**Pediatric Depression**

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**What are the Pediatric Depressive Disorders?**

Children can be diagnosed with any of the same mood or depressive disorders that adults can. There are three major types of disorders in which clinically significant depressions can occur[[1]](#footnote-1): Depressive Disorders, Mood Disorders, and Psychotic Disorders. This review focuses on Depressive Disorders, but first, I’ll very briefly describe mood and psychotic disorders. First, mood and psychotic disorders are EXTREMELY rare in children, especially in younger children. Both are serious mental illnesses. Mood Disorders can also be called the Bipolar Disorders, and include Bipolar I, Bipolar II, Cyclothymia, and Other Mood Disorders. Depressive episodes commonly occur in Bipolar Disorders (in fact, most people with Bipolar Disorders are more often Depressed than Manic). However, to get a bipolar disorder, you also must have a Manic or Hypomanic episode. Psychotic Disorders are also serious. The best-known psychotic disorder is schizophrenia, which, again is exceedingly rare (but not impossible) to have in childhood. Schizoaffective Disorder is another psychotic disorder, characterized by schizophrenia AND major depression, basically at the same time. I have never seen a child diagnosed with schizoaffective disorder in my career. In most children, it is impossible to make that diagnosis. Children that have psychotic symptoms are almost always given a different diagnosis.

These categories of diagnoses only capture the specific diagnoses for which depression is a major feature. However, depressive symptoms can occur in ANY psychiatric condition. **So, your child may have depressive symptoms without being diagnosed with a Depressive Disorder**. For young children, in fact, it is far more common to diagnose an anxiety or adjustment disorder, instead of depression. This has to do with how depression is defined, and how it presents differently in young children. I’ll describe this in a bit more detail below.

There are currently 6 defined Depressive Disorders in the *DSM-5* (which is the primary manual used in the US to describe psychiatric disorders). These include Major Depressive Disorder (MDD), Persistent Depressive Disorder, Disruptive Mood Dysregulation Disorder (DMDD), and Premenstrual Dysphoric Disorder (PMDD). It is also possible to have a Substance/Medication-Induced Depressive Disorder or a Depressive Disorder due to another Medical Condition (such as Huntington’s Disease, Parkinson’s Disease, or Traumatic Brain Injury). Some depressive disorders are more likely in youth than others. For example, DMDD can only be diagnosed during childhood, between the ages of 6 and 18, by definition, while PMDD is less likely in childhood (though it can occur), with symptoms often increasing as women approach menopause. I do not have space in the current document to define all of these disorders, but I will focus on the three that do occur in children more commonly: Major Depressive Disorder, Persistent Depressive Disorder, and DMDD.

*Major Depressive Episode*

Depressive disorders are defined by the presence and persistence of one or more Major Depressive Episodes (MDEs). An MDE includes at least 5 out of 9 possible symptoms, that have to be present for at least a 2-week period. One of the 5 symptoms *must* be 1) depressed mood most of the day, every day, or 2) *anhedonia –* or the decreased interest in pleasure in all or nearly all activities most of the day, every day. The remaining symptoms can include 3) changes in weight or appetite, 4) changes in sleep (needing more or getting less), 5) Restlessness or physical slowness (think moving around like Eeyore) that is observable by others, 6) fatigue or low energy, 7) feelings of worthlessness or guilt, 8) trouble concentrating or indecisiveness, and 9) recurrent thoughts of death or suicide.

*Major Depressive Disorder*

MDD just means that someone has had one or more MDEs, and those MDEs are not better explained by another cause (e.g. Bipolar Disorder, psychoticism, medication-induced depression, etc.). Some people have “simple” MDD, where they’ve just had a single MDE. Some have “recurrent” MDD, where they’ve had multiple MDEs. You can also have mild, moderate, or severe MDD, depending on the symptoms. There are also lots of other “specifiers” for MDD, which capture all of the different ways MDD can present in different people. The point is that different people have different symptoms during an MDE, and even some MDEs can be worse than others in the same person over time.

In children, though, depression often looks different than the way it is described above, especially in younger children (<10 years old). When younger children get depressed, their depressed mood tends to be irritable. They don’t always look sad and dejected, but more often get grumpy and prone to tantrums. They can also have what is called “flat affect,” meaning they don’t really show many emotions at all. Anhedonia can also present differently in children. Young children can’t always tell us clearly that they no longer enjoy things they used to, and it’s actually relatively common in healthy children to lose interest in certain activities over time. Instead, anhedonia in young children shows up when kids stop initiation of play and don’t interact much with caregivers. They are less engaged and less responsive to others.

The rest of the symptoms (3-9, above) are defined roughly the same. However, with regard to changes in weight, depressed children may not have weight change, necessarily, but instead may fail to progress along their normal, expected growth curve. Young children also often don’t give a lot of details in their depressed thoughts. They may say things that suggest sadness (“I’m sad,” or “I hate myself.”) but it is difficult to get them to expand on these thoughts to know whether they are really serious or just a temporary feeling. For this reason, clinicians rely heavily on parent or other caregiver observations over time.

Still, because younger children tend to show their symptoms of depression differently than adolescents and adults, clinicians don’t often diagnose young children with depression. Depressed young children, instead, often seem anxious/scared, tired, and irritable. They also tend to have disruptive behaviors (e.g. tantrums, hyperactivity, etc.). For these reasons, many children who have negative moods are diagnosed with anxiety and/or ADHD, instead of depression. It also has to do with how parents describe symptoms. When diagnosing young children, doctors have to rely heavily on parent report, and when their children are depressed or have depressive symptoms, parents of young children may focus more on the behavioral symptoms than the emotional ones, because those are more noticeable and easier to describe. **This is why it is important to consult a skilled mental health professional with experience in differential diagnosis of children. A skilled professional will be able to listen to the symptoms and will know what questions to ask to sort out the differences between pediatric depression versus anxiety versus ADHD versus anything else.**

Lastly, Major Depressive Disorder should almost never be diagnosed in children <24 months old. In children ages 3-5, MDD is believed to occur in somewhere between 0.5% to 2% of US children. The rates increase sharply as children move into adolescence (see **Overview** section below).

*Persistent Depressive Disorder*

Persistent Depressive Disorder (PDD) is quite similar to depression, but in PDD the symptoms last longer. In adults, symptoms must last 2 years to meet criteria. In children, the duration is shorter – 1 year. PDD was a new diagnosis in the *DSM-5* (published in 2013). It is a combination of two previous diagnoses – 1) dysthymia and 2) chronic MDD. In the former nomenclature, symptoms of dysthymia were usually milder than in major depression, even though they lasted longer. In chronic MDD, the patient has enough symptoms to meet criteria for MDD, but they last for extended periods of time – months to years – or MDEs recur frequently without much of a “break” in between. Now, we call BOTH of these conditions PDD. So, PDD can be characterized by mild, moderate, or severe symptoms of depression that, in children, last for at least 1 year, without having more than a 2-month period of total relief.

Although we technically define PDD as described above, in practice, most clinicians still tend to consider PDD to be milder than MDD. In fact, if you or your child has been diagnosed with PDD, your doctor may even have told you that it is a “mild depression.” However, that’s misleading, because PDD can be severe too, and, for a lot of people, in can feel worse than MDD, because they don’t get relief from the symptoms very often.

*Disruptive Mood Dysregulation Disorder*

Disruptive Mood Dysregulation Disorder (DMDD) is also a new diagnosis that was added to the *DSM-5.* It was actually a somewhat controversial diagnosis at first, which I’ll get into below, but now the diagnosis is fairly widely accepted, although it is still not always accurately made. DMDD is characterized by 1) persistent irritable and/or angry mood, along with 2) frequent (>3 times per week) temper outbursts characterized by verbal rages and/or behavioral outbursts (e.g. aggression toward people or property) that are out of proportion in intensity or duration to the situation. These outbursts are also judged to be inconsistent with developmental level (e.g. 3 year olds commonly throw tantrums, and that is normal). The symptoms above also have to be present for at least 12 months, without any period of 3 or more consecutive months being relatively symptom free.

There are also a lot of other “rules” to this diagnosis, which I won’t outline in detail here, but basically they include age-related guidelines (you cannot diagnose before age 6 or after age 18; symptoms have start before age 10). DMDD is also a “diagnosis of exclusion” – which means a doctor has to exclude other diagnoses before making DMDD. I often call it a sort of “bottom of the list” diagnosis to consider, as I check off other possibilities first.

DMDD was created originally as an alternative to bipolar disorder. Throughout the 90s and early 2000s, diagnoses of childhood bipolar disorder increased somewhat dramatically, as psychiatrists and other clinicians sought to treat children with severe mood disruption and extreme irritability. And this is why the original diagnosis was controversial, because of how it came about. That’s because the symptoms of DMDD that were being diagnosed as bipolar disorder were NOT TRUE BIPOLAR DISORDER. So, we ended up having a fair number of youth being diagnosed with a serious mental illness (bipolar disorder) when they did not really have it. Although children with bipolar disorder can have a lot of the same symptoms as children with DMDD, they are not the same. Bipolar disorder is *episodic,* by definition. In true bipolar disorder, a person has manic or hypomanic *episodes* – they last only a few days to weeks, and during that period behaviors are clearly very different, returning back to normal in between episodes. DMDD, on the other hand, is a more chronic irritability. It is NOT episodic, and, as a result, has more in common with Persistent Depressive Disorder than it does with Bipolar Disorder. **So, DMDD was created to capture children who have persistent, non-episodic, extreme irritability**, so that there is an alternative diagnosis to consider and prevent them from being erroneously diagnosed with bipolar disorder.

Because it is a brand new diagnosis, not all clinicians/doctors know about DMDD. Most in the field of mental health have at least heard of it, but not all are skilled at making the diagnosis, and even fewer know how to treat it. Still, some of the telltale signs of DMDD are frequent, severe disruptive behaviors/tantrums (e.g. a child who attempts to attack his family with a knife; a girl who throws chairs across the classroom in an angry fit) **representing a loss of behavioral control** (children are not doing these behaviors purposefully and they are not planned). Importantly, in between these tantrums, children appear depressed or prone to other types of negative mood.

**Overview of additional features of Depressive Disorders**

*Prevalence (how often a disease occurs, and in whom)*

Major Depressive Disorder is the most common single psychiatric disorder in the United States. In 2017, a Major Depressive Episode (MDE) occurred in approximately 7.1% of U.S. adults. The risk for depression is highest in adolescent and young adult females. In 2017, an MDE was documented in 13.1% of females ages 18-25. In Adolescents, the rates are even higher. An estimated 3.2 million adolescents ages 12-17 had at least one MDE in the past year, which is about 13.3% of all U.S. adolescents. Again, the majority of MDEs are diagnosed in adolescent females. 1 in 5 adolescent females (20%) were diagnosed with a MDE in 2017, compared to only 1 in 15 (6.8%) of adolescent males. For all ages, depression is also more likely in people reporting two or more races (16.9%), followed by American Indian/American Native (16.3%), then White (14%), then Hispanic (13.8%). Those identifying with a Black ethnicity had the lowest rates of adolescent depression, 9.5%.

**What all this means is that adolescents have the highest risk of any age of having Major Depressive symptoms. This is why, at Chattanooga Peds, we screen all of our patients 12 and older for depression.**

There are a number of reasons that depression is more likely in adolescence and in females. We’ll look at each separately below.

*Risk factors in adolescence*

**Brain development.** I’ve split the next sections on brains into Simplified and Advanced versions. For readers interested in more details, I recommend the advanced version, which contains information that would commonly be included in an introductory college-level course on neuro-development (so, even though it’s advanced coverage, the material is still distilled to be digestible by someone without prior knowledge of brain development). If you just want the “quick and dirty” basics, I recommend the simplified version. Both are written to be read independently – you don’t have to read both sections.

**Essentials of brain development – Simplified.**

The brain grows throughout a person’s life, but the majority of growth occurs during infancy, with a second growth spurt happening in adolescence. At birth, babies are born with way, way more brain cells than they’ll ever use. Over time, the brain learns which cells are important and which ones aren’t. It gets rid of the cells it doesn’t need, and it builds up the cells it uses most often. So, a key point in early childhood brain development is that the brain programs itself based on environmental demands and based on usage (and also based on genetics).

During the second growth spurt, in adolescence, the brain is mainly focused not on building brain structures and killing off the “excess” brain cells. Now, it is more focused on organizing what is already there. It’s like playing “Connect-the-Dots,” but with brain cells. In early life, the brain worked to figure which “dots” were part of the picture it needs to draw, and which one’s aren’t. Now, during adolescence, the brain is working to connect these dots in meaningful ways. Importantly, a major area of growth during adolescence is in the “thinking” brain. It starts in puberty and continues until a person is about age 25. Throughout this period, the brain is learning how to think deeply about the world, solve problems, plan for the future, and organize responsibilities. Early adolescence is just the start of this process, so, what happens is that teens finally get brain skills that let them think in new ways about the world, but they are really quite terrible at figuring out what to do about all of this new “thinking.”

Another key part that develops during adolescence is the “limbic system,” which is the emotions center of the brain. Unfortunately, this part develops faster than the thinking part. So, what happens in adolescence is they have lots of new and confusing feelings, but their thinking brains aren’t advanced enough to make sense of them. This makes teens especially prone to depression.

**Essentials of brain development – Advanced.**

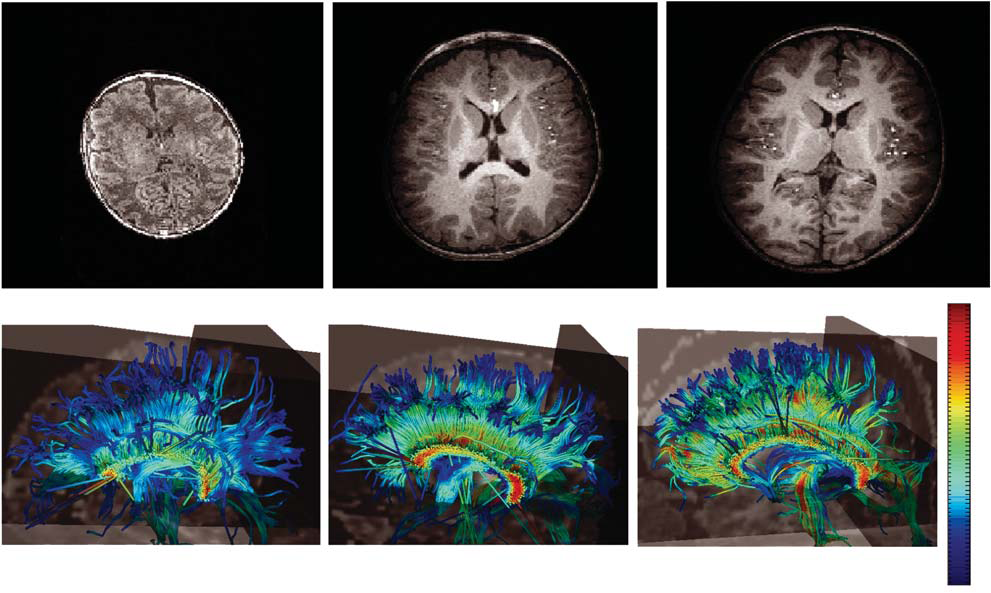
One of the greatest risk factors in adolescence has to do with brain development. During adolescence, the brain goes through a “growth spurt” of sorts. In fact, during adolescence, the brain grows at a rate similar to infancy. But, in adolescence, the growth isn’t about getting a bigger brain. In fact, the brain doesn’t get much bigger after about age 5. During adolescence, the brain is working very hard to reorganize existing structures and functions, to build better efficiency and to promote higher levels of thinking abilities and behaviors.

It helps first to understand *how* the brain develops. Prenatally (before birth), our brains “overproduce and overproliferate.” This means that we are born with way, way more brain cells than we will ever use. Over time, our brain undergoes “pruning,” which is very similar to the pruning many of us do of our bushes and plants when they get out of hand. We get rid of the excess, to have a more manageable final product. The brain actually does this by killing off unnecessary brain cells, through a process called “apoptosis” or “programmed cell death.” Over time, this pruning allows our brains to have better organization and more efficiency. Also, in early development, our brains go through a process called “myelination,” which is another way to make brains more efficient. A good analogy for myelination is to think of a water hose. If you think of the chemicals our brain cells use to communicate with each other like water, then myelination is like the hose that directs that water exactly where you want it. Without a hose, the water just spills out of the spigot and goes everywhere. We’ve got no control. Early in development, metaphorically speaking, we have hoses with holes all over the place, causing water to spill out. Over time, though, our brain learns what parts need the most “watering,” and it then directs the hoses to those areas, over those that do not need it. It also patches the “holes”. There are lots of cells in the brain at birth that don’t need watering, and so they don’t get myelinated, and they eventually die or at least go dormant. Myelination, then, is shaped by experience. It’s how we build skill – the more we use a brain cell, the more myelination it gets, and the better it works at then firing again in the future.

If you ever look at pictures of brains, myelin is white, while other brain cells are gray. That’s because myelin is made of fat, and so it is denser than other brain cells. That’s also why babies need plenty of (healthy) fats in their diet, because it facilitates brain growth (among other benefits).

In the pictures below, the top row shows MRIs of brain development over the first 2 years of life. The most important thing you should notice is that early on (2 weeks) the brain has diffuse, poorly organized myelin (the white parts). Over time, you see it gets better organized and starts to branch as it makes meaningful connections among brain cells.

The bottom row of pictures show “diffusion tensor images,” which basically show how efficiently the brain moves materials around. Cool colors (blue) mean there is a lot of “leakage”, while “warmer” (orange, red) colors mean less leakage. Again, these images just show how over time a child’s brain is getting more and more efficient at doing what it needs to do.



Adult

2 years

1 year

2 weeks

1 year

2 weeks

Overproliferation, overproduction, apoptosis, and myelination slow down dramatically after the first few years of life. During middle and late childhood, our brain cells are still learning, but at nowhere near the pace they did early on. During this break, instead, our brains are learning about the world around us, building up all the basic structures, some of which it organizes along the way, but some of it which it waits to organize later, once it has “all the pieces,” so it can make the best organization possible. If the brain did all of the organization as it grew, it would actually be less efficient. It’s like trying to play “connect the dots” without all the dots, and while knowing someone was going to keep adding dots as you were connecting them. It’s better to wait until the dots are done, then you can connect them better.

So, because of all the above, our brains actually keep growing and maturing throughout our lives, in different ways. Common consensus is that the brain reaches full maturity at around age 25. However, don’t be mislead, the brain keeps maturing (getting better organized) throughout life, at least until old age, at which point in many people it starts to get tired and works less efficiently, but that’s another topic altogether.

**Brain development during adolescence - Advanced.** So, the point of all of that was to set the stage for understanding what exactly happens during adolescence that predisposes someone to emotional difficulties. Why are teenagers so moody?

Well, during adolescence, as I said before, a whole lot of important brain development is happening, and so it ramps up. Not only is this exhausting on the body (ever notice how tired your teen is too?), which can be an indirect cause of moodiness, the parts that are being developed are a direct cause of moodiness. A major brain area that is developing rapidly during adolescence is the prefrontal cortex. This is the part of our brain responsible for reasoning, deep thought, predicting outcomes, and planning. This part continues to develop through our early 20s, but it starts in adolescence. So, what happens is that teenagers are, for the first time in their lives, able to think more deeply about things than ever before – how the world works, why things are the way they are, and what they want to do about changing things they don’t like. Unfortunately, though, they don’t have the full brain capacity to actually organize their thoughts around how to process all of that new thinking. They are terrible (relative to adults) at considering consequences of their actions.

Another major area of the brain that develops during adolescence is the limbic system (our “emotions center” of the brain), and it develops more rapidly than the “thinking” system. So, adolescents end up with really immature connections between their “thinking” brain (the prefrontal cortex) and their “feeling” brain (i.e. the limbic system). **This means that, more so than at any other age, adolescents can feel deeply, but they can’t always connect those feelings to thoughts and reasoning. This, then, is the reason that teens are so prone to depression, anxiety, and other moodiness.**

**Hormones.** Another reason teens are predisposed to moodiness is related to hormonal changes related to puberty. During puberty, teens are releasing new hormones at higher rates than they have ever experienced before. These hormones also wreak havoc on a system (the brain) that is not accustomed so much chaos. The brain doesn’t know yet what to do with all these hormones, and so it can go haywire. Using that same “connect-the-dots” analogy from before, it’s like you’ve started to try to connect some of the dots, and then some jerk comes and slaps you in the face while you’re doing it, while also marking through half of the work that you’ve already started. Yes, teenage hormones are jerks.

But, they are important jerks, because they cause the body to begin to take its adult characteristics. Without them, our species would die off, because we’d never reproduce. Still, one of the reasons teens are moody is because these hormones have direct emotional effects on the body and brain.

Without getting into all the complicated neuroscience specifics, different sex hormones (e.g. testosterone, estrogen, progesterone) also cause direct effects in the way the brain develops, such that certain brain structures exhibit “sexual dimorphism.” In other words, certain brain structures tend to be larger or smaller in males, compared to females, which is a direct result of hormonal exposures.[[2]](#footnote-2) Different hormones also have different behavioral effects. Again, going into the details here is more complicated than we need to be, but for our purposes, it is sufficient just to know that one reason adolescents behave they way they do, and one reason they are prone to emotionality is due to how sex hormones affect behavior.

**Adolescent psychosocial tendencies.** The third major reason teens are prone to depression has to do with cognitive and other psychosocial tendencies that can impact mood. Specifically, teens predictably go through stages of cognitive development where they tend 1) to compare themselves to others, at a very high rate, 2) to believe that everyone pays attention to and cares about everything they do, and 3) think in absolutes. In psychology, these tendencies are often called “adolescent egocentrism” or “the looking glass self,” but they basically mean that **teens believe everything they do could potentially result in a catastrophic social tragedy that dooms them for the rest of their life.**

These tendencies of adolescence map directly onto other cognitive risk factors for depression. **We know, for example, that people who are depressed to tend to have explanations of the world that are 1) global (occur in every location), 2) stable (occur at all times), and 3) internal (occurring due to something they did).** Instead, we know that it is better (less likely to lead to depression) to make unstable, specific, and external explanations for problems. So, when a teen has a breakup with his or her boyfriend (for example), a global, stable, internal explanation may be: “I’ll never find another boy like him (global and stable), and this always happens to me. I think there must be something wrong with me (internal).” Such thinking contributes to depression.

A healthier thought may instead be “It just wasn’t meant to be (external), and my next relationship will be better (unstable). He just wasn’t the right person for me (specific).”

Still, because teens naturally tend toward global, stable, and internal cognitions, they are prone to depression.

The hormonal changes that occur in adolescence are also another contributor to the psychosocial piece. We know from research, for example, that girls who to through puberty earlier than their peers are more likely to be ridiculed at school, which also predisposes them to depression and other negative health effects. Boys, on the other hand, who go through early puberty are *less* likely to be ridiculed at school, which protects them from depression. This is really unfair for girls, of course, and much could be said about what we need to do as a society to change this sad truth, but for our purposes here, it’s important just to know that the timing of puberty contributes to psychosocial outcomes for teens. In a later section, we’ll review how to protect children from these risks.

*Risk factors for females*

As mentioned previously, females are also at higher risk for depression. The reasons for this are complex. One of them is in the way depression is defined and diagnosed, and differences across genders in how similar emotions are expressed. It has also to do with societal norms about what is acceptable in men versus women. Though it’s an oversimplification, in current US society, it is generally more acceptable for women to express sad emotions, while for men, it is more acceptable to express angry emotions, or no emotions at all. In psychological terms, we often call these traits “expressivity” versus “instrumentality,” where women score higher, on average, on expressivity, while men score, on average, higher on instrumentality. Of course, you can have “expressive” men and “instrumental” women too, but on average, there does tend to be a gender difference. Expressivity is what it sounds like, a person’s tendency to express their inner self. Instrumentality, on the other hand, refers to a person’s tendency to prefer to “do/act.” People who score high on instrumentality tend to feel like they have control over the world and their environment, and when faced with a challenge, they focus on finding a solution, rather than dwelling on the challenge. As a result, men don’t often present to doctor’s offices complaining of depressed emotions, at least not as often as women. Even when they are depressed, and when they need help, they are less likely to seek help, due to their “instrumental” preference.

The difference also has to do with diagnostic bias among clinicians. Doctors are also more likely to diagnose a woman as being depressed, whereas with men, they may call the symptoms something else – stress, substance use, etc. Lastly, the difference can also be attributed to the biological effects of sex hormones (especially testosterone). Briefly, testosterone enhances those “do something” personality characteristics I referenced above. The higher a person’s testosterone, the more likely they are to “act” on their environment; people with high testosterone tend toward aggression and “excessive” behavior (e.g. conflict with others, fights, drug use, promiscuity, etc.). They also tend to have higher sociability, self-acceptance, and dominance. Men have a LOT more testosterone than women. In women, testosterone averages around 40 nanograms (ng). In men, it ranges from 300-1000 ng. So, when men have problems with mood, because of their higher testosterone, they also tend toward different types of behaviors than women, such as aggression, conflict, substance use, dominance, etc. These behaviors often mask the root of the real problem, depression, and as a result men who are depressed may often get misdiagnosed. **So, in reality, it could be that men and women actually have similar levels of negative mood symptoms, they just express them differently.**

Another reason women are more prone to depression has to do with something called “minority stress.” In current US society, females, as a whole, have a more difficult time climbing a social hierarchy than men, all other things being equal. Things are certainly getting slowly better in this realm, compared to the past, but the effects on individual women can increase stress enough to also increase risk for depression. **Being exposed to minority stress of any kind enhances risk for depression.**

**Treatment for Pediatric Depression**

There is some good news and bad news when it comes to treating pediatric depression. The good news is that there are really great treatments for adolescents with depression, including both psychological and pharmacological interventions. For adolescents, there are two broad treatment approaches that have the best evidence of efficacy: Cognitive Behavior Therapy (CBT) and Interpersonal Therapy (IPT). CBT and IPT are different, but related approaches to therapy that involve counseling sessions with a trained professional. Treatment usually involves 12-20, 50-minute sessions, usually at a frequency of once per week. That’s the ideal, at least. In real-world practice, though, such treatments are rarely implemented at the recommended dosage. For many people, the cost of psychotherapy may increase financial strain. Others may not be able to attend weekly sessions due to scheduling. As a result, many patients receive treatment every 2 weeks. There isn’t enough research yet though to say how this change in dosage changes treatment outcome. And so that’s part of the bad news. A lot of people don’t get the recommended dosage for maximum benefit. Still, research has found over and over again that, when asked, a majority of people prefer psychotherapy over medication for depression.

For those who do consider medication, there are also good medications for adolescent depression, most of which are the same as those used for adults. A class of medications called SSRIs are the first line of treatment currently. These medications include sertraline (Zoloft) or fluoxetine (Prozac), among others. They are widely prescribed and have been around for many years now. Medications do not come without potential side effects though. Common side effects to SSRIs include nausea, headache, and insomnia, most of which improve after about 1-2 weeks on the medication. There is a serious side effect for adolescents and young adults, in that SSRIs can increase a person’s risk for suicidal thoughts and/or behaviors. This is not a common side effect, but it is possible, and so if your teen starts taking an SSRI, they should be closely monitored for any suicidal thoughts and/or behaviors. This is best managed by a professional, who knows what to look for, and is a reason many doctors strongly prefer their patients who are taking SSRIs to be in therapy. You should also know that these medications, on average take 4-6 weeks to start having an effect, and I generally recommend patients to stay on them for 6-12 months until AFTER REMISSION. So, taking medications for depression is also often a long-term commitment, many times longer in duration than psychotherapy.

Another piece of bad news about treatment for pediatric depression is that **all of the above only applies to adolescents.** **There are no evidence-based treatments for depression in children younger than 12.** That doesn’t mean that treatments don’t work for young children. It just means that no one has completed sufficient research to determine if the treatments we are using are effective. One of the complications for this is that depression is rarely diagnosed in younger children. Young children with mood symptoms are more likely to be diagnosed with anxiety or ADHD (see previous sections above). So, one of the reasons we don’t know much about treating depression in younger children is because we just don’t diagnose it very often. Right now, most clinicians use treatments that work in adolescents and adults (i.e. CBT, IPT) and apply it in ways that are more amenable to young children. We also use lessons from other treatments that are effective for young children with anxiety or ADHD. Personally, I have found these types of treatments to be quite helpful for young children with depressive disorders. We do generally shy away from prescribing antidepressant medications to young children. Instead, there is a strong preference for behavioral and/or psycho-therapies.

**What can parents do at home to help?**

True depression rarely just “gets better” on its own. It often takes effort and support from multiple caregivers. Below is a list of ways you can support your child.

1. **Remind your child that sadness is an okay feeling that plays an important role.** The Disney/Pixar movie *Inside Out* is one recent example that demonstrates how important sadness is in our lives. If you haven’t seen it, plan a time to watch it with your child, and then plan some time after the movie to discuss some of the deeper implications of the movie. In short (minor spoiler alert), sadness brings humans together in ways that no other emotion can! When we get really depressed, though, we tend to forget to let sadness play its intended role. Sometimes we push people away. Other times, we feel like other people don’t notice and/or don’t care. When this happens (sadness doesn’t play its intended role) it tends to stick around, waiting for you to figure out what to do with it. So, one of the best things you can do as a parent is to notice and to just be present. **Know that it is not your job to fix the sadness or make it go away, but just to be with your child when they are sad.** Actually, focusing on “being with,” rather than “making better,” can work wonders for your child’s overall mental health and for your relationship together.
2. **Encourage your child to do fun things, even when they don’t feel like it.** Sure, this is easier said than done. Many parents beg their children to just “get up and have a good time with their friends,” only to be met with a screamed response of “Leave me alone.” Sometimes, your teen may even throw in some expletives. When this happens, it’s natural to get angry yourself, and you may end up fighting and/or punishing your child, which can then things feel worse. While it’s good to have boundaries and consequences for bad behavior, you also have to balance being supportive of their depression. I often encourage parents to:
   1. **Get close to your child and offer options for things to do.** Try not to shout or give demands. Instead, sit next them and gently give encouragement and support. If your teen refuses to get out of bed in the morning, for example, plan some time to sit next to them on the bed, speak gently, and start with “How are you?” Then, offer encouragement, for example, “I know it’s hard, but we’ll get through it together. One way I can help is to tell you that it will get better. This doesn’t last forever.”
   2. **When the timing feels right, remind your child that he/she has to fight the depression for it to get better, and then remind them that one way to fight is to do something fun.** Help them plan something fun. If they’re an older teen, though, play this gently. Older teens also crave independence and don’t want to feel like their mother or father is fixing up “play dates” for them all the time. It’s important to know your teen and know how they may respond to your attempts to plan things for them.
   3. **Back off when necessary.** Be supportive, but take cues from your child about when you might need to back off and try again later. When you do back off, know that it’s only temporary, and remind your child that you’ll be back later to try again. Again, try to do this out of love. When you feel yourself getting frustrated (which is normal) and wanting to say “I’ll come back in 10 minutes and you better be up and doing something by then,” take a deep breath (or a few), center yourself, and say, “I love you, so I’ll come back in 10 minutes and we can try again.”
3. **Help your child practice compassion.** Self-compassion is a wonderful way to fight negative self-thoughts and feelings of guilt or shame. Self-compassion involves loving kindness toward the self. There are many self-compassion exercises online. Here are a few that I like: <http://www.mindfulselfcompassionforteens.com/meditations/>

<https://self-compassion.org/category/exercises/#exercises>

1. **Surround your child with as many positive supports as possible**. This can include same-age friends/peers, older children, younger children, family, teachers, coaches, and so on. Children benefit greatly from feeling like they have a “village” to support them. It’s also good for you as a parent!
2. **Help your child practice healthy sleep habits**. Children and teens have higher sleep needs than adults, and most should be getting around 9 hours of sleep per night. Poor sleep contributes heavily to depression and other mood symptoms. Teens may take occasional naps, but normally should not feel like they need to nap everyday. School aged children rarely need naps. Young (preschool) children may nap more regularly, usually around noon or early afternoon. Below is a table of sleep guidelines from the American Academy of Pediatrics. If your child is getting insufficient sleep, consider talking to your pediatrician for guidelines on how to improve sleep.

|  |  |  |
| --- | --- | --- |
| **Age** | **Hours of sleep per 24 hours (including naps)** | **Naps common?** |
| 4-12 months | 12-16 hours | Yes |
| 1-2 years | 11-14 hours | Yes |
| 3-5 years | 10-13 hours | Yes |
| 6-12 years | 9-12 hours | No |
| 13-18 years | 10-24 hours | No |

1. **Pay attention to your own mental health and get help if you need it.** Depressive symptoms run in families, so you may have a history of depression yourself. Even if you don’t, it can be tough to live with a clinically depressed child, and it’s a lot to handle. Sometimes, getting some of your own therapy can go a long way. It also helps you to learn how model healthy coping skills for your child!

1. Depressive *symptoms* can happen in many more conditions, without meeting criteria for a depressive episode. The disorders listed here include ones in which a major depressive episode can occur. [↑](#footnote-ref-1)
2. The sexual differences aren’t quite as simple as this sentence makes it sound. There are some females with more “male-like” brains and some males with more “female-like” brains. We don’t yet fully understand how this happens. While hormone production during puberty explains part of the differences, it doesn’t account for all differences. [↑](#footnote-ref-2)