mental Health Needs of Children in Response to September 11th and Other Catastrophic Events: An Educational Resource for Pediatricians*. November 2006. Available at: [http://www.aap.org/disasters/pdf/Feelings%20Need%20Check%20ups%20Toolkit\\_0823.pdf](http://www.aap.org/disasters/pdf/Feelings%20Need%20Check%20ups%20Toolkit_0823.pdf). Accessed February 24, 2010

### Articles and Reports

American Academy of Child & Adolescent Psychiatry Practice Parameters available at [www.aacap.org/cs/root/member\\_information/practice\\_information/practice\\_parameters/practice\\_parameters](http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters)

- Depressive Disorders (Vol 46, November 2007)
- Bipolar Disorder (Vol 46, January 2007)

Brown RT, Antonuccio DO, DuPaul GJ, et al. *Childhood Mental Health Disorders: Evidence Base and Contextual Factors for Psychosocial, Psychopharmacological, and Combined Interventions*. Washington, DC: American Psychological Association; 2008

Coleman WL, Richmond JB. After the death of a child: helping bereaved parents and brothers and sisters. In: Carey W, Crocker A, Coleman W, Elias E, Feldman H, eds. *Developmental-Behavioral Pediatrics*. Philadelphia, PA: Saunders-Elsevier; 2009:366–372

Hawaii Department of Health, Child and Adolescent Mental Health Division, Evidence Based Services Committee. 2004 Biennial Report: Summary of Effective Interventions for Youth with Behavioral and Emotional Needs. Available at: <http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs011.pdf>. Accessed February 24, 2010

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- Silverman WK, Ortiz CD, Viswesvaran C, et al. Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. *J Clin Child Adol Psychol*. 2008;37(1):156–183
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- Huey SJ, Polo AJ. Evidence-based psychosocial treatments for ethnic minority youth. *J Clin Child Adol Psychol*. 2008;37(1):262–301

US Preventive Services Task Force. Screening and treatment for major depressive disorder in children and adolescents: recommendation statement. *Pediatrics*. 2009;123(4):1223–1228

## Web Site

World Health Organization Web site. Available at: <http://www.who.int/en>. Accessed February 24, 2010

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2. Zuckerbrot RA, Cheung AH, Jensen PS, Stein RE, Laraque D. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): I. Identification, assessment, and initial management. *Pediatrics*. 2007;120(5):e1299–e1312
3. Cheung AH, Zuckerbrot RA, Jensen PS, Ghalib K, Laraque D, Stein RE. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and ongoing management. *Pediatrics*. 2007;120(5):e1313–e1326
4. American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health, Task Force on Mental Health. The future of pediatrics: mental health competencies for pediatric primary care. *Pediatrics*. 2009;124(1):410–421
5. Evidence-Based Child and Adolescent Psychosocial Interventions. American Academy of Pediatrics Children's Mental Health in Primary Care Web site. Available at: <http://www.aap.org/mentalhealth>. Accessed April 28, 2010

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