ACA-PBs
American Counseling Association Practice Briefs
The Center for Counseling Practice, Policy, and Research
counseling.org/practice_briefs | 703-823-9800 x324

Published December 2015

Depressive Disorders in Youth

Victoria E. Kress, Walden University
Tahani Dari, University of Toledo
Matthew Paylo, Youngstown State University

Description of Depressive Disorders

Disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder, and premenstrual dysphoric disorder are categorized under depressive disorders in the fifth edition of *The Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association [APA], 2013). Youth depression is caused by a combination of genetic, biological, environmental, and psychological factors, with family history accounting for 24% to 58% of depression in youth (Rao & Chen, 2009). Prevalence rates for depression are around 11% in adolescents (Merikangas et al., 2010) and 2.5% in children (Costello, Foley, & Angold, 2006). Younger children (i.e., ages 1-3) are less likely to experience depression, and symptoms gradually increase from middle childhood through adolescence.

Symptoms of depressive disorders vary, but in most instances youth experience a depressed mood or loss of interest in what should be pleasurable activities (e.g., spending time with friends). Counselors should note, however, that in some cases involving children and adolescents, an irritable mood may also be noted (Stringaris, Maughan, Copeland, Costello, & Angold, 2013). Furthermore, youth with a depressive disorder frequently encounter intense and persistent sadness, tiredness/loss of energy, changes in sleep, and somatic complaints. These symptoms may result in school absenteeism, poor academic performance, and even thoughts of death and/or suicide (APA, 2013).

An important distinction between youth and adults includes children expressing depression as physical symptoms such as aches and pains, and specifically abdominal pain (Field, Seligman, & Albrecht, 2008). As they get older, however, youth can communicate more specific depressive symptoms than younger children, including helplessness, hopelessness, sadness, and pessimism (Kendall & Comer, 2010). Although adults frequently withdraw or isolate themselves when they experience depression, adolescents will disengage, but not completely (Field et al., 2008). Instead, youth communication with parents and peers becoming less frequent, or youth might seek alternative friends/social groups. Ultimately, counselors should consider age and developmental factors when assessing symptoms of depression.

Resources:
The American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Depressed-Child-004.asp
The National Institute on Mental Health
http://www.nimh.nih.gov/health/topics/depression/depression-in-children-and-adolescents.shtml
The National Institute on Mental Health
http://www.nimh.nih.gov/health/publications/depression/index.shtml
Help Guide Organization
http://www.helpguide.org/articles/depression/teen-depression-signs-help.htm
National Institute on Mental Health
http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml

IDENTIFICATION/ASSESSMENT STRATEGIES

Thorough assessment strategies are necessary for accurate diagnosis and treatment of depressive disorders, and facilitate the prescription of effective medications by physicians (Evan-Lacko, dosReis, Kastelic, Paula, & Steinwachs, 2010). Although recommendations from the field specify that psychopharmacotherapy should be used in conjunction with counseling, it is an important component to some treatment plans for youth with depressive disorders. The most effective assessment procedures for determining a youth's emotional distress levels involve the collection of multiple data points from self- as well as other-report measures (Kendall & Comer, 2010). Therefore, in addition to using information collected from the youth through either self-report or observation, counselors should also incorporate information collected from the youth's parents/caregivers, siblings, teachers, school staff, and other important people.

Children's Depression Inventory

The Children's Depression Inventory (CDI; Kovacs, 1992) is a 27-item self-report measure used to assess depression in children and adolescents from the previous two-week period. This measure can be used to evaluate five factors (i.e., negative mood, interpersonal problems, ineffectiveness, anhedonia, and negative self-esteem), and one item is included to assess for suicidal ideation. For younger children or those with reading difficulties, the CDI can be administered orally. Additionally, parent-report (17 items) and teacher-report (12 item) versions of the CDI are available. The CDI can be utilized for diagnostic assessment as well as evaluation of progress in counseling.

Beck Depression Inventory for Youth

The Beck Depression Inventory for Youth (BDI-Y; Beck, Beck, & Jolly, 2001) is a 20-item self-report measure used to identify symptoms of depression in children and adolescents. This measure includes items regarding feelings of sadness, guilt, negative thoughts (about self, life, or the future), and disturbances (e.g., sleep, appetite). Written at a second-grade reading level, the BDI-Y can be utilized for diagnostic assessment as well as evaluation of progress in counseling.

Resources:

American Academy of Child and Adolescent Psychiatry. (2007). Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(11), 1503-1526. doi:10.1097/chi.0b013e31814ae1c

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) provides supplemental assessment tools for depression: http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression

INTERVENTION/TREATMENT STRATEGIES

Approaches rooted in cognitive behavioral treatment principles are believed to be the most effective in treating depressive disorders in youth. When working with youth who experience depressive symptoms, counselors should be vigilant about assessing and monitoring for suicide risk. What follows is an overview of the most evidence-based approaches and interventions used to treat youth depression.

Psychoeducation

Regardless of one's treatment approach, when working with youth that have depression, psychoeducation becomes an important aspect of the counseling process (Smith, Jones & Simpson, 2010). Psychoeducation typically involves counselors engaging in conversations with youth and their families about the effects and patterns of depressive concerns. Ultimately, psychoeducation serves to help young people link the relationship between their emotional experiences, thinking, and behaviors. When working with young children, writing, drawing, and play are some techniques that can be used to illustrate the connection between emotions, thoughts, and behaviors (Stark, Streusand, Krumholz, & Patel, 2010).

Psychoeducation enhances a youth's awareness of the effects depressive symptoms have on behaviors and is linked to more positive treatment outcomes (Smith et al., 2010). Counselors are encouraged to consider including pyschoeducation as part of a youth's treatment plan, as increased understanding can also facilitate a sense of empowerment in young clients. Psychoeducation lays the groundwork for youth to participate in self-monitoring, self-initiating, and self-regulating skills that are essential to cognitive behavioral treatment approaches, and help young people to manage depressive symptoms.

Cognitive Behavioral Therapy

A cognitive behavioral therapy (CBT) approach to youth depression involves educating youth to recognize their reactions to depressive symptoms and utilize behavioral and cognitive coping strategies (Friedberg, McClure, & Garcia, 2009; Stark, Streusand, Prerna, & Patel, 2012). When youth are depressed they frequently ruminate and focus on negative thoughts about themselves, their world, or the future. Therefore, the goal of CBT is to assist youth in identifying, challenging, and modifying their thoughts, beliefs, and assumptions in order to generate more adaptive thought processes. The essential goal in CBT is to have youth shift their thinking to becoming aware of their positive attributes and skills (Kress & Paylo, 2015). CBT principles and interventions are important counseling interventions to apply with youth who have depression (Klein, Jacobs, & Reinecke, 2007).

Cognitive restructuring is one technique that may be used in counseling, and this technique involves young clients identifying and replacing distorted cognitions with more positive, adaptive beliefs. Counselors will need to assist youth in identifying cognitive distortions and help them elaborate on their interpretations and assumptions, in alignment with their developmental level. Next, counselors should have clients assess whether or not there is evidence to support the harmful or negative thoughts. With young clients, a visual representation (e.g., the use of pictures, visual or cyclical patterns, drawings, paintings, puppets, or clay) may be used to help identify and challenge distorted thoughts.

Behavioral Activation Therapy

Behavioral activation therapy (BAT; Chartier & Provencher, 2013) is used to modify young clients' behaviors, which consequently reduces their depressive symptoms, feelings, and thoughts. The basic premise of BAT is that if you stay busy and engaged in activities that are enjoyable, you will begin to feel better. When young people are behaviorally activated they are more likely to participate in enjoyable activities, which then contributes to an enhanced mood.

The implementation of BAT with youth involves activity scheduling to assist them in challenging the withdrawal, stagnation, and passivity that depression often invites (Chu, Colognori, Weissman, & Bannon, 2009). When using BAT, a counselor helps youth reflect on previous experiences, identify activities that were once enjoyable, and engage in those pleasurable activities. Youth who have depression often have a difficult time listing previously-enjoyable activities, and counselors will need to be active in facilitating this process. Family members and/or caregivers may also be helpful in identifying previously-enjoyed activities. In between sessions, youth are encouraged to self-monitor their involvement in the activities identified. In addition to documenting their activities, clients are also asked to write down their mood after participating in the activity. The aim of BAT is to emphasize for clients that involvement in pleasurable activities enhances their energy level and improves their general wellbeing.

Psychopharmacotherapy

When counseling youth, some professionals recommend the use of medication in combination with counseling (Sommer-Flanagan & Campbell, 2009). Especially with youth who have severe depression or persistent depression that is not responsive to counseling, medication referrals may be necessary (Kress & Paylo, 2015). In this case, medication compliance should be integrated into the young client's treatment plan. Counselors should attempt to collaborate with medical professionals, the client, and the family to ensure medications are being taken as prescribed.

Research suggests that certain medications are effective in lessening depressive symptoms (Kendall & Comer, 2010). Counselors should be aware that antidepressant medication has been linked to an increased risk of suicidality in adolescents (Barbui, Eposito, & Cipriani, 2009). As such, counselors must regularly assess for suicide,

especially with young people who have recently started to take medication or those who have had changes in their medication (Barbui et al., 2009).

Resources:

Articles on Behavior Activation Therapy
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2223147/
http://www.personal.kent.edu/~dfresco/CBT_Readings/BM_Lejuez_BATD_Manual.pdf

Beck Institute for Cognitive Behavior Therapy
http://www.beckinstitute.org/get-informed/tools-and-resources/professionals/

The American Association of Suicidology provides resources for families and clinicians about suicide risk factors
http://www.suicidology.org/resources/recommended-videos

The Development of the Interpersonal and Social Rhythm Therapy (IPSRT) website was supported by the National Institute of Mental Health grant R34MH091319
https://www.ipsrt.org/

The National Center for Biotechnology Information: Provides information on Interpersonal Therapy
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414693/

Youth Suicide Prevention Program
http://www.yspp.org/downloads/resources/YSPP_depression_Final_low.pdf

REFERENCES

American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Barbui, C., Esposito, E., & Cipriani, A. (2009). Selective serotonin reuptake inhibitors and risk of suicide: A systematic review of observational studies. *Canadian Medical Association Journal, 180*(3), 291-297. doi:10.1503/cmaj.081514.

Beck, J. S., Beck, A. T., & Jolly, J. B. (2001). *Beck youth inventories.* San Antonio, TX: The Psychological Corporation.

Chartier, I. S., & Provencher, M. D. (2013). Behavioural activation for depression: Efficacy, effectiveness and dissemination. *Journal of Affective Disorders 145*(3), 292-299.

Chu, B. C., Colognori, D., Weissman, A. S., & Bannon, K. (2009). An initial description and pilot of group behavioral activation therapy for anxious and depressed youth. *Cognitive and Behavioral Practice, 16*, 408-419. doi: 10.1016/j.cbpra.2009.04.003

Costello, E. J., Foley, D. L., & Angold, A. (2006). 10-year research update review: The epidemiology of child and adolescent psychiatric disorders: II. Developmental epidemiology. *Journal of the American Academy of Child & Adolescent Psychiatry, 45,* 8–25. doi:10.1097/01.chi.0000184929.41423.c0

Evan-Lacko, S. E., dosReis, S., Kastelic, E. A., Paula, C. S., & Steinwachs, D. M. (2010). Evaluation of guidelines-concordant care for bipolar disorder among privately insured youth. *Primary Care Companion to the Journal of Clinical Psychiatry, 12*:3. doi: 10.4088/PCC.09m00837gry.

Field, L. F., Seligman, L., & Albrecht, A. C. (2008). Mood disorders in children and adolescents. In R. R. Erk (Ed.), *Counseling treatment for children and adolescents with DSM-IV-TR disorders* (2nd ed., pp. 253-293). Upper Saddle River NJ: Pearson.

Friedberg, R. D., McClure, J. M., & Garcia, J. H. (2009). *Cognitive therapy techniques for children and adolescents.* New York, NY: Guilford.

Kendall, P. C., & Comer, J. S. (2010). *Childhood disorders* (2nd ed.) London, England: Psychology Press.

Klein, J. B., Jacobs, R. H., & Reinecke, M. A. (2007). Cognitive-behavioral therapy for adolescent depression: A meta-analytic investigation of changes in effect-size estimates. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(11), 1403-1413. doi:10.1097/chi.0b013e3180592aaa.

Kovacs, M. (1992). *The Children's depression inventory manual.* North Tonawanda, NY: Multi-Health Systems.

Kress, V. E., & Paylo, M. J. (2015.) *Treating those with mental disorders: A comprehensive approach to case conceptualization and treatment.* Columbus, OH: Pearson.

Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., … Swendsen, J. (2010). Lifetime

prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A). *Journal of American Academy of Child & Adolescent Psychiatry, 49*(10), 980-989. doi: 10.1016/j.jaac.2010.05.017.

Rao, U., & Chen, L. (2009). Characteristics, correlates, and outcomes of childhood and adolescent depressive disorders. *Dialogues in Clinical Neuroscience, 11*(1), 45-62. Retrieved from http://www.dialogues-cns.org/

Smith, D., Jones, I., & Simpson, S. (2010). Psychoeducation for bipolar disorder. *Advances in Psychiatric Treatment, 16*(2), 147-154. doi: 10.1192/apt.bp.108.006403.

Stark, K. D., Streusand, W., Krumholz, L. S., & Patel, P. (2010). Cognitive-behavioral therapy for depression: The ACTION treatment program for girls. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 93-109). New York, NY: Guilford.

Stark, K. D., Streusand, W., Prerna, A., & Patel, P. (2012). Childhood depression: The ACTION treatment program. In P. C. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioral procedures* (4th ed., pp. 190-223). New York, NY: Guilford.

Sommers-Flanagan, J., & Campbell, D. G. (2009). Psychotherapy and (or) medication for depressed youth? An evidence-based review with recommendations for treatment. *Journal of Contemporary Psychotherapy, 39*, 111-120. doi: 10.1007/s10879-008-9106-0

Stringaris, A., Maughan, B., Copeland, W. S., Costello, E. J., & Angold, A. (2013). Irritable mood as a symptom of depression in youth: Prevalence, developmental, and clinical correlates in the Great Smoky Mountains Study. *Journal of the American Academy of Child and Adolescent Psychiatry*, *52,* 831-840. doi: 10.1016/j.jaac.2013.05.017