

Depression

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## Depression

Depression is one of the most common disorders that effects people of all ages and ethnic backgrounds. It can affect every part of a person's life, including their physical, emotional, and psychological well-being. People who suffer from depression generally experience a persistent feeling of sadness or despair, loss of interest and energy, and the inability to experience pleasure. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised (2000) defines depression as the following:

- A. Five (or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either
  - (1) depressed mood or
  - (2) loss of interest or pleasures.
- (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
- (2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
- (3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
- (4) Insomnia or hypersomnia nearly every day

- (5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
  - (6) Fatigue or loss of energy nearly every day
  - (7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
  - (8) Diminished ability to think concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
  - (9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- B. The symptoms do not meet criteria for a Mixed Episode
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g.,hypothyroidism).
- E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Common depression symptoms to look for in children and adolescents is irritability, hypersomnia, and hopelessness. Suicidal ideation and attempts are not common in childhood, but become more so during adolescences.

### **Prevalence**

Prevalence of depression depends greatly on the age and sex of an individual. For example, the National Institute of Mental Health estimates that depression effect 9.5% of the adult population, or about 20 million Americans per year (2009). For adolescents the prevalence rate is as high as 5-10% (Denton et al., 2002). Some studies put the prevalence rate as high as 14% for ages 15-18 (Hamrin & Pachler, 2005). The rate of depressed females to males increasing during puberty to 2-3 depressed females to one depressed male (Wade, Cairney,& Pevalin, 2002).

Comorbidity is very common among adolescents with depression. In a study done by Greene et al. (2002), 30% of clinically referred youths diagnosed with severe major depression also had conduct problems, and of those with conduct problems, 50% had major depression. Generalized anxiety disorder also had high comorbidity with depression. Studies have found that over half of those who suffer from depression also have an anxiety, and over half of those who have an anxiety disorder also have a depressive disorder (Brown et al. 2001). Attention Deficit Hyperactivity Disorder (ADHD) also has a high comorbidity with depression. People affected with depression are at a higher risk for poor outcomes such as: substance abuse, academic problems, high-risk sexual behavior, physical health problems and are thirty times more likely to commit suicide (Birmaher et al., 1996).

### **Assessment for Depression**

There are several diagnostic instruments that have been designed to use with children and adolescents. Many of these rely on information from parents, guardians, and/or teachers; however, there is a discrepancy between child and adults reports. An explanation offered by Reynolds (1994) is that many internalizing symptoms are not easily observable, and it is best to use the child when gathering information about their depression.

### **Children's Depression Inventory (CDI)**

The CDI is one of the most widely used self-report measures used to assess depression in children seven years in age to adolescents of seventeen years. Youths are asked to assess their mood over the past two weeks. The CDI is widely used in the schools because it has acceptable validity and reliability, is relatively easy to complete and score, and has a cut-off point for screening for depression.

### **Mood and Feeling Questionnaire (MFQ)**

The MFQ is a self-report instrument for youths ages eight to eighteen. It also has a parent report form that can be also be completed. Both the self-report and parent report are available in a short form that has thirteen questions. The MFQ has can distinguish between nondepressed, moderately depressed, and severely depressed youths. All four forms are available free of charge on the internet at <http://devepi.duhs.duke.edu/mfq.html>.

### **Reynolds' Child Depression Scale Second Edition (RADS-2)**

The RADS-2 consists of thirty questions to assess depression in individuals from eleven to twenty years old. It was designed to correspond closer to the DSM-IV-TR criteria. The RADS-2

also has demonstrated reliability and validity. It can be completed and scored quickly, typically in five to ten minutes.

### **Reynolds Child Depression Scale (RCDS)**

The RCDS is a thirty item self-report measure of depression. It can be used on children in grades three through six. Items are scored on a four point scale with smiley faces ranging from sad to happy. It has good validity and reliability.

### **Center for Epidemiological Studies -Depression Scale for Children (CES-D)**

The CES-D is a self-report measure for youths ages seven to seventeen. It consists of twenty questions rated on a three-point scale ranging from “not at all” to “a lot.” Scores of twenty-seven and higher can be indicative of significant levels of major depression. It has good validity and reliability. It is widely available at no cost in the public domain and the internet.

### **Treatment for Depression**

Treatment for depression typically falls into two categories: cognitive-behavior therapy and psychopharmacological. According to the Treatment for Adolescents with Depression Study (TADS, 2004) team, combined therapy of fluoxetine with cognitive-behavior therapy has the most favorable outcomes for individuals with depression. An interesting finding of this study is the rate at which individuals respond to treatment. It found that, after 12 weeks, 73% of individuals responded to combination therapy, 62% of individuals responded to fluoxetine alone, and only 48% responded to cognitive-behavioral therapy alone. The study also contrasts this to rate after 36 weeks, 86% of individuals responded to combination therapy, 81% of individuals responded to fluoxetine alone, and 81% of individuals responded to cognitive-behavioral therapy.

In 2004 the FDA issued a “black box” warning on all antidepressants, not just SSRIs, to underscore the possible risks and thus encourage clinicians and parents to consider alternatives to medication. However, according to the TADS (2004) study, taking benefits and harms into account, combined treatment appears superior to either monotherapy as a treatment for major depression in adolescents.

The TADS (2004) study also studied the suicidal events associated with giving adolescents fluoxetine and found that suicidal ideation was present in 29% of the individuals at the start of the study. Combination treatment of fluoxetine and cognitive-behavioral therapy showed the greatest reduction, suicidal attempts decreased to 1.6%, and there were no completed suicides.

The following are selective serotonin reuptake inhibitors (SSRIs) for depression in children and teens:

\*Fluoxetine (Prozac)

Sertraline (Zoloft)

Fluvoxamine (Luvox)

Citalopram (Celexa)

Escitalopram (Lexapro)

\*Approved by FDA, NIMH for use in children and adolescents.

### **Cognitive-Behavioral Therapy for the Treatment of Depression**

According to a study by David-Feron (2008), there are a few cognitive-behavior therapy techniques that can be implemented in schools that have been found to be well-established evidence-based treatments. One that has been studied extensively is the Penn Prevention Program (PPP). PPP (Roberts, 2003) is a twelve week course designed to address depressive symptoms in at-risk students ages ten through fifteen. PPP consists of two components: cognitive and social

problem solving. The cognitive component includes: thought catching-noticing negative thoughts that affect mood and behavior, evaluating the accuracy of these thoughts and generating more accurate explanations when bad things happen, and decatastrophising. The second part of the program, problem solving, teaches dealing with family conflict, assertion and negotiation, coping skills, social skills training, and decision making. In addition, this portion of the program taught the children skills for managing parental conflict, and behavioral techniques to enhance assertiveness, and relaxation.

Another cognitive-behavioral therapy program mentioned by David-Feron (2008) as a well-established evidence-based practice is Coping with Depression (Clarke & Lewinsohn, 1984; Kahn et al., 1990). The components of this program are: social skills, negotiation, problem solving, relaxation training and video self-modeling. Social skills and relaxation training are components of PPP and Coping with Depression. These skills are key components to effective depression reducing programs.

### **Social Skills Training**

There are many social skills training programs to choose from, but the most successful feature three components (Weissberg & Greenberg, 1998). First, programs are most effective when they are relevant to the challenges that children actually face. Second, programs that teach social competence over several years have been found to have the greatest impact. Last, programs that provide not only training but the opportunity to utilize new skills in a reinforcing environment are most likely to promote and sustain change.

Second Step, a curriculum for teaching anger management, offers the following social skills for young children (Frey, Hirschstein, & Guzzo, 2000):

Joining In (when others are playing):



1. Ask, "What are you doing"
2. Say something nice about it.
3. Ask, "May I play with you?"

#### Sharing:

1. Say, "I like to (name what the other person is doing)."
2. Ask to share by saying, "Will you share that with me?"

#### Taking Turns:

1. Say, "I would like to have a turn."
2. Do something else while you wait.

#### Trading:

1. Chose something the person might like.
2. Say, "Would you like to trade this for that?"

#### Paying Attention:

1. Look at and listen to the teacher.
2. Turn away from people who try to get your attention.

Another social skills training program, Cool Kids, add to the following to important social skills for children to know (Fister-Mulkey, Conrad, & Kemp, 2000):

#### Listening

1. Look
2. Allow speaker to finish
3. Show you are paying attention

#### Following Instructions

1. Look and listen

2. Say, “OK”
3. Do it right away

#### Giving a Compliment

1. Look and smile
2. Use a pleasant voice
3. Make a positive remark about the human being

#### Accepting Feedback or Correction

1. Look and listen
2. Say, “OK”
3. No arguing, whining, or pouting

Cool Kids also lists steps for: disagreeing, greeting, interrupting, making an apology, making a request, accepting “no,” getting an adults attention, and working together. This program also advises adults to prompt students before they need to use a skill, for example: “Get ready to use your skill for (name a skill and review the steps if necessary).”

A “One-Minute Skill Builder” exercise is taught as an important step that allows adults to give children immediate feedback on how they are doing. If a student has forgotten to use a pre-taught social skill, an adult does the following:

#### Express Regard

1. Make eye contact
2. Say name
3. Move close
4. Use a pleasant voice and facial expression
5. Use touch if appropriate

### Describe the Behavior/Give a Reason

1. “Just now . . .” or “Just a minute ago . . .”
2. “When you were given/asked (name the skill), you (specifically describe the behavior).”
3. “A better way to (name the skill) because (give a reason).”

### Practice/Check for Understanding

1. “Let’s try that again. This time you need to use the steps for (name the skill).”
2. “Do you understand?”

### Give Feedback

1. “Nice job! That time you remembered to use the steps for (name the skill).”

Cool Kids also encourages using the following steps if a child is caught spontaneously using a pre-taught social skill:

### Express Regard

1. Make eye contact
2. Say name
3. Move close
4. Use a pleasant voice and facial expression
5. Use touch if appropriate

### Acknowledge/Make a Statement Like:

1. “Nice job”
2. “Wow, that was great!”
3. “How nice!”

### Describe Behavior

- “You remembered to (name the skill) by (say steps for skill).”

### Give a Reason

“It’s important to behave that way because (provide rationale).”

These steps may seem simple and obvious, but for children struggling with social skills deficit they are not. Teaching steps to frequently used social skills give all children an optimum chance to succeed and prevent depression.

### Relaxation Training

Relaxation training is another key component of depression prevention programs. It has typically been used for children with stress, sleep disturbance, hyperactivity and impulsivity problems, but it has also been shown that relaxation is an effective part in empirically supported treatments for children with phobias and anxiety disorders (Ollendick & King, 1998). Because it is so helpful for a variety of problems children face, it is an important part of depression prevention.

There are a variety of ways of teaching relaxation training for young children. According to a study by Heffner, Greco, and Eifert (2003), children understand relaxation training best when it is described to them in a metaphor versus literally describing each step. For example, a child would have a better chance of understanding the phrase, “pretend you are a turtle, and squeeze your head into your shell,” rather than a command to tense and relax major muscle groups in the shoulders and neck. This same study uses other metaphors to teach relaxation, such as:

The first game we will play is called the hand/ lemon game. For this game, we are going to squeeze our fist/a pretend lemon like this (experimenter demonstrates and child practices).

Good job! Next, we will play the arm/cat game, and for this game, we are going to stretch our arms up high like a fat, lazy cat (experimenter demonstrates and child practices). Great!

Then, we will play the shoulder/turtle game, and for this game, we are going to put our heads down into our chest and lift our shoulders up to our ears . . . just like a turtle going

into its shell (experimenter demonstrates and child practices). That's right! Finally, we will play the mouth/jawbreaker game, and for this game, we are going to bite really hard on a pretend jawbreaker candy that's really, really hard to chew (experimenter demonstrates and child practices).

### Conclusion

Depression is a wide-spread mental health concern affecting five to ten percent of the adolescent population. Children and adolescents who suffer from depression are at a greater risk of having a recurrent episode. There are many effective treatments for depression that include psychopharmacological and cognitive-behavior therapy, with a combination of both for maximum results.

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