

DEPRESSION IN CHILDREN AND ADOLESCENTS: DIAGNOSIS AND TREATMENT

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Section I

INTRODUCTION

AFFECTIVE DISORDERS

Introduction

Depression is a word that is bantered about in the media and even in daily conversation. In many communications it is often used to denote a single symptom (mood or sad affect) or a cluster of symptoms (behaviors and emotions, including depressed mood). Common usage has been extended to a simple description of someone's facial expression, as in "you look depressed today." Art, music, and literature may be described as depressed or depressing. The understanding of depression and particularly depression in children has been watered down by its usage in common culture.

The *Diagnostic and Statistical Manual of Mental Disorders – Version IV – Text Revision (1997)* provides a clinical definition and description of a Major Depressive Episode. DSM-IV-TR criteria for a Major Depressive Episode call for the presence of five or more (of nine) specific symptoms as having been present for a two week period, that are a significant change in previous functioning, that cause significant distress or impairment in functioning, are not the result of substance abuse or a general medical condition, and are not better accounted for as Bereavement. The nine specific symptoms include:

- Depressed mood most of the day, nearly every day
- Diminished interest or pleasure in activities (anhedonia)
- Significant weight loss or weight gain
- Insomnia or Hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Diminished ability to think or concentrate
- Recurrent thoughts of death or suicide

The DSM-IV-TR does not include depression in section on childhood disorders. Research does indicate that the criteria for diagnosing adult depression are valid for use with children with slight modification. In Children and adolescents, the depressed mood may be totally absent and replaced by a general level of inappropriate and exaggerated irritability. Also for children and adolescents, the criterion for weight loss or weight gain is modified to include failure to make expected normal weight gains.

In addition, with children and adolescents, a high degree of co-morbidity and several other disorders may appear to present as depression but are not the focus of clinical intervention or diagnosis. For adolescents, many mood disorder symptoms are often the result of abusing substances or exposure to toxins. Separation Anxiety Disorder typically involves many depressive symptoms (sadness, sleep, withdrawal) as a part of the basic fear of separation from family and loved ones. Depressive symptoms occur in reaction to specific stressors and are often more appropriately viewed as an Adjustment Disorder with Depressed Mood. Loss which is a typical part of childhood and adolescence and normal bereavement may be misdiagnosed as depression in children due to our own discomfort with watching children struggle with normal life experience

Childhood Depression

In the recent past depression was not acknowledged by researchers and clinicians. This was particularly true in that parents, teachers and clinicians may have been oblivious to symptoms if a child does not act out. Macro studies (Kessler and Walters, 1998) indicate approximately 2.5 percent of children under 12 suffer from depression. Childhood depression is often comorbid with anxiety disorders, conduct disorders, oppositional defiant disorder, attention deficit disorder, substance use disorders, and eating disorders. Hammen and Rudolph (2003) estimate that 20 percent of all youth will experience a major depressive episode prior to the age of 18. Childhood depression also indicates higher risk for later depression, bipolar disorders, and substance abuse. Cohen, et. al. (1993) have identified higher rates of depression in adolescent girls, although no gender differences exist in pre-pubertal youth.

Signs Of Depression in Elementary School Age Children

Elementary school children often lack a cognitive developmental perspective to deal with the concept of time and often symptoms of hopelessness may be reflected as helplessness. In addition many of these children show irritability, poor social functioning, isolation, lack of interest and activities, and/or school refusal. Sleep difficulties, particularly insomnia, sleepwalking, and night terrors are also frequently observed. A general malaise and passivity may be the reflection of the anhedonia experienced by adults. In small children, suicide attempts may often look like accidents or recurrent carelessness.

Depression in Adolescents

Post-pubertal children display symptoms are more similar to those seen adults and are frequently accompanied by other disorders such as anxiety, oppositional defiant disorder, conduct disorder, substance abuse, eating disorders, or attention deficit hyperactivity disorder (Angold, Costello, and Erkanli (1999). Many of these depressed adolescents struggle with social issues and social functioning that is so critical with this age group. School difficulties, social skills deficits, prominent suicidal thoughts and attempts are frequently observed. These adolescents are often rejected and viewed negatively by peers and teachers. These peer problems typically persist after the resolution of the depressive episode.

Carlson and Kashani (1998) report that the typical, adolescent with depression tends to be an individual with a history of current and past pathology (especially substance abuse and anxiety disorders) and elevated levels of problematic (including suicidal) behaviors as well as physical symptoms. These adolescents frequently manifest a depressotypic cognitive style (e.g. pessimism and internal, global, and stable attributions for failure), a negative body image, low self-esteem, and are excessively emotionally dependent on others. These adolescents report a lack of adequate coping mechanisms, less social emotional support from friends and family, and frequent and angry discussions with parents regarding rules. Many of these adolescents have been victims of abuse neglect or other trauma or have experienced the loss of a parent, loved one, or romantic relationship.

MOOD EPISODES

The approach that the DSM takes to affective disorders is to describe abnormal episodes of affective functioning. These episodes Refer to a period of time when a person feels abnormally happy or sad. These mood episodes are not diagnosable as separate entities, but serve as the “building blocks” for identifying a codeable diagnostic disorder. DSM also establishes a series of specifiers that describe either the most recent mood episode or the course of recurrent episodes. There are four types of episodes: Major Depressive, Manic, Mixed, and Hypomanic.

MAJOR DEPRESSIVE EPISODE

For a period of two weeks the individual feels depressed, cannot enjoy life, has problems with eating and sleeping, guilt, loss of energy, trouble concentrating, and thoughts of death. There is significant impairment in functioning and the symptoms are not a part of the normal grieving process.

DSM-IV Criteria

A. Five or more of the following symptoms have been present during the same two week period nearly every day and represent a major change from previous functioning; and at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure

- 1. depressed mood most of the day nearly every day (in children and adolescents, it can be irritable mood)**
- 2. markedly diminished interest or pleasure in all, or almost all activities**
- 3. significant weight loss or gain (5% change) or decrease or increase in appetite (in children, consider failure to make expected weight gain)**
- 4. insomnia or hypersomnia**
- 5. psychomotor agitation or retardation**
- 6. fatigue or loss of energy**
- 7. feelings of worthlessness or excessive guilt**
- 8. diminished ability to think or concentrate or indecision**
- 9. recurrent thoughts of death, suicidal ideation, a suicide attempt, or suicide plan**

B. Symptoms do not meet criteria for a Mixed Episode

C. Symptoms cause clinically significant distress or impairment in functioning

D. Symptoms are not due to the direct physiological effects of a substance or medical condition

E. Symptoms are not better accounted for by bereavement

ASSOCIATED FEATURES AND DISORDERS

- Panic Attacks**
- Separation Anxiety**
- Sexual Functioning Difficulties**
- Family and Educational Problems**
- Substance Abuse**
- Suicide Attempts**

AGE AND GENDER FEATURES

Core symptoms are essentially the same for adults and children, but somatic complaints, irritability, withdrawal are more prominent in children. Psychomotor retardation, hypersomnia, and delusions are more common in prepubertal children. Irritability, anhedonia, hypersomnia, psychomotor agitation, concentration difficulties, and thoughts of death dominate with adolescents.

In prepubertal children, boys and girls are equally affected, but depression is twice as common in adolescent and adult females as adolescent and adult males. There appears to be a strong genetic component and major depressive episodes are 1.5 to 3 times more common among first degree relatives. Age of onset is most likely after 10, with modal age of onset at 11-12. Depressed children are more likely to be rejected by peers, are perceived as less likeable, and have more negative social behaviors. The association between peer relations and depression is different for boys and girls, as girls tend to place greater emphasis social functioning and popularity.

MANIC EPISODE

For a period of one week, the individual feels elated (or excessively irritable) and may be grandiose, talkative, hyperactive, and distractible. Bad judgment leads to social or occupational impairment. Out of control behavior may result in arrest or hospitalization.

DSM-IV-TR Criteria

- A. Distinct period of abnormally and persistently elevated mood, lasting at least one week (or requiring hospitalization)**
- B. During the period, three or more of the following symptoms (four if the mood is only irritable) have been present to a significant degree**
 - 1. inflated self-esteem or grandiosity**
 - 2. decreased need for sleep**
 - 3. excessively talkative or pressured speech**
 - 4. flight of ideas or subjective experience of racing thoughts**
 - 5. extreme distractibility**
 - 6. increased goal-directed activity or psychomotor agitation**
 - 7. excessive involvement in pleasurable activities that have a high potential for painful consequences (binges, sprees, needless risk-taking)**
- C. Symptoms do not meet criteria for a Mixed Episode**
- D. Mood disturbance is sufficiently severe to cause marked impairment in functioning, require hospitalization to prevent harm to self or others, or there are psychotic features**
- E. Symptoms are not due to the direct physiological effects of a substance or medical condition**

ASSOCIATED FEATURES AND DISORDERS

- **Impulsive Behavior and Decisions**
- **Gambling, Risk-Taking, Hypersexuality, Antisocial Behavior**
- **Aggressive or Assaultive Behavior**
- **Suicide Completions**
- **Substance Abuse**

AGE AND GENDER FEATURES

Manic episodes in adolescents are more likely to include psychotic features, antisocial behavior, school failure or substance abuse. Many adolescents experiencing a manic episode typically have a long history of behavior problems that precede a manic episode and may be thought of as prodromal.

Mean age of onset for the first manic episode is the early 20s, and approximately 10% to 15% of adolescents with recurrent Major Depressive Episodes will go on to develop a Manic Episode. In the United States Bipolar I Disorder is approximately equally common in men and women. Gender appears to be related to the order of affective episodes. The first episode in males is more likely to be a Manic Episode, while the first episode in females is more likely to be a Major Depressive Episode. Women with Bipolar I Disorder have an increased risk for Post-partum Depression.

HYPOMANIC EPISODE

For a period of at least four days, the individual feels elated, grandiose, talkative, hyperactive, and distractible. Loss of functioning is much less severe or noticeable.

DSM-IV-TR Criteria

- A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least four days, that is different from non depressed mood.**
- B. During the period, three or more of the following symptoms (four if the mood is only irritable) have been present to a significant degree**
 - 1. inflated self-esteem or grandiosity**
 - 2. decreased need for sleep**
 - 3. excessively talkative or pressured speech**
 - 4. flight of ideas or subjective experience of racing thoughts**
 - 5. extreme distractibility**
 - 6. increased goal-directed activity or psychomotor agitation**
 - 7. excessive involvement in pleasurable activities that have a high potential for painful consequences (binges, sprees, needless risk-taking)**
- C. The episode is associated with unequivocal change in functioning that is uncharacteristic of the person**
- D. The disturbance in mood and functioning are observable by others**
- E. Mood disturbance is *not* sufficiently severe to cause marked impairment in functioning, or to necessitate hospitalization to prevent harm to self or others, and there are no psychotic features**
- F. Symptoms are not due to the direct physiological effects of a substance or medical condition**

ASSOCIATED FEATURES AND DISORDERS

- Similar to those for Manic Episodes but less pronounced and less debilitating

AGE AND GENDER FEATURES

In adolescents, the episode typically begins suddenly, with a rapid escalation of symptoms and the episode may be preceded or followed by a Major Depressive Episode. Studies suggest that 5% to 15% of the individuals with hypomanic episodes will ultimately develop a manic episode. Bipolar II Disorder may be more common in women than in men.

MIXED EPISODE

Displays symptoms of both mania and depression nearly every day during at least a one week period.

DSM-IV-TR Criteria

- A. The criteria are met for both a Manic Episode and for a Major Depressive Episode nearly every day during a one week period.**
- B. Mood disturbance is sufficiently severe to cause marked impairment in functioning, require hospitalization to prevent harm to self or others, or there are psychotic features**
- E. Symptoms are not due to the direct physiological effects of a substance or medical condition**

DYSTHYMIC DISORDER

This type of depression is not severe enough to be called a major depressive episode, but last much longer than a major depression (at least two years) and there are no manic or hypomanic phases.

DSM-IV-TR Criteria

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation, for at least two years. *Note: in children and adolescents, mood can be irritable and duration must be at least one year.*

B. Presence, while depressed of two or more of the following:

- (1) poor appetite or over eating**
- (2) insomnia or hypersomnia**
- (3) low energy or fatigue**
- (4) low self-esteem**
- (5) poor concentration or difficulty making decisions**
- (6) feelings of hopelessness**

C. During the two-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than two months at a time.

D. No major depressive episode has been present during the first two years of the disturbance (one year for Children and adolescents).

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

F. The disturbance does not occur exclusively during the course of chronic Psychotic Disorder.

G. Symptoms are not due to the direct physiological effects of a substance or medical condition

H. Symptoms cause clinically significant distress or impairment in functioning

AGE AND GENDER FEATURES

For children and adolescents with Dysthymia, there is an early and insidious onset and a chronic course. The modal age of onset is about 7-8 years of age and the average length of Dysthymic episodes of about four years. Dysthymia in children and adolescents is more common among first degree biological relatives of individuals with Major Depressive Disorder. The early onset modifier (prior to age 21) is predictive of Major Depressive Episodes

DEPRESSIVE DISORDER NOT OTHERWISE SPECIFIED (NOS)

The individual has depressive symptoms that do not meet the criteria (PMS, brief depression, and post psychotic depression)

BIPOLAR I DISORDER, SINGLE MANIC EPISODE

DSM-IV-TR Criteria

- A. Presence of only one manic episode and no past major depressive episodes.**
- B. The manic episode is not better accounted for by Schizoaffective Disorder and not superimposed on other psychotic disorders.**

BIPOLAR I DISORDER, MOST RECENT EPISODE HYPOMANIC

DSM-IV-TR Criteria

- A. Currently, or most recently, in a Hypomanic Episode.**
- B. There has previously been at least one Manic Episode or Mixed Episode.**
- C. Symptoms cause clinically significant distress or impairment in functioning.**
- D. The mood episode is not better accounted for by Schizoaffective Disorder and not superimposed on other psychotic disorders.**

BIPOLAR I DISORDER, MOST RECENT EPISODE MANIC

DSM-IV-TR Criteria

- A. Currently, or most recently, in a Manic Episode.**
- B. There has previously been at least one Major Depressive Episode, Manic Episode, or Mixed Episode.**
- C. The mood episode is not better accounted for by Schizoaffective Disorder and not superimposed on other psychotic disorders.**

BIPOLAR I DISORDER, MOST RECENT EPISODE MIXED

DSM-IV-TR Criteria

- A. Currently, or most recently, in a Mixed Episode.**
- B. There has previously been at least one Major Depressive Episode, Manic Episode, or Mixed Episode.**
- C. The mood episode is not better accounted for by Schizoaffective Disorder and not superimposed on other psychotic disorders.**

BIPOLAR I DISORDER, MOST RECENT EPISODE DEPRESSED

DSM-IV-TR Criteria

- A. Currently, or most recently, in a Major Depressive Episode.**
- B. There has previously been at least one Manic Episode or Mixed Episode.**
- C. The mood episode is not better accounted for by Schizoaffective Disorder and not superimposed on other psychotic disorders.**

BIPOLAR I DISORDER, MOST RECENT EPISODE UNSPECIFIED

DSM-IV-TR Criteria

- A. Criteria, except for duration, are currently met for a Manic, Hypomanic, Mixed, or Major Depressive Episode.**
- B. There has previously been at least one Manic Episode or Mixed Episode.**
- C. Symptoms cause clinically significant distress or impairment in functioning.**
- D. The mood episode is not better accounted for by Schizoaffective Disorder and not superimposed on other psychotic disorders.**
- E. Symptoms are not due to the direct physiological effects of a substance or medical condition**

ASSOCIATED FEATURES AND DISORDERS FOR BIPOLAR I

- completed suicide occurs in 10-15 per cent of individuals with Bipolar I**
- high correlation with truancy, academic failure, and delinquency**
- high correlation with eating disorders, Attention Deficit Hyperactivity Disorder, panic attacks, and substance abuse**

AGE AND GENDER FEATURES FOR BIPOLAR I

Approximately 10 to 15 percent of adolescents with recurrent Major Depressive Episodes will go on to develop Bipolar I Disorder. Gender appears to be related to the order of affective episodes. The first episode in males is more likely to be a Manic Episode, while the first episode in females is more likely to be a Major Depressive Episode. First degree biological relatives of individuals with Bipolar I Disorder have elevated rates of Bipolar I (4 – 24%), Bipolar II (1 – 5%), and Major Depression (4 – 24%). Twin and adoptions studies provide strong evidence of a genetic influence for Bipolar I Disorder.

Bipolar Disorder beginning in childhood or adolescence may be a different more severe form than adult onset Bipolar Disorder. Prepubescent onset is characterized by a continuous, rapid cycling, irritable, mixed symptom state; whereas post pubescent onset is sudden, often with a classic manic episode, a more episodic pattern, and relatively stable periods in between mood shifts. Sixty percent of all adult bipolar individuals report onset of symptoms prior to age 18. Many of the children currently diagnosed with Attention Deficit Hyperactivity Disorder may eventually be diagnosed as having bipolar disorder. Many of these children are described as “different” from infancy. These babies were difficult to care for, could not establish a regular sleep schedule, resisted new foods, situations, and transitions, cried more frequently, and were subject to violent and excessive tantrums.

BIPOLAR II DISORDER

Characterized by recurrent major depressive episodes with intermittent hypomanic episodes, but never a manic episode.

DSM-IV-TR Criteria

- A. Presence (or history) of one or more Major Depressive Episodes.**
- B. Presence (or history) of at least one Hypomanic Episode.**
- C. There has never been a Manic Episode or a Mixed Episode.**
- D. The mood episode is not better accounted for by Schizoaffective Disorder and not superimposed on other psychotic disorders.**
- E. Symptoms are not due to the direct physiological effects of a substance or medical condition**

ASSOCIATED FEATURES AND DISORDERS

- completed suicide occurs in 10-15 percent of individuals with Bipolar II**
- high correlation with truancy, academic failure, and delinquency**
- high correlation with eating disorders, Attention Deficit Hyperactivity Disorder, panic attacks, Borderline Personality Disorder, and substance abuse**

CYCLOTHYMIC DISORDER

For at least two years (one for children and adolescents), there have been repeated mood swings, but not of sufficient magnitude to be classified as Major Depression. Sometimes referred to as “bipolar lite.” Some researchers are indicating the need for “Bipolar III” as a “re-current depressions without spontaneous hypomania, but often with hyperthymic temperament and/or a bipolar family history. Many of these individuals have become manic or hypomanic when taking antidepressants without a mood stabilizer.

DSM-IV-TR Criteria

A. For at least two years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet the criteria for a Major Depressive Episode. Note: in children and adolescents, the duration must be at least one year.

B. During the above two-year period (one year in children and adolescents), **the person has not been without the symptoms in criteria A for more than two months at a time.**

C. No Major Depressive Episode, Manic Episode, or Mixed Episode has been present during the first two years of the disturbance

D. The mood episode is not better accounted for by Schizoaffective Disorder and not superimposed on other psychotic disorders.

E. Symptoms are not due to the direct physiological effects of a substance or medical condition.

F. Symptoms cause clinically significant distress or impairment in functioning.

ASSOCIATED FEATURES AND DISORDERS

-often begins early in life and is viewed as a temperamental predisposition to other mood disorders

-high correlation with substance abuse and sleep disorders

ADJUSTMENT DISORDER WITH DEPRESSED MOOD

In the distant past, Adjustment Disorder served as a diagnosis that said nothing, but allowed for third-party reimbursement. The label was so innocuous that practitioners who had concerns about stigmatization could be comfortable they were divulging little or nothing. In DSM-IV, specific criteria have been developed.

DSM-IV-TR Criteria

A. The development of emotional or behavioral symptoms in response to an identifiable stressor occurring within three months of the onset of the stressor.

B. The symptoms or behaviors are clinically significant as evidenced by either of the following:

-marked distress that is in excess of what would be expected from exposure to the stressor.

-Significant impairment in social or occupational (academic) functioning

C. The stress related disturbance does not meet the criteria for another specific Axis I Disorder and is not merely an exacerbation of a preexisting Axis I or Axis II Disorder.

D. The symptoms do not represent Bereavement

E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional six months.

Use the diagnosis of Adjustment Disorder when an identifiable stressor leads to impaired relationships, work performance, social interactions, or when the symptoms seem excessive for the degree of stress that is present. Adjustment Disorder individuals may be responding to one stressor or to a combination of many stressors. The stressor may have been a one time occurrence (tornado, fire, death, divorce separation) or a chronic condition (parental conflict, alcoholism in the family, job dissatisfaction, and chronic illness). Whatever the nature of the stressor, the individual feels overwhelmed by the environment.

The criteria for Adjustment Disorder describes the course (relatively brief); the onset of symptoms (within three months of the stressor); and persistence (no longer than six months after stressor is removed). There must be functional impairment and symptoms in excess of the normal response to similar stressors.

Adjustment Disorder With Depressed Mood is not appropriate for an individual suffering from a chronic, low grade depression which has causes rooted in childhood. There must be an identifiable stressor and the symptoms have typically persisted for six months or less. If there are no identifiable stressors or the client has been experiencing the symptoms for an extended period, you should consider the possibility of Dysthymia or Cyclothymia.

Adjustment Disorders should be reserved as a diagnosis of last resort. In many situations, therapist can rely on these diagnoses to reflect difficulties associated with family changes and developmental crises. However, it is too often used when the clinician has no better idea of what else is going on. Be

sure you can point to an identifiable stressor(s) and symptoms that began within three months of the stressor and have not lasted beyond six months. Careful case documentation in this regard will prevent problems should your diagnosis ever be questioned.

BEREAVEMENT

The focus of clinical attention is a reaction to the death of a loved one. The development of some symptoms consistent with a Major Depressive Episode are a part of the reaction to the loss. Duration and expression of “normal” bereavement may vary from culture to culture. A diagnosis of Major Depression is not typically given unless symptoms persist for two months after the loss.

SECTION II

ASSESSMENT and DIAGNOSIS

Arriving at a Diagnosis

Diagnosing an affective disorder in a child or adolescent is often a very difficult task calling on all the skills and resources of a clinician. In many situations the child may not have the cognitive capacity to self-reflect on their current emotional situation or understand what is happening to them. Often their affective disorder is “acted out” in a way that is primitive and limited, but nevertheless is an awareness of the fact that they are struggling to effectively regulate their affect. The skilled clinician must utilize a variety of skills, information, and techniques to arrive at the appropriate diagnosis to insure the development of an effective treatment plan.

In many situations, what the clinician may be observing is a child in crisis. When individuals are in crisis situations, their behavior becomes “abnormal” and when children and adolescents are in crisis situations, their behavior is likely to be extremely “abnormal.” It would be important for arriving at a proper diagnosis not to be focused on the crisis behavior to the exclusion of the history of the child. In many situations history is often a more accurate reflection of what is going on than the behavior of a child in crisis. In addition, recent history is often more reflective of the affective status of a child than events or behaviors that took place at a much younger stage of development.

In gathering information for a proper diagnosis, it is crucial to obtain information from as many collateral sources as possible. This is particularly critical with younger children who may not be able to accurately report their behavior and feelings. Parents, teachers, siblings, and other significant adults in the child’s life are often critical in arriving at an accurate diagnosis of an affective disorder in a child. However, caution must also be used in relying on collateral information, as the reporter may also have strong feelings about the child and her behavior.

Psychological testing and assessment may provide an objective and impersonal picture of the child and their current emotional status. These objective measures may coincide with information presented or be in contrast to self-report and other report. It is also important to review and rule out any physical or medical reasons that may be producing the affective difficulties. In many situations, physical conditions create psychological

symptoms and impact affective functioning and the ability to regulate affective states.

Of particular significance with children and adolescents is obtaining an accurate and complete family history. It would be crucial to understand the child's genetic and familial history in arriving at a diagnosis and often having an accurate and thorough family history may tip the diagnostic scale in one direction. Obtaining a thorough family history is more than just asking about "Is there a family history of depression?". Careful questioning may lead to clear cut symptoms of an undiagnosed disorder that may be critical in arriving at an accurate diagnosis. The child's age and the presence of parental depression should be taken into account when integrating inconsistent information.

A variety of structured instruments are available to direct and assist in establishing a diagnosis including:

Symptom 90, SCID-I (Structured Interview for DSM Axis I Disorders)

BASC (Behavioral Assessment System for Children)

-4 (Child Symptom Inventory-4)

DICA-IV (Diagnostic Interview for Children and Adolescents)

Child Behavior Checklist (Achenbach) (child, parents, and teacher)

Personality Inventory for Youth

Diagnostic Interview Schedule for Children (NIMH, DISC-4)

Children's Depression Inventory

Reynolds Adolescent Depression Scale

Beck Depression Inventory

Center for Epidemiological Studies of Depression Scale (CES-D)

Additional factors should be considered when diagnosing affective disorders in children and adolescents. Children may be expressing behaviorally their difficulty in regulating affect. Failure to meet developmental milestones may be an indicator of a long-standing difficulty with affective regulation. Poor communication, language difficulties, the absence of or poor quality of social interactions may all be providing behavioral indications of affective difficulties that the child is not capable of evaluating or expressing. Enuresis and encopresis may also be a critical sign of a child who cannot effectively manage their negative feeling state.

DIFFERENTIAL DIAGNOSIS

Depression has one of the highest comorbidity rates, typically 40 to 50 percent. It is often observed in conjunction with anxiety, oppositional defiant disorder, conduct disorder, learning disabilities, bipolar disorder, Dysthymia, and attention deficit/hyperactivity disorder. Many other disorders share the same symptoms and behavioral patterns and arriving at a differential is often critical in determining a treatment approach

Depression and Anxiety Disorders

Affective Disorders and Anxiety share a common component called "generalized negative affect." In many instances it is difficult to distinguish the primary source of the symptoms from other secondary or co-morbid conditions. In many instances "pure" anxiety disorders have chronic high arousal levels, whereas, "pure" depressive disorders have chronic low affect or anhedonia. Often, depressive children have a negative view of self, world, and future, while anxious children have more fears and worries, especially about future events and competency. There is some indication that for many children and adolescents anxiety typically precedes the onset of depression and chronically anxious children may become depressed as a result of the impact that their anxiety levels have on their lives.

Depression and Conduct Disorder

In most situations it is easier to distinguish from a depressed child and a conduct disordered child. In conduct disordered children, positive gains from treatment tended to short-term, and with fewer reoccurrences of depression more of a distinct group. The conduct disorder group tended to display more suicide attempts, more criminal behavior, and a more favorable response to a placebo rather than antidepressant. In children with both a Major Depression Diagnosis and a Conduct Disorder diagnosis, there was more likely to be family violence, familial illegal behavior, impulsivity, and family substance abuse than those diagnosed with only a Major Depressive Disorder. The presence of anxiety occurred more often in Children with only a Major Depression than in children with both a Major Depression Diagnosis and a Conduct Disorder. The presence of a significant level of anxiety would seem to contraindicate a Conduct Disorder diagnosis.

Depression and Bipolar

For many children and adolescents the first indication of Bipolar Disorders is a Major Depressive Episode. A variety of studies have indicated that 6 to 31 percent of children diagnosed with a Major Depressive Disorder eventually develop Bipolar Disorder. Three factors that predict a higher likelihood that

a Major Depressive Episode may actually be the onset of Bipolar Disorder include: 1) rapid and early onset of depression, 2) a family history of mood disorders, especially Bipolar Disorder, and 3) a hypomanic response to antidepressant medication.

Depression and Dysthymia

The comorbidity of Major Depression and Dysthymia is extremely high, and some theorists view Dysthymia to be a precursor for subsequently developing a Major Depressive Disorder. Major Depressive Disorder and Dysthymia share many of the same diagnostic criteria, but are distinguished by severity and chronicity. When Major Depression occurs simultaneously with Dysthymia it is frequently referred to as a "double depression." Lewinsohn and Clark (1996) indicate that as many as 70 percent of children with Dysthymia go on to develop a Major Depressive Disorder within 2-3 years

Schizophrenia and Bipolar

Individuals with Bipolar I Disorder often display many symptoms of psychotic thinking and poor reality testing. One differential is that schizophrenics usually have a blunt affect as opposed to Bipolar I individuals who typically display extreme levels of affect. Bipolar mood swings can be sudden, whereas schizophrenia almost always has a slow, gradual worsening onset. Schizophrenics do not respond to lithium; whereas individuals with Major Depression typically do not respond to neuroleptics.

Oppositional Defiant Disorder and Bipolar

While one of the dominant characteristics of both disorders is the disruptiveness of their behavior, Oppositional Defiant children usually have at least a perceived reason for their tantrums, aggression, and assaultive behavior, whereas the behavior of Bipolar I individuals is more random, driven, and often purposeless. Children with Oppositional Defiant Disorder are much more susceptible to modify their behavior based on the influence of peers. Bipolar children have an elevated or irritable mood along with their antisocial outburst; whereas Oppositional Defiant Disorder children are viewed by others as simply "mean."

Attention Deficit Hyperactivity Disorder vs. Bipolar (Popper, 1990)

While 20 percent of the children with Attention Deficit Hyperactivity Disorder also meet criteria for Bipolar Disorder, 98 percent of the children who had been diagnosed with Bipolar Disorder fit the criteria for Attention Deficit Hyperactivity Disorder. Subtle differences, particularly in terms of thought disorders, rapid mood swings, waxing and waning of symptoms, inappropriate affect, and a disregard for the feelings of others are more

characteristic of Bipolar Disorders than of Attention Deficit Hyperactivity Disorder.

Popper (1990) has identified eleven factors that may assist in differentiating between Bipolar Disorder and Attention Deficit Hyperactivity Disorder.

- 1. Destructiveness – The destructive behavior in Attention Deficit Hyperactivity Disorder seems to be more accidental, whereas in Bipolar Disorder the level of destructiveness is more out of anger and frustration.**
- 2. Duration and Intensity of Outbursts - Tantrums in Attention Deficit Hyperactivity Disorder children are of short duration, 15 to 30 minutes, whereas with Bipolar individuals they can last for hours.**
- 3. Regression - The degree of regressed behavior (disorganized thinking, language, body movement, memory, etc.) is more severe with Bipolar children than with Attention Deficit Hyperactivity Disorder children.**
- 4. Triggers - Attention Deficit Hyperactivity Disorder outbursts are triggered by sensory and emotional overload, whereas Bipolar children react to limit setting and other "no's."**
- 5. Arousal - Bipolar children show irritability in the morning upon arousal, whereas Attention Deficit Hyperactivity Disorder children tend to rise quickly and attain alertness within minutes. Bipolar children are typically very difficult to wake up and get going.**
- 6. Sleep Disturbances- Bipolar children experience frequent violent, gory nightmares or night terrors and these are not typically observed in Attention Deficit Hyperactivity Disorder children.**
- 7. Misbehavior - Misbehavior in children with Attention Deficit Hyperactivity Disorder is often the result of impulsivity or inattention, whereas Bipolar children may intentionally provoke or misbehave.**
- 8. Danger and Risk Taking - Attention Deficit Hyperactivity Disorder children may engage in behavior without awareness of the danger, but Bipolar children are often risk seekers with strong early sexual interest and behavior.**
- 9. Reality Distortion - Attention Deficit Hyperactivity Disorder children do not exhibit psychotic symptoms or poor reality testing, whereas Bipolar children exhibit gross distortions in the perception of reality or in interpreting emotional events.**

10. Stimulant medications - Psychostimulant medications used to treat Attention Deficit Hyperactivity Disorder may worsen manic symptoms.

11. Relational Components - Children with bipolar disorders have more difficulties in situations that involve strong relationships. Their behavior at home may be much worse than it is in the classroom. Children with Attention Deficit Hyperactivity Disorder tend have more behavioral problems at school.

Morrison (1995) outlines a specific structure to develop a differential diagnosis based on the observance of an affective dysfunction. Stepwise method for accurately diagnosing depression

- 1. Identify current and past mood episodes: Major Depression, Manic, Mixed or Hypomanic. If symptoms do not meet criteria for mood episode, consider Dysthymia, Substance-Induced, Adjustment Disorder, and Bereavement.**
- 2. Choose the appropriate type of mood disorder: Depressive or Bipolar. If Bipolar II or Cyclothymic you are done.**
- 3. Select the appropriate fourth digit for Major Depression or Bipolar I**
- 4. Assign the fifth digit severity code.**
- 5. Add specifiers as appropriate.**
- 6. If criteria are not fully met, consider Depressive Disorder NOS, Bipolar Disorder NOS, or Mood Disorder NOS**

There are two possible mistakes when evaluating clients with depressive symptoms. The first mistake is to focus exclusively on individual's anxiety, substance abuse, relational issues, or psychotic symptoms and ignore underlying depression or Dysthymia. Always consider a mood disorder even if the complaint is something else. The second error is in diagnosing depression is failing to notice anxiety, attention deficit, substance abuse, or another disorder. Never assume that a mood disorder is the individuals only Axis I issue. Carefully inquire about Alcohol Dependence in Bipolar I individuals. There is a thirty percent concordance rate and often the alcohol related symptoms appear first.

There is indication that some individuals only experience mania and no accompanying depression. The concept of "unipolar mania" has been debated for a long time. Some individuals never have a depression, but most will if followed for a sufficient period of time. An individual who has Dysthymia and then develops a Major Depression can be given both diagnoses on Axis I. These situations are called "double depression."

It is also important to consider the fact that many medical conditions will result in behavioral symptoms that mimic depression. It is normally a good policy to require

an evaluation by a child's pediatrician to rule out medical disorders before beginning to develop a psychological treatment approach for depression. Thyroid disorders mimic the symptoms of depression and many children initially diagnosed as depressed are found to be suffering from a thyroid condition. Hormonal disorders (including normal puberty) may also present symptoms that look like an affective disorder. Difficulty menstruating, pregnancy, and post partum hormonal changes may mimic affective disorders. Cushing's Disease or Syndrome – tumors on the pituitary or adrenal glands - can cause extreme mood swings, and the medications used to treat lupus and asthmas, especially the corticosteroids can also cause mood swings.

Of particular concern with a child and adolescent population is mononucleosis. The symptoms of general lethargy, anhedonia, lack of energy, hypersomnia, and loss of appetite, while a perfect description of the vegetative symptoms of depression, are also a perfect description of the physical symptoms of mononucleosis.

Section III

INDIVIDUAL TREATMENT

DIAGNOSTICALLY BASED TREATMENT PLANNING

Treatment for Specific Disorders of Childhood and Adolescence must be based on decisions and information arrived at during the assessment and diagnostic process.

Treatment plans should describe outcomes you wish to achieve and the interventions you plan to use to reduce, relieve, ameliorate, or change the symptoms (distress) or impairment (loss of functioning).

By asking yourself “What” questions about the individual, paralleling the Multi-Axial Diagnostic System, (e.g. What is the most distressing aspect of the disorder? What physical factors may contribute to the situation or exacerbate the disorder? What stressors is the individual experiencing? Etc.) the goals of the treatment can be determined.

What Symptoms (distress) and Impairments (loss of functioning) is the individual experiencing (Axis I)?

What are the Underlying or Chronic Issues (Axis II)?

What are the Physical and Medical Aspects (Axis III)?

What are the Psychosocial Stressors (Axis IV)?

What are the Adaptive Behavior Deficits (Axis V)?

What are available Relationships and Support (GARF)?

The objectives of the treatment plan specify the “How” goals are to be addressed and the interventions that will be attempted. (e.g. How will range of affect be expanded? How will self-esteem be increased? How will the client learn to express anger effectively? How will marital tension be reduced? How will family and teachers monitor change? Etc.) These can be quantified by establishing timelines (by July 1), by frequency (bedwetting will occur only once a month), by occurrence (no incidents of assaultive behavior will be reported), by increase in desirable behaviors (falling asleep within less than one hour will increase by 25 percent over baseline), or by decrease (notes from school will decrease by 50 percent as compared to previous month).

FOUR CASE STUDIES ARE PROVIDED STARTING AT PAGE 37 OF THE MANUAL. THESE CASE STUDIES WILL ALLOW PARTICIPANTS TO DEVELOP DIAGNOSTIC AND TREATMENT PLANNING SKILLS FOR WORKING WITH DEPRESSED CHILDREN AND ADOLESCENTS

Intervention with the Child

Cognitive Behavior Therapy has consistently been identified as the most effective treatment modality for affective disorders. The combination of cognitive therapy and antidepressant medication has been shown to be more effective than cognitive behavior therapy alone. Since cognitive behavior therapy focuses on persistent cognitive distortions, it may be less effective on children younger than nine. A recent NIMH study found that 65 percent of adolescents showed remission of symptoms with cognitive behavior therapy, higher than supportive therapy or family therapy.

Components of Cognitive Behavior Therapy

- 1. Affective Education - games and activities to educate and explore feelings and emotions. Talking, Feeling, Doing Game, Ungame, Creating a "feeling book"**
- 2. Activity Planning - positive experiences are prescribed and increased and through pleasurable activities**
- 3. Problem Solving - identifying the problem, generating alternatives, evaluating consequences, choosing one solution, and implementing the plan.**
- 4. Social Skills Training - child is taught assertiveness, communication, conflict resolution, and accepting and giving feedback.**
- 5. Self-instructional Training - self-monitoring of thoughts and feelings and using self-talk to alter negative thoughts**
- 6. Relaxation Training - relaxation techniques combined with positive imagery**
- 7. Cognitive Restructuring - Challenge cognitive distortions, setting reasonable goals, and more adaptive thought processes**

Intervention with Parents

Family focused intervention for childhood depression has advantages and disadvantages. Parents often feel good about the intervention and increased knowledge about childhood depression, but may not reduce child's symptoms. Individual treatment for younger children is often not effective and the focus may need to be on helping parents change the environment. In addition there may be an overall affective tone in the family as the Parent-Child Management training reduces conflict and negative affect.

Medication

SSRI'S

Selective Serotonin Reuptake Inhibitors (SSRI) have been shown to be most effective with children and adolescents. NIMH studies documenting effectiveness of Prozac and Paxil. In a double blind, randomized, placebo-controlled study of 583 depressed youth, Prozac (fluoxetine) was superior in the acute phase of a Major Depressive Episode. However, recent studies have shown an increase in suicide associated with the use of large doses of SSRI's, particularly Paxil. Despite the cautions, some SSRIs continue to be effective in the treatment of affective disorders in children. For children and adolescents SSRI's, used without mood stabilizers, may induce a manic episode if the individual is actually bipolar rather than suffering from a Major Depressive Episode.

SSRI's tend to be more effective with unipolar depression

Celexa (citalopram) - increases the amount of active serotonin, calming effect

Luvox (fluvoxamine) - increases the amount of active serotonin

Paxil (paroxetine) - increases the amount of active serotonin, calming effect

Prozac (fluoxetine) - increases the amount of active serotonin, energizing effect

Zoloft (sertraline) - increases the amount of active serotonin, energizing effect

Tricyclics

Available studies do not support the use of Tricyclics for depression in youth. In a double blind, randomized, placebo-controlled study, Elavil (amitriptyline) was no more effective than the placebo. Tricyclics alone are not effective in improving child and adolescent depression. Psychosocial interventions have demonstrated efficacy over placebo controlled groups in reducing depressive symptoms

Asendin (amoxapine) - blocks norepinephrine and serotonin use

Avenyt (nortriptyline) - blocks norepinephrine and serotonin use

Elavil (amitriptyline) - blocks norepinephrine and serotonin use

Norpramin (desipramine) - blocks norepinephrine and serotonin use

Sinequan (doxepine) - blocks norepinephrine and serotonin use

Tofranil (imipramine) - blocks norepinephrine and serotonin use

Bipolar Medications

Lithium (Eskalith, Lithane, Lithobid, Lithotabs)

alkaline salt

Lithobid R slow release

Eskalith CR sustained release

Depakote (divalproex sodium)

antimanic and anticonvulsant

weight gain

liver toxicity

Tegretol (carbamazepine)

antimanic and antiaggressive

an alternative to lithium for younger children who need mood stabilization

Neurontin (gabapentin)

anticonvulsant drug

little weight gain

Topamax (topiramate)

anticonvulsant

works well on rapid cycling children

little weight gain

MAO Inhibitors

Rarely used with children and teens as a result of potentially life-threatening interaction effects. The use of MAO's requires significant dietary restrictions (chocolate, cheese, sausage, and beer)

Nardil (phenelzine) – increases norepinephrine and other neurotransmitters

Parnate (tranylcypromine sulfate) – increases norepinephrine and other neurotransmitters

Other Antidepressants

Desyrel (trazodone)

Effexor, Effexor XR (venlafaxine) – limits the reabsorption of three neurotransmitters

Remeron (mirtazapine) – impacts serotonin receptors, energizing effect

Serzone(nefazodone) – limits the reabsorption of three neurotransmitters

Wellbutrin (bupropion) – CNS stimulant, suppresses appetite

Self Control Therapy Stark et al. (1996).

Stark (1996) views depression in children and adolescents as a problem with affective regulation. Some children and adolescents do not seem to have the ability to exercise cognitive control over emotional states. They lack the cognitive and coping skills to maintain normal mood states or to disengage from affective states. Self control therapy offers direct training to youth in self-control strategies (self monitoring, evaluation, and reinforcement). The self control therapy can take place in individual or group settings, but consists in skills acquisition involving

- 1. assertiveness training**
- 2. social skills training**
- 3. cognitive restructuring**
- 4. problem solving**
- 5. relaxation training**

Self control therapy also views the role of the family as sustaining or exacerbating affective regulation problems and includes monthly family meetings. The monthly family meeting provide education to all family members about the nature of affective disorders. These family meetings also focus on skill acquisition and specifically teach parents to support their affective disordered children and specific strategies for symptom reduction. Family meetings also enhance family communication and activities during the meetings allow all family members to engage in pleasant activities. This is particularly important in that many of the families of depressed children operate in a “depressive” and joyless fashion.

Coping With Depression-Adolescent Lewinsohn, Clarke, et al. (1996)

Out of their comprehensive study of adolescent depression, Lewinsohn, Clarke, et al. (1996) developed a structured psychosocial treatment approach for treating adolescent depression. The program takes a traditional cognitive-behavioral approach and expands it to deal with some of the unique aspects of adolescent depression. Their cognitive therapy and behavior therapy approach establishes specific goals for the adolescent in the cognitive and behavioral domains.

Cognitive goals include an awareness of unconscious pessimistic and negative thoughts, reduction in depressotypic beliefs and biases, elimination of causal attributions of guilt, shame, and failure, and the substitution more constructive cognitions for destructive ones. Behavioral goals focus on increasing behaviors that elicit positive reinforcement, reducing opportunities for negative reinforcement from the environment, and the acquisition of social and other coping skills.

In addition to the cognitive and behavioral goals, the program concentrates on increasing physical and social activity through developing a schedule of activities. General affective regulation is expanded through learning anger management and problem solving strategies. Depressotypic thinking is altered through challenging faulty information, automatic thoughts, dysfunctional schema and beliefs, and negative self evaluations. The Coping With Depression – Adolescent course also recognizes the role of the family in childhood depression. Parent sessions help the parents to reinforce the adolescent’s newly developed skills, teach communication, and negotiation, and problem solving skills to all family members, and allow the adolescent to practice newly developed skills for affective regulation in the emotionally charged atmosphere of the family.

Interpersonal Psychotherapy for

Adolescent Depression (IPT)

Mufson, Moreau, and Weissman (1993)

IPT is a brief treatment model which places depressive episodes in the context of interpersonal relationships and focuses on current interpersonal conflicts. It is not a family therapy approach, but based on the premise that depression originates and is sustained through relationships and familial patterns. The interpersonal approach attempts to focus on changing relational patterns and minimizes the use of antidepressants medication.

A basic assumption of IPT is that depression for adolescents originates in one of five problem areas: 1) Grief, 2) Interpersonal Role Disputes, 3) Role transitions, 4) Interpersonal Deficits, or 5) Single Parent Family Issues.

Grief and loss are key elements in the development of depression and affective disorders. While loss and accompanying grief are a normal part of life, some individuals have difficulty progressing through the normal stages of grief and develop “pathological mourning” which results in symptoms of an affective disorder. This pathological mourning can be the result of a dysfunctional relational pattern that distorts or exaggerates the significance of the loss. For others, the loss of the relationship is either minimized, denied, or ignored only to surface later as delayed grief and an accompanying affective disorder.

In other situations, the source of the affective disorder may be rooted in an interpersonal role disputes. This is a frequent source of conflict and discomfort for adolescents as they struggle with defining their new roles as emerging adults with increased autonomy and decision making. In many situations, particularly with parents, the expectations and definition of relationships is in conflict, particularly in areas of sexuality, authority, money, peers and values. Without clarifying expectations and developing realistic role expectations, the conflict inherent results in chronic dissatisfaction and conflict between parents and adolescents and affective regulation problems. In some instances these role disputes can never be resolved to the satisfaction of all parties and the treatment approach shifts to the development of strategies for coping with non-negotiable expectations.

Role Transitions are a developmental part of childhood and adolescence; however, in some instances youth are not able to effectively adapt to these transitions and may develop an affective disorder in response to the failure to successfully transition. Puberty, a shift from group to dyadic relationships,

emerging sexuality, separation from parents and family, and academic or career transition are a normal part of adolescence. In some instances, the unforeseen or imposed role transitions can be triggered by circumstances that the youth is unprepared to deal with such as divorce, remarriage, death, impairment, pregnancy, legal, or increased responsibilities. An unsuccessful transition can resemble mourning and an unwillingness to accept the loss of old competencies and familiarity.

Many children and adolescents are painfully aware of the fact that they seem to lack interpersonal skills and that these interpersonal deficits can impede the achievement of developmental tasks (making friends, extracurricular activities, becoming part of a peer group, dating, career choices, and sexuality). In some instances this becomes an open ended feedback loop of lack of social skills leading to externally or self-imposed isolation, which results in depression, leading to a further diminishment of social skills. The impact is an ever widening and deepening cyclical relationship between depression and interpersonal deficits.

Interpersonal Psychotherapy also identifies that depression has been strongly correlated with single parent families. It is not likely that the simple fact of existing in a single parent family is causal for developing an affective disorder, but more likely is multicausal involving a variety of factors including loss, role definition, demands, limited resources, and conflictual relationships. In therapy a number of interpersonal factors that must be addressed include:

- **Acknowledging that the departure of a parent was a significant disruption to their lives**
- **Addressing feelings of loss, rejection, and/or abandonment by the departing parent**
- **Clarifying remaining expectations for the relationship with the absent parent**
- **Negotiating a new working relationship with the custodial parent**
- **Establishing a new relationship with the removed parent**
- **Acceptance of permanency of the current situation**

FAMILY TREATMENT

Family factors related to the development or support of an affective disorder within a child or adolescent cannot be ignored. Children with affective disorders are more likely to exist in families with high rates of psychopathology (mood, anxiety, substance use disorders). In addition, attachment problems and low levels of positive reinforcement, cohesion, and support are frequently observed.

Other characteristics of families with depressed children and adolescents include a history of physical sexual or emotional abuse, inappropriate levels of control, hostility, and criticalness, and high levels of family conflict and ineffective conflict resolution. These families typically display generally impaired communication patterns that may also include the transmission of depressive, irrational cognitions. Many of these families demonstrate high levels of emotionality and intrusiveness and difficulty with affect regulation (i.e. flat line or cycling between sadness and positive affect).

Interpersonal Family Therapy

Kaslow et al. (2000)

Interpersonal Family Therapy (IFT) assumes that depressed children are embedded in a family context marked by mood disorders and a maladaptive interaction patterns. IFT focuses on the entire family and not just the child identified with an affective disorder. It assumes that the symptom of depression is caused, supported, or exacerbated by a family dynamic that is depressive. The approach takes an integrationist perspective combining family systems, cognitive behavioral, object relations, and family play therapy.

Family play therapy allows common ground for communicating, understanding of one another, and resolution of conflicts. All family members' thoughts and feelings are valued equally and all have an equal investment in the resolution of the affective disorder. Family play therapy allows for existing alliances and attachments to be identified and explored in a non-threatening or blaming context thereby lowering resistance to change.

It provides an opportunity for the parent to see in the child's symbolic play how the child feels about the family and individual members and provides access to the child's intrapsychic and interpersonal world. Family play therapy also introduces an element of humor and joy into a family currently experiencing stress. Methods of family play therapy can include games, creating a family genogram, family art, family puppeteering, family storytelling, and family sculpting.

Interpersonal Family Therapy for depressed children is a structured, twelve week program involving: Joining and Assessment, Depression Education, Managing Depressive Symptoms, Affective Functioning, Cognitive Functioning, Problem Solving, Social Skills, and Family Communication and Interaction

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CASE STUDY # 1

Rick Red

For the past three months, nine-year-old Rick has expressed fearfulness about attending classes after school. In spite of being an excellent student, he becomes upset at the prospect of spending time in after school care. He reports a mixture of worries about failure and complains of stomachaches and headaches. Primarily, he feels sad, and for the past few weeks he has been unable to enjoy his usual school activities. Going to sleep is problematic also, because he is worried about doing poorly in school and he is frequently awakened several times during the night. At the same time, his school performance has begun to decline, because of missing school and difficulty in concentrating. He has become very blue and on several occasions he has burst into tears for no apparent reason.

His mother has had three Major Depressive Episodes. During their 20 years of marriage, his parents have had continuing marital problems. Rick and his two brothers have often been at the center of their disputes. Although shy, he is a likable child and has always been a good student. In the past, he has attended summer camp, and, though he was somewhat home sick, he seemed to enjoy the activities. He has stayed overnight several times with friends who live thereby, but does appear to be somewhat tied to his mother.

During the interview, Rick suddenly began to sob and said that he felt terrible all the time. He said that at times he felt he would be better off if he were dead. Although he denied any specific suicidal plan, he indicated that he just didn't want to wake-up in the morning. He feels guilty that he is a problem to his parents and feels responsible for many of their marital difficulties.

Treatment plan for case study No. 1 – Rick Red

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

CASE STUDY # 2

Charles Cabbage

Charles, a 14 year old whose parents had been divorced since he was 8, was evaluated because in the past two months he had been breaking a variety of school rules. He had consistently been getting into fights with other children, which was quite unlike his previous behavior. His mother reports that he is much more emotional than in the past. He was extremely irritable and seemed to always have a chip on his shoulder. His mother found him crying in his room on several occasions when he thought that he was alone in the house. This appeared to start after his return from summer vacation. Charles had always had difficulty with reading and is in a special reading program for junior high school.

Charles had been in California with his father for the summer. The previous summers had been very enjoyable for Charles and his father. This year a girlfriend, who the father plans to marry, had monopolized his father's time. She resented Charles and had arranged his schedule to be a series of day camps so she could spend time with his father alone. Charles' mother was upset because his father was trying to reduce child support in connection with his upcoming marriage.

When interviewed, Charles was friendly towards examiner, but brash in criticizing the schools and pointing out what "dopes" his friends were. His boast of being "a bad ass" is out of proportion to any of his offenses. He said he didn't think that he wanted to continue at that school, but was very receptive to the interest and concern about his future. He stated in the interview that his "life sucked and would always suck." He denies being sad or depressed, and just wants to be left alone. Psychological testing indicates bright normal intelligence, but reading is approximately two years below grade level.

Treatment plan for case study No. 2 – Charles Cabbage

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

CASE STUDY # 3

Laura Lemon

Laura, age 9 was brought to the clinic for excessive shyness, difficulty going to sleep, and an inability to be alone in the house. In addition, she had begun to brood that the family dog might get sick and die and lies awake at night watching the dog breathe. She looked very sad and her affect was generally very flat. She had difficulty making contact and would only answer to direct questions. Her mother had just returned home following three months of psychiatric hospitalization for severe depression. The mother's illness had followed her husband's separation from the family in order to live with a younger woman whom he intended to marry.

Laura had been reluctant to attend school when in kindergarten and first grade, but the school had handled this by setting limits about school attendance. At home, she often attempted to sleep in her parents' bed. In the past two years, the problems had worsened considerably. Frequently, Laura would fake illness on school days, and she had begun to do poorly academically. At school she will not interact with the other children and usually plays by herself on the playground. Nothing seems to interest her or give her pleasure. Recent testing had revealed reading difficulties that were thought to be long-standing, and tutoring had been initiated. This academic year she was repeating third grade. Laura has taken this poorly and has no friends in her current class.

During the interview, Laura spoke with reluctance and appeared sad. She seemed preoccupied with her dog, named Mandy, and feared that the dog might fall ill. When asked about considerable weight while her mother was in the hospital because she hates her father's girlfriend's cooking. When asked directly, she said she did not sleep well unless she was in the same bed as her mother. Although she admitted that she could not stay in her house alone for even 10 minutes, she claimed this was almost never a problem as long as her older sister, a neighbor, or a baby sitter was with her, which was almost all the time. She admitted she wanted to have more friends but was reluctant to spend much time in their houses except for a girl who lived next door, from whose house she could see her own. She reported no interest in playing with another friend who lived two blocks over in the neighborhood, despite the fact that three months ago they had been inseparable. She feels that her life is awful and that it will never get any better. Laura stated that she wishes that her Dad and his girlfriend would die or that she could die and never wake up.

Treatment plan for case study No. 3 – Laura Lemon Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

CASE STUDY # 4

Freddy Fry

Fred is a ten-year old boy who was initially referred for psychological evaluation after he made a threat of bringing a case of dynamite to school. Fred has had a long and colorful academic career dating back to kindergarten. Although he is only in the fourth grade, he has been expelled from three private schools before enrolling in the public schools. Teachers report that he is extremely bright and can be an idea of a student, and then for no apparent reason has a “melt down.” When these melt downs occur he becomes an “argumentative three year old and his thoughts and statements don’t make sense.” The counselor at the school has worked with him to manage his behavior and has been relatively successful for brief periods of time, only to result in another incident of out of control behavior. On one occasion he became so angry in school that he ran out of the building and ran across six lanes traffic.

At the time of the interview Freddy was extremely remorseful. He says that he hates himself and doesn’t “deserve to be on the face of the earth.” He “just wants to die so he’s not a problem to everyone anymore.” He says that he’s always angry and doesn’t know why. He reports that at night he can’t sleep and just lays awake thinking about all the bad things he’s done and then he’s always tired. He couldn’t come up with an answer to a question about what he likes or what makes him happy. When asked how long he’s felt this way, he first stated “forever,” but then said at least since Christmas (six weeks ago).

At home, Fred’s mother reports that he can be an ideal child and very helpful with his younger brothers. And yet the same time, when he does not get his way, he can yell and scream for literally hours at a time. He has been known to follow his mother around house screaming, until he gets his way. On several occasions, as his ultimate threat, he has threatened suicide and his threatened himself, his mother, and brothers with a knife. This episode resulted in a brief psychiatric hospitalization. When he is in one of his “moods” he refuses to go to sleep has been awake for 72 hours straight. He is extremely distractible and jumps task to task. He can be very annoying to other people because he “just won’t shut up.” He has repeatedly been in trouble in the neighborhood for stealing and has been banned from playing with certain children by their parents. Senior citizens in the neighborhood described him as helpful and always willing to assist with chores. His bus driver describes him as Dr. Jekyll/Mr. Hyde and says he can tell if there is going to be trouble by the look in his eye when he gets on the bus, and yet on other days he is extremely affable and a pleasure to be around. He says that he saw Freddy provoke a much bigger boy until he beat Freddy.

Freddy’s teachers in the past have thought he had Attention Deficit Hyperactivity Disorder. His pediatrician put him on Ritalin for brief period, but his mother states that it “made him a crazy man.” His pediatrician then tried Paxil, and it seemed to make an even more angry and more agitated. His mother reports that his father, who is no longer involved and has no contact with Freddy, “was a wild man, especially when he was drunk.” She also stated that Freddy’s father was hospitalized on several occasions when he “just got crazy” but does not know what he was diagnosed as. She reported that Freddy’s father did well as long as he took his medicine, but ultimately would stop taking his medicine and get crazy and violent.

Treatment plan for case study No. 4 Freddy Fry

Diagnostic impression

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V (GAF) _____

Goal I _____

Objective A _____

Objective B _____

Objective C _____

Goal II _____

Objective A _____

Objective B _____

Objective C _____

Goal III _____

Objective A _____

Objective B _____

Objective C _____

Goal IV _____

Objective A _____

Objective B _____

Objective C _____

Treatment plan for case study No. 1 – Rick Red

Diagnostic impression

AXIS I 296.21 Major Depression, Single Episode, Mild 309.21 Separation Anxiety Disorder.

AXIS II V71.09 No Diagnosis

AXIS III None Reported

AXIS IV school performance, parental conflict

AXIS V (GAF) 60

Goal I Alleviate Depressed Mood and Other Symptoms of Depression

Objective A Identify and verbalize source of depressed mood

Objective B Encourage expression of repressed anger, hurt, and loss

Objective C Identify and counter “depressed thinking” patterns

Goal II Develop Contract for Safety

Objective A Inform parents of passive suicidal ideation

Objective B Psychoeducation with parents around suicide issues and risk signs

Objective C Establish access to “sources of safety” outside the family

Goal III Decrease Anxiety Around Separation Issues

Objective A Confront irrational fears through cognitive therapy

Objective B Instruct client on relaxation techniques

Objective C Teach positive “self talk” strategies

Goal IV Reduce Parental Conflict

Objective A Refer parents for marriage therapy

Objective B Encourage differentiation between client and parents

Objective C Conduct psychoeducational efforts with parents

Treatment plan for case study No. 2 – Charles Cabbage

Diagnostic impression

AXIS I 309.0 Adjustment Disorder with Depressed Mood 315.00 Reading Disorder.

AXIS II V71.09 No Diagnosis

AXIS III None Reported

AXIS IV father's new relationship, parental conflict

AXIS V (GAF) 65

Goal I Reduce Emotional Stress Around Father's Marriage

Objective A Participate in divorce support group

Objective B Resolve unanswered questions about impact of father's marriage

Objective C Gradually increased exposure to new stepmother

Goal II Improve Coping and Problem Solving Skills

Objective A Discuss other options of expressing unhappiness

Objective B Develop increased interest outside of the family

Objective C Increase sense of autonomy and self-sufficiency

Goal III Reduce Impact of Reading Difficulties

Objective A Obtain psychoeducational evaluation

Objective B Conduct IEP meeting

Objective C Determine necessary educational accommodations

Goal IV Reduce Unacceptable Behavior

Objective A Develop behavioral contract and contingencies

Objective B Obtain commitment from both parents to behavior contract

Objective C Implement behavior modification program

Treatment plan for case study No. 3 – Laura Lemon

Diagnostic impression

AXIS I 309.21 Separation Anxiety Disorder 296.21 Major Depression, Single Episode, Mild

AXIS II V71.09 No Diagnosis

AXIS III None Reported

AXIS IV parent's separation, mother's depression

AXIS V (GAF) 55

Goal I Decrease Excessive Anxiety

Objective A Explore recent and anticipated losses in individual therapy

Objective B Minimize rational fears with coping strategies

Objective C Develop capacity for positive self-talk

Goal II Increase Autonomous Behaviors

Objective A Gradually require her to sleep in her own bed

Objective B Increase time and frequency of separation from parents

Objective C Desensitize her to being alone in the house

Goal III Reduce Parental Conflict

Objective A Family therapy to minimize impact of divorce

Objective B Children of Divorce support group

Goal IV Minimize Impact of Depression

Objective A Psychoeducation for child about the nature of depression

Objective B Individual therapy with mother to focus on impact of disorder on her daughter

Objective C Increase physical exercise and activity

Objective C Increase participation in enjoyable activities

Treatment plan for case study No. 4 – Freddy Fry

Diagnostic impression

AXIS I Bipolar I Disorder, Most Recent Depressed, with Rapid Cycling, R/O Oppositional Defiant

AXIS II V71.09 No Diagnosis

AXISIII None Reported

AXIS IV Academic Difficulties, Parent Child Conflict

AXIS V (GAF) 55

Goal I *Alleviate Depressed Mood and Other Symptoms of Depression*

Objective A Identify feelings of anger and irritation and normalize

Objective B Reframe that he is not bad or the problem

Objective C Increase participation in enjoyable activities

Goal II *Establish Greater Control over Possible Self-Injurious Behaviors*

Objective A Contract for safe behaviors at home and school

Objective B Instruct Client on Relaxation Techniques

Objective C Teach Positive Self Talk and other coping strategies

Goal III *Reduce Parent Child Conflict*

Objective A Conduct Psychoeducational efforts with mother about SED Children

Objective B Training in Effective Parenting and Behavior Management Strategies

Objective C Establish Clear Expectations for Behavior at Home and School with Appropriate Consequences

Goal IV *Obtain Appropriate Medical Intervention*

Objective A Continue to work with Psychiatrist to establish effective medication regimen

Objective B Establish a Medication and Behavioral Daily Log

Objective C Insure that medication is available on a consistent basis

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POST TEST- Depression in Children/Adolescents

- 1. T F As specified in the DSM-IV-TR, the diagnostic criteria for a Major Depressive Disorder are the same for both adults and children and adolescents.**
- 2. T F A child suffering from Dysthymia is very similar to a Bipolar individual, but the duration of symptoms is much longer**
- 3. T F Individuals diagnosed with Bipolar II differ from Bipolar individuals in that they have experienced a hypomanic episode and have never experienced a manic episode along with their depressive episode.**
- 4. T F A diagnosis of Adjustment Disorder with Depressed Mood is the most appropriate diagnosis for a child or adolescent who is experiencing typical grief over the loss of a friend or relative.**
- 5. T F There are no known psychological tests or psychometric measures that can objectively assess the level of depressive symptoms in children or adolescents.**
- 6. T F Affective Disorders and Anxiety share a common component called "generalized negative affect."**
- 7. T F A hypomanic response to antidepressant medication may be indicative of a Bipolar Disorder.**
- 8. T F Duration and Intensity of Outbursts /Tantrums in Bipolar individuals are of short duration, 15 to 30 minutes, whereas with Attention Deficit Hyperactivity Disorder Children they can last for hours.**
- 9. T F Children with bipolar disorders have more difficulties in situations that involve strong relationships. Their behavior at home may be much worse than it is in the classroom.**
- 10. T F Many medical conditions will result in behavioral symptoms that mimic depression.**
- 11. T F A recent NIMH study found that very few adolescents showed remission of symptoms with cognitive behavior therapy. Supportive therapy or family therapy was much more effective.**
- 12. T F Available studies show support the use of Tricyclics, particularly Elavil, for depression in youth.**

- 13. T F MAO Inhibitors are rarely used with children and teens as a result of potentially life-threatening interaction effects.**
- 14. T F Self Control Therapy as espoused by Stark et al. views depression in children and adolescents as a problem with affective regulation.**
- 15. T F Goals of Cognitive Therapy would not typically include an awareness of unconscious pessimistic and negative thoughts, reduction in depressotypic beliefs and biases, elimination of causal attributions of guilt, shame, and failure, and the substitution more constructive cognitions for destructive ones.**
- 16. T F Depressotypic thinking is altered through challenging faulty information, automatic thoughts, dysfunctional schema and beliefs, and negative self evaluations.**
- 17. T F A basic assumption of Interpersonal Psychotherapy for Adolescent Depression is that depression for adolescents originates in one of five problem areas: 1) Grief, 2) Interpersonal Role Disputes, 3) Role transitions, 4) Interpersonal Deficits, or 5) Single Parent Family Issues.**
- 18. T F It is likely that the simple fact of existing in a single parent family is causal for developing an affective disorder**
- 19. T F Children with affective disorders are more likely to exist in families with high rates of psychopathology (mood, anxiety, substance use disorders).**
- 20. T F Interpersonal Family Therapy (IFT) assumes that depressed children are embedded in a family context marked by mood disorders and a maladaptive interaction patterns. IFT focuses on the entire family and not just the child identified with an affective disorder.**

I, _____ (name of participant) affirm that I am the person who completed this home study and am responsible for this post test.

Signature: _____

HOME STUDY EVALUATION FORM

In the interest of continued improvement, we greatly appreciate your evaluation of this workshop. Please be as specific as possible. Thank you for your assistance.

A: Home Study Workshop: Diag. & Tx of Depression in Children & Adolescents

B: Date Evaluated: _____

C. What is your overall evaluation of this home study workshop?

1	2	3	4	5	6	7	8	9	10
poor				average					excellent

D. The material was interesting and informative. It held my interest.

1	2	3	4	5	6	7	8	9	10
strongly disagree				neither agree nor disagree					strongly agree

E. I feel like I learned something useful to my work.

1	2	3	4	5	6	7	8	9	10
strongly disagree				neither agree nor disagree					strongly agree

F. Was the process of using our website, downloading the text and sending in the test easy?

1	2	3	4	5	6	7	8	9	10
no				OK					yes

G. Would you recommend this workshop to a colleague?

1	2	3	4	5	6	7	8	9	10
no				Maybe					yes

Additional Comments:
