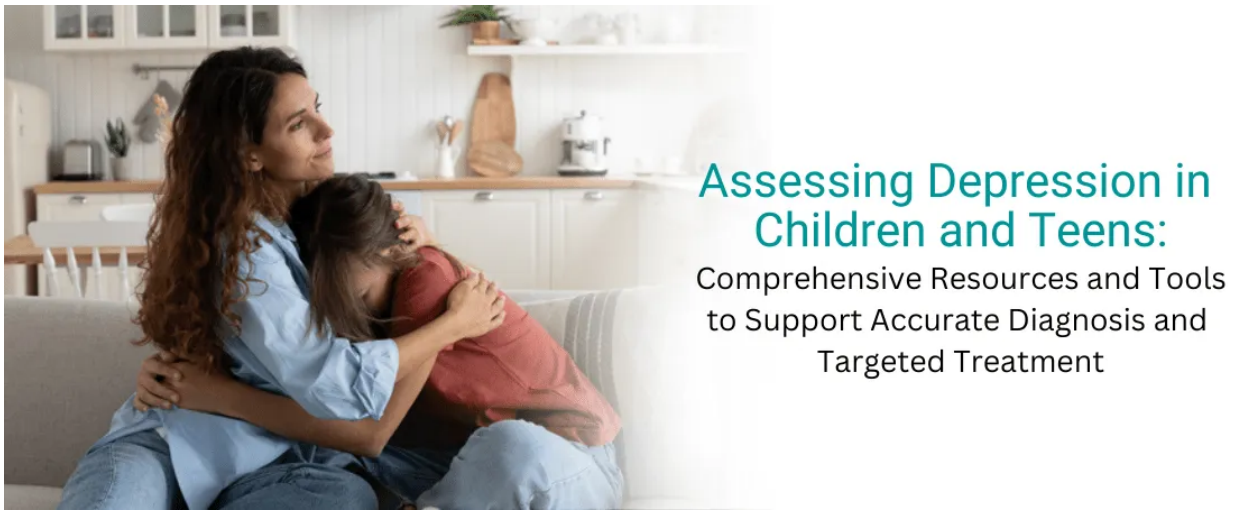

Assessing Depression in Children and Teens

A message from WPS: Reading about children and teens with depression can be distressing, even for experienced practitioners. You may want to take breaks as you process the information in this guide.

It's a painful and unsettling reality that children and teens may be more vulnerable to depression today than they have been in the past. Researchers estimate that around 2% of children experience depression before they experience puberty (Patra, 2019). And the rate rises for teens.

The Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey Data Summary and Trends Report: 2011–2021 states that "nearly 60% of female students and 70% of LGBQ+ students experienced persistent feelings of sadness or hopelessness" (CDC, 2023). Across every racial and ethnic subgroup, feelings of persistent sadness and hopelessness rose during the past decade, the report said.

In response to these trends, the U.S. Preventive Services Task Force in 2022 recommended screening for major depressive disorder in all adolescents ages 12 to 18 years. What do clinicians and educators need to know to identify depression in teens and children? What tools are available to make the evaluation process simpler?

If you are working with someone in crisis, the National Guidelines for Child and Youth Behavioral Health Crisis Care or the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit may be helpful.

Learn more: CDC Releases Report Showing Downturn in Youth Well-Being

Research and Resources:

Centers for Disease Control and Prevention. (2023). Youth behavior risk survey data summary & trends report. https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf

Patra, S. (2019). Assessment and management of pediatric depression. *Indian Journal of Psychiatry, 61*(3), 300–306. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_446_18

Substance Abuse and Mental Health Services Administration. (2022). *National guidelines for child and youth behavioral health crisis care*. Publication No. PEP22-01-02-001. Retrieved from https://www.samhsa.gov/data/

U.S. Preventive Services Task Force. (2022 October 11). Depression and suicide risk in children and adolescents: Screening. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-children-adolescents

Diagnostic Criteria for Depressive Disorders in Children and Teens

The *Diagnostic and Statistical Manual* (5th ed., text revision; DSM-5-TR) identifies these separate depressive disorders:

- Major depressive disorder, described as depressed mood or a loss of interest or pleasure in activities for a period of 2 consecutive weeks or longer

- Persistent depressive disorder, described as depressed or irritable mood or loss of interest and pleasure that lasts for 1 year or longer

The DSM-5-TR also identifies other depressive disorders in which mood changes are brought about by substances, medications, other health conditions, or other causes, whether known or unknown.

Symptoms can be mild, moderate, or severe, and they'll be present most of the day on most days during a depressive episode. With mild symptoms, children and teens may still be able to function, but it will take a lot of effort for them to do so.

The *International Code of Disorders* (11th ed.; ICD-11) identifies these depressive disorders:

- Single depressive episode, described as a period of 2 weeks or longer with depressed mood or lack of interest in pleasurable activities for most of the day, on most days
- Recurrent depressive episode, described as at least two depressive episodes, separated by several months, with no significant depressive mood symptoms
- Dysthymic disorder, described as a persistent depressive mood most of the day, on most days, lasting 2 years or longer

The ICD-11 notes that these symptoms cause people with the condition to have trouble functioning at work, school, home, and in social relationships. If people can carry out their daily activities, it usually takes a great deal of effort. Symptoms can be characterized as mild, moderate, or severe.

It's important to understand that subthreshold depression—depression symptoms that don't reach the full diagnostic criteria—can still have profound effects on the lives of children and teens. In a 2022 study, researchers said subthreshold depression affected teens' ability to function, changed their brains, caused them to think about suicide, and responded to treatment in close to the same ways as major depressive disorder (Noyes et al., 2022).

Learn more: Depression Is Hitting Teens and Children Hard: Can You Spot the Signs?

Research and Resources:

American Psychiatric Association. (2022). Depressive disorders. In *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787.x04_Depressive_Disorders

Noyes, B. K., Munoz, D. P., Khalid-Khan, S., Brietzke, E., & Booij, L. (2022). Is subthreshold depression in adolescence clinically relevant? *Journal of Affective Disorders, 309*, 123–130. https://doi.org/10.1016/j.jad.2022.04.067

World Health Organization. (2019). *International statistical classi cation of diseases and related health problems* (11th ed.). https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/1563440232

Symptoms of Depression in Children and Teens

As is true of many health conditions, depression symptoms can change as people mature. Around 1.4% of preschool children experience depression, studies show (Grover & Avasthi, 2019). In preschool children, depression can look like this:

- crying much of the time
- showing signs of anxiety, sensitivity, or irritability
- lack of interest in toys or playing
- significant weight gain or loss
- problems falling asleep or refusal to sleep alone
- talking about or thinking about death or suicide (Donohue et al., 2019)

In some young children with depression, developmental delays can happen.

Childhood depression can cause symptoms like these:

- feeling or seeming to feel irritable, sad, numb, or empty
- not gaining weight as they're expected to
- losing weight without trying (5% of body weight or more)
- experiencing significant weight gain (5% of body weight or more)
- suddenly losing interest in food or having an appetite increase
- sleeping much more or much less than usual
- losing interest in once-loved activities
- being visibly restless or visibly sluggish
- having excessive guilt or feelings of worthlessness
- having trouble thinking, paying attention, or making decisions
- thinking about, talking about, planning, or attempting suicide (Patra, 2019)

As a clinician or educator, you may hear comments or concerns such as these:

- *She gets headaches and stomachaches when she thinks about schoolwork.*
- *He throws up when it's time to leave for school.*
- *My child used to love drawing but doesn't pick up the sketchbook anymore.*
- *My child's grades have plummeted.*
- *Her room (or locker or book bag) is a total disaster all of a sudden.*
- *He has no interest in hanging out with his friends.*
- *One minute she seems okay, and the next she's having a temper tantrum.*
- *She's sullen and withdrawn, and she can't explain why.*
- *My child says she doesn't want to kill herself—she just wishes she weren't here anymore.*
- *He blames himself for things that aren't his fault at all.*
- *Her self-confidence seems to have drained away.*
- *I can't get him to eat.*
- *She used to love soccer; now all she does is sleep.*

When you interview a child or teen with depression, you may notice behaviors like these:

- avoids eye contact
- looks unkempt or disheveled
- keeps face turned down or away
- frustrates easily
- seems restless or sluggish
- uses few words

- cries or appears sad expresses anger in bursts
- ruminates on the same topic (AACAP, 2022)

Teens can behave in these ways for lots of different reasons. One of the challenges of evaluation is gathering enough information to be able to determine whether these behaviors are symptoms of depression or are the outgrowth of another condition.

There's some evidence that teens with depression have a distinctive kind of dysphoria that involves "misery and self-doubt that go largely undetected." Some researchers think depression in children and teens may affect self-perception, causing them to write negative internal scripts about themselves. The result? Disordered beliefs about their safety, ability to cope, or self-image (Rikard-Bell et al., 2022).

Learn more: Day-to-Day Depression—What to Look For in Teens

Research and Resources:

Donohue, M. R., Whalen, D. J., Gilbert, K. E., Hennefield, L., Barch, D. M., & Luby, J. (2019). Preschool depression: A diagnostic reality. *Current Psychiatry Reports, 21*(12), 128. https://doi.org/10.1007/s11920-019-1102-4

Grover, S., & Avasthi, A. (2019). Clinical practice guidelines for the management of depression in children and adolescents. *Indian Journal of Psychiatry, 61*(Suppl 2), 226–240. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_563_18

Patra, S. (2019). Assessment and management of pediatric depression. *Indian Journal of Psychiatry, 61*(3), 300–306. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_446_18

Rikard-Bell, C., Hunt, C., McAulay, C., Hay, P., Morad, A., Cunich, M., & Touyz, S. (2022). Adolescent depression from a developmental perspective: The importance of recognizing developmental distress in depressed adolescents. *International Journal of Environmental Research and Public Health, 19*(23), 16029. https://doi.org/10.3390/ijerph192316029

Risk Factors to Explore When Diagnosing Depression in Children and Teens

Depression is rarely caused by a single factor. Generally, it can be traced to a combination of environmental, psychological, and physical factors. In fact, researchers in the Identifying Depression Early in Adolescence (IDEA) project have found that composite risk scores are better predictors of who is vulnerable to depression than single factors. Combining risk factors into a composite score can also help practitioners see depth and dimension in depression risk—more like a spectrum and less like a binary yes-or-no diagnosis.

One IDEA study looked for similarities between adolescents 14 to 16 years old with a high risk for depression and those who had been diagnosed with major depressive disorder. After collecting extensive family histories, personal background information, and biometric data, researchers found several common factors.

Students in both groups were more likely to have

- a family history of depression,
- lower income/economic status,
- more social isolation,
- school failure,
- a history of running away from home,
- a history of drug usage,
- a history of fighting,
- less-positive relationships with parents,

- parents whose relationship with each other was troubled, and
- experiences of severe childhood maltreatment (Keiling et al., 2021).

Here's a closer look at risk factors to consider when evaluating a child or teen for depression.

Heritability

Genes play a distinct role in the risk of depression. Children whose parents have depression are 2 to 4 times more likely to experience depression themselves.

Traumatic Childhood Experiences

Children who have experienced multiple high-stress events have a greater risk of developing depression symptoms. Adverse childhood events couldinclude

- natural disasters,
- neglect,
- abuse,
- loss,
- divorce,
- injury or illness,
- poverty, and
- discrimination.

It's important to be cautious about assessing this risk factor, however. Researchers have found that asking children to discuss, describe, or even enumerate adverse events can re-traumatize young people, especially when assessment takes place without adequate support.

Cognitive Factors

When people have depression, they are also likely to develop biases that change what they pay attention to and remember. That is, they may spend more time thinking about negative memories than positive ones. In some cases, they may literally remember more negative words than positive ones. This thinking pattern can make depression symptoms worse.

Physiological Factors

Having certain health conditions can raise the risk of depression in young people. If a child or teen has one of these heath conditions, it's important for practitioners to be aware of the heightened risk of depression symptoms:

- sleep disturbance
- attention-deficit/hyperactivity disorder (ADHD)
- autism
- dyslexia
- neurological conditions such as epilepsy
- anxiety
- mental health conditions such as obsessive-compulsive disorder

- sleep disturbance
- attention-deficit/hyperactivity disorder (ADHD)
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- dyslexia
- neurological conditions such as epilepsy
- anxiety
- mental health conditions such as obsessive-compulsive disorder

Some medications can cause depression, too. While there's no blood or imaging test that can reveal depression, some tests can help to identify conditions that could contribute to a child's or teen's mood changes. Reviewing medical records and collaborating with family physicians may be the best way to find out about interactions like these.

A person's sex can also raise the risk of developing depression, especially among teens. During adolescence, girls are roughly twice as likely as boys to experience depression.

Learn more: Study Highlights the Need to Assess Mental Health in Autistic Youth

Research and Resources:

Kieling, C., Buchweitz, C., Caye, A., Manfro, P., Pereira, R., Viduani, A., Anés, M., Battel, L., Benetti, S., Fisher, H. L., Karmacharya, R., Kohrt, B. A., Martini, T., Petresco, S., Piccin, J., Rocha, T., Rohde, L. A., Rohrsetzer, F., Souza, L., Velazquez, B., … Mondelli, V. (2021). The Identifying Depression Early in Adolescence Risk Stratified Cohort (IDEA-RiSCo): Rationale, methods, and baseline characteristics. *Frontiers in Psychiatry*, 12, 697144. https://doi.org/10.3389/fpsyt.2021.697144

Building a Comprehensive Depression Assessment

As accurate as depression assessments have become, no child's mental health can be fully explained by a single test score. Creating a complete picture of how depression is affecting a child takes

- validated assessment tools designed for children and teens;
- careful review of health and education records;
- keen observation by trained professionals; and
- honest conversations with teachers, health professionals, caregivers, and the child at the center of the evaluation.

Information From Multiple Sources and Settings

The American Psychological Association recommends the use of a variety of assessment tools. Depending on your resources and the age of the child, you may want to use a combination of

- self-report measures;
- teacher and parent rating scales;
- standardized questionnaires or checklists; and
- observational interviews.

Whichever measures you choose, it's important to look for emotional, cognitive, and behavioral symptoms of depression in different settings. On rating scales, parents and caregivers may notice more externalizing symptoms, such as outbursts and changes in activity level or academic performance. Children, on the other hand, tend to focus their responses on what's happening in their hearts and minds.

Gathering information from different people will help you see the child more clearly. It will also help you identify sources of emotional support in the child's life.

Suicidality Screening

The Centers for Disease Control and Prevention (CDC) ranks suicide as the second-leading cause of death among children ages 10–14 (CDC, 2023). Researchers say mental health concerns were identified in roughly one third of those deaths. Among the children and teens who died by suicide, depression and ADHD were the two most common mental health conditions identified. About a quarter of the children had experienced trauma.

Because suicide risk is higher among children and teens with depression, it's important to screen for suicidality early in the evaluation so you can pursue crisis care and evidence-based treatment (Ruch et al., 2022).

You can find a deeper look at suicide risk assessment below.

Functional Assessments

One of the symptoms that first catches the eye of caregivers and educators is a change in the way a child or teen takes care of themselves. Depression makes it harder for people to keep up with basic activities of daily living. Depression can also make it harder to take care of routine tasks at home, at school, and at work. Functional assessments and adaptive behavior measures can help you clarify how, and how much, depression is affecting someone's daily life.

Sometimes, functional assessments are criterion-referenced. An occupational therapist or another professional measures whether a person can do specific cognitive, emotional, or practical tasks based on the requirements of a certain setting (Rogers, 2016).

But it's also possible to measure skills using more formal, norms-based assessments such as the Adaptive Behavior Assessment System, Third Edition (ABAS®-3) or the Behavior Rating Inventory of Executive Function, Second Edition (BRIEF-2).

Testing executive functioning is especially important in children and teens with depression. That's because depression can affect this group of thinking skills, leading to learning difficulties. One researcher said, "The assessment of the executive functions and attention is an important part in the assessment of children with depression; intervention and treatment programs for depression should include components focused on executive functions and attention" (Ciuhan & Iliescu, 2021).

The kind of assessments you use will depend on the needs of the child and the resources available to you as the evaluator. It may be a good idea to combine measures to get a clear sense of what a child *can* do, as well as what the child *usually* does, especially when the child is coping with depression.

Learn more: Enhance Your Adaptive Behavior Evaluations

Detailed Histories

Taking thorough family and developmental histories can give you information about exposures that increase the risk of depression. Su et al. (2020) found a link between childhood depression and exposure to these conditions during gestation or shortly after birth:

- low birth weight or being small for gestational age
- birth before 37 weeks
- mother with fewer than 9 years of education
- low family income
- parents younger than 20 years
- parents older than 35 years
- mother or father who smokes
- mother with significant stress, anxiety, or depression

Reviewing school records and medical histories may also help you confirm when symptoms began, what interventions or treatments have been tried, and what the outcomes have been.

Additional Assessments

To get as clear a picture as possible of each person's risk factors, protective factors, and co-occurring conditions, you may find it useful to assess for

- anxiety,
- self-concept,
- co-occurring conditions such as ADHD or autism,
- learning disabilities, and
- executive function.

Assessing broadly can also help you find out how depression may be affecting the child's ability to function across different settings. And it can help you prioritize important areas in your intervention plan.

Referral for Medical Testing

If your evaluation suggests someone does have a depressive disorder, it's important to find out whether the individual has access to health care providers who could look for medical or physical causes. Providers may also be able to prescribe medication for those who need it.

Research and Resources:

Centers for Disease Control and Prevention. (2023). *Child health*. https://www.cdc.gov/nchs/fastats/child-health.htm

Ciuhan, G. C., & Iliescu, D. (2021). Depression and learning problems in children: Executive function impairments and inattention as mediators. *Acta Psychologica, 220*, 103420. https://doi.org/10.1016/j.actpsy.2021.103420

Grover, S., & Avasthi, A. (2019). Clinical practice guidelines for the management of depression in children and adolescents. *Indian Journal of Psychiatry, 61*(Suppl 2), 226–240. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_563_18

Rogers, J. C., & Holm, M. B. (2016). Functional assessment in mental health: Lessons from occupational therapy. *Dialogues in Clinical Neuroscience, 18*(2), 145–154. https://doi.org/10.31887/DCNS.2016.18.2/jrogers

Ruch, D. A., Heck, K. M., Sheftall, A. H., Fontanella, C. A., Stevens, J., Zhu, M., Horowitz, L. M., Campo, J. V., & Bridge, J. A. (2021). Characteristics and precipitating circumstances of suicide among children aged 5 to 11 years in the United States, 2013–2017. *JAMA Network Open, 4*(7), e2115683. https://doi.org/10.1001/jamanetworkopen.2021.15683

Su, Y., D'Arcy, C., & Meng, X. (2021). Research review: Developmental origins of depression—A systematic review and meta-analysis. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 62*(9), 1050–1066. https://doi.org/10.1111/jcpp.13358

Assessing the Risk of Suicide

Assessing suicide risk won't give you a fail-safe way of knowing whether someone might attempt suicide (Hawton et al., 2022). In fact, current evidence suggests that most formal suicide risk assessments aren't very reliable as predictors of suicide (Large et al., 2018).

Instead, experts say, the goal of suicide risk assessment should be broader: to find out whether someone is in crisis and to identify ways to support that individual to prevent a crisis from worsening (Fortune & Hetrick, 2022). An assessment is a resource—but one that must be seen as an aid to your own clinical judgment and a guide to the pressing needs in a child's life.

Common Components of Suicide Risk Assessments

Formal and informal suicide risk assessments often gather information about these broad indicators of risk:

- how often someone thinks about suicide
- whether the person in crisis also thinks about harming others
- whether someone has formed an intention to end their life

- whether thoughts are passive (hoping not to wake up) vs. active (thinking about hurting oneself)
- how intense the negative feelings are
- whether someone has acted on the desire for self-harm
- whether someone is thinking about how to end their life or has taken steps in that direction
- whether someone has access to lethal means
- whether someone has self-harmed or attempted suicide before

Suicide Risk Factors

Some circumstances or life events could lead someone vulnerable to think about suicide at some point. On their own, these events may not pose an immediate risk. But they could add to a sense of despair or hopelessness—especially if someone experiences more than one in a short time frame. Risk factors could include

- job loss,
- divorce or relationship problems,
- social isolation,
- death of a close loved one,
- financial stress,
- abuse,
- discrimination,
- bullying,
- chronic physical or mental health conditions, or
- trauma.

The Centers for Disease Control and Prevention adds these community and societal risk factors:

- lack of access to health care
- the stress of adjusting to a different culture
- local violence
- historical trauma
- discrimination
- stigma around mental illness
- easy access to lethal means
- media portrayals of suicide

Identifying risk factors like these can give you a starting place for interventions that may help avert a crisis in the future.

What Can You Say?

- *"Sometimes when kids talk to me about their parents getting a divorce, they say they feel pretty hopeless. Do you ever feel that way?"*
- *"Sometimes when kids are being bullied, they tell me they have thoughts about suicide. Are you having thoughts like that?"*
- *"Sometimes when kids are dealing with pain and sadness, they tell me they are worried about being a burden to their families. Do you ever worry about that?"*

Warning Signs

Some of the thoughts and behaviors described below may be seen as more urgent warning signs:

- feeling hopeless, isolated, trapped, angry, or in pain
- feeling like a burden to other people
- increasing substance use
- sleeping much more or much less than normal
- searching for information about or access to lethal means
- talking about, posting about, or planning suicide

Learn more: CDC's Vital Signs

Protective Factors

Protective factors are those skills and supports that empower people to cope with hard times.

They drive resilience—so these are the factors you may want to strengthen and build into an intervention plan.

The CDC says these factors can help protect people from a higher risk of suicide:

- connection to partners, family, friends, and co-workers
- well-developed problem-solving skills
- sense of cultural identity
- connection to faith community
- access to good-quality mental and physical health care
- cultural or faith-based teachings about suicide

It's important to pay special attention to culture as you think about treatment following a suicide risk assessment. Suicide assessments may not be responsive to individual differences in culture, faith, and language. Understanding as much as possible about these factors can help you accurately interpret assessment results.

The National Institute of Mental Health has developed The Ask Suicide-Screening Questions Tool Kit, which includes screening questions and a brief suicide assessment. The tool kit may help you determine whether a full evaluation is needed. Screening questions are available in 16 languages.

Challenges of Suicide Risk Assessment

Evaluating a person for the risk of suicide can be emotionally fraught, both for you and for the person in crisis. Some of the most common challenges for practitioners include

- being so worried about the outcome that you rush the process or avoid it altogether
- overestimating the need to call 911 or transport a child to the ER
- worrying that you'll say something that makes suicide more likely
- feeling powerless to help
- experiencing anxiety, sadness, guilt, and other emotions during or after an evaluation

Working with others to screen, assess, evaluate, and draft safety plans can help with some of these challenges—but assessing for suicide risk may always cause distress for an empathetic practitioner (K. Béland, personal communication, April 13, 2023).

Learn more: Preventive Self-Care for Practitioners

Safety Planning

The purpose of a safety plan is to help people recognize their own warning signs and to use a pre-defined set of coping strategies to keep themselves safe in a crisis. There's some evidence that safety plans can be effective at lowering suicide risk among adults, but more research needs to be done to understand their effectiveness for children and teens.

Abbott-Smith et al. (2023) found that these plans can be effective with children and teens when

- children collaborate with health professionals and parents or caregivers,
- plans are developmentally appropriate for the individual child, and
- health professionals are well-trained in safety planning.

Safety plans often cover topics such as these:

- coping strategies children can use to distract themselves
- a short list of safe and reliable people and social settings to distract children when they're feeling low or in danger
- a short list of trusted people to call in case of a crisis (and what these people could do to help)
- a list of resources (including hospitals and mental health professionals) to call in crisis
- ways to make surroundings safe when a child is having suicidal thoughts or desires
- a list of reasons to keep living

Child- and teen-friendly templates are available online to help you collaborate with children and their families in creating safety plans.

Reading about suicide risk can bring up all kinds of emotions and memories. This might be a good moment to stretch, drink some water, or take a walk if you need a break.

Read more about How to Communicate with Families to Build Trust, Connection, and Engagement.

Research and Resources:

Abbott-Smith, S., Ring, N., Dougall, N., & Davey, J. (2023). Suicide prevention: What does the evidence show for the effectiveness of safety planning for children and young people? A systematic scoping review. *Journal of Psychiatric and Mental Health Nursing*, 10.1111/jpm.12928. Advance online publication. https://doi.org/10.1111/jpm.12928

Centers for Disease Control and Prevention. (2023). *Risk and protective factors*. https://www.cdc.gov/suicide/factors/index.html

Fortune, S., & Hetrick, S. (2022). Suicide risk assessments: Why are we still relying on these a decade after the evidence showed they perform poorly? *The Australian and New Zealand Journal of Psychiatry, 56*(12), 1529–1534. https://doi.org/10.1177/00048674221107316

Hawton, K., Lascelles, K., Pitman, A., Gilbert, S., & Silverman, M. (2022). Assessment of suicide risk in mental health practice: Shifting from prediction to therapeutic assessment, formulation, and risk management. *The Lancet. Psychiatry, 9*(11), 922–928. https://doi.org/10.1016/S2215-0366(22)00232-2

Large, M. M. (2018). The role of prediction in suicide prevention. *Dialogues in Clinical Neuroscience, 20*(3), 197–205. https://doi.org/10.31887/DCNS.2018.20.3/mlarge

National Institute of Mental Health. (n.d.) *Ask suicide-screening questions tool kit*. https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

Trauma-Informed Depression Assessment

The National Child Traumatic Stress Network offers some guidance when it comes to mental health assessment of children exposed to trauma.

1. Build choice into the evaluation process.

Trauma can take away a person's belief that they have control over what happens to them. When practitioners give families and children choices, it can give them back a sense of agency. Choice leads to greater trust and involvement.

Here are some basic choices that may be available:

- which language to take an assessment in
- how to respond to questions (i.e., digital vs. paper, drawing vs. writing)
- the order of assessments
- items read aloud or presented in writing
- how many sessions an assessment could take
- when to meet
- how and how often to receive communications
- in-person or online meetings
- the language the report is presented in
- which interpreter to use if one is needed

2. Communicate clearly and respectfully.

When people have experienced trauma, their brains may process information differently. Trauma and depression can both change executive functions such as working memory, cognitive flexibility (switching back and forth between tasks), problem-solving, and inhibition or self-control (Op den Kelder et al., 2018; Ciuhan & Iliescu, 2021).

Trauma and depression also affect people's ability to recognize and regulate emotions, especially in interactions where they may feel threatened. Changes in executive function can alter the way people hear, remember, and respond to what you're saying.

The words you choose are important, and so are the tone and volume of your voice when you speak.

As you move through the evaluation process, you can use strategies like these to lower stress and build a therapeutic alliance:

- describing the information you'll get from each assessment
- sharing why that information is needed
- explaining what note-taking is for and offering to show notes to clients
- giving each person time to discuss their concerns, goals, and priorities
- being transparent about timelines for each step of the process
- using visuals to talk about data and other important ideas
- simplifying the language in all written and verbal communications
- allowing lots of time for questions
- answering questions patiently and respectfully
- asking for responses to results so you understand where people agree and disagree with findings
- emphasizing strengths and positive information
- providing methods for feedback about the process
- explaining treatment options
- collaborating to make the treatment plan
- summarizing and repeating important information

3. Be mindful of no erbal communication.

When people have experienced trauma, they may respond differently to unspoken aspects of communication. Subtle shifts in tone of voice or physical position can telegraph aggression or threat in ways you may not intend.

You can create a safer-feeling communication style by:

- keeping your facial expressions “soft,”
- maintaining a respectful distance from people,
- using a gentle or relaxed tone of voice,
- slowing down your speech,
- being aware of what you’re doing with your hands, and
- welcoming feedback from trauma survivors.

4. Consider the atmosphere in assessment and meeting spaces.

You may not have complete control over the appearance of an assessment environment. To the extent possible, keep surroundings calm and friendly-looking. Comfortable, appropriately scaled furniture, play areas, and available art supplies or toys can send a message that children and teens are welcome.

It’s also a good idea to arrange seating so that everyone sits roughly at eye level. Visually, the space should feel collaborative, not confrontational.

If you need to change something about the environment during an assessment—for example, closing a door or changing the lighting—it’s a good idea to explain what you’re doing. People who have experienced trauma can be highly attuned to changes in their physical environment that they may associate with danger.

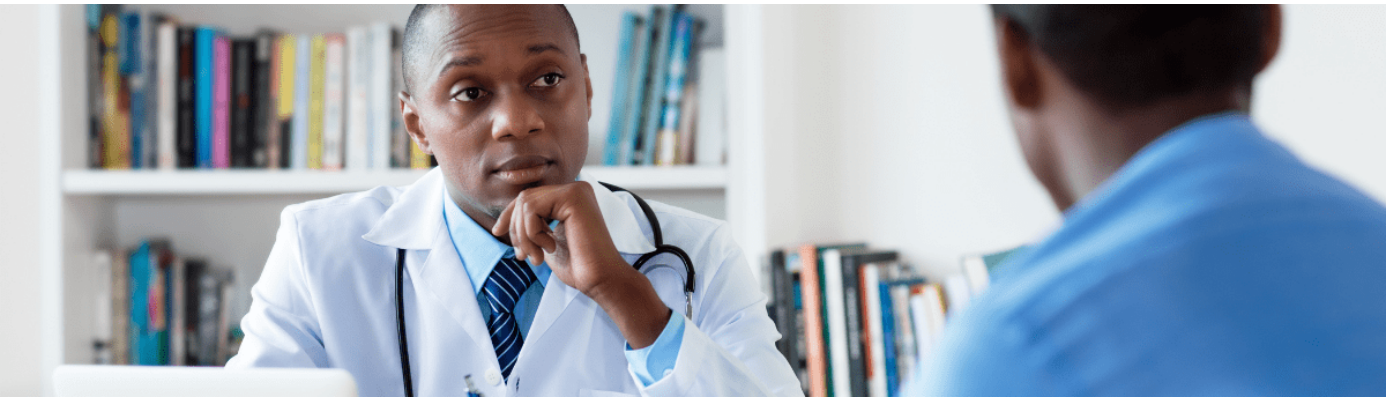
Creating a child-friendly space isn’t just about how a space looks. It’s also about how it feels. The goal is to create an environment where people feel safe, heard, and accepted for who they are.

Learn more: How to Communicate with Families to Build Trust, Connection, and Engagement

Research and Resources:

The National Child Traumatic Stress Network. (n.d.) Trauma-informed mental health assessment. https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-informed-mental-health-assessment

Challenges in Diagnosing Depression in Children and Teens



Diagnosing depression in children and teens can be challenging for several reasons.

Children and teens differ in their ability to talk about what they're feeling and thinking. In addition, depression itself can hinder a person's ability to communicate what's going on. People may have trouble finding the right words or remembering when symptoms began, for example.

- Most models of depression explain the condition as adults experience it. Some researchers have pointed out that an adult model may not align completely with depression in children and teens because their self-concept, emotions, cognitive functioning, communication abilities, and coping skills are still developing.
- People may have trouble talking. Anxiety, language barriers, anger, trust issues, embarrassment, social-skill development, and the effects of trauma can keep kids from
- speaking openly with you. Disabilities may also prevent someone from speaking.
- It can be hard to distinguish depression symptoms such as fatigue or sleep disturbance from the symptoms of other medical or health conditions.
- Depression can be secondary. People may experience depression symptoms on their own or because of something else, such as a medication, health condition, or societal circumstances.
- People experience depression in widely varying symptom patterns. For some people, physical pain is a marker, while others may feel numbness, sadness, aggression, or other emotional symptoms. Understanding symptom variations is important.

- Culture can influence where in the body people experience depression symptoms. Culture can also affect people's willingness to share the symptoms they're experiencing.
- Depression symptoms can begin gradually or subtly, so it can be hard to pinpoint exactly how long someone has been in a depressive episode.
- Practitioners are often pressed for time, and many haven't had enough training to feel confident about diagnosing depression in children and teens (Beck et al., 2022).
- Bias can influence how practitioners look at symptoms, leading to disparities in the diagnosis of depression among racialized groups. For example, a 2022 study found that Black teens had a greater chance of being diagnosed with an impulse control disorder and a lower chance of receiving a depression diagnosis than their White peers (Martin et al., 2022).

When children and teens receive a diagnosis, follow-up care is the next challenge. In one study, around 23% of teens received a depression diagnosis based on a screening that took place at their 16-year-old primary care visit. Over the next year, 60% of those with mild depression did not receive follow-up treatment, and 25% of those with moderate-to-severe depression didn't have follow-up care, either (Farley et al., 2020).

Research and Resources:

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Assessment Tools for Depression Evaluations

Mental health assessments can empower practitioners to respond to the current crisis among children and teens. They can help you identify conditions like depression and anxiety, and they can also reveal which areas of a child's life are being most affected.

WPS is proud to offer a range of assessments to help diagnose depression, anxiety, and co-occurring conditions for children in preschool, elementary, middle school, high school, and beyond.

Assessments for Depression

- Children's Depression Inventory, Second Edition (CDI 2)
- Risk Inventory and Strengths Evaluation (RISE™ Assessment)
- Trauma Symptom Checklist for Children (TSCC)
- Trauma Symptom Checklist for Young Children (TSCYC)
- Trauma Symptom Inventory-2 (TSI-2)

Assessments to Measure Effects of Depression

- Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS™-2)
- Behavior Rating Inventory of Executive Function, Second Edition (BRIEF2)
- Behavior Rating Inventory of Executive Function–Preschool Version (BRIEF-P)
- Adaptive Behavior Assessment System, Third Edition (ABAS®-3)

Assessments for Co-Occurring Neurodevelopmental Conditions

- Conners Fourth Edition™ (Conners 4®)
- Autism Diagnostic Observation Schedule™, Second Edition (ADOS®-2)
- Monteiro Interview Guidelines for Diagnosing the Autism Spectrum, Second Edition (MIGDAS 2)
- Tests of Dyslexia™ (TOD)

Is It Depression or Something Else?

Depression can co-occur or overlap with several other conditions. In addition, some physical and mental health conditions can cause depression or depression-like symptoms. Determining whether a child's symptoms stem from depression alone or another condition is one of the most challenging aspects of an evaluation.

Here's a brief look at some of the other diagnoses that have been linked to depression-like symptoms:

Health Conditions

Some illnesses can cause low mood, fatigue, irritability, and other symptoms that look and feel like depression, including

- thyroid problems,
- irritable bowel syndrome,
- epilepsy,
- systemic lupus erythematosus,
- premenstrual dysphoric disorder, and
- anemia.

Medication-Induced Symptoms

Some medications (or combinations of medications) can cause side effects that look and feel like depression symptoms, including:

- hormonal contraceptives,
- anti-seizure medications,
- corticosteroids,
- beta-blockers,
- stimulants, and
- opioids.

Sometimes, depression-like symptoms are the result of *stopping* a medication, rather than starting one.

Neurodevelopmental and Mental Health Conditions

Some neurodevelopmental and mental health conditions also cause symptoms that look like depression. Treating the primary condition may relieve or reduce depression symptoms—but the relationship between conditions could be more complex than that.

For example, children with ADHD have a higher risk of depression during teen and young adult years—as much as 21% higher than neurotypical peers, some studies suggest (Riglin et al., 2021). The connection is partly explained by the genetic factors ADHD and depression share (Faraone & Larsson, 2019). But depression could also be related to the functional differences, stress, and social difficulty children and teens with ADHD often experience.

Conditions that can cause depression symptoms include

- ADHD,
- autism,
- specific learning disorders,
- conduct disorders,
- disordered eating,
- personality disorders,
- substance use disorder,
- anxiety disorder, and
- bipolar disorder.

Grief

Bereavement, loss, and grief are part of most people's lives at some point. The sorrow involved

can *look like* depression and can *lead to* depression. For example, a 2023 study explored the experiences of 622 young adults in Sweden who had lost a parent to cancer during their teen years.

Those whose families weren't close and cohesive in the year after the loss had a higher risk of depression 6–9 years later (Birgisdóttir et al., 2023). Knowing about a child's losses—and about family dynamics—can help you determine the risk of depression for a child, even if the loss was years earlier.

Trauma

Trauma can have both initial and delayed symptoms that are like depression symptoms. When a trauma is recent, children may have symptoms like these:

- exhaustion
- sadness
- numbness
- blunt or flat affect
- anxiety
- confusion
- anger, fear, shame, and other strong emotion

These symptoms are not considered pathological in the aftermath of a trauma. Delayed or more severe trauma symptoms can include

- long-term fatigue,
- disrupted sleep,
- vulnerability to substance use disorder,
- physical symptoms such as headache and stomachache, and
- dissociation.

These symptoms can be part of depression, too.

The link between exposure to trauma and later depression is well studied. Recent research shows a higher depression risk among people who were first exposed to trauma in early childhood. The risk is particularly high for children who experience abuse before the age of 5 years. Even trauma exposure in middle childhood (ages 6 to 10) carries a depression risk nearly twice as high as children without trauma exposure (Dunn et al., 2017).

Research and Resources:

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Addressing Disparities in Depression Diagnosis

The American Academy of Pediatrics has stated that around half of the children in the U.S. with a treatable mental health condition don't get the care they need. Children and teens in minoritized groups often face additional barriers to mental health services, making care even harder to access.

Access to good mental health care can be limited by

- language barriers;
- lack of health insurance;
- practical difficulties such as transportation issues;

- lower rates of referral for screening or assessment;
- stigma around mental health conditions;
- fear of child protective services becoming involved;
- lack of cultural sensitivity or awareness in providers;
- use of ER or primary care for mental health services, where providers may not be as experienced with diagnosing depression;
- distrust of health care processes and providers; and bias in the diagnostic process.

When biases affect the diagnostician, the diagnostic measure, or the diagnostic criteria, the resulting diagnosis is likely to be less accurate for some groups than for others.

Here are some ways you can help to improve the accuracy of depression assessment and shrink the disparities in depression care:

- Use validated assessments that have been normed with widely representative populations, along with other sources of information that allow you to consider the whole child or teen in context.
- Seek out additional training in recognizing and reducing biases in assessment practice.
- Advance your knowledge of the historical misuse of psychological assessment and treatment so you can better understand any reluctance, anxiety, or distrust in patients.
- Become aware of variations in symptom presentation, such as intentional fighting and unsafe sex as means of self-harm.
- Add culturally sensitive components to your evaluation, such as assessing exposure to racism, personal beliefs about getting help for mental health, and faith perspectives on mental health care.
- Assess community connections and family cohesion as possible protective factors or sources of support.

- Be aware of power dynamics during evaluations, including the ways you may be perceived as an authority figure or a kind of “gatekeeper” to services.
- Build your connections within the communities you serve.
- Provide educational materials to children, teens, and families to reduce stigma and foster open conversations.

Learn more: How WPS Is Building Greater Diversity, Equity, and Inclusion

Research and Resources:

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Evidence-Based Interventions

With a clear picture of the way depression is affecting the life of a child in your care, you and your team can plan evidence-based interventions. The list below isn’t exhaustive, but it’s a good starting place for exploring interventions supported by research.

Shared Decision-Making

The American Academy of Pediatricians recommends that practitioners, children, and families collaborate when creating a treatment plan—especially when there are several evidence-based options available. A shared decision-making framework can be supported with questions like these:

- Is there more than one evidence-based treatment option?
- Are any of the options limited or guided by laws, regulations, or policies?
- Do the child and family fully understand the risks, costs, and benefits of each option?
- What are the family/individual values, preferences, and priorities that could shape treatment choices?
- Will financial stress or cultural perspectives affect treatment decisions?
- Have you considered the child's cognitive development, comfort, preferred activities, rights, and personal characteristics?
- Have the family and child had the time they need to ask questions?
- Are any of the options clearly better for the child, teen, or family, given the evidence and available resources?

Making treatment decisions can be stressful for everyone involved because so much is riding on the outcomes. On the other hand, shared decision-making offers everyone involved, especially the child, an opportunity to learn about depression, express fears and concerns, be heard, and build greater self-confidence through self-advocacy.

Clinical Interventions for Depression

In 2019, the American Psychological Association (APA) published the APA Clinical Practice Guideline for the Treatment of Depression. In it, the APA recommended the following interventions for treating depression in children and teens:

- After analyzing available research on medications and psychotherapy options, the APA said there is "insufficient evidence" for recommending any specific treatment for depression in children.
- After reviewing the evidence, the APA recommended both cognitive behavioral therapy and interpersonal psychotherapy, adapted for adolescents, as initial interventions for depression in teens.
- The APA also recommended fluoxetine as a first-line medication for treating depression in teens. If fluoxetine isn't an option, the APA recommends that families, patients, and practitioners share decision-making around other options.

- Based on its review of risks and safety concerns, the APA recommended against the use of certain other depression medications for teens. To review medication recommendations in detail, read the Guideline in full.

Psychotherapy

The American Academy of Child & Adolescent Psychiatry lists several types of therapy that may be useful in treating mental health conditions in young people, including

- cognitive behavioral therapy,
- acceptance and commitment therapy,
- dialectical behavior therapy,
- mentalization therapy,
- family therapy,
- interpersonal therapy,
- play therapy, and
- parent/child interaction therapy.

Lifestyle Interventions

Healthy habits can have a positive effect on depression symptoms. Here's a quick look at interventions that show some promise in reducing symptoms of depression.

Exercise

Physical activity has been shown to reduce depression symptoms in children and teens. Researchers say it's important to strike a balance: To be beneficial, exercise should be intense enough to make a slight change in breathing and heart rate—but not strenuous enough to deplete energy (Gu et al., 2022).

In one recent research review, researchers found that the most effective exercise interventions for teens with depression took place three times a week for at least 30 minutes, over a period of 6 weeks (Wang et al, 2022).

A word of caution: The nature of the activity could be important. For example, household chores that are physically demanding have been linked to increased depression in teens (Gu et al., 2022). Some studies have found that exercise is beneficial for children with depression when they find it positive, playful, and noncompetitive (Phillippot et al., 2019).

It's not just the physical movement that helps with depression symptoms. Exercise often happens in social settings, giving children a chance to connect with other people. Those social interactions can help children feel less alone.

Diet

There is some evidence that a healthy diet can influence depression symptoms, so it may be helpful to include a dietician on your evaluation or intervention team. Brain chemicals, including those associated with depression, can be affected by the foods people eat.

Here's a partial list of foods that have been linked to depression-related brain chemicals:

Brain chemical	Depression symptoms	Eat less	Eat more
acetylcholine	memory problems, confusion, forgetfulness, organization problems	processed foods, fried foods, sugar, alcohol	free-range eggs, wild fish (salmon, mackerel, sardines, tuna)
serotonin	sad or low moods, sleep problems, dissociation	alcohol	fish, fruits, eggs, poultry, avocado
dopamine	low motivation, desire for stimulants	tea, coffee, and other sources of caffeine	fruits, vegetables high in vitamin C, fermented foods
GABA	anxiety, irritability, self-criticism	sugar, alcohol, tea, coffee, caffeine	green vegetables, nuts, seeds, potatoes, eggs, bananas

(Dietary Recommendations Source: Khanna et al., 2019)

Diet has also been linked to inflammation, which has been implicated in depression and in a wide

range of autoimmune conditions. In fact, there is increasing evidence of “crosswalks” between the immune system and depression.

For example, long-term studies show that people with depression have up to a 2.5-fold increase in their risk of developing autoimmune conditions such as rheumatoid arthritis, inflammatory bowel disease, and systemic lupus erythematosus (Chan et al., 2019). In fact, some people initially diagnosed with depression later find out they have an autoimmune condition instead (Ravan et al., 2021).

Inflammation is linked to both autoimmune conditions and depression in children and teens. Researchers don’t go so far as to suggest that one causes the other, but the two may influence each other (Colasanto et al., 2020). More research needs to be done to understand whether dietary interventions could lower inflammation and reduce depression symptoms.

The good news is that 60–90% of teens with mild to moderate depression will improve within a year—though there is some risk that depression could recur within 5 years for some (Alsaad et al., 2022).

WPS is pleased to offer the expertise of our Assessment Consultants to help you select the right depression assessments for your needs. We also provide training and continued education to help you use assessment tools with greater ease and confidence.

Research and Resources:

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