Depression:

Parents' Medication Guide

American Academy of Child & Adolescent Psychiatry
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American Psychiatric Association

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The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children's mental health.

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Introduction

The original Parents Medical Guide on treating depression was published in 2005, and a revision was published in 2010, through collaboration by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA). The current revision has been updated to include new research on effective treatments for child and adolescent depression. The goal of this guide is to help parents make informed decisions about getting the best care for a child or adolescent with depression.

What is depression?

Depression is a serious illness that can affect almost every part of a young person's life and significantly impact his or her family.

Depression is a type of mood disorder that can damage relationships among family members and friends, harm school performance, and limit other educational opportunities. Depression can negatively affect eating, sleeping, and physical activity. Because it can result in so many health problems, it is important to recognize the signs of depression and get the right treatment. When depression is treated successfully, most children can get back on track with their lives.

Although depression can occur in young children, it is much more common in adolescents (youth ages 12–18 years). Depression before children reach puberty occurs equally in boys and girls. After puberty, depression is more common in girls.

Causes and Symptoms

Why does my child have depression?

We don't fully understand all the causes of depression; we think it's a combination of genetics (inherited traits) and environmental factors (events and surroundings). There is no single cause. Stressors or events that cause a stressful response and genetic factors can cause depression. Stressors can be triggers that result from pediatric illnesses and diseases, such as viral infections; diseases of the thyroid and endocrine system; head injury; epilepsy; and heart, kidney, and lung diseases. A family history of depression is a major genetic factor; a child can be more prone to becoming depressed if a parent or sibling has been diagnosed with depression. Stressors in everyday life also contribute to the development of depression, for example, the loss of a close loved one; parents frequently arguing, separating, or divorcing; school changes; and family financial problems. Finally, developmental factors, such as learning and language disabilities, are sometimes overlooked. Other mental illnesses and symptoms, such as attention-deficit/hyperactivity disorder (ADHD), anxiety, fears, and excessive shyness, in addition to not having opportunities to develop interests and show strengths and talents, can add to depression.

What are the symptoms of depression?

- Depressed, sad, or irritable mood
- Significant loss of interest or pleasure in activities
- Significant weight loss, weight gain, or appetite changes
- Difficulty falling asleep and/or staying asleep or sleeping too much
- Restlessness, unable to sit still (referred to as psychomotor agitation), or being slowed down (referred to as psychomotor slowing)
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate feelings of guilt
- Difficulties in concentrating or making decisions
- Constant thoughts of death, suicidal thinking, or a suicide attempt

According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, an episode of major depression is characterized by 5 or more of these symptoms (with at least one of the symptoms noted as a depressed and/or irritable mood or having reduced interests or little pleasure) that have lasted for at least 2 weeks and affected a child's performance at school, at work, with family, or with friends. These symptoms are not caused by medication, drug abuse, or alcohol and are not the result of another medical or mental illness.

The symptoms of major depressive disorder (MDD) in youth and adults are the same. However, the symptoms of depression may look differently in children and adolescents than in adults. For example, children may have difficulty expressing their sad mood and may complain of headaches or stomachaches instead. Listed below are other ways that depression may look differently in youth:

- Irritable or cranky mood
- Boredom, giving up favorite activities, toys, and interests
- Failure to gain weight as expected
- Delays in going to sleep, refusal to wake up for school or get out of bed
- Difficulty sitting still or very slowed movements
- Tired all the time, feeling "lazy"
- Self-critical or blaming self for everything
- Decline in school performance, failing grades or classes
- Frequent thoughts and discussion about death, giving away favorite belongings

How do the symptoms of depression differ from typical sadness?

It is normal for children and adolescents to feel sad sometimes or be irritated in response to stressors. Depression is different from occasional sadness. A child or adolescent with depression has a significant **change** in their typical mood and interest level and is persistent (ie, most of the time for several weeks). Youth with depression show symptoms that are significant enough to cause them problems at home, at school, and/or with friends and family. Youth with depression may report that their symptoms are in response to a stressful or upsetting event, or they may not know what caused them to feel this way.

Diagnosing Depression in Children and Adolescents

How is depression in children and adolescents diagnosed?

If you are concerned that your child is depressed, it's important to discuss this with your child's doctor. Your child's doctor may recommend a thorough assessment. A thorough assessment includes getting information about the degree and severity of symptoms, psychosocial stressors and functioning from the child, parent, caregiver and/or guardian who lives with the child and reports from the school.

This assessment should be done by someone with experience in evaluating children for mental illness, such as a child and adolescent psychiatrist. A child and adolescent psychiatrist is a doctor who specializes in the diagnosis and treatment of disorders of thinking, feeling and/or behavior affecting children, adolescents and their families. Child and adolescent psychiatry training requires four years of medical school, at least three years of residency training in general psychiatry with adults, and two years of additional specialized training in treating children, adolescents and families.

A medical history and physical exam, as well as a detailed history of biologically related family members, are also recommended to rule out or identify other co-existing medical and mental health conditions that may require treatment.

What other conditions can accompany depression?

Up to 50% of children and adolescents diagnosed with depression may have other mental health disorders, including bipolar disorder. Children and adolescents with depression may also have anxiety, ADHD, and learning differences or be at risk of abusing drugs or alcohol.

If you are concerned that your child is depressed, it's important to discuss this with your child's doctor.

Suicide and Youth with Depression

Youth with depression are at increased risk for suicide attempts and suicide. It is important to ask your child whether they are having thoughts about hurting themselves. If your child expresses suicidal thoughts, this is an opportunity to discuss taking precautions to make the child's environment safe. Talking with your child about suicide does not cause suicide, but it does let your child know that you are concerned and that you want to know whether they have any thoughts about it.

How common are suicidal thoughts, behaviors, and death by suicide in youth?

Among students in grades 9–12 in the United States in 2015, 18% reported seriously considering attempting suicide in the previous 12 months, whereas 15% actually made a suicide plan. Nine percent of students attempted suicide one or more times, and 3% made an attempt that resulted in an injury, poisoning, or an overdose that required medical attention.

In 2015, suicide was the third leading cause of death among youth between the ages of 10 and 14 years and the second leading cause of death among individuals between the ages of 15 and 34 years. Suicide claims more lives than many diseases in children and adolescents. More adolescents and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.

What factors other than depression may increase suicide risk?

Additional risk factors for suicide include having a family member who died by suicide or knowing someone else who died by suicide. Other factors include family conflict, sleep problems, substance use, school problems, impulsivity, other mental illnesses, not feeling connected to others, and easy access to lethal means of self-harm.

Do antidepressant medications increase the risk of suicide?

Determining whether antidepressant medications increase the risk for suicide is quite hard, particularly because children and adolescents with depression are more likely to think about suicide and attempt it than other children. With this concern, the FDA (US Food and Drug Administration) reviewed all published and unpublished clinical trials of antidepressants in children and adolescents, and in 2004, it issued a black box warning about an increased risk of suicidal thoughts and/or behaviors in youth who take antidepressants. There was no record of completed suicides in their review of over 2,000 youth who were treated with antidepressant medications, but the rate of suicidal thinking/behavior (including actual suicide attempts) was twice as high in youth taking medications (4%) than those taking placebo or sugar pills (2%).

Treating underlying depression in youth who are thinking about suicide is an important strategy, because antidepressant medications improve depressive symptoms, which is the best way to treat suicidal thoughts and behavior. Antidepressant medication may increase the risk for suicidal thoughts and/or behaviors in a small percentage of youth. If a doctor determines that medication is appropriate for your child, it is important to weigh the pros and cons of antidepressants. If your child has moderate to severe depression, the benefit of reducing depressive symptoms may outweigh the risks of medication side effects. Maintaining regular follow-ups and monitoring throughout treatment helps manage any uncertainty. It is important that your child be monitored closely for all side effects, including suicidal thinking and behavior, particularly in the first few weeks after beginning treatment with an antidepressant and after adjusting the antidepressant dose.

Treating Depression

A single episode of depression, if left untreated, often lasts from 6 to 9 months, which can be an entire school year for most children.

The first step to treatment is a thorough assessment. Once your child has been diagnosed with depression, there are several important factors to consider before moving forward with treatment. It is important to get as much information as possible from your child's doctor on effective treatment options, potential side effects, and treatment expectations. You and your child should have the opportunity to ask questions about treatment options before you make a decision about your child's care.

It is important to share with your child's doctor your understanding of depression and related treatment options. Family values and norms—which can be heavily influenced by ethnicity and culture—may play a role in decision making regarding your child's wellness.

If your child's depression is not so severe or does not significantly impair his or her functioning and they do not have suicidal thoughts or psychosis, your child's doctor may recommend active support and monitoring. During a period of active support and monitoring, it is important for your child to have positive interactions with peers, to exercise, to follow a healthy diet, and to practice good sleep patterns. It is also important to reduce stressors, if possible. If your child's depressive symptoms get worse or do not improve, his or her doctor may recommend that you consider specific treatment, such as psychotherapy and/or antidepressant medications for your child.

The primary goals of treatment are as follows: 1) to shorten the duration of your child's depressive episode; 2) to provide treatment until your child's symptoms are in remission (having minimal or no depressive symptoms); and 3) to prevent relapse or recurrence (a return of depressive symptoms).

Will my child's depression pass without treatment?

A single episode of depression, if left untreated, often lasts from 6 to 9 months, which can be an entire school year for most children. When left untreated, the consequences can be serious, including a high risk for substance abuse, eating disorders, teenage pregnancy, and/or suicidal thinking and behaviors. Suicide attempts and completed suicide are risks of untreated depression. Children with untreated depression are also likely to have ongoing problems in school, at home, and with their friends; it can also lead to a higher risk of developing a more chronic, difficult-to-treat form of depression.

Taking Medication for Depression

Are medications effective for depression in youth?

Antidepressant medications can be effective in relieving depressive symptoms in children and adolescents. Approximately 55–65% of children and adolescents will respond to initial treatment with antidepressant medication. Of those who don't respond to the first treatment, a high number will respond to another medication and/or a different form of therapy, such as cognitive-behavioral therapy (CBT) or dialectical behavior therapy (DBT).

What types of medications are available to treat my child's depression?

To date, fluoxetine [a selective serotonin reuptake inhibitor (SSRI), also known as Prozac] is the only antidepressant approved by the FDA for the treatment of depression in both children and adolescents (ages 8 years and older). Escitalopram (an SSRI also known as Lexapro) is approved by the FDA for the treatment of depression in adolescents (ages 12 years and older). No other antidepressants have been approved by the FDA for the treatment of depression in youth, although some have been approved for the treatment of other mental health conditions. Your child's doctor may prescribe other antidepressant medications that are not FDA approved based on available data. You should know that prescribing an antidepressant that has not been approved by the FDA for use in children and adolescents (referred to as off-label use or prescribing) is common and is consistent with accepted clinical practice.

Factors that might influence a doctor's choice(s) of medication include, but are not limited to, specific characteristics of the patient, comorbid or coexisting mental or medical conditions, and patient or parent/caregiver's preference for treatment with medication, psychotherapy, or combined psychotherapy and medication treatment.

Selective Serotonin Reuptake Inhibitors (SSRIs)

Medications called SSRIs are the first-line treatment for youth with depression.

SSRIs work by increasing the levels of serotonin in the brain. Serotonin is a neurotransmitter that sends signals between brain cells. It is common to experience side effects from SSRIs right after beginning treatment; it can take up to 4 to 6 weeks of taking an SSRI regularly for the medication levels in the brain to be steady enough to decrease the symptoms of depression. SSRIs are also used for treating conditions other than depression, such as anxiety disorders.

The table on page 10 includes the most commonly used SSRIs for youth with depression.

Other Antidepressants

Although SSRIs are usually the first choice of medication for children and adolescents with depression, your doctor may recommend different types of medications if in certain circumstances, such as your child does not improve with an SSRI. These medications have unique qualities that make them effective, some of which involve serotonin and other neurotransmitters. The table on page 10 includes non–SSRI antidepressants that are approved by the FDA for adults with depression and are often prescribed for youth with depression in clinical practice.

Other prescribed antidepressant medications, such as tricyclic antidepressants (TCAs, eg, imipramine and amitriptyline) and older monoamine oxidase inhibitors [MAOIs, eg,

Medications called SSRIs are the first-line treatment for youth with depression.

SELECTIVE SEROTONIN REUPTAKE INHIBITORS

Medication	Formulations	Daily Dose Range
Citalopram (Celexa)	Tablet: 10/20/40 mg Suspension: 10 mg/5 ml	10–40 mg
Escitalopram (Lexapro)*	Tablet: 5/10/20 mg Suspension: 1 mg/1 ml	10–20 mg (initial dose may be 2.5–5 mg)
Fluoxetine (Prozac)**	Tablet and capsule: 10/20/40/60 mg Suspension: 20 mg/5 ml	20–60 mg (initial dose may be 10 mg)
Fluvoxamine (Luvox)	Tablet: 25/50/100 mg	50–200 mg (initial dose may be 25 mg)
Paroxetine (Paxil)	Tablet: 10/20/30/40 mg Tablet CR: 12.5/25/37.5 mg Suspension: 10 mg/5 ml	10–50 mg
Sertraline (Zoloft)	Tablet: 25/50/100 mg Suspension: 20 mg/ml	50–200 mg (initial dose may be 12.5–25 mg)

Note: CR = controlled release
**FDA approved for children age 12 and up.*
***FDA approved for children age 8 and up.*

NON–SSRI ANTIDEPRESSANTS

Medication	Formulations	Daily Dose Range
Bupropion, Bupropion SR (Wellbutrin)	Tablet: 75/100 mg Tablet ER 12 hour: 100/150/200 mg	150–300 mg (first dose may be 37.5–75 mg)
Bupropion XL (Wellbutrin)	Tablet ER 24 hour: 150/300/450 mg	150–450 mg
Desvenlafaxine (Pristiq)	Tablet ER 24 hour: 25/50/100 mg	50–100 mg (first dose may be 25–50 mg)
Duloxetine (Cymbalta)	Tablet: 20/30/40/60 mg	40–60 mg (first dose may be 20 mg)
Levomilnacipran (Fetzima)	Capsule ER 24 hour: 20/40/80/120 mg	40–120 mg (first dose may be 20 mg)
Mirtazapine (Remeron)	Tablet: 7.5/15/30/45 mg Tablet disintegrating: 15/30/45 mg	15–45 mg (first dose may be 7.5–15 mg)
Trazodone (Desyrel)	Tablet: 50/100/150/300 mg	100–150 mg (first dose may be 25–50 mg)
Venlafaxine XR (Effexor)	Tablet: 25/37.5/50/75/100 mg Capsule and Tablet ER 24 hour: 37.5/75/150/225 mg	150–300 mg (first dose may be 37.5 mg)
Vilazodone (Viibryd)	Tablet: 10/20/40 mg	15–40 mg (first dose may be 10 mg)
Vortioxetine (Trintellix)	Tablet: 5/10/20 mg	20 mg (first dose may be 10 mg)

Note: SR = sustained release, ER = extended release, XL = extended release, XR = extended release

phenelzine (Nardil) and tranylcypromine (Parnate)], are not recommended as a first-line treatment for youth with depression because they have not been proven to be effective and have negative side effects. A newer MAOI called selegiline (Emsam) appears to be as good as other antidepressants in treating adults with depression, with few negative side effects. Although selegiline was not shown to be effective in treating adolescents with depression, it was safe and well tolerated in a recent study.

Sometimes more than one antidepressant medication may be prescribed for a youth who has shown only partial response to initial treatment, has lingering symptoms, or has not responded to treatment. Other types or classes of medications, particularly mood stabilizers and atypical antipsychotic medications, may also improve the effects of antidepressant medications, but they are not used as often because of the risk of more serious side effects like weight gain, obesity, and metabolic syndrome.

Side Effects

The most common side effects of SSRIs are as follows:

- gastrointestinal symptoms (nausea, stomachaches, and/or diarrhea)
- headaches
- agitation
- sleep disturbance
- irritability
- activation

Sexual side effects, increased bruising and/or bleeding, and mania are also possible, although they are less common side effects of SSRIs. The most common side effects of non–SSRI antidepressants vary quite a bit among the individual medications. If your child has been prescribed a non–SSRI antidepressant, you should ask your child's doctor about the side effects that are specific to that medication.

Some side effects may be managed easily. For example, if your child experiences the side effect of sleepiness throughout the day, it may be wise to take the antidepressant at bedtime, or if your child experiences nausea as a side effect, it might be helpful to take the antidepressant with meals. If your child experiences side effects from one SSRI, they will not necessarily experience the same side effects from all SSRIs, so it is important for you and your child to discuss all of their side effects with their doctor. It is important to contact your child's doctor immediately if your child experiences any unusual change in behavior at any time after starting treatment with an antidepressant.

Serotonin syndrome is a rare but serious potential side effect of SSRIs. Serotonin

syndrome occurs when high levels of serotonin accumulate in the body, and it most often happens when a person is taking more than one medication that affects the serotonin level. Symptoms of serotonin syndrome may include fever, confusion, tremor, restlessness, sweating, and increased reflexes.

Other medications, in addition to those that affect serotonin, can interact with SSRIs and other antidepressants and cause problems. Therefore, it is very important that you tell your child's doctor about all the medications and supplements that your child takes. It is also important to discuss with your child's doctor any new supplements or over-the-counter medications or medications prescribed to your child by other doctors before taking those medications.

How can I help monitor my child during treatment?

Because some youth have adverse physical and/or emotional reactions to antidepressants, parents should pay attention to any signs of increased anxiety, agitation, aggression, or impulsivity. Parents should also check their children for involuntary restlessness or unexplained happiness or energy accompanied by fast, driven speech, and unrealistic plans or goals. These reactions are more common at the start of treatment, but they can occur at any time during treatment. If your child shows any of these symptoms or any other concerning changes in behavior, consult your child's doctor immediately, because it may be necessary to adjust the dose, change to a different medication, or stop using the medication.

The following precautions for suicide prevention should be put into place if a child or any other family member has depression:

- Dangerous means of suicide, such as guns, should be removed from the home, and potentially dangerous medications, including over-the-counter drugs like acetaminophen (Tylenol) should be locked away.
- You should work with your child's doctor or other mental health provider to develop an emergency safety plan, which consists of a planned set of actions for you, your child, and your child's doctor to take if your child has more thoughts of suicide. This should include access to a 24-hour crisis phone number available to deal with such crises.
- If your child expresses new or more frequent thoughts of wanting to die or self-harm or takes steps to do so, you should implement the safety plan and contact your child's doctor immediately.

How do I know if my child's medication is working?

You may notice that your child's medication is working if your child's depressive symptoms (mood, interest, appetite, sleep, concentration, or suicidal thinking/behavior) improve or if they are functioning better at school, at home, or with peers. Your child's doctor will know whether your child's medication is working by collecting information from

you, your child's school team, and your child through clinical assessments and self-reports and parent questionnaires and other reports.

It is important for your child to have more frequent visits with their doctor soon after they start their treatment with an antidepressant. More frequent visits early in treatment and during times of antidepressant medication dose adjustments will allow your child's treatment provider to address any concerns about treatment response or side effects and to monitor your child for suicidal thinking and behavior.

What can be done if my child's depression is not improving on medication?

Depending on the specific antidepressant that your child is taking, it may take 4–6 weeks of treatment before your child's depressive symptoms begin to show improvement. This may be the case, even if your child started to have side effects shortly after taking an antidepressant for the first time. If your child's depressive symptoms have not improved after taking an antidepressant regularly for 4–6 weeks, their doctor may consider increasing the antidepressant dose. An appropriate trial of an antidepressant may last up to 12 weeks. If your child's depressive symptoms have not responded to an adequate trial of an antidepressant or if your child experiences unacceptable side effects from an antidepressant, their doctor may recommend switching to a different antidepressant or adding an additional antidepressant.

When a child or adolescent fails to respond to treatment with an SSRI, it is extremely important to understand why and address the cause. In addition to problems with finding the right dose or the duration of medication therapy, nonresponse may be the result of a number of other factors, including wrong diagnosis, another medical illness, extreme stress, poor management of comorbid mental conditions, or not properly following the instructions on taking the medication. If your child does not respond to a first SSRI, your child's doctor might recommend a second SSRI. Research has shown that approximately half of youth who don't respond to one SSRI will still respond to a second SSRI. If your child does not respond to a second SSRI, non–SSRI antidepressants are then considered.

Once my child is well, how long do they need to continue taking medication?

If your child responds to treatment with an antidepressant, which is when depressive symptoms are reduced by 50% or more, it is recommended that they continue taking antidepressants for 6–12 months after achieving this response. Youth who don't continue treatment, especially if they still have leftover symptoms, are at increased risk of sinking back into depression.

Six to 12 months after responding to treatment, stopping antidepressants medication may be the right choice for some youth. Stopping antidepressant treatment should be done only under the care and monitoring of your child's doctor. Youth who stop taking antidepressants should be reassessed by their doctor within 1–2 weeks to check for any withdrawal effects and/or return of depressive symptoms.

Psychosocial Treatments for Depression

What treatments other than medication are available to help my child's depression?

There is a great deal of scientific support showing the effectiveness of psychosocial treatments for youth with depression. Cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), and attachment-based family therapy are several examples.

Cognitive-behavioral Therapy

CBT is the most widely studied psychotherapy for the treatment of youth with depression. CBT is a form of psychotherapy that targets thoughts and behaviors that are related to mood. The individual is taught to identify patterns of thinking and behavior that add to their depressed mood. CBT may be used as a form of treatment by itself, or it can be combined with antidepressant medication. There is some evidence that CBT is most effective when combined with antidepressant therapy, particularly for adolescents with more severe depression or in those with treatment-resistant depression. Pediatric guidelines say that CBT alone may be an appropriate first-line treatment for those with mild depression.

Interpersonal Psychotherapy

Although there are fewer clinical trials of IPT compared with CBT, IPT is a well-established intervention in adolescents. IPT works by focusing on improving relationships with friends and family, increasing social support, and improving problem-solving skills.

Family-based Treatment

Studies involving family therapy are more difficult to evaluate because of the diversity of interventions. However, one treatment model—attachment-based family therapy—has been manualized, meaning that therapists follow the same process, and it has been shown to be effective in studies. This intervention, which promotes family alliances and connection, builds on family strengths and also improves the adolescent's success outside of the home.

Dialectical Behavior Therapy

DBT, originally developed in adults, has recently been adapted for adolescents. It has been proven to be effective in treating moderate to severe depression and co-occurring disorders, along with self-harm and suicidal behaviors. It was originally based on CBT but it also includes strategies for controlling emotions and handling stressful situations.

Supplementary Interventions

Other work has focused on using high-dose exercise programs to reduce depressive symptoms, improve mood, and reduce relapse into depression. Studies have shown that exercise can be an effective way to treat depression. Furthermore, interventions that improve sleep can also be used to improve depressive symptoms. Motivational interviewing strategies can be used to improve adolescents' participation with all interventions and improve their desire to stick with the treatment program.

Although there is little research to support its use to treat depression in children and adolescents, psychodynamic psychotherapy may be a helpful part of an individualized treatment plan for some youth.

Promoting wellness and emotional resilience, not just reducing depressive symptoms, is an overall goal of positive mental health. Strategies focus on youth participating in activities that develop self-confidence or a sense of purpose, increase feeling connected with other people, and foster gratitude or willingness to help others.

Promoting wellness and emotional resilience, not just reducing depressive symptoms, is an overall goal of positive mental health.

Other and/or Unproven Treatments for Depression

Several herbal supplements on the market (eg, St John's Wort, etc.) may claim to treat symptoms of depression; however, it is important to understand that there is little scientific research showing that these supplements work in treating depression. In addition, these supplements are not regulated by the FDA or any other agency. If you are considering giving your child herbal supplements, always check with the doctor as supplements may interact with prescribed medications.

There are treatments for MDD in youth that are currently being studied under the oversight of the FDA, including esketamine and transcranial magnetic stimulation (TMS). These treatments may or may not be available in your area. Youth who do not improve clinically during other stages of treatment may be candidates for such interventions. Before starting new or investigational treatment, your child's doctor may consider conducting a reassessment to determine whether the initial diagnosis was correct, evaluate whether there are ongoing or unrecognized comorbid disorders, and assess how well psychosocial interventions are being implemented.

Several herbal supplements on the market (eg, St John's Wort, etc.) may claim to treat symptoms of depression; however, it is important to understand that there is little scientific research showing that these supplements work in treating depression.

Helping the Depressed Child

What is my role in my child's treatment?

Provide Support and Reduce Stress

It is important to remember that depression is an illness, and you will need to provide support, avoid blame, and reduce as much stress as possible for your child. It will be necessary to work with your child to review their current schedule and/or activities to determine what might need to be adjusted. It may be necessary to modify your expectations for your child, at least until symptoms improve. When disciplining or punishing your child, don't deny them access to things that make them happy or help them cope (eg, don't take away access to friends or extracurricular activities, if possible). As needed, work with and involve school professionals to adjust academic workloads, pace, and expectations. Communicate to the teachers and other school staff that your child suffers from mental health challenges and that from time to time they may require special accommodations for learning and/or interaction with peers. Assumptions about what your child can manage in school, based only on periods of good moods (also known as euthymia), should be strongly avoided.

Help Teenagers Practice New Skills and New Ways of Thinking

It is important to be involved in your child's treatment. This includes knowing the new skills/strategies that your child is learning in treatment. Parents can help to model these skills at home and point out opportunities to practice and apply them in the home setting. Some therapists envision the parents' role as serving as a "coach" to help with learning these strategies and extending them to other settings.

Reduce Negative Emotion in the Home (Sarcasm, Criticism)

Having family members in the home who suffer from depression can be challenging. It is important to avoid criticism and blame. While your child is depressed you may consider calling a truce on "hot topics" or subjects that can lead to high conflict and disagreement. Finding activities that the family can do together to promote positive emotions and increase activity level can be helpful. Parents may seek out parent psychoeducation or couples therapy, and you may check to see whether parent coaching is available in the community. The National Alliance on Mental Illness (NAMI), Depression and Bipolar Support Alliance (DBSA), and other mental health organizations offer a variety of options for support and information. Because childhood or adolescent depression affects the whole household, all family members can benefit from supportive treatment.

Develop Communication Strategies

When there is conflict and when emotions are high, developing a solid communication plan is recommended. An "exit and wait" strategy to allow family members to gain control of their emotions can help to manage difficult communication and conflict.

Participate in Safety Plan; Keep Environment Safe

A safety plan that includes strategies for managing mood, getting support, and knowing when to get professional help is important. In addition, making the environment safe by removing all access to dangerous tools, such as medications, knives or other blades, weapons, and firearms, is an essential part of treating youth with depression.

Monitoring Social Media, Peer Influence, Social Stress

Youth who are depressed can be especially vulnerable to social media and conflict with peers. Teenagers may see others as having more friends or more fun than themselves, which may make them feel even more excluded or not liked by others. Constantly checking social media sites to make sure that they haven't been left out can be a source of stress for youth. Parents need to be vigilant and aware of the impact of social media and peers on their child. Protective monitoring, such as having guidelines and rules for using technology, is important. Technological tools, such as parental control software, to control and monitor use of media are more and more available and may be needed for youth who are negatively affected by social media and/or cyberaggression or cyberbullying by their peers.

Is there anything else that I can do to help my child?

It's important for parents and caregivers to practice self-care. Find support and learn more about what's going on with your child so that you can be as effective as possible in helping them get the care they need. The National Alliance on Mental Illness (NAMI), Depression and Bipolar Support Alliance (DBSA), and other mental health organizations offer a variety of options for support and information. Depression tends to run in families, so it's important to know that if anyone else in the family is experiencing symptoms of depression, they need to also seek treatment.

Resources

- American Academy of Child & Adolescent Psychiatry (AACAP) https://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Depression_Resource_Center/Home.aspx
- National Alliance on Mental Illness (NAMI) https://www.nami.org/Find-Support/Family-Members-and-Caregivers
- Depression and Bipolar Support Alliance (DBSA) http://www.dbsalliance.org/site/PageServer?pagename=home
- National Institute of Mental Health (NIMH) https://www.nimh.nih.gov/health/publications/teen-depression/index.shtml

  https://www.nimh.nih.gov/health/publications/depression-what-you-need-to-know/index.shtml
- Centers for Disease Control and Prevention (CDC) https://www.cdc.gov/childrensmentalhealth/depression.html

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Medication Tracking Form

Use this form to track your child's medication history. Bring this form to appointments with your provider and update changes in medications, doses, side effects and results.

Date	Medication	Dose	Side Effects	Reason for keeping/stopping

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