Instant Help for
Children and Teens with Depression

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Defining the Problem

Depression is more than just "the blues." It is a treatable illness that can range from mild to severe. Dysthymia, the mild form, involves long-term, chronic symptoms that do not seriously debilitate but do prevent a sense of general well-being. Many people with dysthymia also experience more severe depression or a major depressive episode at some time in their lives. The American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) defines a major depressive episode as either a depressed mood or lack of interest or pleasure in most activities, for most of the day nearly every day, that lasts for at least two consecutive weeks, is not accounted for by other reasons (e.g., bereavement, physical illness), and seriously impacts day-to-day functioning.

Children and adolescents with depression may appear irritable rather than sad. Additional symptoms for this group may include the following:

- Missed school or worsened academic performance
- Changes in eating and sleeping habits (e.g., weight gain or loss, insomnia or oversleeping)
- Social withdrawal
- Disinterest in previously enjoyed activities
- Persistent sadness and hopelessness
- Problems with authority
- Indecision; forgetfulness; inability to concentrate

(*continued on p. 2*)

Goals in Developing a Treatment Plan

- To teach children to understand and express their feelings (stronger communication, conflict resolution, anger management)
- To teach self-identification and self-correction strategies
- To control stress
- To enhance self-concept and boost self-esteem
- To identify problems and life events contributing to depression
- To help the child regain a sense of emotional control

Counseling Children and Teens with Depression

Cognitive behavioral therapy (CBT) is considered the most effective way to treat depression in children and teens. CBT involves helping patients adjust their dysfunctional thoughts and feelings and modify their behavior. This kind of treatment can be done in individual therapy or in a group-counseling situation. Medication is sometimes recommended to alleviate severe symptoms.

Children (and adults) with depression tend to have unrealistic views of themselves, known as cognitive distortions. Counseling aims to

(*continued on p. 3*)

About *Instant Help* Charts

This chart is intended to provide a summary of the critical information available on helping children with depression to insure that every child gets the most appropriate and comprehensive consideration.

Assessing Depression

An assessment of a child with moderate to severe depression should include:

- A physical exam and lab work by the child's physician to rule out physical causes for the depression
- Interviews with the child, parents, and teachers about symptoms, history, and current stressors
- Psychological evaluation by a psychiatrist or psychologist
- A review of school reports and records

A more thorough assessment would also entail:

- An exam of mental status, including memory and speech patterns to learn whether these areas have been affected
- Consideration of possible cultural biases for children from minority backgrounds

Commonly used assessment tools include:

- *Child Behavior Checklist for Ages 6–18* (CBCL/6–18), ASEBA
- *Children's Depression Inventory*, MHS
- *Piers-Harris Children's Self-Concept Scale*, Western Psychological Services
- *Adjustment Scales for Children and Adolescents* (ASCA), Edumetric & Clinical Science
- *Beck's Depression Inventory*, Psychological Corporation

An evaluation should always consider the biological, psychological, emotional, and social components of a child's life, viewed in the context of his or her age and development.

Fast Facts

- The National Institute of Mental Health estimates that 2.5 million children under age 18 have experienced clinical depression. Approximately 2% of children and 2–5% of adolescents in the United States have depression at any given time.
- Boys and girls can experience depression at equal rates in childhood; after about age 14, depressed girls outnumber depressed boys 2:1.
- Children who are under stress or have experienced loss, or those with attention, learning, behavioral, or anxiety disorders are at a higher risk for depression.
- Children with depression are four to five times less likely to receive treatment than children with disruptive disorders. Research has indicated that only about 10% of adolescents with depression receive treatment.
- Forty to 70% of children with major depressive disorders also have a second psychiatric disorder, such as anxiety and disruptive disorders.
- Nearly 40–50% of children treated for depression do not respond. Those who do recover from a depressive episode have a 50% chance of a relapse within the next two years.
- Girls are more likely to attempt suicide, but boys who make an attempt are more likely to succeed.

Defining the Problem (*continued*)

- Low self-esteem or self-confidence
- Overreaction to criticism
- Feelings of guilt
- Frequent physical complaints, such as headaches and stomachaches
- Anger and rage
- Low energy or motivation; boredom
- Drug and/or alcohol abuse, especially among adolescents
- Talk of, or attempts at, running away from home
- Recurring thoughts of death or suicide

Not all people with depression have all of these symptoms. In children, especially, depression often goes undiagnosed because these symptoms are attributed to normal changes that occur as part of growing up.

Children can become depressed for several reasons. High-stress environments, disruptive family life, separation from a parent or impending divorce, disappointing social interactions or a romantic breakup, the loss of a loved one, and long-term hospitalization can all lead to depression. A family history of the illness increases the risk of depression, since it appears that depression has several genetic components.

Depression may coexist with other mental illnesses and behavioral disorders, such as attention deficit hyperactivity disorder and anxiety. When it alternates with mania—characterized by euphoria, agitation, and hurried speech and movements—the child may be diagnosed with bipolar disorder.

What Teachers Need to Know

Teachers can play a critical role in identifying children and teens who may have depression. Problem behavior, angry outbursts, and inability to concentrate may be masking depression or another mental disorder. Children who avoid interacting with peers and spend most of their time alone at lunch or recess may very well be depressed. When facing a challenging learning task, children who are depressed might react with passivity or a sense of helplessness. Blaming other people or events for their poor test grades or missed homework, for example, is common. A loss of pleasure in life may be indicated by a monotone voice or lack of facial expression. Depressed children take criticism more deeply than other students, and they may react by withdrawing or, conversely, lashing out uncharacteristically. When troubles with peers arise, children with depression may refuse to take responsibility for their role in the conflict or overreact angrily. Children who make recurrent requests to see the school nurse with physical ailments may be masking depression. Finally, teachers should note children who seem preoccupied with death, keeping in mind the warning signs of suicide (also see "What Parents Need to Know").

Teachers can also contribute to effective treatment by working with parents to observe changes in children's behavior and affect. If a student begins taking antidepressants, teachers should note any positive changes as well as any side effects.

Highlighting children's strengths and offering positive reinforcement for well-done work and good behavior can help to ease these students' emotional symptoms in the classroom. Teachers can also help to relieve depressed students of their exaggerated sense of responsibility, self-blame, or guilt for minor infractions. These students will need consistent and patient support. One-on-one tutoring may be a helpful means to boost these youngsters' self-confidence and belief in their abilities. Finally, teachers can make sure depressed students are full participants in group activities and are not left to withdraw.

Counseling Children and Teens with Depression *(continued)*

replace cognitive distortions, and the problematic behaviors they can inspire, with realistic statements that lead to more appropriate actions.

The following techniques are commonly used to teach new skills:

- Verbal instruction
- Socratic questioning
- Modeling
- Role-playing
- Behavioral homework
- Assertiveness training
- Time management
- Relaxation training
- Graduated task assignments

The Dos and Don'ts of Communicating

DON'T	DO
• Blame or criticize.	• Focus on solutions and positive aspects of the child's reality.
• Discipline with shame.	• Use positive reinforcement for good behavior.
• Make assumptions about a child's behavior.	• Educate yourself and ask questions of the child.
• Force a conversation before a child is ready.	• Be extremely patient in keeping lines of communication open.
• Lecture.	• Use short statements expressing love and commitment.
• Lose your temper.	• Speak calmly and lovingly.
• Dismiss a child's concerns.	• Listen carefully for issues possibly causing the depression.

What Parents Need to Know

An estimated 1 in 10 children in the United States have a serious mental illness, yet fewer than 1 in 5 receive treatment. Parents who feel embarrassed, ashamed, or guilty or who attach a stigma to mental illness may not promptly seek the help of a physician or psychologist. It's critical to realize that depression is a real illness with real treatment options and that help should be obtained as soon as possible.

Certain events and scenarios in the family can lead to depression: a death or serious illness, dire financial straits or poverty, separation and divorce, a sudden move, and natural disaster. Children with a family history of depression, especially in parents, are at greater risk of experiencing depression themselves.

Parents may dismiss symptoms of depression in their child as "normal" phases of growing up. Indeed, some behaviors and moods may pass quickly and not require professional attention. However, symptoms outside the realm of a child's typical physical and emotional development that persist over two weeks and affect everyday activities warrant an appointment with the child's doctor. Parents need to note how long any suspect behaviors have been occurring. They should gather additional observations from other family members, teachers, coaches, and others who regularly interact with their child.

As an assessment process unfolds, parents should feel free to ask questions. They should inquire, for example, about a therapist's qualifications, the recommended course of treatment, definition of terms, and any side effects of prescribed medications. Parents must consider physicians, psychiatrists, psychologists, and other specialists as full partners in helping their child.

The use of psychotropic drugs, including antidepressants, among children has received heightened public attention in the last few years. The points parents need to know about antidepressants include the following:

- Medication is rarely the first choice in treating children with depression, often being prescribed only after therapy alone has not been effective.
- These drugs are not habit forming.
- Doctors often need to try several types of medication to find the one that works best for an individual.
- Improvements are sometimes noticed in the first few weeks, but antidepressants must be taken every day for three to four weeks, and sometimes as long as eight weeks, to reach their full therapeutic effect.
- Medication should be taken for at least four to nine months, as prescribed, even if the child feels better or, conversely, believes the drug is having no effect at all. Medication should never be stopped without conferring with a physician.

Parents of children with depression must continually watch for more dramatic symptoms that might indicate a risk for suicide:

- Heightened social isolation
- Feelings of hopelessness and worthlessness
- Talk about death and dying, and suicide
- Increased acting-out and risk-taking behaviors
- Frequent accidents
- Substance abuse
- Focus on morbid and negative themes
- Increased crying or reduced emotional expression
- Giving away possessions

Most people who are depressed do not commit suicide, and it is extremely rare in children under age 12. Nevertheless, depression does increase the risk for suicide or suicide attempts. In the United States, suicide is the third leading cause of death in people between the ages of 15 and 24, after car accidents and homicides. Of that age group, in 2001, about six times more males than females took their own life. Suicidal thoughts, remarks, or attempts always require immediate professional attention.

Parents with children who have depression can help themselves, as well as their youngsters, by taking these steps:

- Get accurate, up-to-date information about depression and its treatment options from libraries, reputable Web sites, physicians, counselors, and other sources.
- Talk with teachers, clergy, and other members of the community for advice and support.
- Participate in family support groups on depression.
- Practice sound nutrition and exercise to preserve their own health, energy, and peace of mind.

Instant Help for
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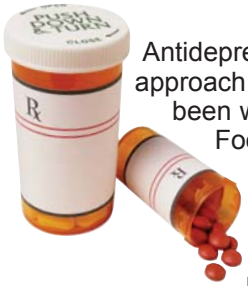
Medication Protocol

Medication is usually only prescribed after less invasive approaches have been tried and should only be prescribed by a child psychiatrist or physician with experience in treating depression. Important steps include:

- Physical and psychiatric evaluation
- Review of other treatment interventions used thus far
- Assessment of symptom severity
- Consideration of how medication will be monitored at home and school
- Close observation at the start of medical therapy for worsening of symptoms or change in behavior
- Counseling for the child about the medication and its possible effects
- Regular monitoring by a physician

Medication and Depression



Antidepressants as a treatment approach for children have not been well researched, and the Food and Drug Administration (FDA) has approved just one, fluoxetine (Prozac), for use with this group. Moreover, in October 2004, the FDA required that all antidepressants come with a "black box warning" stating that these drugs may increase the risk of suicidal thinking and behavior among children and adolescents. It is crucial, therefore, that this risk—and other possible side effects—be carefully weighed against a child's clinical need and that parents and teachers be alert to any change in behavior that might suggest that the child is at risk of suicidal behavior.

Antidepressants focus on the specific neurotransmitters tied to depression—serotonin, dopamine, and norepinephrine—increasing the amount of neurotransmitter available between neurons. Some groups of these drugs also affect the reuptake (reabsorption) process that occurs during synapses in the brain. For example, the popular medications known as selective serotonin reuptake inhibitors (SSRIs) block the proteins that reabsorb serotonin; that is, they inhibit the reuptake process, as their name implies. The newer serotonin and norepinephrine reuptake inhibitors (SNRIs) target both serotonin and norepinephrine.

Examples of antidepressants include:

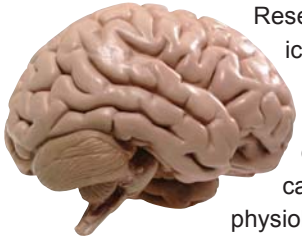
SSRIs (Prozac, Zoloft, Paxil, Celexa, Lexapro)

SNRIs (Effexor, Cymbalta)

Bupropion (Wellbutrin, Zyban)

Tricyclics (Elavil, Anafranil, Tofranil, Pamelor)

The Brain and Depression



Research suggests that damage in specific areas of the left half of the brain, especially the left frontal lobe, can significantly increase the risk of depression. This damage may be caused by genetic, environmental, or physiological factors. Studies also suggest the presence of abnormalities, particularly decreased blood flow with decreased oxygen or glucose utilization, in the prefrontal cortical and limbic areas in individuals with recurrent or chronic depressive disorders. It is generally agreed that depression also involves an imbalance of two neurotransmitters, norepinephrine and serotonin.

Depression changes not only how the brain functions but also how much of the rest of the body functions. For example, many hormones have significant effects on brain function and can cause serious problems when present in abnormal amounts.

Resources for Helping Children and Teens with Depression

Books for Parents

Raising Depression-Free Children: A Parent's Guide to Prevention and Early Intervention. Kathleen Hockey, Hazelden Press, 2003

The Depressed Child: A Parent's Guide for Rescuing Kids. Douglas A. Riley, Taylor Trade Publishing, 2001

It's Nobody's Fault: New Hope and Help for Difficult Children and Their Parents. Harold Koplewicz, Three Rivers Press, 1997

"Help Me, I'm Sad": Recognizing, Treating, and Preventing Childhood and Adolescent Depression. David G. Fassler and Lynne S. Dumas, Penguin Books, 1998

Books for Children and Teens

Jenny Is Scared: When Sad Things Happen in the World. Carol Shuman, Magination Press, 2003

The Boy Who Didn't Want to Be Sad. Rob Goldblatt, Magination Press, 2004

Feeling Better: A Kid's Book about Therapy. Rachel Rashkin, Magination Press, 2005

Kid Power Tactics for Dealing with Depression. Nicholas and Susan Dubuque, Center for Applied Psychology, 1996

When Nothing Matters Anymore: A Survival Guide for Depressed Teens. Bev Cobain, Free Spirit Press, 1998

Books for Professionals

What Works for Whom: A Critical Review of Treatments for Children and Adolescents. Peter Fonagy et al., Guilford Press, 2005

Cognitive Therapy with Children and Adolescents: A Casebook for Clinical Practice. Mark A. Reinecke et al., Guilford Press, 2003

More Than Moody: Recognizing and Treating Adolescent Depression. Harold Koplewicz, Perigree Books, 2003

The Childhood Depression Sourcebook. Jeffrey A. Miller, McGraw-Hill, 1999

Understanding Teenage Depression: A Guide to Diagnosis, Treatment, and Management. Maureen Empfield and Nicholas Bakalar, Owl Books, 2001

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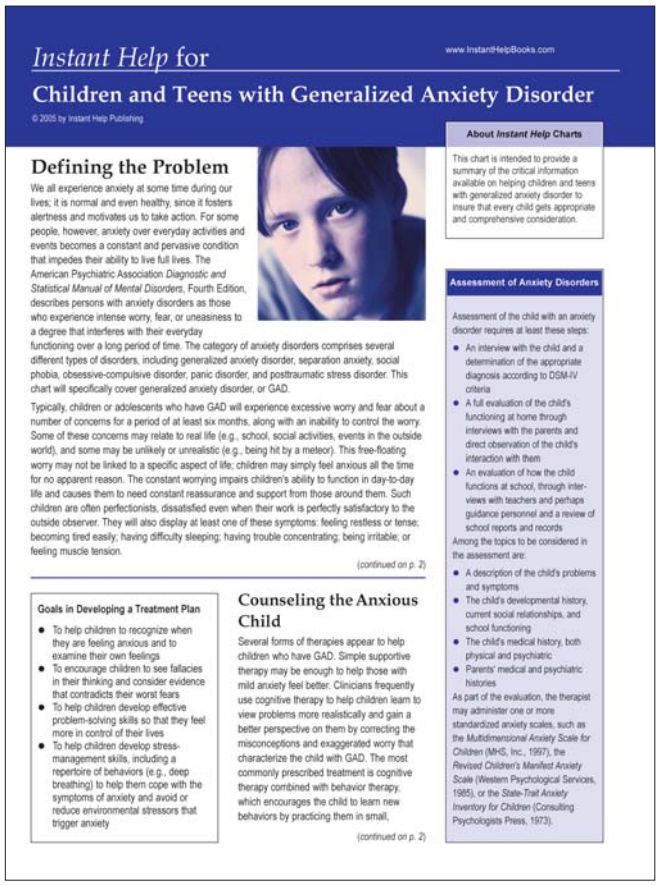
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Children and Teens with Generalized Anxiety Disorder
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Defining the Problem
We all experience anxiety at some time during our lives; it is normal and even healthy, since it fosters alertness and motivates us to take action. For some people, however, anxiety over everyday activities and events becomes a constant and pervasive condition that impedes their ability to live full lives. The American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, describes persons with anxiety disorders as those who experience intense worry, fear, or uneasiness to a degree that interferes with their everyday functioning over a long period of time. The category of anxiety disorders comprises several different types of disorders, including generalized anxiety disorder, separation anxiety, social phobia, obsessive-compulsive disorder, panic disorder, and posttraumatic stress disorder. This chart will specifically cover generalized anxiety disorder, or GAD.
Typically, children or adolescents who have GAD will experience excessive worry and fear about a number of concerns for a period of at least six months, along with an inability to control the worry. Some of these concerns may relate to real life (e.g., school, social activities, events in the outside world), and some may be unlikely or unrealistic (e.g., being hit by a meteor). This free-floating worry may not be linked to a specific aspect of life; children may simply feel anxious all the time for no apparent reason. The constant worrying impairs children's ability to function in day-to-day life and causes them to need constant reassurance and support from those around them. Such children are often perfectionists, dissatisfied even when their work is perfectly satisfactory to the outside observer. They will also display at least one of these symptoms: feeling restless or tense; becoming tired easily; having difficulty sleeping; having trouble concentrating; being irritable; or feeling muscle tension.
(continued on p. 2)
About *Instant Help* Charts
This chart is intended to provide a summary of the critical information available on helping children and teens with generalized anxiety disorder to insure that every child gets appropriate and comprehensive consideration.
Assessment of Anxiety Disorders
Assessment of the child with an anxiety disorder requires at least these steps:
- An interview with the child and a determination of the appropriate diagnosis according to DSM-IV criteria
- A full evaluation of the child's functioning at home through interviews with the parents and direct observation of the child's interaction with them
- An evaluation of how the child functions at school, through interviews with teachers and perhaps guidance personnel and a review of school reports and records

Among the topics to be considered in the assessment are:
- A description of the child's problems and symptoms
- The child's developmental history, current social relationships, and school functioning
- The child's medical history, both physical and psychiatric
- Parents' medical and psychiatric histories

As part of the evaluation, the therapist may administer one or more standardized anxiety scales, such as the *Multidimensional Anxiety Scale for Children* (MHS, Inc., 1997), the *Revised Children's Manifest Anxiety Scale* (Western Psychological Services, 1985), or the *State-Trait Anxiety Inventory for Children* (Consulting Psychologists Press, 1973).
(continued on p. 2)
Goals in Developing a Treatment Plan
- To help children to recognize when they are feeling anxious and to examine their own feelings
- To encourage children to see fallacies in their thinking and consider evidence that contradicts their worst fears
- To help children develop effective problem-solving skills so that they feel more in control of their lives
- To help children develop stress-management skills, including a repertoire of behaviors (e.g., deep breathing) to help them cope with the symptoms of anxiety and avoid or reduce environmental stressors that trigger anxiety

Counseling the Anxious Child
Several forms of therapies appear to help children who have GAD. Simple supportive therapy may be enough to help those with mild anxiety feel better. Clinicians frequently use cognitive therapy to help children learn to view problems more realistically and gain a better perspective on them by correcting the misconceptions and exaggerated worry that characterize the child with GAD. The most commonly prescribed treatment is cognitive therapy combined with behavior therapy, which encourages the child to learn new behaviors by practicing them in small,
(continued on p. 2)

#7913 Generalized Anxiety Disorder


#7989 Bipolar Disorder


#7915 Asperger Syndrome


#7911 Eating Disorders


#7914 Depression


#7990 Autism


#7991 Self-Injury


#7909 Oppositional Defiant Disorder


#7910 Obsessive-Compulsive Disorder


#7912 Tourette Syndrome

Each chart features:

- A quick summary of the problem
- Critical information for parents
- Best treatment practices
- Resources
- Common ways to assess the problem
- Critical information for teachers
- Neuropsychological considerations
- Medication information

...And more!

Instant Help Charts have been designed to give professionals and parents a quick synopsis of the most important information regarding the psychological problems of children and teens. Just published, this product will give you the critical information you need to make sure that every client gets quick and effective treatment.

$4.95 each chart
$19.95 for a 5-pack of same title
(Please write a "p" after the Item # when ordering a 5-pack)

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