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Depression in children

Learn how to determine the best treatment options using BNFC through MedicinesComplete

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Available through



Jenny is a 14 year old teenager who has gradually become withdrawn over the past two months, no longer participating in the activities she used to enjoy. Her friends have noticed Jenny's persistently low mood and that she has been missing school on a regular basis. Her teachers have noticed her frequent absence from school, scruffy presentation and lack of concentration; worried about Jenny they have alerted her mother.

These features have been present on most days during the two month period, progressively becoming worse. Her mother had initially thought Jenny was staying up late and studying due to increased demands from school and exam preparation, unaware that Jenny was persistently exhausted and had stopped socialising with her friends.



What are the core symptoms of depression?

Core symptoms of depression are a persistently low mood, loss of interest in normal activities, and feeling deflated with little or no energy. These negative feelings and thoughts interfere with daily life becoming an illness. Associated symptoms that determine severity are sleep and appetite disturbance, lack of concentration, agitation, low self-confidence, guilt or self-blame and suicidal thoughts or acts. The presence of a single core symptom for more than two weeks warrants investigation for any associated symptoms of depression.

BNFC depression treatment summary contains further information

Medicines Complete

Depression

BNFC for Children
Publication last updated on 08-Jul-25

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Depression

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Description of condition

Depression is characterised by persistent low mood which can present as irritability, fatigue, and/or a loss of interest or pleasure in most activities and may be accompanied by symptoms of anxiety.

Associated symptoms, which determine disease severity, are sleep and appetite disturbance, lack of concentration, low self-confidence, agitation, guilt or self-blame and suicidal thoughts or acts.

Based on the International Statistical Classification of Diseases (ICD-10), depression can be classified as mild (four symptoms), moderate (five to six symptoms) or severe (seven or more symptoms, with or without psychotic symptoms).

Depression in childhood is not common and can have a more gradual onset than in adults. Affecting twice as many adolescent females than males, depression often occurs with other behavioural disorders. In almost half of the cases it resolves spontaneously within the first year.

Which symptoms has Jenny shown that indicate possible depression?

Jenny has shown all three core symptoms for a significant period of time.

Which tool is used to diagnose depression in children and adolescents and how is it used?

The International Statistical Classification of Diseases (ICD-10) is used to classify depression. The severity of depression is classed by the number of depressive symptoms (including at least one core symptom). Under ICD-10, depression can be classified as mild (4 symptoms), moderate (5-6 symptoms) or severe (7 or more symptoms, with or without psychotic symptoms).

How would you class Jenny's depression severity? As an adolescent female, is Jenny more likely to be affected?

Jenny has the associated symptoms of poor concentration at school and diminished sleep resulting in tiredness which, combined with her core symptoms, indicates moderate depression. Children and adolescents can all be affected by depression, adolescent girls like Jenny are twice as likely to be affected than their male counterparts.

Her mother noticed Jenny's increasing weight loss and pale appearance which prompted her to contact the GP.

During the appointment, Jenny's GP undertook a full history and examination and recognised conceivable signs of depression with the addition of reduced appetite. Medically she has no other presenting or past conditions and does not take any regular medicines. She denies any use of alcohol or drugs. She did mention not wanting to go to school because of previous bullying and emotional abuse from another school pupil.

She was diagnosed with moderate depression with six features.



What is the most probable cause of Jenny's symptoms?

Bullying and emotional abuse.

Mild depression is amenable to psychological interventions, however, in Jenny's case moderate depression may require a combination of psychological therapy and drug treatment.

What are the aims of treatment?

The goals of therapy are to positively improve symptoms and mood, prevent illness from returning and support the person in leading a normal life.

As part of a shared decision plan, Jenny is not keen on medical intervention involving drug treatment. She would like to know what non-pharmacological therapies are available to her and how they can help.



What are the non-drug options for managing depression?

Non-drug treatment options include lifestyle changes and psychological therapy. Lifestyle changes include advice about good sleep hygiene to improve sleep outcomes, anxiety management, nutrition and healthy eating; and regular exercise following a structured programme to keep the body and mind focused on tasks. Options for psychological therapy could include cognitive behavioural therapy (either individual or group therapy where patients are taught to change their ways of unhelpful and negative thinking during depression and replace these with positive actions) or interpersonal psychotherapy (this helps patients deal with the social aspects of their depression).

Information on the non-pharmacological management of depression can be found in the treatment summary for depression in **BNFC**.

The screenshot shows the Medicines Complete website interface. At the top, there is a search bar with 'Depression' entered. Below the search bar, there are several icons representing different medical specialties. The main content area is titled 'Non-drug treatment' and includes the following text:

When assessing a child or young person with depression, take into account family history of mood disorders, experience of bullying or abuse, any alcohol and drug misuse and the possibility of parental substance misuse as this may impact on disease severity or affect treatment efficacy. **A**

Any comorbid diagnoses and developmental, social and educational problems should be assessed and managed, either in sequence or in parallel with the treatment for depression. **A**

St John's wort is a herbal remedy available without prescription for treating mild depression in adults. It should not be used for the treatment of depression in children. **A**

Lifestyle changes

Regular exercise (45 minutes to 1 hour per session, up to 3 times a week) following a structured programme for 10 to 12 weeks, should be encouraged. Give children, and their parents or carers, advice about good sleep hygiene, anxiety management, nutrition and the benefits of a balanced diet. **A**

Psychological therapy

Offer 3 months of psychological therapy as first-line treatment from a therapist trained in child and adolescent mental health, or a healthcare practitioner specifically trained in the psychological therapy. Therapy options include cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT), IPT for adolescents (IPT-A), non-directive supportive therapy (NDST), psychodynamic psychotherapy, family therapy, brief psychosocial

After 6 sessions of cognitive behavioural therapy (CBT) and lifestyle changes, Jenny and her mother noticed a partial response, however, Jenny had increased episodes of being tearful throughout the sessions. These sessions have helped Jenny admit she needs further support.



When would drug treatment be appropriate and what would be the most suitable first-line option?

For children aged 12 years and older, following a multidisciplinary review, combination therapy may be considered as an alternative to psychological therapy alone, or when psychological therapy has not been effective. In cases of moderate to severe depression, antidepressants should only be prescribed alongside ongoing psychological therapy.

See **NICE guidance 134** for further information. Depression in children and young people: identification and management.

The screenshot shows the Medicines Complete website interface. The search bar contains 'Depression'. The page title is 'Drug treatment'. The left sidebar has 'Subsections' and 'Related Content' tabs, with 'Drug treatment' selected. The main content area includes the following text:

Child aged 5 years and over

Antidepressants should not be used for the initial treatment of children with mild depression. For cases refractory to psychological treatment, antidepressant therapy may be considered under specialist advice. **A**

Drug treatment should only be prescribed following assessment and diagnosis by a child and adolescent psychiatrist. **A**

When an antidepressant is prescribed, the SSRI **fluoxetine** is the first-line treatment in children. **A**

The use of **fluoxetine** in children aged 5 to 11 years should be cautiously considered as effectiveness in this age group is not established. **A**

For moderate to severe depression, antidepressants should only be offered to children in combination with concurrent psychological therapy. **A**

In children aged 12 years and over, following multidisciplinary review, combination therapy can be considered as an alternative to psychological monotherapy, or in cases refractory to psychological therapy. **A**

Children should be carefully monitored at the start of treatment (for example weekly contact for the first 4 weeks or according to individual needs). Following remission (no symptoms and full functioning for at least 8 weeks).

The screenshot shows the 'Useful resources' section of the Medicines Complete website. It lists the following resources:

Depression in children and young people: identification and management. National Institute for Health and Care Excellence. National Guideline 134. September 2005 (updated June 2019)
<https://www.nice.org.uk/guidance/ng134>

Depression in children. National Institute for Health and Care Excellence. Clinical Knowledge Summary. March 2016
<https://cks.nice.org.uk/depression-in-children>

Selective serotonin reuptake inhibitors (SSRIs) and serotonin and noradrenaline reuptake inhibitors (SNRIs): use and safety. Medicines and Healthcare products Regulatory Agency. Guidance. December 2014.
<https://www.gov.uk/government/publications/ssris-and-snr-is-use-and-safety/selective-serotonin-reuptake-inhibitors-ssris-and-serotonin-and-noradrenaline-reuptake-inhibitors-snr-is-use-and-safety>

As a shared decision, Jenny agrees to start medication but has some questions. She is anxious and wants to know how long it will take for the medicine to work and how long she will need to take it for.



What information would you give Jenny and her mother about the side-effects of fluoxetine?

Prewarning Jenny of common side-effects and what to expect can help treatment success and ensure adherence. Common side-effects include anxiety, changes in appetite, arthralgia, stomach upset, vomiting, diarrhoea, constipation, taste disturbances, headache, dry mouth, dizziness and drowsiness to name a few. It is important to mention that although these are listed effects in the patient information leaflet, each patient is different and Jenny may experience very few or none of these.

Her mother is also concerned after reading on the internet that these drugs can cause many side-effects and even thoughts of suicide.

There is a link between suicidal thoughts and behaviour with the use of antidepressant drugs, particularly when used by children, adolescents or young adults. Children should be monitored carefully, especially at the beginning of treatment, with medication changes and at times of increased stress. If Jenny or her mother notice anything unusual and are concerned, they should discuss this with the doctor or a pharmacist.

Further information can be found in the Fluoxetine drug monograph in **BNFC**.

The screenshot shows the Medicines Complete website interface. At the top, there is a search bar containing 'Fluoxetine' and a 'BNFC' logo. Below the search bar, the page title is 'Fluoxetine' with a sub-header 'BNF for Children' and a note 'Publication last updated on 08-Jul-25'. The page is divided into two main sections: 'Subsections' and 'Related Content'. The 'Subsections' list includes 'Drug action', 'Indications and dose', 'Unlicensed use', 'Important safety information', 'Contra-indications', 'Cautions', 'Interactions', 'Side-effects', 'Pregnancy', 'Breast feeding', and 'Hepatic impairment'. The 'Related Content' section shows the 'Drug action' section, which states: 'For all SELECTIVE SEROTONIN RE-UPTAKE INHIBITORS : Selectively inhibit the re-uptake of serotonin (5-hydroxytryptamine, 5-HT)'. The 'Indications and dose' section is also visible, with a sub-section for 'Major depression' and 'By mouth', and a specific section for 'Child 5–17 years' detailing the initial and subsequent dosing regimen.

Jenny is concerned that fluoxetine may not work for her.



What other treatment options are there for treating depression?

In children who cannot tolerate or do not respond to fluoxetine, citalopram or sertraline may be considered under specialist supervision. These are not licensed for use in children but are supported by a strong evidence base. Antidepressant treatment may be augmented with antipsychotics under specialist care, in children with psychotic depression.

Further information including dosing for different age groups can be found in the drug monographs for Fluoxetine, Citalopram and Sertraline in **BNFC**.

The screenshot shows the Medicines Complete website interface. At the top, there is a search bar containing 'Sertraline' and a 'BNFC' logo. Below the search bar, there are several icons representing different categories or features. The main content area is titled 'Indications and dose' and is divided into two sections: 'Obsessive-compulsive disorder' and 'Major depression'. Each section provides dosing instructions for different age groups of children.

Indication	Route	Age Group	Dosing
Obsessive-compulsive disorder	By mouth	Child 6–12 years	Initially 25 mg once daily for 1 week, then increased if necessary to 50 mg once daily, then increased in steps of 50 mg at intervals of at least 1 week if required; maximum 200 mg per day.
		Child 13–17 years	Initially 50 mg once daily, then increased in steps of 50 mg at intervals of at least 1 week if required; maximum 200 mg per day.
Major depression	By mouth	Child 12–17 years	Initially 50 mg once daily, then increased in steps of 50 mg at intervals of at least 1 week if required; maximum 200 mg per day.

Other drugs such as paroxetine, venlafaxine and tricyclic antidepressants should **not** be used in children with depression unresponsive to fluoxetine. Electroconvulsive therapy may be suitable under specialist care.

Jenny has read about a herbal product called St John's Wort available without prescription. She asks whether a natural product might be better?

What would you advise Jenny and her mother?

St John's Wort is considered a herbal remedy, but it should not be used to treat depression in children. Although Jenny's mother believes natural products are safe, it's important she understands that they can still cause harm—St John's Wort can be toxic and is known to interact with various other medications.

BNF for Children aims to provide prescribers, pharmacists, and other healthcare professionals with sound up-to-date information on the use of medicines for treating children.



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MedicinesComplete makes it easy for health professionals to access essential medicines information at the point of care. Providing trusted evidence-based knowledge for confident decision-making and effective patient care.



For more information on accessing BNF and BNFC through MedicinesComplete go to PharmaceuticalPress.com/products/bnf-for-children

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