Depression
**Depressive Symptoms?**

Unexplained Somatic Complaints?

**Safety screen:**
- Neglect/Abuse?
- Medical condition (i.e. anemia, thyroid problem?)
- Thoughts of hurting oneself?
  - if yes, are there plans and means available?

**Think about comorbidity:**
- Anxiety, ODD, Conduct Disorder, ADHD, Dysthymia, Substance Abuse

**Diagnosis:**
- DSM-5 Diagnostic Criteria
- Rating Scale: SMFQ or PHQ-9 (others available for a fee)
- Label as “Unspecified Depressive Disorder” if significant symptoms but not clear if Major Depression

**Can problem be managed in primary care?**

**YES**

**Mild Problem**

(noticeable, but basically functioning OK)

- Educate patient and family
  - Support increased peer interactions.
  - Behavior activation, exercise.
  - Encourage good sleep hygiene.
  - Reduce stressors, if possible.
  - Remove any guns from home.
  - Offer parent/child further reading resources.

- **Follow up** appointment in 2-4 weeks to check if situation is getting worse.
  - Repeating rating scales helps comparisons.
  - Those not improving on their own are referral candidates for counseling.

**Moderate/Severe Problem**

(significant impairment in one setting, or moderate impairment in multiple settings)

- **Recommend individual psychotherapy**
  - CBT and IPT are preferred, where available.
  - Psychoeducation, coping skills, and problem solving focus are all helpful therapy strategies.
  - Educate patient and family (as per mild problem list on left).
  - Consider family therapy referral.

- **Consider starting SSRI, especially if severe.**
  - Fluoxetine is the first line choice.
  - Escitalopram/Sertraline second line.
  - Third line agents are other SSRIs, buproprion, mirtazepine.
  - Wait four weeks between dose increases to see changes.
  - Check for side effects every 1-2 weeks in first month of use to ensure no new irritability or suicidality (phone or in person).
  - Stop SSRI if get agitation, anxiety or suicidal thoughts.
  - Consult MH specialist if monotherapy is not helping.
  - Monitor progress with repeat use of rating scale.

**NO**

**Referral**

**Judgment Call**

**Primary References:**
Arlington, VA: National Center for Education in Maternal and Child Health: 203-211
Zuckerbrot R ed: “Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit.”
Columbia University: Center for the Advancement of Children’s Mental Health
Short Mood and Feelings Questionnaire

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way *in the past two weeks*.

If a sentence was true about you most of the time, check TRUE.
If it was only sometimes true, check SOMETIME.
If a sentence was not true about you, check NOT TRUE.

<table>
<thead>
<tr>
<th>TRUE</th>
<th>SOMETIMES</th>
<th>NOT TRUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt miserable or unhappy</td>
<td>❏</td>
<td>❏</td>
</tr>
<tr>
<td>2. I didn’t enjoy anything at all</td>
<td>❏</td>
<td>❏</td>
</tr>
<tr>
<td>3. I felt so tired I just sat around and did nothing</td>
<td>❏</td>
<td>❏</td>
</tr>
<tr>
<td>4. I was very restless</td>
<td>❏</td>
<td>❏</td>
</tr>
<tr>
<td>5. I felt I was no good any more</td>
<td>❏</td>
<td>❏</td>
</tr>
<tr>
<td>6. I cried a lot</td>
<td>❏</td>
<td>❏</td>
</tr>
<tr>
<td>7. I found it hard to think properly or concentrate</td>
<td>❏</td>
<td>❏</td>
</tr>
<tr>
<td>8. I hated myself</td>
<td>❏</td>
<td>❏</td>
</tr>
<tr>
<td>9. I was a bad person</td>
<td>❏</td>
<td>❏</td>
</tr>
<tr>
<td>10. I felt lonely</td>
<td>❏</td>
<td>❏</td>
</tr>
<tr>
<td>11. I thought nobody really loved me</td>
<td>❏</td>
<td>❏</td>
</tr>
<tr>
<td>12. I thought I could never be as good as other kids</td>
<td>❏</td>
<td>❏</td>
</tr>
<tr>
<td>13. I did everything wrong</td>
<td>❏</td>
<td>❏</td>
</tr>
</tbody>
</table>

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Parent Report Version — SMFQ

Short Mood and Feelings Questionnaire

This form is about how your child may have been feeling or acting recently.

For each question, please check how much she or he has felt or acted this way *in the past two weeks*.

If a sentence was true about your child most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about your child, check NOT TRUE.

<table>
<thead>
<tr>
<th></th>
<th>TRUE</th>
<th>SOMETIMES</th>
<th>NOT TRUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. S/he felt miserable or unhappy</td>
<td>🟢</td>
<td>🟡</td>
<td>🟠</td>
</tr>
<tr>
<td>2. S/he didn’t enjoy anything at all</td>
<td>🟢</td>
<td>🟡</td>
<td>🟠</td>
</tr>
<tr>
<td>3. S/he felt so tired that s/he just sat around and did nothing</td>
<td>🟢</td>
<td>🟡</td>
<td>🟠</td>
</tr>
<tr>
<td>4. S/he was very restless</td>
<td>🟢</td>
<td>🟡</td>
<td>🟠</td>
</tr>
<tr>
<td>5. S/he felt s/he was no good any more</td>
<td>🟢</td>
<td>🟡</td>
<td>🟠</td>
</tr>
<tr>
<td>6. S/he cried a lot</td>
<td>🟢</td>
<td>🟡</td>
<td>🟠</td>
</tr>
<tr>
<td>7. S/he found it hard to think properly or concentrate</td>
<td>🟢</td>
<td>🟡</td>
<td>🟠</td>
</tr>
<tr>
<td>8. S/he hated him/herself</td>
<td>🟢</td>
<td>🟡</td>
<td>🟠</td>
</tr>
<tr>
<td>9. S/he felt s/he was a bad person</td>
<td>🟢</td>
<td>🟡</td>
<td>🟠</td>
</tr>
<tr>
<td>10. S/he felt lonely</td>
<td>🟢</td>
<td>🟡</td>
<td>🟠</td>
</tr>
<tr>
<td>11. S/he thought nobody really loved him/her</td>
<td>🟢</td>
<td>🟡</td>
<td>🟠</td>
</tr>
<tr>
<td>12. S/he thought s/he could never be as good as other kids</td>
<td>🟢</td>
<td>🟡</td>
<td>🟠</td>
</tr>
<tr>
<td>13. S/he felt s/he did everything wrong</td>
<td>🟢</td>
<td>🟡</td>
<td>🟠</td>
</tr>
</tbody>
</table>

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Scoring the SMFQ

Note: the SMFQ has been validated for use in children age 6 years and up.

The SMFQ should not be used to make a definitive diagnosis of depression. It has usefulness as a screening tool for situations where depression is suspected, and as an aid toward following a child’s symptom severity and treatment response over time.

Scoring:

Assign a numerical value to each answer as follows:
Not true = 0
Sometimes = 1
True = 2

Add up the assigned values for all 13 questions. Record the total score.

A total score on the child version of the SMFQ of 8 or more is considered significant.


Sensitivity/specificity statistics of the parent version is not reported in the literature. If your patient does not complete the child version of SMFQ, repeated administration of the parent version over time should still be useful for symptom tracking.
Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use “x” to indicate your answer).

<table>
<thead>
<tr>
<th></th>
<th>Little interest or pleasure in doing things</th>
<th>Feeling down, depressed, or hopeless</th>
<th>Trouble falling or staying asleep, or sleeping too much</th>
<th>Feeling tired or having little energy</th>
<th>Poor appetite or overeating</th>
<th>Feeling bad about yourself — or that you are a failure or have let yourself or your family down</th>
<th>Trouble concentrating on things, such as reading the newspaper or watching television</th>
<th>Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</th>
<th>Thoughts that you would be better off dead, or of hurting yourself in some way</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Several days</td>
<td>More than half the days</td>
<td>Nearly every day</td>
<td>Not at all</td>
<td>Several days</td>
<td>More than half the days</td>
<td>Nearly every day</td>
<td>Not at all</td>
</tr>
<tr>
<td>1.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>2.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>3.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>4.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>5.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>6.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>7.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>8.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>9.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people.

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

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Scoring the PHQ-9

Note: this scale has not been evaluated for use with pre-pubertal children. A number of studies have used this scale for adolescent patients.

The PHQ-9 should not be used to make a definitive diagnosis of depression. It has usefulness as a screening tool for situations where depression is suspected, and as an aid toward following a child’s symptom severity and treatment response over time.

Any positive response to question 9 should be followed up with questions about the child’s current safety. Any immediate plans for suicide require an emergent response.

Question 10 should be noted as at least “somewhat difficult” to be consistent with a diagnosis of depression. A depression diagnosis requires a functional impairment to be present.

Add up the total number from items 1-9
Estimated depression severity:

0-4 None
5-9 Minimal symptoms
10-14 Possible dysthymia, or mild Major Depression
15-19 Consistent with Major Depression
≥ 20 Consistent with severe Major Depression

* As recommended by Macarthur Foundation and Pfizer, Inc.
## Depression Medications

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosage Form</th>
<th>Usual starting dose for adolescent</th>
<th>Increase increment (after ~4 weeks)</th>
<th>RCT evidence in kids</th>
<th>FDA depression approved for children?</th>
<th>Editorial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fluoxetine</strong> (Prozac)</td>
<td>10, 20, 40mg 20mg/5ml</td>
<td>10 mg/day (60mg max)*</td>
<td>10-20mg**</td>
<td>Yes</td>
<td>Yes (Age ≥ 8)</td>
<td>Long 1/2 life, no side effect from a missed dose</td>
</tr>
<tr>
<td><strong>Sertraline</strong> (Zoloft)</td>
<td>25, 50, 100mg 20mg/ml</td>
<td>25 mg/day (200mg max)*</td>
<td>25-50mg**</td>
<td>Yes</td>
<td>No</td>
<td>May be prone to side effects when stopping</td>
</tr>
<tr>
<td><strong>Escitalopram</strong> (Lexapro)</td>
<td>5, 10, 20mg 5mg/5ml</td>
<td>5 mg/day (20mg max)*</td>
<td>5-10mg**</td>
<td>Yes</td>
<td>Yes (Age ≥ 12)</td>
<td>The active isomer of citalopram.</td>
</tr>
<tr>
<td><strong>Citalopram</strong> (Celexa)</td>
<td>10, 20, 40mg 10mg/5ml</td>
<td>10 mg/day (40mg max)*</td>
<td>10-20mg**</td>
<td>Yes</td>
<td>No</td>
<td>Few drug interactions</td>
</tr>
<tr>
<td><strong>Bupropion</strong> (Wellbutrin)</td>
<td>75, 100mg 100, 150, 200mg SR forms 150, 300mg XL forms</td>
<td>75 mg/day (later dose this BID) (400mg max)*</td>
<td>75-100mg**</td>
<td>No</td>
<td>No</td>
<td>Can have more agitation risk. Avoid if eat d/o. Also has use for ADHD treatment.</td>
</tr>
<tr>
<td><strong>Mirtazapine</strong> (Remeron)</td>
<td>15, 30, 45mg</td>
<td>15 mg/day (45mg max)*</td>
<td>15mg**</td>
<td>No</td>
<td>No</td>
<td>Sedating, increases appetite</td>
</tr>
<tr>
<td><strong>Venlafaxine</strong> (Effexor)</td>
<td>25, 37.5, 50, 75, 100mg 37.5,75, 150 mg ER forms</td>
<td>37.5 mg/day (225mg max)*</td>
<td>37.5 to 75mg**</td>
<td>No</td>
<td>No</td>
<td>Only recommended for older adolescents. Withdrawal symptoms can be severe.</td>
</tr>
<tr>
<td><strong>Duloxetine</strong> (Cymbalta)</td>
<td>20, 30, 40, 60mg</td>
<td>30 mg/day (120mg max)*</td>
<td>30mg</td>
<td>No</td>
<td>No</td>
<td>May cause nausea. May help with somatic symptoms.</td>
</tr>
</tbody>
</table>

*Fluoxetine considered first line per the evidence base in children*

*Escitalopram and Sertraline considered second line per the evidence base in children*

*Citalopram, bupropion, mirtazapine, venlafaxine, and duloxetine considered third line treatments per the evidence base in children*

---

Starting doses in children less than 13 may need to be lowered using liquid forms

Successful medication trials should continue for 6 to 12 months

* Recommend decrease maximum dosage by around 1/3 for pre-pubertal children

** Recommend using the lower dose increase increments for younger children.
Crisis Prevention Plan Aid

A parent’s guide to creating a crisis prevention plan

Crisis Prevention Plans (CPP) are intended to help children/adolescents and their caregivers prevent minor problems from escalating into crisis events. CPPs provide an opportunity for the child/adolescent and the caregiver to logically think through situations by identifying the cause of distress, understanding and discussing options for minimizing difficult situations, and encouraging coping skills to help decrease the distress. Key components of a CPP include understanding triggers, identifying warning signs, and helping to facilitate interactions that will decrease the possibility of further difficulties. A thoughtful and carefully constructed CPP can help families make choices and take actions to diffuse difficult situations.

Steps for creating your own Crisis Prevention Plan:

- **Discuss triggers** — Triggers are things that cause distress for the child/adolescent. Common triggers include peer conflict, homework, chores, feeling sad or angry, and being told “no" or being unable to get their way. The child/adolescent and caregiver should be honest and explicit about the triggers for what is currently causing them the most difficulty.

- **Identify early warning signs** — Warning signs are physical clues the child/adolescent does (sometimes without their knowledge) that show others that they are upset or distressed. Common warning signs include blushing/flushed face, clenching fists, pacing, yelling, or withdrawing/becoming quiet.

- **List interventions the caregiver can do to help the child/adolescent calm down** — Discuss what the child/adolescent would want, and how the caregiver could provide that for them. Examples include giving the child/adolescent space to calm down, reminding them to use a coping skill, talking with them, or offering a hug.

- **List things the child/adolescent can do to help calm themselves** — This typically includes coping skills such as listening to music, talking a walk, doing deep breathing exercises, taking time to themselves (include a mention of how long to let the child/adolescent “cool off” before being expected to reengage with the family), writing, drawing/coloring, or other relaxation techniques.

- **Identify other supports if the above interventions aren't helpful or are unavailable** — for instance, list three people the child/adolescent can contact, beside the caregiver, when distressed. Examples include peers who would have a positive influence, relatives, older siblings, therapists, or teachers/coaches. The child/adolescent and caregiver should agree who are a good resource. Also identify and list the crisis line where you live. A hotline such as the Suicide Prevention Lifeline (800-273-8255) or https://suicidepreventionlifeline.org is also helpful.

Christina Clark, MD
Crisis Prevention Plan

My triggers are:
1. 
2. 
3. 
4. 
5. 

My early warning signs are:
1. 
2. 
3. 
4. 
5. 

When my parents/caregivers notice my early warning signs, they can:
1. 
2. 
3. 
4. 
5. 

Things I can do when I notice my early warning signs:
1. 
2. 
3. 
4. 
5. 

If I am unable to help myself I can call:
1. 
2. 
3. 
4. 
5. 

- State Mental Health Crisis Line
  Careline Alaska 1-877-266-4357
  https://carelinealaska.com

- Text HOME to 741741 or visit: https://www.crisistextline.org

- National Suicide Prevention Lifeline Phone Number: 1-800-273-8255

This Crisis Prevention Plan was created to give your family strategies you can use in your home to help calm your child during an escalation before they reach a crisis point. We do not advise using restraint, such as holding your child down, because you or your child could get hurt. Please call 911 if you or your child is in imminent danger.
General Home Safety Recommendations
After a Child Crisis Event

The following safety tips may help to keep things safe right now after an escalated crisis event, and help to reduce further escalations/crises:

1. In the home environment, maintain a “low-key” atmosphere while maintaining regular routines.
2. Follow your typical house rules, but pick your battles appropriately, for example:
   • immediately intervene with aggressive or dangerous behaviors
   • if your child is just using oppositional words, it may be wise to ignore those behaviors
3. Provide appropriate supervision until the child’s crisis is resolved.
4. Make a crisis prevention plan by identifying likely triggers for a crisis (such as an argument), and plan with your child what the preferred actions would be for the next time the triggers occur (such as calling a friend, engaging in a distracting activity or going to a personal space).
5. Encourage your child to attend school, unless otherwise directed by your provider.
6. Make sure that you and your child attend the next scheduled appointment with their provider.
7. Administer medications as directed by your child’s medical or psychiatric provider.
8. Go into each day/evening with a plan for how time will be spent — this should help prevent boredom and arguments in the moment.
9. Secure and lock up all medications and objects your child could use to hurt him/herself and/or use to attempt suicide. When locking up items, ensure your child does not have knowledge of their location, the location of the key, or the combination to any padlock used to secure them. This includes:
   • Sharp objects like knives and razors
   • Materials that can be used for strangulation attempts, such as belts, cords, ropes and sheets
   • Firearms and ammunition (locked and kept in separate/different locations from each other)
   • All medications of all family members, including all over the counter medicines. If your child takes medication of any type, you should administer it for the time being (unless instructed to stop it by your care provider).

In the event of another crisis, please do the following:
   • If you believe that you, your child, or another person is no longer safe as a result of your child’s behavior, call 911 to have your child transported to the emergency department closest to your home.
   • Consider calling your local crisis hotline: Careline Alaska 1-877-266-4357
     https://carelinealaska.com
   • Consider calling the National Suicide Prevention Lifeline: 1-800-784-2433

This resource page is now available in Spanish at www.seattlechildrens.org/pal
Depression Resources

Information for Families

Books families may find helpful:
- The Childhood Depression Sourcebook (1998), by Jeffery Miller
- The Depressed Child: Overcoming Teen Depression (2001), by Mariam Kaufman
- The Explosive Child (2001), by Ross Greene

Books children may find helpful:
- Taking Depression to School (2002), by Kathy Khalsa (for young children)
- Where’s Your Smile, Crocodile? (2001), by Clair Freedman (for young children)
- Feeling Good: The New Mood Therapy (1999), by David Burns (for adolescents)
- My Feeling Better Workbook: Help for Kids Who Are Sad and Depressed (2008), by Sara Hamil (for elementary school students)

Crisis Hotlines:
- Careline Alaska: 1-877-266-4357 (HELP)
- National Suicide Prevention Lifeline: 1-800-273-8255
- START text - 741741: www.crisistextline.org

Websites families may find helpful:
- Guide to depression medications from APA and AACAP professional societies: www.parentsmedguide.org
- National Institute of Mental Health: www.nimh.nih.gov/health/topics/depression/index.shtml
- National Alliance for Mental Illness: www.nami.org/Find-Support/Teens-and-Young-Adults
- American Foundation for Suicide Prevention: https://afsp.org
- Youth Suicide Prevention Program: www yspp.org

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