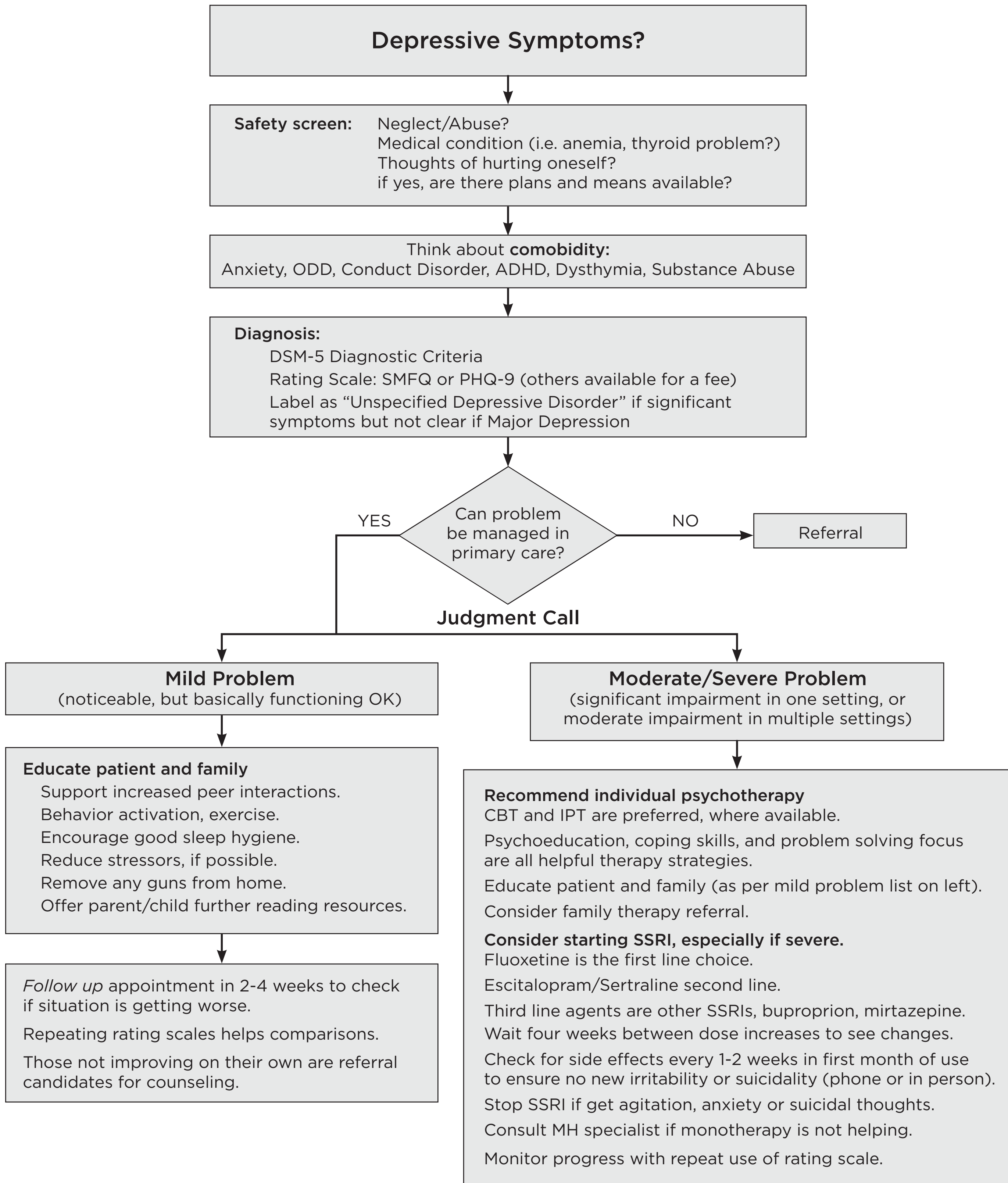
# Depression

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Marek JS, Silva S, Vitiello B, TADS team (2006): "The treatment for adolescents with depression study (TADS): methods and message at 12 weeks." JAACAP 45:1393-1403

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# 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 SOMETIMES.
If a sentence was not true about you, check NOT TRUE.

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

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# 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.

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

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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 of 60% and specificity of 85% for major depression at a cut off score of 8 or higher. Source is Angold A, Costello EJ, Messer SC. "Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents." *International Journal of Methods in Psychiatric Research* (1995), 5:237-249.

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)

NAME.................................................................................................................................................. DATE...............................................

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

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. 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 | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | 0 | 1 | 2 | 3 |
| **add columns** | | + | + | |
| *(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).* | **TOTAL:** | | | |

10. If you checked off *any* problems, how *difficult* have these problems made it for you to 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

| Drug Name | Dosage Form | Usual starting dose for adolescent | Increase increment (after ~4 weeks) | RCT evidence in kids | FDA depression approved for children? | Editorial Comments |
|---|---|---|---|---|---|---|
| Fluoxetine (Prozac) | 10, 20, 40mg 20mg/5ml | 10 mg/day (60mg max)* | 10-20mg** | Yes | Yes (Age ≥8) | Long 1/2 life, no side effect from a missed dose |
| *Fluoxetine considered first line per the evidence base in children* | | | | | | |
| Sertraline (Zoloft) | 25, 50, 100mg 20mg/ml | 25 mg/day (200mg max)* | 25-50mg** | Yes | No | May be prone to side effects when stopping |
| Escitalopram (Lexapro) | 5, 10, 20mg 5mg/5ml | 5 mg/day (20mg max)* | 5-10mg** | Yes | Yes (Age ≥12) | The active isomer of citalopram. |
| *Escitalopram and Sertraline considered second line per the evidence base in children* | | | | | | |
| Citalopram (Celexa) | 10, 20, 40mg 10mg/5ml | 10 mg/day (40mg max)* | 10-20mg** | Yes | No | Few drug interactions, dose maximum 40mg/day due to risk of QT prolongation |
| Bupropion (Wellbutrin) | 75, 100mg<br><br>100, 150, 200mg SR forms<br><br>150, 300mg XL forms | 75 mg/day (later dose this BID) (400mg max)* | 75-100mg** | No | No | Can have more agitation risk. Avoid if eat d/o. Also has use for ADHD treatment. Seizure risk limits dose. |
| Mirtazapine (Remeron) | 15, 30, 45mg | 15 mg/day (45mg max)* | 15mg** | No | No | Sedating, increases appetite |
| Venlafaxine (Effexor) | 25, 37.5, 50, 75, 100mg<br><br>37.5,75, 150 mg ER forms | 37.5 mg/day (225mg max)* | 37.5 to 75mg** | No<br><br>(May have higher SI risk than others for children) | No | Only recommended for older adolescents.<br><br>Withdrawal symptoms can be severe. |
| Duloxetine (Cymbalta) | 20, 30, 40, 60mg | 30 mg/day (120mg max)* | 30mg | No | No | May cause nausea. May help with somatic symptoms. |
| *Citalopram, bupropion, mirtazapine, venlafaxine, and duloxeline 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 teen hotline such as Teen Link (1-866-833-6546 or https://www.teenlink.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. ........................................

- Your County Crisis Line Phone Number: ........................................
(you can look it up here:
www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/mental-health-crisis-lines)
- Text HOME to 741741 or visit: https://www.crisistextline.org
- Teen Link Hotline: 1-866-833-6546 or https://www.teenlink.org/
- The National Suicide Hotline: 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 county crisis hotline, which are listed at: www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/mental-health-crisis-lines
- Consider calling the national suicide hotline: 1-800-273-8255

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

# Depression Information for Teens and Parents/Caregivers

*First Approach Skills Training for Depression (FAST-D)*

QUICK SUMMARY

### What is depression?

Depression is when normal feelings like being sad, down, grumpy or irritable are very intense, go on too long, and get in the way of normal life. About 1 in 5 teens have serious depression at some point. Here are the common signs:

- ❍ *Easily irritated*
- ❍ *Sad, down, or hopeless*
- ❍ *Less interest or enjoyment in things you used to enjoy*
- ❍ *Appetite or weight change*
- ❍ *Sleeping problems*
- ❍ *Changes in how fast you move or speak*
- ❍ *Low energy/tiredness*
- ❍ *Feeling worthless or guilty*
- ❍ *Problems thinking clearly*
- ❍ *Trouble making decisions or concentrating*
- ❍ *Thinking about death or hurting yourself*

### What causes depression?

Many things can cause depression: losses, disappointments, stressful or traumatic events, social or family problems, medical problems, loneliness, changes in the family such as divorce, transitions like moving to a new school, or anxiety problems. Sometimes depression seems to come out of the blue. Depression can also run in families.

### How can depression make you stuck?

Depression makes it hard to do things that might help you feel better. And problems can start to pile up, making you feel overwhelmed.

THINGS TEENS CAN DO

### What can teens do to feel better?

*Even small changes can make a big difference. Are there are 1 or 2 things below you could try this week? Consider talking with a family member, friend or counselor for support.*

**Sleep better:** Aim for 8-10 hours. Avoid naps and caffeine, stick to regular sleep and wake times, no screens the hour before bed, keep phones out of the bedroom at night, and try to get outside during the day. These changes alone can have a huge impact.

**Exercise:** Even a little daily exercise can boost mood and help with sleep and energy.

**Connect:** Find ways to be social. Reconnect with old friends or try make new ones. Try to have fun with relatives.

**Have fun:** Even if you don't feel like it, set a time for activities you would normally enjoy.

**Solve problems:** Are you stressed by problems in your life? Talk with a trusted person about what is going on, or write in a journal, and figure out a plan that might help.

**Move toward goals:** Figure out a small step you can take toward a goal you care about.

**Deal with anxiety:** Lots of anxiety (feeling too worried or nervous) can lead to depression. Ask your primary care provider or counselor about how to overcome anxiety problems.

**Deal with trauma:** Traumatic events (like abuse or violence) can cause depression. Consider getting support from a counselor or talking to someone you trust about what happened.

**Avoid alcohol or drugs:** These make depression worse. Look for other ways to cope.

— Nathaniel Jungbluth, PhD

WAYS YOU CAN HELP YOUR TEEN

## Try these strategies to help your teen

**Support sleep:** Encourage healthy sleep habits (see page 1). Consider having a device curfew so screens and technology do not interfere with sleep. Having devices like cell phones charge overnight where you can monitor them, and setting up parental controls (check with your cell carrier) can sometimes help.

**Support socializing and getting active:** If there are ways you can help your teen get out of the house, get physical activity, or connect with healthy peers, do it! If your teen is depressed, try to avoid using punishments like grounding them at home.

**Spend quality time:** Spend one-on-one time with your teen at least a few times each week. Do something they like and follow their lead. Avoid lectures or criticism. Ask them about things they are into and show interest. Consider asking them to teach you about something they know more about (like their favorite music or hobby).

**Hold your criticism:** It is easy to find things to criticize when your teen is depressed. Often they are avoiding important tasks (like schoolwork or chores) and they might be grumpy and withdrawn. If you do have to give your teen negative feedback, try not to criticize their personality (don't call them lazy or selfish) but instead focus on the behaviors you don't like.

**Comment on positive steps:** Try to find examples of small positive steps or healthy choices and comment on those. Look for one or two each day. Keep it totally positive! (Don't add on comments like "I wish you would do that more often.")

**Be a good listener:** Ask your teen about their life and their interests. When they do open up, don't punish their openness by giving lectures, telling them what to do, or criticizing. Don't give advice unless they want it. Tell them you understand what they are feeling even if you don't totally agree.

**Deal with screen problems:** If your teen is using screens or technology in an unhealthy way, and it is getting in the way of their relationships or responsibilities, consider putting limits on it. Parental control apps (like Circle, or cell carrier parental controls) can help you block off times of the day for school, homework, and sleep. Parental controls can also turn devices off until teens have met daily responsibilities.

**Tell them you believe in them:** Let your teen know they are strong and you know they can get through this hard time.

***Safety:*** *If you have a depressed teen in your house, remove any guns from the home. If you think your teen might try to hurt themselves, seek professional support right away.*

***Medication:*** *Some medications have been found to help with teen depression, especially when combined with effective therapy. Your primary care provider can tell you more.*

— Nathaniel Jungbluth, PhD

# 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

Helping Teens Who Cut: Understand and Ending Self-Injury (2008), by Michael Hollander

### 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)

When Nothing Matters Anymore: A Survival Guide for Depressed Teens (2007),
by Bev Cobain and Elizabeth Verdick

### Crisis Hotlines:

National Suicide Prevention Lifeline
1-800-273-8255

Text HOME to 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
https://www.nami.org/Your-Journey/Teens-Young-Adults

American Foundation for Suicide Prevention
https://afsp.org/

American Academy of Child and Adolescent Psychiatry
www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Depression_Resource_Center/Home.aspx

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

PARTNERSHIP ACCESS LINE
Child Psychiatric Consultation
for Primary Care Providers

# Peripartum Mood and Anxiety Disorders

Nearly 1 in 5 women experience a peripartum mood or anxiety disorder. Untreated peripartum mood or anxiety disorder presents serious risks.

- Risks to mothers: delayed or poor prenatal care, low birth weight, spontaneous abortion, impaired bonding with child, increased substance abuse (including nicotine), psychiatric hospitalization, postpartum psychosis, and suicide.
- Risks to offspring: decreased cognitive abilities, increased risk of affective, anxiety, and conduct disorders, increased risk of ADHD and learning disorders, increased risk of failure to thrive, delayed immunization, decreased car seat safety, and infanticide.

**RISK FACTORS:** history of traumatic birth, fussy baby, difficulty breastfeeding, unplanned C-section, stressful life events during peripartum period, financial hardship, NICU visit, or history of mental health difficulties in the mother.

**SYMPTOMS:**

- Sadness, hopelessness, emptiness
- Crying more often than usual for no apparent reason
- Increased worry, anxiety, panic or feeling overwhelmed
- Moodiness, irritability, restlessness, anger, rage
- Oversleeping, or being unable to sleep even when her baby is asleep
- Difficulty concentrating, remembering details, making decisions
- Losing interest in activities that are usually enjoyable
- Physical aches and pains, e.g., frequent headaches, stomach problems, and muscle pain.
- Increased or decreased appetite
- Social withdrawal or avoidance
- Difficulty emotionally attaching to her baby
- Persistently doubting ability to care for her baby
- Thinking about harming herself or her baby

**SCREENING:** The American Academy of Pediatrics recommends screening of mothers at 1, 2, 4, and 6 months well child visits. The PHQ-2, PHQ-9 and the Edinburgh Postnatal Depression Scale (EPDS) are free, brief rating scales. Patients who screen positive on the PHQ-2 (score ≥ 3) should be further evaluated with the PHQ-9. The EPDS removes some signs of depression that are difficult to distinguish from the average parenting experience, such as diminished sleep. To bill for screening, use the infant's MRN and CPT code 96161.

**TREATMENT:**

If screening is positive for mild symptoms (PHQ-9 10-14 or EPDS 9-13),

a) Let the mother know that postpartum depression and anxiety are common, treatable, and not her fault.
b) Support parenting through feeding support, sleep training support, etc.
c) Enlist social and community support.
d) Refer to a support group and/or for maternal or dyadic (mother/baby) therapy.
e) Consider referral for medication.

If screening is positive for moderate symptoms (PHQ-9 15-19 or EPDS 14-18) or severe symptoms (PHQ-9>20 or EPDS >19), in addition to above interventions for mild symptoms,

a) Strongly consider medication intervention.
b) Consider hospitalization when safety is a concern.

Kisha Clune, MD

**Perinatal Psychiatry Consultation Line (PAL for Moms)**

- Free phone consultation for healthcare providers
- Monday – Friday 9-5
- Toll Free: 1-877-PAL4MOM (1-877-725-4666)

References:
NIMH, "Postpartum depression facts;" https://www.nimh.nih.gov/health/publications/perinatal-depression/index.shtml
MCPAP for Moms, "Assessment of Depression Severity And Treatment Options;" https://www.mcpapformoms.org/Docs/Assessment%20of%20Depression%20Severity%20and%20Tx%20Options%2009.09.14.pdf,
Maternal depression and child development. Paediatrics & Child Health. 2004;9(8):575-583.