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)

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

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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**
- Blame or criticize.
- Discipline with shame.
- Make assumptions about a child’s behavior.
- Force a conversation before a child is ready.
- Lecture.
- Lose your temper.
- Dismiss a child’s concerns.

**DO**
- Focus on solutions and positive aspects of the child’s reality.
- Use positive reinforcement for good behavior.
- Educate yourself and ask questions of the child.
- Be extremely patient in keeping lines of communication open.
- Use short statements expressing love and commitment.
- Speak calmly and lovingly.
- 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 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.
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**

**Books for Children and Teens**
- Books for Children and Teens
  - The Boy Who Didn’t Want to Be Sad. Rob Goldblatt, Magination Press, 2004
  - Kid Power Tactics for Dealing with Depression. Nicholas and Susan Dubuque, Center for Applied Psychology, 1996

**Books for Professionals**
- Cognitive Therapy with Children and Adolescents: A Casebook for Clinical Practice. Mark A. Reinecke et al., Guilford Press, 2003
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### #7911 Eating Disorders
- #7989 Bipolar Disorder
- #7915 Asperger Syndrome
- #7914 Depression
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- #7913 Generalized Anxiety Disorder
- #7909 Oppositional Defiant Disorder
- #7990 Autism
- #7991 Self-Injury

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