Depression Toolkit for Primary Care Clinicians

The Patient Health Questionnaire (PHQ-9) Adolescent Toolkit

AmeriHealth Caritas
District of Columbia

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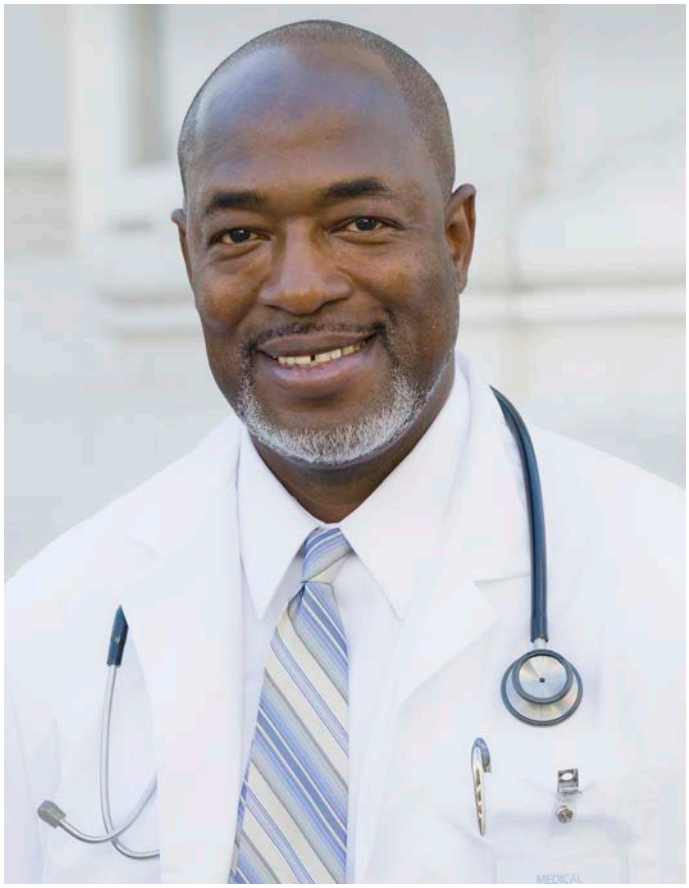

Introduction

At AmeriHealth Caritas District of Columbia we recognize the earliest and best opportunities to identify depression are in the offices of primary care providers, since depressive disorders are commonly seen in primary care settings. Teenage depression is a serious mental illness that affects millions of teenagers in the United States each year. Unfortunately only a small portion of teens with depression ever get professional help for their struggles. The STAR*D (Sequenced Treatment Alternatives to Relieve Depression) study found that nearly 40 percent of youth had their first depressive episode before the age of 18.[1]

Depression is associated with substantial morbidity and disability for individuals. Yet, depression is a highly treatable condition. AmeriHealth Caritas District of Columbia believes that primary care providers should be equipped to screen for depression and provide immediate treatment either in their own practices or by referring to a mental health professional. Toward this end, AmeriHealth Caritas District of Columbia is seeking your assistance in the identification and treatment of depression.

This Depression Toolkit is intended to help primary care clinicians effectively assess, treat and monitor depression in adolescents with this condition. The kit will provide you with easy-to-use tools to engage the member in the process of treatment, and to educate and empower the member to participate in his or her own treatment plan. As a clinician, you can effectively select an appropriate management approach for treating depression by using the evidenced-based guidelines and management tools for treating depression that were adopted by the American Psychiatric Association. These guidelines cannot replace good clinical judgment, and they should not be the sole source of guidance for adolescent depression management.

The screening process starts with the Patient Health Questionnaire (PHQ-9), a well-known and valid tool. You may already have this depression tool in your electronic health records system. If not, the PHQ-9 is included in this manual. The PHQ-9 is a nine-item self-report depression scale that guides the clinician in making criteria-based diagnoses of depression and assessing the severity of depressive disorders. Additionally, the measure's sensitivity to severity makes it useful in monitoring response to treatment.

The PHQ-9 is based on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual 5th Edition (DSM-5) and has excellent psychometric properties. Additional benefits in using the PHQ-9 are the short administration time and the easy score tabulation and interpretation.

AmeriHealth Caritas District of Columbia will support your screening process by providing staff who can guide your process and, if necessary, provide member outreach and interventions. Thank you in advance for your participation in this crucial program.

Recognition and Diagnosis of Depression in Adolescents

Recognizing depression and safety tools

AmeriHealth Caritas District of Columbia has adopted the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition. You can find this guideline online at the link below. The original guidelines are from 2010, but there was an update in December 2011 with no changes noted and the current guidelines were re-adopted.

http://psychiatryonline.org/guidelines.aspx

Additionally, Up To Date at **http://www.uptodate.com/home** is an excellent source for clinicians on updated research, evidence-based treatment and recommendations to improve patient outcomes.

Overall, the clinical picture of major depressive disorder in adolescents is similar to that of adults, but there are some differences. For example, adolescents may experience low frustration tolerance and exhibit social withdrawal instead of verbalizing their feelings of depression. They appear sulking, grouchy or negative. They often are critical of themselves and feel they are a failure, and do not recognize their feelings and symptoms as depression. Below is a resource that outlines some differences that might help you assess the adolescent.

Differences between teenage and adult depression

Depression in teens can look very different from depression in adults. The following symptoms of depression are more common in teenagers than in their adult counterparts.

- **Irritable or angry mood** — As noted above, irritability, rather than sadness, is often the predominant mood in depressed teens. A depressed teenager may be grumpy, hostile, easily frustrated or prone to angry outbursts.
- **Unexplained aches and pains** — Depressed teens frequently complain about physical ailments such as headaches or stomachaches. If a thorough physical exam does not reveal a medical cause, these aches and pains may indicate depression.
- **Extreme sensitivity to criticism** — Depressed teens are plagued by feelings of worthlessness, making them extremely vulnerable to criticism, rejection and failure. This is a particular problem for "overachievers."
- **Withdrawing from some people, but not all** — While adults tend to isolate themselves when depressed, teenagers usually keep up at least some friendships. However, teens with depression may socialize less than before, pull away from their parents, or start hanging out with a different crowd.

Source: Teen Depression: A Guide for Parents at **Helpguide.org**. All rights reserved. Helpguide.org is an ad-free nonprofit resource for supporting better mental health and lifestyle choices for adults and children. (2)

An adolescent is usually defined as being 13 – 18 years of age, but some literature supports expanding the age range, depending on the developmental status of the adolescent, to include 11- and 12-year-olds. Additionally, an individual between 18 and 21 years may be considered an adult, but the clinician can choose the adolescent version for the member if he or she chooses.

The use of the DSM-5 criteria and symptoms for depression is relevant to the adolescent population. Typical symptoms noted in adolescents include moodiness, a change in grades, a change in appetite or sleep, difficulty concentrating, and a lack of enthusiasm for or motivation in usual hobbies or activities.

DSM-5 diagnostic criteria for depression

For major depressive disorders, at least five of the following symptoms must be present most of the day for at least two weeks. Also, at least one of the first two symptoms must be present.

- Depressed mood
- Marked diminished interest in usual activities
- Significant increase or loss in appetite or weight
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Difficulty with thinking, concentration or making decisions
- Recurrent thoughts of death or suicide

Source: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition 2013. (3)

Addressing risk

Warning signs of adolescent suicide risk include talking or joking about committing suicide:

- Saying things like, “I’d be better off dead,” “I wish I could disappear forever,” or “There’s no way out”
- Speaking positively about death or romanticizing dying (“If I died, people might love me more”)
- Writing stories and poems about death, dying or suicide
- Engaging in reckless behavior or having a lot of accidents resulting in injury
- Giving away prized possessions
- Saying goodbye to friends and family as if for the last time
- Seeking out weapons, pills or other ways to kill themselves

Factors to consider in assessing suicide risk

- Presence, history, lethality of suicidal ideation, intent or plans
- Access to means for suicide and the lethality of those means, such as access to a firearm
- Lifetime history, nature, seriousness, and number of previous attempts and aborted attempts
- Presence of hopelessness, psychic pain, decreased self-esteem or narcissistic vulnerability
- Presence of severe anxiety, panic attacks, agitation or impulsivity
- Presence and history of aggression and violence
- Presence of alcohol or other substances
- Presence of psychotic symptoms, such as command hallucinations or poor reality testing
- Presence of acute or chronic psychosocial stressors, which may include actual or perceived interpersonal losses, financial difficulties or changes in socioeconomic status, family discord, domestic partner violence, and past or current sexual or physical abuse or neglect
- Absence of psychosocial support, such as poor relationships with family, unemployment, living alone, unstable or poor therapeutic relationship, or recent loss of a relationship
- History of childhood traumas, particularly sexual and physical abuse
- Family history of or recent exposure to suicide

Source: Adapted from APA's Practice Guideline for Assessment and Treatment of Patients with Suicidal Behaviors (4)

Suicide screening questions

1. In the past month, have you made any plans or considered a method that you might use to harm yourself? If yes, what?
2. There is a big difference between having a thought and acting on a thought. Do you think you might actually attempt to hurt yourself in the near future? If so, what is the plan?
3. Do you think there is any risk that you might hurt yourself before your next visit (with your doctor)?

Action steps	
No current thoughts with or without risk factors.	Continue to monitor the member and schedule follow-up appointments.
Current thoughts with no plan, or intent with or without risk factors.	Contract with the member for safety. Monitor him or her with each visit. Monitor his or her response to medication. Educate the member and his or her family. Provide a local crisis intervention number. Consider behavioral health referral if the member's thoughts continue despite support and treatment.
Current thoughts with a plan.	Immediate response: direct the member to a crisis center or local emergency room.

When initially assessing the member, the clinician should consider other conditions that may appear with depressive-like symptoms, such as hypothyroidism, medication side effects or the use of alcohol and street drugs that can influence presentation.

Use of the Adolescent Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9) can be self-administered before or during the office visit. The PHQ-9 can be found on the next page with scoring and further explanations to follow. The English version is available for you to use and reproduce as needed. Translations into other languages are available by going to **www.phqscreeners.com**. Many of the translations have been developed by the MAPI Research Institute using an internally accepted translation methodology.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
Little interest or pleasure in doing things.				
Feeling down, depressed or hopeless.				
Trouble falling or staying asleep, or sleeping too much.				
Feeling tired or having little energy.				
Poor appetite or eating.				
Feeling bad about yourself — or that you are a failure or have let yourself or your family down.				
Trouble concentrating on things like reading the newspaper or watching television.				
Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.				
Thoughts that you would be better off dead, or thoughts of hurting yourself in some way.				
In the past year have you felt depressed or sad most days, even if you felt okay sometimes?			☐ Yes	☐ No
If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?			☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult	
Has there been a time in the past month when you have had serious thoughts about ending your life?			☐ Yes	☐ No
Have you ever in your whole life tried to kill yourself or made a suicide attempt?			☐ Yes	☐ No
(Office use only) **Severity Score** _____				

PHQ-9 adapted from PRIME MD TODAY, developed by Dr. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, made possible by Pfizer, Inc. Used with permission from Pfizer, Inc. PRIME MD TODAY is a trademark of Pfizer, Inc.

Directions

1. The member should complete the PHQ-9 by circling the number that most closely reflects his or her thinking for the past **two weeks**
2. Add up each column and place the score at the end of column in the box
3. Add together column scores to get a total score. The PHQ-9 score for the nine items ranges from 0 – 27.
4. Interpret the total score by using the below box

PHQ-9 proposed treatment actions

PHQ-9 score	Depression severity	Proposed treatment actions
0 – 4	None to minimal	None
5 – 9	Mild	Watchful waiting. Repeat PHQ-9.*
10 – 14	Moderate	Treatment plan, and consider counseling, follow-up and/or pharmacotherapy.
15 – 19	Moderately severe	Active treatment with pharmacotherapy and/or psychotherapy.
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if the member shows severe impairment or poor response to therapy, initiate an expedited referral to a mental health specialist for psychotherapy and/or collaborative management.

* This may not be necessary until member is further in treatment. Source: Kroenke K, Spitzer, Psychiatric Annals (4).

Please note the final question of the PHQ-9 asks the member to report "How difficult have these problems made it for you to do your work, take care of things at home or get along with other people?" This single member-rated difficulty item is not used in calculating the PHQ-9 score or in diagnosis, but rather provides an impression of how the symptoms impair the member and can be useful in deciding or adjusting treatment options.

Treatment

The Texas Algorithm is one approach the clinician may want to review when treating depression. It can be viewed at: **http://www.pbhcare.org/pubocs/upload/documents/TMAP%20Depression%202010.pdf.**

Once the PHQ-9 is completed and scored, treatment planning should be initiated. Targeting both the member and the family may positively impact adherence and success in treatment. Member and family education, member symptom self-monitoring, and support from the clinician may successfully treat mild depressive symptoms. If the member scores higher or risk factors are high, safety planning may be necessary with clear follow-up with a behavioral health provider. Organized support groups in the community are another source of support and resources.

The clinician can start with educating the member and family members. The clinician should focus on causes, symptoms, course and different treatment options, as well as the risk to engage in each treatment. Active listening, problem solving and suggesting coping skills are the key responsibilities of the clinician. The parent or guardian also plays an important role in supporting the adolescent and offering additional vital information to the clinician about the adolescent's environment. The parent or guardian can also monitor progress and motivate the member to begin treatment. Interventions should always take into account the family's cultural and religious backgrounds.

Occasionally, the school may need to provide accommodations for the member to recover successfully. Of course, the parent and member will need to approve of the release of any confidential information to the school.

For adolescents with moderate to severe depression, specific types of therapy may be needed as well as pharmacological treatments. Several factors need to be considered in treating youth with moderate depression, including prior response to previous treatment, familial and environmental factors, and member and family preference. Counseling alone may be appropriate, but for some adolescents, therapy and medication may be necessary. The clinician will want to refer the member to a behavioral health specialist in adolescent therapy. A customer service representative at AmeriHealth Caritas District of Columbia can assist in finding a provider who meets the preferences of the member.

The Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders, written by the American Academy of Child and Adolescent Psychiatry, is a good resource on the treatment of children and adolescents. These practice parameters can be found at **www.aacap.org.**

There are different types of medication for the treatment of depression, such as selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitor (SNRIs), atypical antidepressants, tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs). The most widely prescribed antidepressants are the SSRIs in adults, and this is also true for adolescents. The SSRIs include well-known antidepressants such as Prozac, Zoloft and Paxil. Research suggests there is little difference in the effectiveness of these newer antidepressants, but there may be differences in side effects, costs and how long the medication takes to work.

The use of SSRI medications among children and adolescents ages 10 to 19 has risen dramatically in the past several years. Fluoxetine (Prozac) is the only medication approved by the FDA for use in treating depression in children ages 8 and older. The other SSRI medications and the SNRI antidepressant venlafaxine (Effexor) have not been approved for treatment of depression in children or adolescents, but doctors still sometimes prescribe them to children on an "off-label" basis. In June 2003, however, the FDA recommended that paroxetine not be used in children and adolescents for treating depression because it may increase the risk for suicidal behaviors in a small subset of adolescents. As with all medical decisions, doctors and families should weigh the risks and benefits of treatment for each individual patient.

The most common side effects associated with SSRI and SNRI include:

- Headache, which usually goes away within a few days
- Nausea, which also usually goes away within a few days
- Agitation, jitteriness
- Sexual dysfunction, reducing sex drive
- Sleeplessness or drowsiness, which may go away, but not for some individuals. Sometimes the dose may need reduction or the time of day to take the medication may need adjustment.

In 2004, the Food and Drug Administration (FDA) looked at medication trials of nearly 4,400 children and adolescents and found that 4 percent of those taking antidepressants thought about or tried suicide (although no suicides occurred), compared to 2 percent of those receiving placebos. In 2005, the FDA decided to add a warning to all antidepressant boxes indicating this increased risk of suicidal thinking or attempts. In 2007, they increased the age group to 25. Further comprehensive studies suggested the benefits of antidepressants likely outweigh their risks to children and adolescents with major depression and anxiety disorders. The latest information from the FDA can be found at **http://www.fda.gov/**.

Additionally, some members, especially adolescents, may respond to antidepressants by becoming overly talkative and overactive, and sleeping less than normal. These adolescents may be in a manic state and should be seen by a clinician for an evaluation to rule out bipolar disorder. For this reason, after completing the PHQ-9, a brief bipolar screener should be completed on any member you are considering for an antidepressant. Antidepressants are augmented with mood stabilizers for individuals with bipolar symptoms. It is also important to consider family history of bipolar disorder. A positive family history would increase the likelihood of bipolarity in the member. Below is a brief screener for manic symptoms.

Mania

Has there ever been a period of at least four to seven days when you felt very happy, excited and full of energy, or really agitated, or have your family, friends or a therapist said you were manic?

A "yes" response indicates the potential for bipolar disorder. The member should be assessed further for mania.

DSM-5 diagnostic criteria for bipolar disorder

For bipolar disorder, at least four of the following symptoms must be present most of the day for at least four – seven days. Also, one of the symptoms must be the first symptom listed.

- A period of persistent elevated, expansive or irritable mood
- Marked diminishment in sleep
- Pressured speech
- Flight of ideas or racing thoughts
- Distractibility
- Increased goal-directed activity or psychomotor agitation
- Excessive involvement in activities that have high potential for consequences (spending sprees or risky ventures)
- Inflated self-esteem or grandiosity

Source: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition 2013. (9)

Monitoring and follow-up

The goal of the acute phase is remission of symptoms, which should lower the PHQ-9 score. The clinician may repeat the PHQ-9 to measure the initial response after four weeks of an adequate dose of antidepressant or six weeks of counseling; however, the clinician may choose to repeat the PHQ-9 after true stability occurs, which could be several months into treatment. Below is a table that can guide treatment planning decisions.

Antidepressant only		
PHQ-9 score	**Treatment response**	**Treatment plan**
Drop of 5 points from baseline	Adequate	No change needed. Follow up in 4 weeks.
Drop of 2 – 4 points	Possibly adequate	May warrant an increase in antidepressant dose.
Drop of 1 point or no change or increase	Inadequate	Increase dose, augment, switch, and/or add psychiatric consultation or counseling.

Counseling only		
PHQ-9 score	**Treatment response**	**Treatment plan**
Drop of 5 points from baseline	Adequate	No change needed. Follow up in 4 weeks.
Drop of 2 – 4 points	Possibly adequate	Probably no treatment change needed. Share PHQ-9 with psychiatrist or psychologist.
Drop of 1 point or no change or increase	Inadequate	• If depression-specific psychological counseling (CBT, PST, IPT*), discuss with therapist and consider adding an antidepressant • Members satisfied in their other type of therapy consider antidepressant • Members dissatisfied in other psychological counseling, review other treatment options and preferences

*CBT — Cognitive Behavioral Therapy; PST — Problem Solving Treatment; IPT — Interpersonal Therapy

Source: Depression Management Tool Kit, MacArthur Initiative. (10)

To reduce the risk of relapse, ongoing medication treatment may be necessary for four to nine months, especially if there are additional risk factors for likelihood of recurrence, such as family history, co-occurring disorders or continued residual symptoms. Ongoing collaboration and communication are encouraged between clinician and psychiatrist or therapist. A release of information is necessary and should be completed at the time of referral.

A referral to behavioral health treatment may be necessary if the member is voicing:

- Threat of harm to self or others
- Significant change in emotions or behavior with no obvious precipitants
- A loss of function at home, school or work
- Poor response to current medication regimen
- Current or past trauma issues
- Chronic medical issues compounding behavioral health symptoms
- Recent psychiatric admission
- Poor response to current counseling offered by PCP
- Suggestion or knowledge of drug and alcohol issues
- Signs of changing to "manic" behaviors

Member resources

Materials are in the public domain and can be reproduced by clinicians.

In a recent Web-based survey conducted in 2009 by the National Alliance on Mental Illness, parents and caregivers of children and adolescents living with mental illness were asked to give feedback on their experiences discussing mental health concerns with primary medical providers and staff. Families were asked what would help them feel more comfortable. The top five responses that caregivers mentioned were:

- Resources — Include materials on mental health in waiting rooms
- Private area — Have a private area to discuss mental health issues with or without children present
- More knowledgeable staff — Evidence through discussions and materials that primary care staff are knowledgeable about mental health issues and resources
- Supportive, nonjudgmental staff — Show support to those with mental illness by actively listening, using positive language and providing prompts to discuss mental health concerns
- Screening tools, questionnaires and checklists — Ask about and screen for developmental, emotional and behavioral issues during well-child visits to help normalize mental health issues. Families want screening as a part of routine clinical practice.

The entire report can be accessed at:
http://www.nami.org/Content/ContentGroups/CAAC/PC&MHIntegrationSurveyReport_Final.pdf.

Member tools are located in the appendix.

Support and how to refer for behavioral health services

AmeriHealth Caritas District of Columbia can support members during their treatment phases. If you feel barriers are present that prevent our member from achieving his or her behavioral health care goals, such as medication noncompliance, not showing up for appointments, inappropriate use of the emergency room or limited knowledge concerning his or her behavioral needs, please call our Rapid Response and Outreach Team (RROT). A Member Intervention Request Form can also be completed and faxed directly to the RROT in lieu of calling. Both numbers are available on your contact list.

To refer a member for behavioral health treatment, please call the behavioral health managed care number provided on the member's card.

Reimbursement

The Behavioral Health screening code recommended for your state and based on the 2013 AMA CPT Manual will be reviewed by your AmeriHealth Caritas District of Columbia trainer.

Payment for completion of a PHQ-9 can occur at initiation of treatment (baseline) and one additional during treatment to establish adequacy of treatment.

Continuing medical education (CME) opportunities for the clinician

The Agency for Healthcare Research and Quality offers CME opportunities on various topics, including mental health, at: **http://www.effectivehealthcare.ahrq.gov/index.cfm/tools-and-resources/cmece-activities/#mental/**.

Additional resources for physicians

Kids Health:
http://kidshealth.org/teen/

American Foundation for Suicide Prevention:
http://www.afsp.org/understanding-suicide

Depression and Bipolar Support Alliance:
http://www.dbsalliance.org/site/PageServer?pagename=home

National Alliance of Mental Illness:
http://www.nami.org/

Mental Health America:
http://www.mentalhealthamerica.net/

American Psychiatric Association:
http://www.psychiatry.org/mental-health/

American Academy of Family Physicians/FamilyDoctor.org:
http://familydoctor.org familydoctor/en/diseases-conditions/depression.html

National Institute of Mental Health:
http://www.nimh.nih.gov/health/index.shtml

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10. MacArthur Initiative on Depression and Primary Care Depression Management Toolkit 2009, 3CM, LLC.

Additional references

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Cheung A, Zuckerbrot RA, Jensen PS, et al. Guidelines for Adolescent Depression in Primary Care (GLAD_PC): Part II-Treatment and Ongoing Management.

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Rapid Response and Outreach Team Numbers

State	Phone number	Fax number
Pennsylvania, Indiana, Nebraska	1-800-573-4100	1-800-647-5627
South Carolina	1-866-899-5406	1-866-279-6377
Louisiana	1-888-643-0005	1-877-724-4838
Florida	1-866-935-6686	1-855-894-6888
Washington, D.C.	1-877-759-6222	1-888-607-6405
Michigan	1-888-288-1722	1-855-851-0433

Appendix

Help Yourself

The first thing you can do is get help from your doctor, family, friends or a therapist, and people with depression can also do other things to help themselves.

Some simple things can lift your mood, such as exercising every day, eating healthy foods and getting the right amount of sleep. Also, just being around people who have a positive outlook can lift your spirits. Find an activity that you may enjoy doing with a group of people, such as yoga, dance, art, music or writing clubs. If you are on edge when you are in groups, you can draw, listen to music, play with your pet, watch a fun movie, sew or play computer games on your own. Spending too much time alone can make the depression worse, so try to find a balance between being alone and spending time with your family and friends.

Sometimes with depression you can also feel stressed out, nervous or even angry. These feelings can be confusing, but as your depression starts to lift, some of the anxiety and anger will also lessen. If you are feeling too much pressure at school or it takes you longer to do a task because you are nervous or upset, ask your teacher for more time. Talk to your parents or your doctor about what is bothering you. Sometimes just by talking about the anxiety and anger, they become manageable. You can do something about the anxiety by practicing deep breathing exercises or yoga, or listening to calming music. Usually some type of physical activity helps with anger. Writing all the reasons for your anger and then ripping the paper up and throwing it away can also help. If neither of these works, ask your doctor or therapist for other suggestions.

Here are some other ideas you can do to restore your mood and lift your depression:

1. **Identify.** Try to decide what may be causing your depression. When did you start feeling down? What was going on at the time? Did anything make it better or worse? Talking to a friend and hearing the words out loud may help you understand depression a little better. Sometimes people have a hard time talking to other people, even if they are friends, but you can still write your feelings down on paper. Just by writing the feelings down, you can see where they began more clearly.

2. **Plan.** Now that you have thought about how your depression started, you now think about what steps to take to lower your depression. Thinking about it but not taking any steps will not solve your depression. Take action! Set a few goals that are easy and realistic for you. Share the plan with your doctor, your therapist or your family. Look at it every day but take your time and don't be too hard on yourself. Changes are easier when you break them down into small steps. (See sample plan below.)

3. **Celebrate.** Don't forget to celebrate when you meet a goal! Reward yourself in some small way and share your success with your doctor, therapist and family. Now move on to the next goal! Be kind and patient with yourself. Think positive and your depression will get better over time.

Problem	Goals	Steps to my goal
Example: Tired and no energy	**Example:** I will feel like I have more energy and can do the things I want to do.	**Examples:** I will go to bed at 10 p.m. every night. I will exercise in the morning for 20 minutes before school. I will try not to nap after school by taking the dog for a walk instead.

Cómo ayudarte

Lo primero que puedes hacer es conseguir ayuda de tu médico, tu familia, tus amigos o un terapeuta, pero las personas con depresión pueden hacer otras cosas para ayudarse.

Algunas cosas sencillas pueden levantar tu estado de ánimo, como hacer ejercicio todos los días, comer alimentos sanos y conseguir dormir lo suficiente. También puede levantar tu ánimo el solo hecho de estar cerca de personas que tienen una actitud positiva. Encuentra una actividad que disfrutes hacer con un grupo de personas, como yoga, danzas, artes, música o talleres de escritura. Si te pone nervioso estar en grupos, puedes dibujar, escuchar música, jugar con tu mascota, mirar una película divertida, coser o jugar juegos de computadora solo. Pasar demasiado tiempo solo puede empeorar la depresión, de manera que trata de encontrar un equilibrio entre estar solo y pasar tiempo con tu familia y tus amigos.

A veces la depresión también te puede hacer sentir estresado, nervioso o hasta enojado. Estos sentimientos pueden confundir, pero a medida que tu depresión empiece a pasar, algo de la ansiedad y el enojo se pasarán también. Si estás sintiendo demasiada presión en la escuela o te lleva más tiempo hacer la tarea porque estás nervioso o molesto, pídele más tiempo a tu maestro. Habla con tus padres o tu médico sobre lo que te está molestando. A veces tan solo hablar de la ansiedad y el enojo los hace más controlables. Puedes hacer algo con la ansiedad si practicas ejercicios de respiración profunda, yoga o escuchas música relajante. Por lo general, algún tipo de actividad física ayuda con el enojo. Escribir todos los motivos de tu enojo y luego romper el papel y tirarlo también puede ayudar. Si ninguna de estas cosas funciona, pídele otras sugerencias a tu médico o a tu terapeuta.

Aquí tienes algunas otras ideas que puedes hacer para levantar tu estado de ánimo y mejorar la depresión.

1. **Identificar.** Trata de determinar qué puede estar causando tu depresión. ¿Cuándo empezaste a sentirte decaído? ¿Qué estaba pasando en ese momento? ¿Hubo algo que te hizo sentir mejor o peor? Hablar con un amigo y oír las palabras en voz alta tal vez te ayude a entender un poco mejor la depresión. A veces a las personas les cuesta hablar con otros, aunque sean sus amigos, pero podrías también escribir tus sentimientos en un papel. Con solo escribirlos, puedes ver con más claridad dónde empezaron.

2. **Planear.** Ahora que has pensado cómo empezó tu depresión, puedes pensar qué pasos dar para disminuirla. Pensar en ello, pero no dar los pasos no resolverá tu depresión. ¡Actúa! Fija nuevas metas que sean fáciles y realistas para ti. Comparte el plan con tu médico, tu terapeuta o tu familia. Míralo todos los días, pero tómate tu tiempo y no seas demasiado severo contigo. Los cambios son más fáciles cuando los divides en pequeños pasos. (Abajo puedes ver un plan modelo.)

3. **Celebrar.** ¡No te olvides de celebrar cuando alcanzas una meta! Recompénsate de alguna forma pequeña y comparte tu éxito con tu médico, tu terapeuta o tu familia. ¡Ahora a seguir con la próxima meta! Sé bueno y paciente contigo mismo. Piensa en positivo y tu depresión mejorará con el tiempo.

Problema	Metas	Pasos para alcanzar mi meta
Ejemplo: Cansado y sin energías.	**Ejemplo:** Me sentiré como si tuviera más energía y pudiera hacer lo que quiero.	**Ejemplo:** Me iré a la cama a las 10 p. m. todas las noches. Haré ejercicio 20 minutos a la mañana antes de ir a la escuela. Trataré de no hacer una siesta después de la escuela; en cambio, llevaré al perro a pasear.

This is to help you learn about your medical condition. It is not to take the place of your doctor. If you have questions, talk with your doctor. If you think you need to see your doctor because of something you have read in this information, please contact your doctor. Never stop or wait to get medical attention because of something you have read in this material.

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