http://www.supreme.state.az.us/casa/prepare/depression.html

Childhood Depression

Clinical depression goes beyond sadness. It's more than having a bad day or coping with a major loss such as the death of a parent, grandparent, or even a favorite pet. It's also not a personal weakness or a character flaw. Youth suffering from clinical depression cannot simply "snap out of it."

As many as one in every 33 children and one in eight adolescents may have depression. Two-thirds of children with mental health problems do not get the help they need. Suicide is the third leading cause of death for 15- to 24-year-olds and the sixth leading cause of death for 5- to 15-year-olds.

Depression is a brain disorder (mental illness) that affects the entire body. Depression affects the way one feels, thinks, and acts. Early-onset depression in children can lead to school failure, alcohol or other drug use, and even suicide. Fortunately, it is highly treatable.

Misconceptions

There are two main misconceptions about childhood depression. The first actually applies to both adults and children. This misconception is that someone can just get over depression. Clinical depression is more than just feeling "blue." Everyone can feel "down" from time to time. This can be attributed to stress or unhappiness with some aspect of their life. While depression may appear similar to these down moods, it is much more pervasive and can even be life threatening. Clinical depression also is not triggered by a single event in a person's life.

The second misconception is that children do not have any reason to be depressed. Childhood is viewed as a carefree period of life. Adults forget that children are essentially powerless and have no control over their lives. Children also have to deal with peer acceptance, school life, and any pressures or expectations that their parents have. This can be a difficult situation to live with day to day.

Risk Factors

In childhood, boys and girls appear to be at equal risk for depressive disorders; but during adolescence, girls are twice as likely as boys to develop depression. Diagnosis of depression in children is not as clear-cut as it is for other ailments. There are no tests that can be given which will positively say that an individual has depression, much less pinpoint the causes. Studies have shown that certain children have risk factors in their lives which could predispose them to depression or "trigger" depression. Some of the recognized risk factors are:

- Stress
- Cigarette smoking
- A loss of a parent or loved one
- Break-up of a romantic relationship
- Attention, conduct, or learning disorders
- Chronic illnesses, such as diabetes
- Abuse or neglect

- Other trauma, including natural disasters

However, some infants exhibit depressive symptoms at an early age before most of these factors come into play, so an argument can be made for depression being wholly chemical in some children. Researchers also feel that children inherit a predisposition to depression and anxiety, but that environmental triggers are necessary to elicit the first episode of major depression.

Family history and genetics can have a connection to whether a child develops depression. Factors associated with childhood depression include inconsistent parenting, stressful life experiences, and a negative way of viewing the world. Research suggests that parental patterns of irritability and withdrawal lead to low self-esteem in the child, and this poor self-image predisposes the child to depression. Childhood depression is also associated with a family history of mood disorders and with the existence of other psychiatric conditions. If a parent has had childhood or recurrent depression, the child is at an even higher risk of developing depression. When depressed adults are asked about their childhood experiences, they are more likely to report neglect, abuse, rejection, and parental conflict. It is also noteworthy that 30-40% of affectively ill children will have a biologic parent who is also affectively ill (most commonly depression) at the time the young person presents for initial evaluation.

Each child's depression is individual, and causes will be different for each one. The depression could be wholly chemical, wholly due to psychological factors, or a combination of the two. More important than the cause is identifying the illness and treating it.

Early Signs

Before a child ever receives professional attention, they exhibit symptoms of depression. Family, friends, and even some doctors may discount this behavior as being part of adolescence or side effects of growing older. But in depression the symptoms are pervasive and long lasting. They do not pass with the "bad day" or the mood swing.

Here is a list of symptoms that can indicate a child is suffering from depression.

- Bad temper, irritable, easily annoyed, quarrelsomeness, lack of respect for authority, and difficulty getting along with others
- Change in sleep habits, insomnia
- School performance has dropped, indecision, lack of concentration, or forgetfulness
- Withdrawal from friends and loss of interest most activities
- Repeated physical complaints without medical cause (unexplained aches and pains)
- Fatigue and loss of energy nearly every day
- Significant increase or decrease in appetite
- Persistently discouraged and sad, and feelings of being helpless, hopeless, or worthless

Serious And Critical Symptoms

- Suicidal thoughts, feelings, or self-harming behavior
- Abuse or prolonged use of alcohol or other drugs
- Symptoms of depression combined with strange or unusual behavior

There are several useful tools that evaluators use for screening children and adolescents for possible depression. When a youngster screens positive, a comprehensive diagnostic evaluation by a mental health professional is warranted. The evaluation should include

interviews with the youth, parents, and when possible, other informants such as teachers and social services personnel.

Diagnosis

It usually takes more time to diagnose major depression in a child than in an adult. The diagnostic process includes interviews of parents and the child. Parents are more likely to report outward signs of depression, while the child may be more aware of inward signs. But children and young adolescents with depression may have difficulty in properly identifying and describing their internal emotional or mood states. For example, instead of communicating how bad they feel, they may act out and be irritable toward others, which may be interpreted simply as misbehavior or disobedience. Research has also found that parents are even less likely to identify major depression in their adolescents than are the adolescents themselves. Sometimes a parent's report is skewed by the parent's own agenda, so school and other outside reports are useful.

The correct diagnosis of depression is complicated. There are many alternative diagnostic systems and criteria for depressive syndromes. Using the Diagnostic and Statistical Manual of Mental Disorders, there are four diagnostic categories involving depression.

1. *Major Depression* - A severe form of depression that may involve disturbed sleep, appetite, suicidal thinking or self-harming behavior, loss of interest, problems thinking or concentrating, fatigue or loss of energy, restlessness or lethargy, and lowered self-esteem.
2. *Dysthymia* - A less severe form of major depression in which symptoms are less evident and may appear chronic and last more than 2 years.
3. *Separation anxiety disorder* - Depressive symptoms that are clearly associated with a child's separation from those to whom he or she is attached.
4. *Adjustment disorder with depressed mood* - Depressive symptoms that emerge as a reaction to an identifiable psychosocial stressor. The reaction is viewed as maladaptive and the symptoms are considered in excess of what is usually expected.

To diagnose a child with depression, both dysphoric moods (a state of feeling unwell) and self-deprecatory ideation must be manifest. Examples of these criteria are listed on the Early Signs page of this training module. A depressed child should exhibit at least four of the listed behaviors. Most young people diagnosed with depression actually match seven or eight of the criteria.

Other Syndromes

Depression in children often co-occurs with other mental disorders, most commonly anxiety, disruptive behavior, or substance abuse disorders, and with physical illnesses, such as diabetes. Children can also suffer Attention Deficit Disorder, and, especially in teenage girls, eating disorders and self-injury. Studies have shown a cyclical effect between eating disorders and depression. Clinical depression can lead to eating disorders and eating disorders can lead to clinical depression.

Here is a list of several of the illnesses that can effect depressed children. If you would like more specific information on any of these illnesses and how they relate to depression, click here.

- Addiction
- Anxiety and Panic
- Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
- Borderline Personality Disorder
- Eating Disorders
- Obsessive-Compulsive Disorder

- Seasonal Affective Disorder
- Self-Injury

Almost one-third of 6- to 12-year-old children diagnosed with major depression will develop bipolar disorder within a few years. Children diagnosed with one of the above syndromes may also have depression as an underlying illness. In any case, when there are multiple disorders affecting a child, all of the disorders need to be treated at the same time for treatment to be effective.

Treatment

Depression and other patterns of manic-depressive disease are chemical disorders of the brain. They can occur spontaneously or be promoted or induced by other medical illnesses, drugs and medications, and environmental events.

A large number of strategies have been developed for the treatment of depression. Many of these approaches can be implemented individually, in groups, or family therapy environment. The management of children, adolescents, and young adults with affective illness should be multimodal. Patients must be informed about the nature, course, and treatment of this disease. There is considerable evidence to suggest that interventions which emphasize treatment of the family, and not just the "identified patient," are critical to positive treatment outcomes. Peer group approaches have been found to be effective for children. Play therapy is sometimes appropriate with younger children.

Here is a list of different treatment methods that are used for depression.

- *Cognitive* - Cognitive approaches utilize specific strategies designed to alter negatively-based cognitions. Depressed patients are trained to recognize the connections between their thoughts, feelings, and behavior; to monitor their negative thoughts; to challenge their negative thoughts with evidence; to substitute more reality-based interpretations for their usual interpretations; and to focus on new behaviors outside treatment.
- *Behavioral* - Behavioral approaches designed to increase pleasant activities include several components such as self-monitoring of activities and mood; identifying positively reinforcing activities that are associated with positive feelings; increasing positive activities; and decreasing negative activities.
- *Social Skills* - Social skills training consists of teaching children how to engage in several concrete behaviors with others. Initiating conversations, responding to others, refusing requests, making requests, etc. Children are provided with instructions, modeling by an individual or peer group, opportunities for role playing, and feedback. The object of this approach is to provide children with an ability to obtain reinforcement from others.
- *Self-Control* - Self-control approaches are designed to provide the self-control strategies including self-monitoring, self-evaluation, and self-reinforcement. Depressive symptoms are considered to be the result of deficits from one or more areas and are reflected in attending to negative events, setting unreasonable self-evaluation criteria for performance, setting unrealistic expectations, providing insufficient reinforcement, and excessive self-punishment.
- *Interpersonal* - Interpersonal approaches focus on relationships, social adjustment, and mastery of social roles. Treatment usually includes non-judgmental exploration of feelings, elicitation and active questioning on the part of the therapist, reflective listening, development of insight, exploration and discussion of emotionally laden issues, and direct advice.
- *Medications* - Several classes of medications are used with adult populations. Major types include monoamine oxidase inhibitors (e.g., phenelzine), tricyclics (e.g., imipramine and amitriptyline) and SSRIs (e.g., Prozac, Paxil, Zoloft, Serazone, Luvox), but other classes have emerged as well. While these drugs are not without side effects, they have been shown to be 50-70% more effective with adults than placebos and no other treatment. Very little is know about the

safe use of antidepressants with children. The risks and side effects of medications, and the findings that competent therapy and counseling interventions may be more effective restrict, the use of medications with children.

Medication as a first-line course of treatment should be considered for children and adolescents with severe symptoms that would prevent effective psychotherapy, those who are unable to undergo psychotherapy, those with psychosis, and those with chronic or recurrent episodes. Following remission of symptoms, continuation treatment with medication and/or psychotherapy for at least several months may be recommended by the psychiatrist, given the high risk of relapse and recurrence of depression. Discontinuation of medications, as appropriate, should be done gradually over a period of 6 weeks or longer.

Antidepressant medication for children is a controversial topic. Currently no medications have FDA approval for use with children, although most of the major drug companies have submitted data. There are no long-term studies that show what kind of impact this medication will have on a child's development.

If a child's depression has been caused wholly or in part by psychological factors, medication may relieve the depression, but the underlying cause will not be "cured" by medication alone. Therapy can help the child deal with his past in a healthy manner, and to learn ways to cope with the very difficult process of growing up.

Recent research shows that certain types of short-term psychotherapy, particularly cognitive-behavioral therapy (CBT), can help relieve depression in children and adolescents. CBT is based on the premise that people with depression have cognitive distortions in their views of themselves, the world, and the future. CBT, designed to be a time-limited therapy, focuses on changing these distortions. A study supported by the National Institute of Mental Health (NIMH) found that CBT led to remission in nearly 65 percent of cases, a higher rate than either supportive therapy or family therapy. CBT also resulted in a more rapid treatment response.

Psychotherapy is almost always the first treatment of choice, except in cases where depressive symptoms are so severe or critical that immediate relief is necessary to restore functioning and to prevent immediate and severe consequences. Medication is usually the second choice after a comprehensive and competent trial of psychotherapy. Combined use of medications and psychotherapy at the onset of treatment can confound evaluation of treatment effectiveness and the observed source of change. It is harder in a combined medication and therapy approach to tell which approach is or is not helping and how much it is helping. However, research has found that combined psychotherapy and medication is often necessary and beneficial. Psychotherapy can be a very effective alternative to the use of medications.

Psychotherapy requires significant commitment whereas treatment of depressive disorders with medication requires less effort. Since normal depression can improve over time and without therapy, a brief period of medication may not be of benefit. Psychotherapy can be helpful in cases of normal depression and can help insure the condition does not become chronic. Psychotherapy can generally be considered ineffective if a trial of three months has not produced a measurable and noticeable improvement. A decision to change therapists or to start a medication may be necessary at this point. Antidepressant medications require a substantial period of time before they take effect and several trials of different medications may be necessary to find a medication that actually works. Medications alone appear to be helpful in approximately 50% of the cases. However, the use of medications require a substantial commitment for a period of time up to nine months. In some cases, a patient can terminate their medications after six to nine months without a risk of relapse. Unfortunately, there is no way to know if a person will relapse. Several trials of psychotherapy or medications may be necessary to successfully treat depressive disorders.

The prognosis for treatment of depression in children is good. Positive treatment outcomes are primarily dependent on a correct diagnosis, an understanding of the etiology, and implementing an appropriate intervention.

Family Advice

If parents or other adults in a child's life suspect a problem with depression, there are a couple of tasks they can do to help the child. First, be aware of the behaviors and note how long the behaviors have been going on, how often they occur, and how severe they seem. This will allow a professional to better diagnose what is happening in the child's life and set up possible treatment options. Second, see a mental health professional or the child's doctor for evaluation and diagnosis. The child can not fully recover without the help of professionals. Some individuals have only one episode of depression, but often depression becomes a recurrent condition. A doctor can educate the child and family about the early warning symptoms of depression so that the family can recognize when depression is reoccurring and get immediate help. The doctor can also teach the child and family about therapies to help reduce the chances of reoccurrence.

It is very important for parents to understand their child's depression and the treatments that may be prescribed. Physicians can help by talking with parents about their questions or concerns, reinforcing that depression in youth is not uncommon, and reassuring them that appropriate treatment with psychotherapy, medication, or a combination can lead to improved functioning at school, with peers, and at home with family.

The following are some suggestions about how caregivers can help a depressed child function in normal life and aid in their recovery.

- Seek advice and consultation as soon as possible from a qualified mental health professional if the symptoms of depression are severe, prolonged, debilitating, unexplained, or unusual.
- Learn more about any medications the child is taking. Ask the child's physician and pharmacist about potential interactions and side effects.
- A normal depression is usually temporary, can come and go, but should diminish over time. Allow the child space and time.
- Maintain a regular and nutritional diet. Avoid meal skipping. A proper diet is a critical source of energy and the child's ability to cope and recover.
- Maintain a regular sleep cycle. Avoid the child sleeping or napping during the day if it is difficult to sleep during regular times. Irregular sleep patterns prolong or worsen symptoms of depression.
- Maintain regular or routine physical activity that is appropriate for any existing medical condition. Activity can help relieve or manage depression.
- Spend time with the child, be caring, listen well, and be understanding.
- Stay involved and avoid extended isolation from positive activities and influences.
- Take time on a regular basis to help the child enjoy pleasurable activities and recreational interests.

With proper treatment children with depression can have functional happy lives. If depression goes untreated, it can dramatically impact a child's entire life and even lead to suicide. Family support is critical in helping a child deal with depression and to improve self-image.