



*From the Center's Clearinghouse ...**

An Introductory packet on

Affect and Mood Problems Related to School Aged Youth



This document is a hardcopy version of a resource that can be downloaded from the Center's website (<http://smhp.psych.ucla.edu>). The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspice of the School Mental Health Project, Dept. of Psychology, UCLA.

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The Center encourages widespread sharing of all resources.



UCLA CENTER FOR MENTAL HEALTH IN SCHOOLS*

Under the auspices of the School Mental Health Project in the Department of Psychology at UCLA, our center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

MISSION: *To improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools.*

Through collaboration, the center will

- enhance practitioner roles, functions and competence
- interface with systemic reform movements to strengthen mental health in schools
- assist localities in building and maintaining their own infrastructure for training, support, and continuing education that fosters integration of mental health in schools

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About the Center's Clearinghouse

The scope of the Center's Clearinghouse reflects the School Mental Health Project's mission -- to enhance the ability of schools and their surrounding communities to address mental health and psychosocial barriers to student learning and promote healthy development. Those of you working so hard to address these concerns need ready access to resource materials. The Center's Clearinghouse is your link to specialized resources, materials, and information. The staff supplements, compiles, and disseminates resources on topics fundamental to our mission. As we identify what is available across the country, we are building systems to connect you with a wide variety of resources. Whether your focus is on an individual, a family, a classroom, a school, or a school system, we intend to be of service to you. Our evolving catalogue is available on request; and available for searching from our website.

What kinds of resources, materials, and information are available?

We can provide or direct you to a variety of resources, materials, and information that we have categorized under three areas of concern:

- Specific psychosocial problems
- Programs and processes
- System and policy concerns

Among the various ways we package resources are our *Introductory Packets*, *Resource Aid Packets*, *special reports*, *guidebooks*, and *continuing education units*. These encompass overview discussions of major topics, descriptions of model programs, references to publications, access information to other relevant centers, organizations, advocacy groups, and Internet links, and specific tools that can guide and assist with training activity and student/family interventions (such as outlines, checklists, instruments, and other resources that can be copied and used as information handouts and aids for practice).

Accessing the Clearinghouse

- E-mail us at smhp@ucla.edu
- FAX us at (310) 206-8716
- Phone (310) 825-3634
- Toll Free (866) 846-4843
- Write School Mental Health Project/Center for Mental Health in Schools,
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Check out recent additions to the Clearinghouse on our Web site: <http://smhp.psych.ucla.edu>

All materials from the Center's Clearinghouse are available for order for a minimal fee to cover the cost of copying, handling, and postage. Most materials are available for free downloading from our website.

If you know of something we should have in the clearinghouse, let us know.

Center for Mental Health in Schools at UCLA



The *Center for Mental Health in Schools* operates under the auspices of the School Mental Health Project at UCLA.* It is one of two *national centers* concerned with mental health in schools that are funded in part by the U.S. Department of Health and Human Services, Office of Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration -- with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (Project #U93 MC 00175).

The UCLA Center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. In particular, it focuses on comprehensive, multifaceted models and practices to deal with the many external and internal barriers that interfere with development, learning, and teaching. Specific attention is given policies and strategies that can counter marginalization and fragmentation of essential interventions and enhance collaboration between school and community programs. In this respect, a major emphasis is on enhancing the interface between efforts to address barriers to learning and prevailing approaches to school and community reforms.

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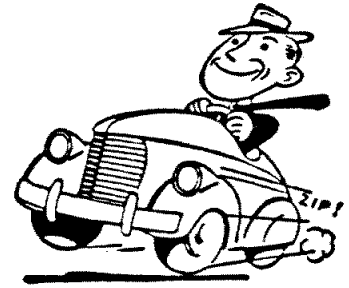
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Affect and Mood Problems



This introductory packet contains:

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Overview

Affect and mood problems related to school aged youth covers a broad range of concerns. This Introductory Packet provides frameworks related to affect and mood for

- defining and describing,
- understanding causes of problems,
- Promoting health and positive development,
- Responding to the first signs of problems,
- interventions for serious problems.

Resources are provided for more in depth information.

I. What Do We Mean When We Talk About Affect and Mood?

- A. Defining Affect and Mood
- B. The Broad Continuum of Affect and Mood

A. Defining Affect and Mood

Affect

From: Gale Encyclopedia of Childhood and Adolescence

The expressions of emotion or feelings to others include facial expressions, gestures, tone of voice, and other signs of emotion such as laughter or tears. As a child grows and develops, environmental factors, such as peer pressure, and internal factors, such as self-consciousness, help to shape the affect.

What is considered a normal range of affect--display of emotion--varies from family to family, from situation to situation, and from culture to culture. Even within a culture, a wide variation in affective display can be considered normal. Certain individuals may gesture prolifically while talking, and display dramatic facial expressions in reaction to social situations or other stimuli. Others may show little outward response to social environments, expressing only a narrow range of affect to the outside world.

When psychologists describe abnormalities in a child's affect, they use specific terminology. The normal affect--which is different for each child and changes with each stage of childhood--is termed broad affect, to describe the range of expression of emotion that is considered typical. Persons with psychological disorders may display variations in their affect. A constricted affect refers to a mild restriction in the range or intensity of display of feelings; as the display of emotion becomes more severely limited, the term blunted affect may be applied. The absence of any exhibition of emotions is described as flat affect; in this case, the voice is monotone, the face is expressionless, and the body is immobile. Extreme variations in expressions of feelings is termed labile affect. When the outward display of emotion is inappropriate for the situation, such as laughter while describing pain or sadness, the affect is described as inappropriate. Labile affect, also called lability, is used to describe emotional instability or dramatic mood swings.

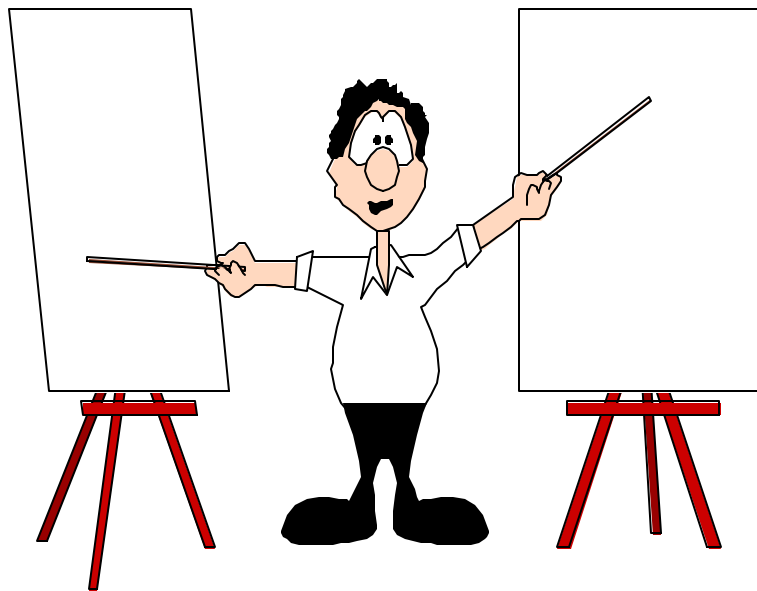
Mood

From: Gale Encyclopedia of Psychology

A mood, while relatively pervasive, is typically neither highly intense nor sustained over an extended period of time. Examples of mood include happiness, sadness, contemplativeness, and irritability. The definitions of phrases to describe moods--such as good mood and bad mood--are imprecise. In addition, the range of what is regarded as a normal or appropriate mood varies considerably from individual to individual and from culture to culture.

B. The Broad Continuum of Affect and Mood

- 1. *Developmental Variations***
- 2. *Problems***
- 3. *Disorders***



1. Developmental Variations: Behaviors within the Range of Expected Behaviors for That Age Group*

DEVELOPMENTAL VARIATION

Sadness Variation

Transient depressive responses or mood changes to stress are normal in otherwise healthy populations.

Bereavement

Sadness related to a major loss that typically persists for less than 2 months after the loss. However, the presence of certain symptoms that are not characteristic of a "normal" grief reaction may be helpful in differentiating bereavement from a major depressive disorder. These include guilt about things other than actions taken or not taken by the survivor at the time of death, thoughts of death, and morbid preoccupation with worthlessness.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

The infant shows brief expressions of sadness, which normally first appear in the last quarter of the first year of life, manifest by crying, brief withdrawal, and transient anger.

Early Childhood

The child may have transient withdrawal and sad affect that may occur over losses and usually experiences bereavement due to the death of a parent or the loss of a pet or treasured object.

Middle Childhood

The child feels transient loss of self-esteem after experiencing failure and feels sadness with losses as in early childhood.

Adolescence

The adolescent's developmental presentations are similar to those of middle childhood but may also include fleeting thoughts of death. Bereavement includes loss of a boyfriend or girlfriend, friend, or best friend.

SPECIAL INFORMATION

A normal process of bereavement occurs when a child experiences the death of or separation from someone (person or pet) loved by the child. There are normal age-specific responses as well as responses related to culture, temperament, the nature of the relationship between the child and the one the child is grieving, and the child's history of loss. While a child may manifest his or her grief response for a period of weeks to a couple of months, it is important to understand that the loss does not necessarily go away within that time frame. Most children will need to revisit the sadness at intervals (months or years) to continue to interpret the meaning of the loss to their life and to examine the usefulness of the coping mechanisms used to work through the sadness. A healthy mourning process requires that the child has a sense of reality about the death and access to incorporating this reality in an ongoing process of life. Unacknowledged, invalidated grief usually results in an unresolving process and leads to harmful behaviors toward self or others. Symptoms reflecting grief reaction may appear to be mild or transient, but care must be taken to observe subtle ways that unexpressed sadness may be exhibited.

Children in hospitals or institutions often experience some of the fears that accompany a death or separation. These fears may be demonstrated in actions that mimic normal grief responses.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care*. (1996) American Academy of Pediatrics.

DEVELOPMENTAL VARIATION

Thoughts of Death Variation

Anxiety about death in early childhood.

Focus on death in middle childhood or adolescence.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Not relevant at this age.

Early Childhood

In early childhood anxiety about dying may be present

Middle Childhood

Anxiety about dying may occur in middle childhood, especially after a death in the family.

Adolescence

Some interest with death and morbid ideation may be manifest by a preference for black clothing and an interest in the occult. If this becomes increased to a point of preoccupation, a problem or a serious ideation should be considered.

DEVELOPMENTAL VARIATION

Thoughts of Death Problem

The child has thoughts of or a preoccupation with his or her own death.

If the child has thoughts of suicide, consider suicidal ideation and attempts (next page).

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Unable to assess

Early and Middle Childhood

The child may express a wish to die through discussion or play. This often follows significant punishment or disappointment.

Adolescence

The adolescent may express nonspecific ideation related to suicide.

SPECIAL INFORMATION

Between 12% and 25% of primary school and high school children have some form of suicidal ideation. Those with a specific plan or specific risk factors should be considered at most risk.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care*. (1996) American Academy of Pediatrics

2. Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria

PROBLEM

Sadness Problem

Sadness or irritability that begins to include some symptoms of major depressive disorders in mild form.

- depressed/irritable mood
- diminished interest or pleasure
- weight loss/gain, or failure to make expected weight gains
- insomnia/hypersomnia
- psychomotor agitation/retardation
- fatigue or energy loss
- feelings of worthlessness or excessive or inappropriate guilt
- diminished ability to think/concentrate

However, the behaviors are not sufficiently intense to qualify for a depressive disorder.

These symptoms should be more than transient and have a mild impact on the child's functioning.

Bereavement that continues beyond 2 months may also be a problem.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in primary Care*. (1996) American Academy of Pediatrics

Notes: Dots (...) indicate that the original text has a reference to another section of the book that was omitted here because that section was not included in this guide.

Infancy

COMMON DEVELOPMENTAL PRESENTATIONS

The infant may experience some developmental regressions, fearfulness, anorexia, failure to thrive, sleep disturbances, social withdrawal, irritability, and increased dependency, which are responsive to extra efforts at soothing and engagement by primary caretakers.

Early Childhood

The child may experience similar symptoms as in infancy, but sad affect may be more apparent. In addition, temper tantrums may increase in number and severity, and physical symptoms such as constipation, secondary enuresis (...), encopresis (...), and nightmares may be present.

Middle Childhood

The child may experience some sadness that results in brief suicidal ideation with no clear plan of suicide, some apathy, boredom, low self-esteem, and unexplained physical symptoms such as headaches and abdominal pain (...).

Adolescence

Some disinterest in school work, decrease in motivation, and day-dreaming in class may begin to lead to deterioration of school work. Hesitancy in attending school, apathy, and boredom may occur.

SPECIAL INFORMATION

Sadness is experienced by some children beyond the level of a normal developmental variation when the emotional or physiologic symptoms begin to interfere with effective social interactions, family functioning, or school performance. These periods of sadness may be brief or prolonged depending on the precipitating event and temperament of the child. Reassurance and monitoring is often needed at this level. If the sad behaviors are more severe, consider major depressive disorders.

The potential for suicide in grieving children is higher. Evaluation of suicidal risk should be part of a grief workup for all patients expressing profound sadness or confusion or demonstrating destructive behaviors toward themselves or others.

Behavioral symptoms resulting from bereavement that persist beyond 2 months after the loss require evaluation and intervention. Depressed parents or a strong family history of depression or alcoholism (...) puts youth at very high risk for depressive problems and disorders. Family and marital discord, ... exacerbates risk. Suicidal ideation should be assessed (see Suicidal Thoughts or Behaviors cluster).

Lying, stealing, suicidal thoughts (see Suicidal Thoughts or Behaviors cluster), and promiscuity may be present. Physical symptoms may include recurrent headaches, chronic fatigue, and abdominal pain (...).

3. Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the

DISORDERS

Major Depressive Disorder

Significant distress or impairment is manifested by five of the nine criteria listed below, occurring nearly every day for 2 weeks.

These symptoms must represent a change from previous functioning and that either depressed or irritable mood or diminished interest or pleasure must be present to make the diagnosis.

- depressed/irritable
- diminished interest or pleasure
- weight loss/gain
- insomnia/hypersomnia
- psychomotor agitation/retardation
- fatigue or energy loss
- feelings of worthlessness
- diminished ability to think/concentrate
- recurrent thoughts of death and suicidal ideation

(see *DSM-IV* Criteria ...)

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COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

True major depressive disorders are difficult to diagnose in infancy. However, the reaction of some infants in response to the environmental cause is characterized by persistent apathy, despondency (often associated with the loss of a caregiver or an unavailable [e.g., severely depressed] caregiver), nonorganic failure-to-thrive (often associated with apathy, excessive withdrawal), and sleep difficulties. These reactions, in contrast to the “problem” level, require significant interventions.

Early Childhood

This situation in early childhood is similar to infancy.

Middle Childhood

The child frequently experiences chronic fatigue, irritability, depressed mood, guilt, somatic complaints, and is socially withdrawn (...). Psychotic symptoms (hallucinations or delusions) may be present.

Adolescence

The adolescent may display psychomotor retardation or have hypersomnia. Delusions or hallucinations are not uncommon (but not part of the specific symptoms of the disorder).

SPECIAL INFORMATION

Depressed parents or a strong family history of depression or alcoholism puts youth at very high risk for depressive disorder (...). Risk is increased by family and marital discord (...), substance abuse by the patient (...), and a history of depressive episodes. Suicidal ideation should be routinely assessed.

Sex distribution of the disorder is equivalent until adolescence, when females are twice as likely as males to have a depressive disorder.

Culture can influence the experience and communication of symptoms of depression, (e.g., in some cultures, depression tends to be expressed largely in somatic terms rather than with sadness or guilt). Complaints of “nerves” and headaches (in Latino and Mediterranean cultures), of weakness, tiredness, or “imbalance” (in Chinese and Asian cultures), of problems of the “heart” (in Middle Eastern cultures), or of being heartbroken (among Hopis) may express the depressive experience.

Subsequent depressive episodes are common. Bereavement typically improves steadily without specific treatment. If significant impairment or distress is still present over 2 months following the acute loss or death of a loved one, or if certain symptoms that are not characteristic of a “normal” grief reaction are present (e.g., marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation), consider diagnosis and treatment of major depressive disorder.

DISORDER

Dysthymic Disorder

The symptoms of dysthymic disorder are less severe or disabling than those of major depressive disorder but more persistent.

Depressed/irritable mood for most of the day, for more days than not (either by subjective account or observations of others) for at least 1 year.

Also the presence, while depressed/ irritable, of two (or more) of the following:

- poor appetite/overeating
- insomnia/hypersomnia
- low energy or fatigue
- poor concentration/difficulty making decisions
- feelings of hopelessness

(see *DSM-IV* Criteria ...)

Adjustment Disorder With Depressed Mood

(see *DSM-IV* Criteria ...)

Depressive Disorder, Not Otherwise Specified

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Not diagnosed.

Early Childhood

Rarely diagnosed.

Middle Childhood and Adolescence

Commonly experience feelings of inadequacy, loss of Interest/pleasure, social withdrawal, guilt, brooding, irritability or excessive anger, decreased activity/productivity. May experience sleep/ appetite/weight changes and psychomotor symptoms. Low self-esteem is common.

SPECIAL INFORMATION

Because of the chronic nature of the disorder, the child may not develop adequate social skills.

The child is at risk for episodes of major depression.

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DISORDER

Bipolar I Disorder, With Single Manic Episode

(see DSM-IV CRITERIA...)

Bipolar II Disorder, Recurrent Major Depressive Episodes With Hypomanic Episodes

Includes presence (or history) of one or more major depressive episodes, presence of at least one hypomanic episode, there has never been a manic episode (similar to manic episodes but only need to be present for 4 or more days and are not severe enough to cause marked impairment in function) or a mixed episode. The symptoms are not better accounted for by schizoaffective disorder, schizophrenia, delusional disorder, or psychotic disorder. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Not diagnosed.

Early Childhood

Rarely diagnosed.

Middle Childhood

The beginning symptoms as described for adolescents start to appear.

Adolescence

During manic episodes, adolescents may wear flamboyant clothing, distribute gifts or money, and drive recklessly. They display inflated self-esteem, a decreased need for sleep, pressure to keep talking, flights of ideas, distractibility, unrestrained buying sprees, sexual indiscretion, school truancy and failure, antisocial behavior, and illicit drug experimentation.

SPECIAL INFORMATION

Substance abuse is commonly associated with bipolar disorder (...).

Stimulant abuse and certain symptoms of attention-deficit/ hyperactivity disorder may mimic a manic episode (see Hyperactive/ Impulsive Behaviors cluster).

Manic episodes in children and adolescents can include psychotic features and may be associated with school truancy, antisocial behavior (...), school failure, or illicit drug experimentation. Long-standing behavior problems often precede the first manic episode.

One or more manic episodes (a distinct period of an abnormally and persistently elevated and expansive or irritable mood lasting at least 1 week if not treated) frequently occur with one or more major depressive episodes. The symptoms are not better accounted for by other severe mental disorders (e.g., schizoaffective, schizophrenogenic, delusional, or psychotic disorders). The symptoms cause mild impairment in functioning in usual social activities and relationships with others.

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics

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DISORDER

Suicidal Ideation and Attempts

The child has thoughts about causing intentional self-harm acts that cause intentional self-harm or death.

This code represents an unspecified mental disorder. It is to be used when no other condition is identified.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Unable to assess.

Early Childhood

The child expresses a wish and intent to die either verbally or by actions.

Middle Childhood

The child plans and enacts self-injurious acts with a variety of potentially lethal methods.

Adolescence

The adolescent frequently shows a strong wish to die and may carefully plan and carry out a suicide.

SPECIAL INFORMATION

A youngster's understanding that death is final is not an essential ingredient in considering a child or adolescent to be suicidal. However, very young children, such as preschoolers who do not appreciate the finality of death, can be considered to be suicidal if they wish to carry out a self-destructive act with the goal of causing death. Such behavior in preschoolers is often associated with physical or sexual abuse (...).

Prepubertal children may be protected against suicide by their cognitive immaturity and limited access to more lethal methods that may prevent them from planning and executing a lethal suicide attempt despite suicidal impulses.

The suicide rate and rate of attempted suicide increase with age and with the presence of alcohol and other drug use. Psychotic symptoms, including hallucinations, increase risk as well.

Because of societal pressures, some homosexual youth are at increased risk for suicide attempts (...).

In cases of attempted suicide that are carefully planned, adolescents may leave a note, choose a clearly lethal method, and state their intent prior to the actual suicide. In contrast, most suicide attempts in adolescence are impulsive, sometimes with little threat to the patient's life. The motivation for most attempts appears to be a wish to gain attention and/or help, escape a difficult situation, or express anger or love. However, irrespective of motivation, all suicide attempts require careful evaluation and all patients with active intent to harm themselves should have a thorough psychiatric evaluation.

Although suicidal ideation and attempts is not a disorder diagnosis, more extensive evaluation may identify other mental conditions (e.g., major depressive disorder).

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II. Understanding the Causes of Problems Related to Affect and Mood

- A. Keeping the Environment in Perspective as a Cause of Commonly Identified Psychosocial Problems
- B. Environmental Situations and Potentially Stressful Events and Common Behavioral Responses
- C. Overview of Risk Factors and Prevention

II. A. Understanding the Causes of Problems Related to Affect and Mood: Environment in Perspective

A. Keeping The Environment in Perspective as a Cause of Commonly Identified Psychosocial Problems.

A large number of students are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters have trouble behaving in classrooms; only a small percent have attention deficit or a conduct disorder. In some schools, large numbers of students have problems learning; only a few have learning disabilities. Individuals suffering from true internal pathology represent a relatively small segment of the population. A caring society tries to provide the best services for such individuals; doing so includes taking great care not to misdiagnose others whose "symptoms" may be similar, but are caused by factors other than internal pathology. Such misdiagnoses lead to policies and practices that exhaust available resources in ineffective ways. A better understanding of how the environment might cause problems and how focusing on changing the environment might prevent problems is essential.

A. Labeling Troubled and Troubling Youth: The Name Game

She's depressed.

*That kid's got an attention deficit
hyperactivity disorder.*

He's learning disabled.

What's in a name? Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" -- making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as ADHD, depression, and LD. This happens

despite the fact that the problems of most youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

Diagnosing Behavioral, Emotional, and Learning Problems

The thinking of those who study behavioral, emotional, and learning problems has long been dominated by models stressing *person* pathology. This is evident in discussions of cause, diagnosis, and intervention strategies. Because so much discussion focuses on person pathology, diagnostic systems have not been developed in ways that adequately account for psychosocial problems.

Many practitioners who use prevailing diagnostic labels understand that most problems in human functioning result from the interplay of person and environment. To counter nature *versus* nurture biases in thinking about problems, it helps to approach all diagnosis guided by a broad perspective of what determines human behavior.

A Broad View of Human Functioning

Before the 1920's, dominant thinking saw human behavior as determined primarily by person variables, especially inborn characteristics. As behaviorism gained in influence, a strong competing view arose. Behavior was seen as shaped by environmental influences, particularly the stimuli and reinforcers one encounters.

Today, human functioning is viewed in *transactional* terms -- as the product of a reciprocal interplay between person and environment (Bandura, 1978). However, prevailing approaches to labeling and addressing human problems still create the impression that problems are determined by *either* person or environment variables. This is both unfortunate and unnecessary -
- unfortunate because such a view limits progress with respect to research and practice, unnecessary because a transactional view encompasses the position that problems may be caused by person, environment, or both. This broad paradigm encourages a comprehensive perspective of cause and correction.

Toward a Broad Framework

A broad framework offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid over-diagnosing internal pathology. Such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems caused by the environment are placed at one end of the continuum (referred to as Type I problems). At the other end are problems caused primarily by pathology

within the person (Type III problems). In the middle are problems stemming from a relatively equal contribution of environmental and person sources (Type II problems).

Diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->P). Toward the other end, person variables account for more of the problem (thus e<--->P).

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the the person (P)
E	(E<--->p)	E<--->P
----- ----- ----- ----- -----		
Type I problems	Type II problems	Type III problems
<ul style="list-style-type: none"> •caused primarily by environments and systems that are deficient and/or hostile •problems are mild to moderately severe and narrow to moderately pervasive 	<ul style="list-style-type: none"> •caused primarily by a significant <i>mismatch</i> between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology) •problems are mild to moderately severe and pervasive 	<ul style="list-style-type: none"> •caused primarily by person factors of a pathological nature •problems are moderate to profoundly severe and moderate to broadly pervasive

Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. However, the above conceptual scheme shows the value of starting with a broad model of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward blaming the victim (Ryan, 1971). It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

There is a substantial community-serving component in policies and procedures for classifying and labeling exceptional children and in the various kinds of institutional arrangements made to take care of them. "To take care of them" can and should be read with two meanings: to give children help and to exclude them from the community.

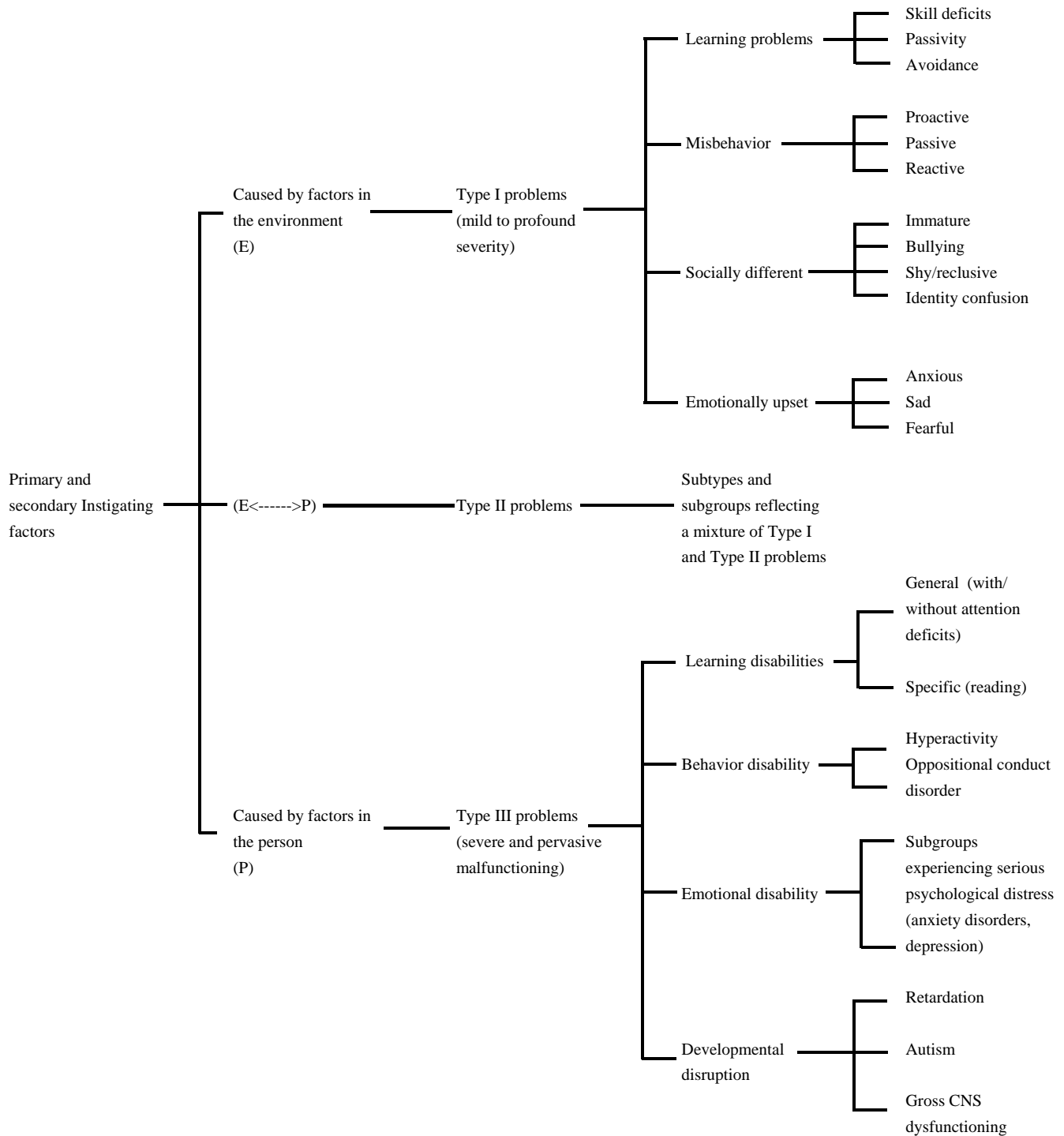
Nicholas Hobbs

After the general groupings are identified, it becomes relevant to consider the value of differentiating subgroups or subtypes within each major type of problem. For example, subtypes for the Type III category might first differentiate behavioral, emotional, or learning problems arising from serious internal pathology (e.g., structural and functional malfunctioning within the person that causes disorders and disabilities and disrupts development). Then subtypes might be differentiated within each of these categories. For illustrative purposes: Figure 2 presents some ideas for subgrouping Type I and III problems.

References

- Bandura, A. (1978). The self system in reciprocal determination. *American Psychologist*, 33, 344-358.
- Ryan, W. (1971). *Blaming the victim*. New York: Random House.

Figure 2: Categorization of Type I, II, and III Problems



Source: H. S. Adelman and L. Taylor (1993). Learning problems and learning disabilities. Pacific Grove. Brooks/Cole. Reprinted with permission.

B. Environmental Situations and Potentially Stressful Events

The American Academy of Pediatrics has prepared a guide on mental health for primary care providers. The guide suggests that commonly occurring stressful events in a youngsters life can lead to common behavioral responses. Below are portions of Tables that give an overview of such events and responses.

Environmental Situations and Potentially Stressful Events Checklist

Challenges to Primary Support Group

- Challenges to Attachment Relationship
- Death of a Parent or Other Family Member
- Marital Discord
- Divorce
- Domestic Violence
- Other Family Relationship Problems
- Parent-Child Separation

Changes in Caregiving

- Foster Care/Adoption/Institutional Care
- Substance-Abusing Parents
- Physical Abuse
- Sexual Abuse
- Quality of Nurture Problem
- Neglect
- Mental Disorder of Parent
- Physical Illness of Parent
- Physical Illness of Sibling
- Mental or Behavioral disorder of Sibling

Other Functional Change in Family

- Addition of Sibling
- Change in Parental Caregiver

Community of Social Challenges

- Acculturation
- Social Discrimination and/or Family Isolation

Educational Challenges

- Illiteracy of Parent
- Inadequate School Facilities
- Discord with Peers/Teachers

Parent or Adolescent Occupational Challenges

- Unemployment
- Loss of Job
- Adverse Effect of Work Environment

Housing Challenges

- Homelessness
- Inadequate Housing
- Unsafe Neighborhood
- Dislocation

Economic Challenges

- Poverty
- Inadequate Financial Status

Legal System or Crime Problems

Other Environmental Situations

- Natural Disaster
- Witness of Violence

Health-Related Situations

- Chronic Health Conditions
- Acute Health Conditions

Common Behavioral Responses to Environmental Situations and Potentially Stressful Events

INFANCY-TODDLERHOOD (0-2Y)
BEHAVIORAL MANIFESTATIONS

- Illness-Related Behaviors**
N/A
- Emotions and Moods**
Change in crying
Change in mood
Sullen, withdrawn
- Impulsive/Hyperactive or Inattentive Behaviors**
Increased activity
- Negative/Antisocial Behaviors**
Aversive behaviors, i.e., temper tantrum, angry outburst
- Feeding, Eating, Elimination Behaviors**
Change in eating
Self-induced vomiting
Nonspecific diarrhea, vomiting
- Somatic and Sleep Behaviors**
Change in sleep
- Developmental Competency**
Regression or delay in developmental attainments
Inability to engage in/sustain play
- Sexual Behaviors**
Arousal behaviors
- Relationship Behaviors**
Extreme distress with separation
Absence of distress with separation
Indiscriminate social interactions
Excessive clinging
Gaze avoidance, hypervigilance

MIDDLE CHILDHOOD (6-12Y)
BEHAVIORAL MANIFESTATIONS

- Illness-Related Behaviors**
Transient physical complaints
- Emotions and Moods**
Sadness
Anxiety, Changes in mood
Preoccupation with stressful situations
Self-destructive
Fear of specific situations
Decreased self-esteem
- Impulsive/Hyperactive or Inattentive Behaviors**
Inattention, High activity level, Impulsivity
- Negative/Antisocial Behaviors**
Aggression
Noncompliant
Negativistic
- Feeding, Eating, Elimination Behaviors**
Change in eating
Transient enuresis, encopresis
- Somatic and Sleep Behaviors**
Change in sleep
- Developmental Competency**
Decrease in academic performance
- Sexual Behaviors**
Preoccupation with sexual issues
- Relationship Behaviors**
Change in school activities
Change in social interaction such as withdrawal
Separation fear/ Fear being alone
- Substance Use/Abuse...**

EARLY CHILDHOOD (3-5Y)
BEHAVIORAL MANIFESTATIONS

- Illness-Related Behaviors**
N/A
- Emotions and Moods**
Generally sad
Self-destructive behaviors
- Impulsive/Hyperactive or Inattentive Behaviors**
Inattention
High activity level
- Negative/Antisocial Behaviors**
Tantrums
Negativism
Aggression
Uncontrolled, noncompliant
- Feeding, Eating, Elimination Behaviors**
Change in eating
Fecal soiling
Bedwetting
- Somatic and Sleep Behaviors**
Change in sleep
- Developmental Competency**
Regression or delay in developmental attainments
- Sexual Behaviors**
Preoccupation with sexual issues
- Relationship Behaviors**
Ambivalence toward independence
Socially withdrawn, isolated
Excessive clinging
Separation fears
Fear of being alone

ADOLESCENCE (13-21Y)
BEHAVIORAL MANIFESTATIONS

- Illness-Related Behaviors**
Transient physical complaints
- Emotions and Moods**
Sadness, Self-destructive
Anxiety
Preoccupation with stress
Decreased self-esteem
Change in mood
- Impulsive/Hyperactive or Inattentive Behaviors**
Inattention, impulsivity
High activity level
- Negative/Antisocial Behaviors**
Aggression
Antisocial behavior
- Feeding, Eating, Elimination Behaviors**
Change in appetite
Inadequate eating habits
- Somatic and Sleep Behaviors**
Inadequate sleeping habits
Oversleeping
- Developmental Competency**
Decrease in academic achievement
- Sexual Behaviors**
Preoccupation with sexual issues
- Relationship Behaviors**
Change in school activities
School absences
Change in social interaction such as withdrawal
- Substance Use/Abuse...**

* Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics

II. C. Understanding the Causes of Problems Related to Affect and Mood: Overview of Risk Factors

C. Overview of Risk Factors and Prevention

Excerpts from: Mental Health: A Report of the Surgeon General

Current approaches to understanding the etiology of mental disorders in childhood are driven by empirical advances in neuroscience and behavioral research rather than by theories. Epidemiological research on the factors that make children vulnerable to mental illness is important for several reasons: delineating the range of risk factors for particular mental disorders helps to understand their etiology; the populations most at risk can be identified; understanding the relative strength of different risk factors allows for the design of appropriate prevention programs for children in different contexts; and resources can be better allocated to intervene so as to maximize their effectiveness.

Risk Factors

There is now good evidence that *both* biological factors and adverse psychosocial experiences during childhood influence - but not necessarily "cause"- the mental disorders of childhood. Adverse experiences may occur at home, at school, or in the community. A stressor or risk factor may have no, little, or a profound impact, depending on individual differences among children and the age at which the child is exposed to it, as well as whether it occurs alone or in association with other risk factors. Although children are influenced by their psychosocial environment, most are inherently resilient and can deal with some degree of adversity. However, some children, possibly those with an inherent biological vulnerability (e.g., genes that convey susceptibility to an illness), are more likely to be harmed by an adverse environment, and there are some environmental adversities, especially those that are long-standing or repeated, that seem likely to induce a mental disorder in all but the hardiest of children. A recent analysis of risk factors by Kraemer and colleagues (1997) has provided a useful framework for differentiating among categories of risk and may help point this work in a more productive direction.

Risk factors for developing a mental disorder or experiencing problems in social-emotional development include prenatal damage from exposure to alcohol, illegal drugs, and tobacco; low birth weight; difficult temperament or an inherited predisposition to a mental disorder; external risk factors such as poverty, deprivation, abuse and neglect; unsatisfactory relationships; parental mental health disorder; or exposure to traumatic events...

Psychosocial Risk Factors

A landmark study on risks from the environment (Rutter & Quinton, 1977) showed that several factors can endanger a child's mental health. Dysfunctional aspects of family life such as severe parental discord, a parent's psychopathology or criminality, overcrowding, or large family size can predispose to conduct disorders and antisocial personality disorders, especially if the child does not have a loving relationship with at least one of the parents (Rutter, 1979). Economic hardship can indirectly increase a child's risk of developing a behavioral disorder because it may cause behavioral problems in the parents or increase the risk of child abuse (Dutton, 1986; Link et al., 1986; Wilson, 1987; Schorr, 1988). Exposure to acts of violence also is identified as a possible cause of stress-related mental health problems (Jenkins & Bell, 1997). Studies point to poor caregiving practices as being a risk factor for children of depressed parents (Zahn-Waxler et al., 1990).

The quality of the relationship between infants or children and their primary caregiver, as manifested by the security of attachment, has long been felt to be of paramount importance to mental health across the life span. In this regard, the relationship between maternal problems and those factors in children that predispose them to form insecure attachments, particularly young infants' and toddler's security of attachment and temperament style and their impact on the development of mood and conduct disorders, is of great interest to researchers. Many investigators have taken the view that the nature and the outcome of the attachment process are related to later depression, especially when the child is raised in an abusive environment (Toth & Cicchetti, 1996), and to later conduct disorder (Sampson & Laub, 1993). The relationship of attachment to mental disorders has been the subject of several important review articles (Rutter, 1995; van IJzendoorn et al., 1995).

There is controversy as to whether the key determinant of "insecure" responses to strange situations stems from maternal behavior or from an inborn predisposition to respond to an unfamiliar stranger with avoidant behaviors, such as is found in socially phobic children (Belsky & Rovine, 1987; Kagan et al., 1988; Thompson et al., 1988; Kagan, 1994, 1995). Kagan demonstrated that infants who were more prone to being active, agitated, and tearful at 4 months of age were less spontaneous and sociable and more likely to show anxiety symptoms at age 4 (Snidman et al., 1995; Kagan et al., 1998). These findings are of considerable significance, because long-term study of such highly reactive, behaviorally inhibited infants and toddlers has shown that they are excessively shy and avoidant in early childhood and that this behavior persists and predisposes to later anxiety (Biederman et al., 1993). There is also some controversy as to whether "difficult" temperament in an infant is an early manifestation of a behavior problem, particularly in children who go on to demonstrate such problems as conduct disorder (Olds et al., 1999). One analysis of the attachment literature suggests that abnormal or insecure forms of attachment are largely the *product* of maternal problems, such as depression and substance abuse, rather than of individual differences in the child (van IJzendoorn et al., 1992).

The relationship between a child's temperament and parenting style is complex (Thomas et al., 1968); it may be either protective if it is good or a risk factor if it is poor. Thus, a difficult child's chances of developing mental health problems are much reduced if he or she grows up in a family in which there are clear rules and consistent enforcement (Maziade et al., 1985), while a child exposed to inconsistent discipline is at greater risk for later behavior problems (Werner & Smith, 1992).

Family and Genetic Risk Factors

As noted above in the relationships between temperament and attachment, in some instances the relative contributions of biologic influences and environmental influences are difficult to tease apart, a problem that particularly affects studies investigating the impact of family and genetic influences on risk for childhood mental disorder. For example, research has shown that between 20 and 50 percent of depressed children and adolescents have a family history of depression (Puig-Antich et al., 1989; Todd et al., 1993; Williamson et al., 1995; Kovacs, 1997b). The exact reasons for this increased risk have not been fully clarified, but experts tend to agree that both factors interact to result in this increased risk (Weissman et al., 1997). Family research has found that children of depressed parents are more than three times as likely as children of nondepressed parents to experience a depressive disorder (see Birmaher et al., 1996a and 1996b for review). Parental depression also increases the risk of anxiety disorders, conduct disorder, and alcohol dependence (Downey & Coyne, 1990; Weissman et al., 1997; Wickramaratne & Weissman, 1998). The risk is greater if both parents have had a depressive illness, if the parents were depressed when they were

young, or if a parent had several episodes of depression (Merikangas et al., 1988; Downey & Coyne, 1990; McCracken, 1992a, 1992b; Mufson et al., 1992; Warner et al., 1995; Wickramaratne & Weissman, 1998).

Effects of Parental Depression

Depressed parents may be withdrawn and lack energy and consequently pay little attention to, or provide inadequate supervision of, their children. Alternatively, such parents may be excessively irritable and overcritical, thereby upsetting children, demoralizing them, and distancing them (Cohn et al., 1986; Field et al., 1990). At a more subtle level, parents' distress - being pessimistic, tearful, or threatening suicide - is sometimes seen or heard by the child, thereby inducing anxiety. Depressed parents may not model effective coping strategies for stress; instead of "moving on," some provide an example of "giving up" (Garber & Hilsman, 1992). Depression is also often associated with marital discord, which may have its own adverse effect on children and adolescents. Conversely, the behavior of the depressed child or teenager may contribute to family stress as much as being a product of it. The poor academic performance, withdrawal from normal peer activities, and lack of energy or motivation of a depressed teenager may lead to intrusive or reprimanding reactions from parents that may further reduce the youngster's self-esteem and optimism.

The consequences of maternal depression vary with the state of development of the child, and some of the effects are quite subtle (Cicchetti & Toth, 1998). For example, in infancy, a withdrawn or unresponsive depressed mother may increase an infant's distress, and an intrusive or hostile depressed mother may lead the infant to avoid looking at and communicating with her (Cohn et al., 1986). Other studies have shown that if infants' smiles are met with a somber or gloomy face, they respond by showing a similarly somber expression and then by averting their eyes (Murray et al., 1993).

During the toddler stage of development, research shows that the playful interactions of a toddler with a depressed mother are often briefer and more likely to be interrupted (by either the mother or the child) than those with a nondepressed parent (Jameson et al., 1997). Research has shown that some depressed mothers are less able to provide structure or to modify the behavior of excited toddlers, increasing the risk of out-of-control behavior, the development of a later conduct disorder, or later aggressive dealings with peers (Zahn-Waxler et al., 1990; Hay et al., 1992). A depressed mother's inability to control a young child's behavior may result in the child failing to learn appropriate skills for settling disputes without reliance on aggression.

Stressful Life Events

The relationship between stressful life events and risk for child mental disorders is well established (e.g., Garnezy, 1983; Hammen, 1988; Jensen et al., 1991; Garber & Hilsman, 1992), although this relationship in children and adolescents is complicated, perhaps reflecting the impact of individual differences and developmental changes. For example, there is a relationship between stressful life events, such as parental death or divorce, and the onset of major depression in young children, especially if they occur in early childhood and lead to a permanent and negative change in the child's circumstances. Yet findings are mixed as to whether the same relationship is true for depression in midchildhood or in adolescence (Birmaher et al., 1996a and 1996b; Garrison et al., 1997).

Childhood Maltreatment

Child abuse is a very widespread problem; it is estimated that over 3 million children are maltreated every year in the United States (National Committee to Prevent Child Abuse, 1995). Physical abuse is associated with insecure attachment (Main & Solomon, 1990), psychiatric disorders such as post-traumatic stress disorder, conduct disorder, ADHD (Famularo et al., 1992), depression (Kaufman, 1991), and impaired social functioning with peers (Salzinger et al., 1993). Psychological maltreatment is believed to occur more frequently than physical maltreatment (Cicchetti & Carlson, 1989); it is associated with depression, conduct disorder, and delinquency (Kazdin et al., 1985) and can impair social and cognitive functioning in children (Smetana & Kelly, 1989).

Peer and Sibling Influences

The influence of maladaptive peers can be very damaging to a child and greatly increases the likelihood of adverse outcomes such as delinquency, particularly if the child comes from a family beset by many stressors (Friday & Hage, 1976; Loeber & Farrington, 1998). One way to reduce antisocial behavior in adolescents is to encourage such youths to interact with better adapted youths under the supervision of a mental health worker (Feldman et al., 1983). Sibling rivalry is a common component of family life and, especially in the presence of other risk factors, may contribute to family stresses (Patterson & Dishion, 1988). Although almost universal, in the presence of other risk factors it may be the origin of aggressive behavior that eventually extends beyond the family (Patterson & Dishion, 1988). In stressed or large families, parents have many demands placed on their time and find it difficult to oversee, or place limits on, their young children's behavior. When parental attention is in short supply, young siblings squabbling with each other attract available attention. In such situations, parents rarely comment on good or neutral behavior but do pay attention, even if in a highly critical and negative way, when their children start to fight; as a result, the act of fighting may be inadvertently rewarded. Thus, any attention, whether it be praise or physical punishment, increases the likelihood that the behavior is repeated.

Correlations and Interactions Among Risk Factors

Recent evidence suggests that social/environmental risk factors may combine with physical risk factors of the child, such as neurological damage caused by birth complications or low birthweight, fearlessness and stimulation-seeking behavior, learning impairments, autonomic underarousal, and insensitivity to physical pain and punishment (Raine et al., 1996, 1997, 1998). However, testing models of the impact of risk factor interactions for the development of mental disorders is difficult, because some of the risk factors are difficult to measure. Thus, the trend these days is to move away from the consideration of *individual* risk factors toward identifying *measurable* risk factors and their *combinations* and incorporating all of them into a single model that can be tested (Patterson, 1996).

The next section describes a series of preventive interventions directed against the environmental risk factors described above.

Prevention

Childhood is an important time to prevent mental disorders and to promote healthy development, because many adult mental disorders have related antecedent problems in childhood. Thus, it is logical to try to intervene early in children's lives before problems are established and become more refractory. The field of prevention has now developed to the point that reduction of risk, prevention of onset, and early intervention are realistic possibilities. Scientific methodologies in prevention are increasingly sophisticated, and the results from high-quality research trials are as credible as those in other areas of biomedical and psychosocial science. There is a growing recognition that prevention does work; for example, improving parenting skills through training can substantially reduce antisocial behavior in children (Patterson et al., 1993).

The wider human services and law enforcement communities, not just the mental health community, have made prevention a priority. Policymakers and service providers in health, education, social services, and juvenile justice have become invested in intervening early in children's lives: they have come to appreciate that mental health is inexorably linked with general health, child care, and success in the classroom and inversely related to involvement in the juvenile justice system. It is also perceived that investment in prevention may be cost-effective. Although much research still needs to be done, communities and managed health care organizations eager to develop, maintain, and measure empirically supported preventive interventions are encouraged to use a risk and evidence-based framework developed by the National Mental Health Association (Mrazek, 1998).

Some forms of primary prevention are so familiar that they are no longer thought of as mental health prevention activities, when, in fact, they are. For example, vaccination against measles prevents its neurobehavioral complications; safe sex practices and maternal screening prevent newborn infections such as syphilis and HIV, which also have neurobehavioral manifestations. Efforts to control alcohol use during pregnancy help prevent fetal alcohol syndrome (Stratton et al., 1996). All these conditions may produce mental disorders in children...

III. Promoting Healthy Development and Preventing Mood and Affect Problems

- A. The Prevention of Mental Disorders in School-Aged Children:
State of the Field
- B. Annotated “Lists” of Empirically Supported / Evidence Based
Interventions for School Aged Children and Adolescents
- C. The Prevention of Depression in Youth

III. A. Promoting Healthy Development: Prevention of Mental Disorders in School-Aged Children

A. The Prevention of Mental Disorders in School-Aged Children: State of the Field

Excerpts from Greenberg, Domitrovich, & Bumbarger (2001). *Prevention & Treatment*, 4(1)

The Role of Risk and Protective Factors in Preventive Interventions

Public health models have long based their interventions on reducing the risk factors for disease or disorder as well as promoting processes that buffer or protect against risk. Community-wide programs have focused on reducing both environmental and individual behavioral risks for both heart and lung disease and have demonstrated positive effects on health behaviors as well as reductions in smoking (Farquhar et al., 1990; Jacobs et al., 1986; Pushka, Tuomilehto, Nissinen, & Korhonen, 1989).

Risk factors and their operation. During the past decades, a number of risk factors have been identified that place children at increased risk for psychopathology. Coie et al. (1993, p. 1022) grouped empirically derived, generic risk factors into the following seven individual and environmental domains:

1. *Constitutional handicaps:* perinatal complications, neurochemical imbalance, organic handicaps, and sensory disabilities;
2. *Skill development delays:* low intelligence, social incompetence, attentional deficits, reading disabilities, and poor work skills and habits;
3. *Emotional difficulties:* apathy or emotional blunting, emotional immaturity, low self-esteem, and emotional dysregulation;
4. *Family circumstances:* low social class, mental illness in the family, large family size, child abuse, stressful life events, family disorganization, communication deviance, family conflict, and poor bonding to parents;
5. *Interpersonal problems:* peer rejection, alienation, and isolation;
6. *School problems:* scholastic demoralization and school failure;
7. *Ecological risks:* neighborhood disorganization, extreme poverty, racial injustice, and unemployment.

Theory and research support a number of observations about the operation of these risk factors and the development of behavioral maladaptation. First, development is complex and it is unlikely that there is a single cause of, or risk factor for, any disorder. It is doubtful that most childhood social and behavioral disorders can be eliminated by only treating causes that are purported to reside in the child alone (Rutter, 1982). Furthermore, there are multiple pathways to most psychological disorders. That is, different combinations of risk factors may lead to the same disorder and no single cause may be sufficient to produce a specific negative outcome (Greenberg, Speltz, & DeKlyen, 1993). In addition, risk factors occur not only at individual or family levels, but at all levels within the ecological model (Kellam, 1990)...

Protective factors and their operation. Protective factors are variables that reduce the likelihood of maladaptive outcomes under conditions of risk. Although less is known about protective factors and their operation (Kazdin, 1991; Luthar, 1993; Rutter, 1985), at least three broad domains of protective factors have been identified. The first domain includes characteristics of the individual such as cognitive skills, social-cognitive skills, temperamental characteristics, and social skills (Luthar & Zigler, 1992). The quality of the child's interactions with the environment comprise the second domain. These interactions include secure attachments to parents (Morissett, Barnard, Greenberg, Booth, & Spieker, 1990) and attachments to peers or other adults who engage in positive health behaviors and have prosocial values (Hawkins & Catalano, 1992). A third protective domain involves aspects of the mesosystem and exosystem, such as school-home relations, quality schools, and regulatory activities. Similar to risk factors, some protective factors may be more malleable and thus, more effective targets for prevention...

Preventive Intervention: Definition of Levels

The Institute of Medicine (1994) report clarified the placement of preventive intervention within the broader mental health intervention framework by differentiating it from treatment (i.e., case identification; standard treatment for known disorders) and maintenance (i.e., compliance with long-term treatment to reduce relapse; after-care, including rehabilitation). Based, in part, on Gordon's (1983, 1987) proposal to replace the terms primary, secondary, and tertiary prevention, the IOM Report defined three forms of preventive intervention: universal, selective, and indicated. Notwithstanding the recent redefinition of prevention by NIMH (Greenberg & Weissberg, in press; National Institute of Mental Health, 1998), we retain the distinctions as defined by the IOM report as well as the recent Surgeon General's report (U.S. Department of Health and Human Services, 1999).

Universal preventive interventions target the general public or a whole population group that has not been identified on the basis of individual risk. Exemplars include prenatal care, childhood immunization, and school-based competence enhancement programs. Because universal programs are positive, proactive, and provided independent of risk status, their potential for stigmatizing participants is minimized and they may be more readily accepted and adopted. Selective interventions target

individuals or a subgroups (based on biological or social risk factors) whose risk of developing mental disorders is significantly higher than average. Examples of selective intervention programs include: home visitation and infant day care for low-birth weight children, preschool programs for all children from poor neighborhoods, and support groups for children who have suffered losses/traumas. Indicated preventive interventions target individuals who are identified as having prodromal signs or symptoms or biological markers related to mental disorders, but who do not yet meet diagnostic criteria. Providing social skills or parent-child interaction training for children who have early behavioral problems are examples of indicated interventions...

Effective Preventive Interventions: Universal Programs

Fourteen universal programs were identified as meeting our criteria for inclusion based on study design and positive outcomes related to psychopathology. For ease of discussion, they can be classified into 4 categories: violence prevention programs; more generic social/cognitive skill-building programs, programs focused on changing the school ecology, and multi-component, multi-domain programs. Although we will use this typology for discussion purposes, in actuality the programs do not fall along a linear continuum and may include characteristics of more than one of the above categories. This typology is useful however in that it is somewhat representative of the recent progress of prevention science, as the field continues to move in the direction of comprehensive, multi-system programs that target multiple risk factors across both individual and ecological domains...

III. B. Promoting Healthy Development: Empirically Supported Interventions

B. ANNOTATED "LISTS" OF EMPIRICALLY SUPPORTED/EVIDENCE BASED INTERVENTIONS FOR SCHOOL-AGED CHILDREN AND ADOLESCENTS

The following table provides a list of lists, with indications of what each list covers, how it was developed, what it contains, and how to access it.

I Universal Focus on Promoting Healthy Development

A. *Safe and Sound. An Educational Leader's Guide to Evidence-Based Social & Emotional Learning Programs* (2002). The Collaborative for Academic, Social, and Emotional Learning (CASEL).

1. *How it was developed:* Contacts with researchers and literature search yielded 250 programs for screening; 81 programs were identified that met the criteria of being a multiyear program with at least 8 lessons in one program year, designed for regular ed classrooms, and nationally available.
2. *What the list contains:* Descriptions (purpose, features, results) of the 81 programs.
3. *How to access:* CASEL (<http://www.casel.org>)

B. *Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs* (2002). Social Develop. Res. Group, Univ. of Wash.

1. *How it was developed:* 77 programs that sought to achieve positive youth development objectives were reviewed. Criteria used: research designs employed control or comparison group and had measured youth behavior outcomes.
2. *What the list contains:* 25 programs designated as effective based on available evidence.
3. *How to access:* Online journal *Prevention & Treatment* (<http://journals.apa.org/prevention/volume5/pre0050015a.html>)

II Prevention of Problems; Promotion of Protective Factors

A. *Blueprints for Violence Prevention* (1998). Center for the Study and Prevention of Violence, Institute of Behavioral Science, University Colorado, Boulder.

1. *How it was developed:* Review of over 450 delinquency, drug, and violence prevention programs based on a criteria of a strong research design, evidence of significant deterrence effects, multiple site replication, sustained effects.
2. *What the list contains:* 10 model programs and 15 promising programs.
3. *How to access:* Center for the Study and Prevention of Violence (<http://www.colorado.edu/cspv/blueprints/model/overview.html>)

B. *Exemplary Substance Abuse Prevention Programs* (2001). Center for Substance Abuse Prevention (SAMHSA).

1. *How it was developed:* (a) Model Programs: implemented under scientifically rigorous conditions and demonstrating consistently positive results. These science-based programs underwent an expert consensus review of published and unpublished materials on 15 criteria (theory, fidelity, evaluation, sampling, attrition, outcome measures, missing data, outcome data, analysis, threats to validity, integrity, utility, replications, dissemination, cultural/age appropriateness. (b) Promising Programs: those that have positive initial results but have yet to verify outcomes scientifically.
2. *What the list contains:* 30 substance abuse prevention programs that may be adapted and replicated by communities.
3. *How to access:* SAMHSA (<http://www.modelprograms.samhsa.gov>)

C. Preventing Drug Use Among Children & Adolescents. *Research Based Guide* (1997). National Institute on Drug Abuse (NIDA).

1. *How it was developed:* NIDA and the scientists who conducted the research developed research protocols. Each was tested in a family/school/community setting for a reasonable period with positive results.
2. *What the list contains:* 10 programs that are universal, selective, or indicated.
3. *How to access:* NIDA (www.nida.nih.gov/prevention/prevopen.html)

B. *Safe, Disciplined, and Drug-Free Schools Expert Panel Exemplary Programs* (2001). U.S. Dept. of Educ. Safe & Drug Free Schools

1. *How it was developed:* Review of 132 programs submitted to the panel. Each program reviewed in terms of quality, usefulness to others, and educational significance.
2. *What the list contains:* 9 exemplary and 33 promising programs focusing on violence, alcohol, tobacco, and drug prevention.
3. *How to access:* U.S. Dept. of Education – (http://www.ed.gov/offices/OERI/ORAD/KA D/expert_panel/drug-free.html)

III Early Intervention: Targeted Focus on Specific Problems or at Risk Groups

A. *The Prevention of Mental Disorders in School-Aged Children: Current State of the Field* (2001). Prevention Research Center for the Promotion of Human Development, Pennsylvania State University.

1. *How it was developed:* Review of scores of primary prevention programs to identify those with quasi-experimental or randomized trials and been found to reduce symptoms of psychopathology or factors commonly associated with an increased risk for later mental disorders.
2. *What the list contains:* 34 universal and targeted interventions that have demonstrated positive outcomes under rigorous evaluation and the common characteristics of these programs.
3. *How to access:* Online journal *Prevention & Treatment* <http://journals.apa.org/prevention/volume4/pre0040001a.html>

IV Treatment for Problems

A. *The American Psychological Association, Division of Child Clinical Psychology, Ad Hoc Committee on Evidence-Based Assessment and Treatment of Childhood Disorders*, published its initial work as a special section of the *Journal of Clinical Child Psychology* in 1998.

1. *How it was developed:* Reviewed outcomes studies in each of the above areas and examined how well a study conforms to the guidelines of the Task Force on Promotion and Dissemination of Psychological Procedures (1996).
2. *What it contains:* reviews of anxiety, depression, conduct disorders, ADHD, broad spectrum Autism interventions, as well as more global review of the field. For example:
>*Depression:* results of this analysis indicate only 2 series of studies meet criteria for probably efficacious interventions and no studies meet criteria for well-established treatment.
>*Conduct disorder:* Two interventions meet criteria for well established treatments: videotape modeling parent training programs (Webster-Stratton) and parent training program based on Living with Children (Patterson and Guillion). Twenty additional studies identified as probably efficacious.
>*Attention Deficit Hyperactivity Disorder:* behavioral parent training and behavioral interventions in the classroom meet criteria for well established treatments. Cognitive interventions do not meet criteria for well established or probably efficacious treatments.
>*Phobia and Anxiety:* for phobias participant modeling and reinforced practice are well established; filmed modeling, live modeling, and cognitive behavioral interventions that use self instruction training are probably efficacious. For anxiety disorders, only cognitive-behavioral procedures with and without family anxiety management were found to be probably efficacious. *Caution:* Reviewers stress the importance of devising developmentally and culturally sensitive interventions targeted to the unique needs of each child; need for research that is informed by clinical practice.
3. *How it can be accessed:* *APA Journal of Clinical Child Psychology* (1998) v.27, pp. 156-205.

V Review/Consensus Statements/ Compendia of Evidence Based Treatments

A. School-Based Prevention Programs for Children & Adolescents (1995). J.A. Durlak. Sage: Thousand Oaks, CA. Reports results from 130 controlled outcome studies that support "a secondary prevention model emphasizing timely intervention for subclinical problems detected early.... In general, best results are obtained for cognitive-behavioral and behavioral treatments & interventions targeting externalizing problems."

B. Mental Health and Mass Violence: Evidence-based early psychological intervention for victims/ survivors of mass violence. A workshop to reach consensus on best practices (U.S. Departments of HHS, Defense, Veterans Affairs, Justice, and American Red Cross). Available at: (<http://www.nimh.nih.gov/publicat/massviolence.pdf>)

C. Society of Pediatric Psychology, Division 54, American Psychological Association, *Journal of Pediatric Psychology*. Articles on empirically supported treatments in pediatric psychology related to obesity, feeding problems, headaches, pain, bedtime refusal, enuresis, encopresis, and symptoms of asthma, diabetes, and cancer.

D. Preventing Crime: What works, what doesn't, what's promising. *A Report to the United States Congress* (1997) by L.W. Sherman, Denise Gottfredson, et al. Washington, DC: U.S. Dept. of Justice. Reviews programs funded by the OJP for crime, delinquency and substance use. (<http://www.ncjrs.org/pdffiles/171676.pdf>). Also see Denise Gottfredson's book: *Schools and delinquency* (2001). New York: Cambridge Press.

E. School Violence Prevention Initiative Matrix of Evidence-Based Prevention Interventions (1999). Center for Mental Health Services SAMHSA. Provides a synthesis of several lists cited above to highlight examples of programs which meet some criteria for a designation of evidence based for violence prevention and substance abuse prevention. (i.e., Synthesizes lists from the Center for the Study and Prevention of Violence, Center for Substance Abuse Prevention, Communities that Care, Dept. of Education, Department of Justice, Health Resources and Services Administration, National Assoc. of School Psychologists)(http://modelprograms.samhsa.gov/matrix_all.cfm)

BUT THE NEEDS OF SCHOOLS ARE MORE COMPLEX!

Currently, there are about 91,000 public schools in about 15,000 districts. Over the years, most (but obviously not all) schools have instituted programs designed with a range of behavior, emotional, and learning, problems in mind. Schoolbased and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. Some programs are provided throughout a district, others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at risk." The activities may be implemented in regular or special education classrooms or as "pull out" programs and may be designed for an entire class, groups, or individuals. There also may be a focus on primary prevention and enhancement of healthy development through use of health education, health services, guidance, and so forth – though relatively few resources usually are allocated for such activity. There is a large body of research supporting the promise of specific facets of this activity. However, no one has yet designed a study to evaluate the impact of the type of comprehensive, multifaceted approach needed to deal with the complex range of problems confronting schools.

It is either naive or irresponsible to ignore the connection between children's performance in school and their experiences with malnutrition, homelessness, lack of medical care, inadequate housing, racial and cultural discrimination, and other burdens . . .

Harold Howe II

. . . consider the American penchant for ignoring the structural causes of problems. We prefer the simplicity and satisfaction of holding individuals responsible for whatever happens: crime, poverty, school failure, what have you. Thus, even when one high school crisis is followed by another, we concentrate on the particular people involved – their values, their character, their personal failings – rather than asking whether something about the system in which these students find themselves might also need to be addressed.

Alfie Kohn, 1999

What the best and wisest parent wants for (her)/his own child that must the community want for all of its children. Any other idea . . . is narrow and unlovely.

John Dewey

C. The Prevention of Depression in Youth

by William R. Beardslee, M.D., and Tracy R. G. Gladstone, Ph.D.

(<http://www.mhsource.com/depression/youth.html>)

Excerpt:

Historically, research on childhood depression has focused on clinical trials and longitudinal outcome studies, rather than on prevention. In recent years, however, with advances in the science of prevention, data suggest that those at risk for depression can be identified before symptoms emerge (Hammen et al., 1990; Lewinsohn et al., 1994). Examples of successful prevention trials (Mrazek and Hagerty, 1994; National Institute of Mental Health, 1993) have prompted researchers to attend to the primary prevention of depression in youth (Beardslee and Gladstone, 2001). In fact, research on childhood depression has shifted from tertiary treatment efforts to primary prevention studies and from primary prevention approaches aimed at general, unselected populations to prevention programs that focus on populations identified as having an increased risk of future depression.

Prevention programs for childhood depression must be informed by research on factors that place youngsters at risk for the disorder. This will enable us to know which factors to target in treating and preventing this disorder in children either at risk for depression or already exhibiting symptoms of depression. To date, research on risk factors for youth depression reveals that, among other factors, depression in children has been associated with a history of psychopathology, suicide attempts, depressotypic cognitive style, low self-esteem, poor social support, lack of peer acceptance and hostile relationships with peers (Lewinsohn et al., 1994; Reinherz et al., 1999;

...A review of these prevention programs and our experience developing and implementing a family-based preventive intervention program reveal six key points that we believe may prove helpful in treating children at risk for depression.

Resilience

Resilience refers to competence despite adversity (Luthar et al., in press) and provides an important foundation for the treatment of children with depression. Treatment of children at risk for depression must focus on identifying children's strengths and resources and on encouraging the development of factors that may protect children from the onset of illness. Our work with at-risk pre-adolescents has indicated that resilient children remained active in school and social activities outside of the home, maintained a view of themselves as separate from their parents' illness, and developed relationships with adults outside of the family (Beardslee and Podorefsky, 1988). Treatment with mildly depressed or at-risk children must focus on enhancing these characteristics.

Psychoeducation

In our work with families with parental depression, we found that adults knew little about this disorder and that children frequently did not have a name for their parent's depressed mood or irritability. Providing at-risk children with information about depression, identifying symptoms as an illness rather than as difficult behavior, and defining depression as a highly treatable mental illness will help reduce children's feelings of guilt or fear about their parents' or their own symptoms. In addition, providing children with information about causes, symptoms and risk factors for depression may assist them in identifying their own symptoms and seeking help when necessary.

Family-based Approach

Depression influences marital and family functioning (Keitner and Miller, 1990), and family members reinforce depressive behaviors in each other (Kaslow and Racusin, 1994), thus supporting the use of a family-centered approach in preventing the onset of depression in children at risk for depression. Parental involvement in treating at-risk children is crucial to successful prevention in this population, as parents may provide support and encourage resilience so that children are better able to negotiate developmental challenges successfully.

We have found that families with parental depression are characterized by poor cross-generational communication, poor understanding of disorder by children and feelings of guilt among children for any role they may have played in their parent's illness (Beardslee et al., 1997). Family meetings and family involvement in treatment may address these concerns and promote understanding and communication in families with depression. The principles of family-based prevention recently have been presented in a format that families themselves can use (Beardslee, 2002).

Developmental Perspective

Intervention for children at risk for depression must attend to developmental issues as well as emotional concerns. In fact, the risks for depression, and the valence of those risks, shift over the life span, and the expression of symptoms of depression varies developmentally. Thus, an intervention approach that is appropriate for a 4-year-old may be quite different from one that is appropriate for a 14-year-old. For example, parental involvement in intervention is appropriate for early adolescents, but a peer focus group may be more useful with young adults as they make the transition from home to college or the work force.

Address All Risks

Research tells us that depression in parents or children often signals a constellation of risk factors that, when considered together, puts children at risk for poor outcomes. In fact, social adversity predicts poor mental health outcomes in children, even beyond the effects of parental mood disorder (Rutter, 1986 as cited in Beardslee et al., 1996). Thus, comprehensive concern for the prevention of childhood depression must be based on all the risks a child faces, and treatment must attend to the range of risks present in any child, particularly in children who face social disadvantage.

Treatment

Although primary prevention programs aim to reach youth before they are ill, an essential precondition for prevention involves competent treatment for all those who experience illness. It is crucial that adequate treatment for children and adults who already suffer from illness be incorporated into any prevention approach. In fact, illness cannot be prevented in children at risk for depression until their parents who suffer from mental illness receive appropriate treatment services.

Conclusions

Successful preventive interventions offer great benefit to families because they can relieve the enormous burden of suffering caused by mental illness. The study of prevention requires new, nontraditional ways of thinking, however; and scientific advances in neuroscience and developmental epidemiology have provided an empirical knowledge base from which to mount prevention efforts.

In addition, prevention programs targeting children at risk for disorder must consider the plasticity of development and the multiple influences on children's development. Current research in neuroscience emphasizes the capacity of individuals to change and grow. Knowledge of what influences plasticity at the molecular, individual and familial levels, even in the face of significant adversity, is needed to guide the development of preventive interventions across the life span.

Finally, advocates for the study of the prevention of depression must recognize the need for comprehensive programs to prevent risk factors for depression, including exposure to violence, social isolation and discrimination. Indeed, from a public health point of view, those concerned about the prevention of depression can find common ground with others in advocating for adequate health care for all children and all caregivers.

Acknowledgement

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Dr. Beardslee is chair of the department of psychiatry at Children's Hospital in Boston and has directed the NIMH-funded Preventative Intervention Project for the last 15 years.

Dr. Gladstone is senior research associate at Judge Baker Children's Center in Boston and is co-investigator on the Preventative Intervention Project.

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IV. Responding to The First Signs of Problems

- A. Internalizing Disorders Overlooked in Schools
- B. Loneliness in Young Children
- C. Depression in School: A Student's Trial
- D. Adolescent Depression
- E. Children and Depression

A. Internalizing Disorders Overlooked in Schools

Nathan Seppa

American Psychological Association Monitor

(<http://ericcass.uncg.edu/virtuallib/depress/1044.html>)

Excerpt:

School teachers and counselors can easily spot poorly behaved children, but miss those who may have depression or anxiety.

The classic "problem child" in elementary school acts out, draws attention to himself and is reprimanded the most. Counselors and teachers devote a lot of time to counseling and contending with this child.

But what about the quiet child who suffers from an equally serious and diagnosable problem, such as depression or anxiety? School counselors busy with disruptive children often miss those who have "internalizing" disorders...

The signs: Internalizing disorders can include or arise from sleep disorders, elimination disorders, speech problems or anxiety...



B. Loneliness in Young Children. ERIC Digest.

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Author: Bullock, Janis R.

**Source: ERIC Clearinghouse on Elementary and Early Childhood Education
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Loneliness is a significant problem that can predispose young children to immediate and long-term negative consequences. However, only recently have research and intervention in educational settings focused on young children who are lonely. It is becoming increasingly clear that many young children understand the concept of loneliness and report feeling lonely. For example, kindergarten and first-grade children responded appropriately to a series of questions regarding what loneliness is ("being sad and alone"), where it comes from ("nobody to play with"), and what one might do to overcome feelings of loneliness ("find a friend") (Cassidy & Asher, 1992). In a more recent study (Ladd, Kochenderfer, & Coleman, 1996), kindergarten children's loneliness in school was reliably measured with a series of questions such as, "Are you lonely in school?"; "Is school a lonely place for you?"; and "Are you sad and alone in school?" These studies suggest that young children's concepts of loneliness have meaning to them and are similar to those shared by older children and adults. This Digest presents an overview of loneliness with suggestions for practitioners on how they can apply the research in early childhood settings.

CONSEQUENCES OF LONELINESS

Children who feel lonely often experience poor peer relationships and therefore express more loneliness than peers with friends. They often feel excluded--a feeling that can be damaging to their self-esteem. In addition, they may experience feelings of sadness, malaise, boredom, and alienation. Furthermore, early childhood experiences that contribute to loneliness may predict loneliness during adulthood. Consequently, lonely children may miss out on many opportunities to interact with their peers and to learn important lifelong skills. Given the importance placed on the benefits of peer interactions and friendships to children's development, this potential lack of interaction raises many concerns for teachers who work with young children. Peer relations matter to children, and lonely children place as much importance on them as do other children (Ramsey, 1991).

CONTRIBUTING FACTORS OF LONELINESS

Several factors contribute to feelings of loneliness in young children. Some that occur outside of the school setting are conflict within the home; moving to a new school or neighborhood; losing a friend; losing an object, possession, or pet; experiencing the divorce of parents; or experiencing the death of a pet or significant person. Equally important are factors that occur within the child's school setting, such as being rejected by peers; lacking social skills and knowledge of how to make friends; or possessing personal characteristics (e.g., shyness, anxiety, and low self-esteem) that contribute to difficulties in making friends. Kindergarten children who are victimized by peers (e.g., picked on, or physically or verbally attacked or taunted) report higher levels of loneliness, distress, and negative attitudes toward school than nonvictimized children (Kochenderfer & Ladd, 1996).

OBSERVING AND ASSESSING YOUNG CHILDREN

Participating in careful observation of children is a necessary first step to gain insights into children's loneliness. While observing children, teachers can focus on the following, which may suggest signs of loneliness: Does the child appear timid, anxious, unsure of himself or herself, or sad? Does the child show a lack of interest in the surroundings? Does the child seem to be rejected by playmates? Does the child avoid other children by choice? Does the child appear to lack social skills that might prevent him or her from initiating or maintaining interactions? Does the child have the necessary social skills but is reluctant to use them? Is the child victimized by peers? Does the child's apparent loneliness seem to be a consistent pattern over time, or is it a more recent phenomenon? In addition, because loneliness cannot always be observed in children (e.g., there are children who appear to have friends but report feeling lonely), teachers can spend time talking individually with children. They might ask children, "What does sad and lonely mean?"; "Are you sad and lonely?"; or "What would make you happier?" (Cassidy & Asher, 1992; Ladd, Kochenderfer, & Coleman, 1996).

When observing and assessing children, it is important to be sensitive to and aware of their developmental abilities and personal inclinations. For example, it has been suggested that young children who play alone may be at increased risk for later problems, both socially and cognitively. Many preschool and kindergarten children, however, engage in nonsocial activities that are highly predictive of competence. Therefore, over time, teachers need to observe children's interactions with their peers, talk to children about their feelings, and document their behaviors and responses to determine whether they are lonely or are happily and productively self-engaged.

INTERVENTION STRATEGIES AND RECOMMENDATIONS

Although research in support of specific practices assisting lonely children in the classroom is weak, teachers might consider several approaches that may be adapted to individual children. Children who are aggressive report the greatest degrees of loneliness and social dissatisfaction (Asher, Parkhurst, Hymel, & Williams, 1990). Children are rejected for many reasons, and teachers will need to assess the circumstances that seem to lead to the rejection. Is the child acting aggressively toward others? Does the child have difficulty entering ongoing play and adapting to the situation? Does the child have difficulty communicating needs and desires? Once the problem is identified, teachers can assist the child in changing the situation. The teacher can point out the effects of the child's behavior on others, show the child how to adapt to the ongoing play, or help the child to clearly communicate feelings and desires. Children who are supported, nurtured, and cherished are less likely to be rejected and more likely to interact positively with peers (Honig & Wittmer, 1996).

Children who are neglected or withdrawn also report feelings of loneliness, although to a lesser extent than do aggressive-rejected children. Because these children often lack social skills, they have difficulty interacting with their peers. These children may also be extremely shy, inhibited, and anxious, and they may lack self-confidence (Rubin, LeMare, & Lollis, 1990). If children lack certain skills, the teacher can focus on giving feedback, suggestions, and ideas that the child can implement. Children who possess adequate social skills but are reluctant to use them can be given opportunities for doing so by being paired with younger children. This experience gives the older child an opportunity to practice skills and boost self-confidence.

Children who are victimized by others believe that school is an unsafe and threatening place and often express a dislike for school. Furthermore, these children report lingering feelings of loneliness and a desire to avoid school even when victimization ceases (Kochenderfer & Ladd, 1996). These findings point to the importance of implementing immediate intervention strategies to reduce victimization. Teachers can provide firm but supportive suggestions to the aggressor. For example, teachers might guide and assist children in developing the life skills they need, such as respecting others and self, engaging in problem solving, working together on skills and tasks that require cooperation, and expressing feelings and emotions in appropriate ways (Gartrell, 1997).

Teachers can think about how the curricula might be helpful to a child who is feeling lonely. Some children may benefit by being given opportunities to express their feelings of sadness or loneliness through manipulation, drawing, movement, music, or creative activities (Edwards, Gandini, & Forman, 1993). Arranging the dramatic play area with props may help some children act out or express their feelings and feel a sense of control. Use of crisis-oriented books with children, referred to as bibliotherapy, may assist a child in coping with a personal crisis. Sharing carefully selected literature with children may assist in facilitating emotional health. Children who are able to express and articulate their concerns may want to talk about their unhappiness.

Developing close relationships with children and communicating with their primary caregivers can give teachers valuable insights and guidance. When teachers become aware of children who are experiencing loneliness caused by a family situation, they can lend their support in a variety of ways. Spending extra time listening can be reassuring and helpful to some children. Suggesting to a parent the possibility of inviting a peer over to the child's home may be a good idea and may help the child to form a friendship. In addition, teachers can ask parents for their recommendations about what might make the child feel more comfortable at school, and they can share relevant resources with parents, such as literature or information on parent discussion groups.

CONCLUSION

The issues of loneliness were once considered relevant only to adolescents and adults. Research suggests that this notion is misguided and that a small but significant portion of young children do in fact experience feelings of loneliness (Asher, Parkhurst, Hymel, & Williams, 1990). As a result, the immediate and long-term negative consequences associated with loneliness in children are becoming apparent, and the need to observe children and to develop and implement intervention strategies is becoming critical. When teachers take time to focus on individual needs of children, build relationships, and assist them with their needs, children thrive (Kontos & Wilcox-Herzog, 1997).



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IV. C. Responding to the First Signs of Problems: Depression in School

HealthyPlace.com Depression Community

(<http://www.healthyplace.com/Communities/Depression/related/school.asp>)

C. Depression in School: A Student's Trial

Teachers are trained to handle students who lack discipline, the slow learners, the extremely bright, and even kids faced with ADHD. What I've discovered, though, is that they aren't prepared to teach the students suffering from depression. Just like anyone else, teachers are very perceptive when it comes to identifying disturbed, possibly depressed students in their class, yet they often seem incapable of and uninterested in helping that student.

When I was depressed my sophomore and junior years in high school, the academic world was the last place I wanted to be. Like anyone suffering from depression, I wasn't deliberately trying to disrespect the teacher's efforts to conduct a class, but the depression overwhelmed me so that I could only see things in the broad spectrum, as opposed to concentrating on one situation at a time, such as a single class.

I found that the majority of my teachers dealt with me in one of two ways. The solution easiest for them was to ignore the fact that I wasn't absorbing any of the information being taught and simply assume that the apathy they were perceiving was typical of high schoolers. The other path was that of talking to me on a personal level. I think we are all aware of the very well defined student-teacher line; therefore, for teachers to ask the student to discuss their problems puts them in a very awkward position. Teachers are different from other adults because they hold a position of superiority over students that is especially apparent when discussing something of a personal matter.

Teachers can help to lighten a depressed student's load by creating a comfortable classroom where the student knows he/she is cared for and where the student doesn't have a time limit to suddenly cheer up. Depression takes a lot of time to get over, and school does not have to be a negative place of responsibility. If I had had a teacher that did at least one of the following things during the period of time I was depressed, I might have turned my act around a little sooner, or I might have had a more positive outcome in school.

Three tips for dealing with students who are depressed in the classroom:

1. Don't ignore depressed students. It shows that you don't care and invites the students to give up, guaranteeing their failure. Draw them out in class discussion and do whatever it takes to stimulate their minds so that they don't, in turn, learn to ignore you.
2. Let them know that you care, but without getting too personal. Help them to update any missing assignments, or set up extra study time - whether they accept your efforts or not all depends upon the severity of the depression. The fact that you've proven you care can make all the difference in the world.
3. Never give up on the student - regardless of how long they haven't wanted to put forth any effort in your class. Students can tell when a teacher no longer believes in them and expects them to fail, and it only ends up making the situation worse than necessary.

Contributed By Alexandra Madison

IV. D. Responding to the First Signs of Problems: Adolescent Depression

National Mental Health Association

(<http://www.nmha.org/infoctr/factsheets/24.cfm>)

D. Adolescent Depression Helping Depressed Teens

It's not unusual for young people to experience "the blues" or feel "down in the dumps" occasionally. Adolescence is always an unsettling time, with the many physical, emotional, psychological and social changes that accompany this stage of life.

Unrealistic academic, social, or family expectations can create a strong sense of rejection and can lead to deep disappointment. When things go wrong at school or at home, teens often overreact. Many young people feel that life is not fair or that things "never go their way." They feel "stressed out" and confused. To make matters worse, teens are bombarded by conflicting messages from parents, friends and society. Today's teens see more of what life has to offer — both good and bad — on television, at school, in magazines and on the Internet. They are also forced to learn about the threat of AIDS, even if they are not sexually active or using drugs.

Teens need adult guidance more than ever to understand all the emotional and physical changes they are experiencing. When teens' moods disrupt their ability to function on a day-to-day basis, it may indicate a serious emotional or mental disorder that needs attention — adolescent depression. Parents or caregivers must take action.

Dealing With Adolescent Pressures

When teens feel down, there are ways they can cope with these feelings to avoid serious depression. All of these suggestions help develop a sense of acceptance and belonging that is so important to adolescents.

- **Try to make new friends.** Healthy relationships with peers are central to teens' self-esteem and provide an important social outlet.
- **Participate in sports, job, school activities or hobbies.** Staying busy helps teens focus on positive activities rather than negative feelings or behaviors.
- **Join organizations that offer programs for young people.** Special programs geared to the needs of adolescents help develop additional interests.
- **Ask a trusted adult for help.** When problems are too much to handle alone, teens should not be afraid to ask for help.

But sometimes, despite everyone's best efforts, teens become depressed. Many factors can contribute to depression. Studies show that some depressed people have too much or too little of certain brain chemicals. Also, a family history of depression may increase the risk for developing depression. Other factors that can contribute to depression are difficult life events (such as death or divorce), side-effects from some medications and negative thought patterns.

Recognizing Adolescent Depression

Adolescent depression is increasing at an alarming rate. Recent surveys indicate that as many as one in five teens suffers from clinical depression. This is a serious problem that calls for prompt, appropriate treatment. Depression can take several forms, including bipolar disorder (formally called manic-depression), which is a condition that alternates between periods of euphoria and depression.

Depression can be difficult to diagnose in teens because adults may expect teens to act moody. Also, adolescents do not always understand or express their feelings very well. They may not be aware of the symptoms of depression and may not seek help.

These symptoms may indicate depression, particularly when they last for more than two weeks:

- Poor performance in school
- Withdrawal from friends and activities
- Sadness and hopelessness
- Lack of enthusiasm, energy or motivation
- Anger and rage
- Overreaction to criticism
- Feelings of being unable to satisfy ideals
- Poor self-esteem or guilt
- Indecision, lack of concentration or forgetfulness
- Restlessness and agitation
- Changes in eating or sleeping patterns
- Substance abuse
- Problems with authority
- Suicidal thoughts or actions

Teens may experiment with drugs or alcohol or become sexually promiscuous to avoid feelings of depression. Teens also may express their depression through hostile, aggressive, risk-taking behavior. But such behaviors only lead to new problems, deeper levels of depression and destroyed relationships with friends, family, law enforcement or school officials.

Treating Adolescent Depression

It is extremely important that depressed teens receive prompt, professional treatment. Depression is serious and, if left untreated, can worsen to the point of becoming life-threatening. If depressed teens refuse treatment, it may be necessary for family members or other concerned adults to seek professional advice.

Therapy can help teens understand why they are depressed and learn how to cope with stressful situations. Depending on the situation, treatment may consist of individual, group or family counseling. Medications that can be prescribed by a psychiatrist may be necessary to help teens feel better.

Some of the most common and effective ways to treat depression in adolescents are:

- Psychotherapy provides teens an opportunity to explore events and feelings that are painful or troubling to them. Psychotherapy also teaches them coping skills.
- Cognitive-behavioral therapy helps teens change negative patterns of thinking and behaving.
- Interpersonal therapy focuses on how to develop healthier relationships at home and at school.
- Medication relieves some symptoms of depression and is often prescribed along with therapy.

When depressed adolescents recognize the need for help, they have taken a major step toward recovery. However, remember that few adolescents seek help on their own. They may need encouragement from their friends and support from concerned adults to seek help and follow treatment recommendations.

Facing The Danger Of Teen Suicide

Sometimes teens feel so depressed that they consider ending their lives. Each year, almost 5,000 young people, ages 15 to 24, kill themselves. The rate of suicide for this age group has nearly tripled since 1960, making it the third leading cause of death in adolescents and the second leading cause of death among college-age youth.

Studies show that suicide attempts among young people may be based on long-standing problems triggered by a specific event. Suicidal adolescents may view a temporary situation as a permanent condition. Feelings of anger and resentment combined with exaggerated guilt can lead to impulsive, self-destructive acts.

Recognizing The Warning Signs

Four out of five teens who attempt suicide have given clear warnings. Pay attention to these warning signs:

- Suicide threats, direct and indirect
- Obsession with death
- Poems, essays and drawings that refer to death
- Dramatic change in personality or appearance
- Irrational, bizarre behavior
- Overwhelming sense of guilt, shame or rejection
- Changed eating or sleeping patterns
- Severe drop in school performance
- Giving away belongings

REMEMBER!!! These warning signs should be taken seriously. Obtain help immediately. Caring and support can save a young life.

Helping Suicidal Teens

- **Offer help and listen.** Encourage depressed teens to talk about their feelings. Listen, don't lecture.
- **Trust your instincts.** If it seems that the situation may be serious, seek prompt help. Break a confidence if necessary, in order to save a life.
- **Pay attention to talk about suicide.** Ask direct questions and don't be afraid of frank discussions. Silence is deadly!
- **Seek professional help.** It is essential to seek expert advice from a mental health professional who has experience helping depressed teens. Also, alert key adults in the teen's life — family, friends and teachers.

Looking To The Future

When adolescents are depressed, they have a tough time believing that their outlook can improve. But professional treatment can have a dramatic impact on their lives. It can put them back on track and bring them hope for the future.

For More Information:

Contact your local Mental Health Association, community mental health center, or:
If you or someone you know is contemplating suicide, call 1-800-SUICIDE.

National Mental Health Association

2001 N. Beauregard Street, 12th Floor
Alexandria, VA 22311
Phone 703/684-7722
Fax 703/684-5968
Mental Health Resource Center 800/969-NMHA
TTY Line 800/433-5959

American Academy for Child and Adolescent Psychiatry

3615 Wisconsin Avenue NW
Washington, DC 20016-3007
Phone 202/966-7300 & Fax 202/966-2891
www.aacap.org

American Association of Suicidology

4201 Connecticut Avenue NW; Suite 408
Washington, DC 20008
Phone: 202-237-2280
www.suicidology.org

E. Children and Depression

Accommodations to Reduce Affect and Mood Problems

by Janzen, HJ & Saklofske, DH

National Association of School Psychologists

»Background

Depressed mood is a common and universal part of human experience that can occur at any age and has various causes. Over time, many children report or give the appearance of feeling unhappy, sad, dejected, irritable, "down" or "blue" but most of them quickly and spontaneously recover from these brief and normal moods or emotional states. However, for others, the depression can be severe and long lasting, and interfere with all aspects of daily life from school achievement to social relationships.

The incidence of more severe depression in children is probably less than 10% although exact figures are not known. Girls are more likely than boys to develop mood disorders. The associated risk of suicide increases significantly during adolescence.

»Development

Recognizing and diagnosing childhood depression is not always an easy task. The onset of depression can be gradual or sudden, it may be a brief or long term episode, and may be associated with other disorders such as anxiety. The presence of one or two symptoms is not sufficient evidence of a depressive disorder. It is when a group of such symptoms occur together over time that a more serious mood disorder should be considered. The DSM-III- R manual published by the American Psychiatric Association classified depression according to severity, duration and type.

The definition of major depression requires the presence of five or more of the following symptoms for at least two weeks. One or both of the essential features of depressed or limitable mood, and loss of interest or pleasure in almost all activities must be observed. Other symptoms include appetite disturbance and significant weight loss or gain, sleep

difficulties or too much sleep, slow or agitated and restless behavior (many depressed children become overly aggressive), decreased energy or fatigue, feeling of worthlessness or self-blame and guilt, concentration and thinking difficulties, and thoughts of death or suicide.

Less severe forms of depression include dysthymia (moderately depressed mood over one year) and adjustment disorder with depressed mood caused by some known stress and lasting less than 6 months. Depressive features will vary in relation to the age and developmental level of the child. For example, physical complaints, agitation, anxiety and fears are more often seen in younger children while adolescents are more likely to engage in antisocial behavior or become sulky, overly emotional, and withdrawn.

There are a number of suggested causes of childhood depression. Biological explanations of depression have examined the roles of hereditary, biochemical, hormonal, and brain factors. More recently, the amount of light associated with seasonal changes has been suspected to affect mood.

Psychological descriptions have linked depression to the loss of loved ones, disturbances in parent-child relationships, and threats to self-esteem. Attention has also been focused on the way children interpret and structure everyday experiences and the belief they have about their ability to control and shape their world. Any of a number of psychological stressors may be able to significantly affect the mood of some children.

Given the various kinds and causes of childhood depression, there are different treatments that may be required. The "treatment" for the disappointment that follows the loss of a ball game may be a visit to

the local hamburger restaurant, or the feelings of failure and irritability caused by a poor school mark could signal the need to improve study habits and pay

closer attention in school. When the signs of depression described above occur and persist, the professional assistance of a psychologist or psychiatrist should be obtained. Antidepressant (tricyclics and MAO inhibitors) and anti-anxiety medications are very beneficial in the treatment of severe depression. Several effective forms of psychological treatment include behavioral, cognitive-behavioral, and interpersonal (IPT) therapy. Combined medication and psychotherapy programs are frequently employed in the treatment of depression.

»What can I do as a parent?

The list of suggestions follows the most frequently cited symptoms of childhood depression.

—Self-esteem and self-critical tendencies: give frequent and genuine praise; accentuate the positive; supportively challenge self-criticism; point out negative thinking.

—Family stability: maintain routine and minimize changes in family matters; discuss changes beforehand and reduce worry.

—Helplessness and hopelessness: have the child write or tell immediate feelings and any pleasant aspects 3 or 4 times a day to increase pleasant thoughts over 4-6 weeks.

—Mood elevation: arrange one interesting activity a day; plan for special events to come; discuss enjoyable topics.

—Appetite and weight problems: don't force eating; prepare favorite foods; make meal-time a pleasant occasion.

—Sleep difficulties: keep regular bed-time hours; do relaxing and calming activities one hour before bed-time such as reading or listening to soft music; end the day on a "positive note."

—Agitation and restlessness: change activities causing agitation; teach the child to relax; massage may help; encourage physical exercise and recreation

activities.

—Excessive fears: minimize anxiety-causing situations and uncertainty; be supportive and reassuring; planning may reduce uncertainty; relaxation exercises might help.

—Aggression and anger: convey a kind but firm unacceptance of destructive behavior; encourage the child to his angry feelings; do not react with anger.

—Concentration and thinking difficulties: encourage increased participation in games, activities, discussions; work with the teachers and school psychologist to promote learning.

—Suicidal thoughts: be aware of the warning signs of suicide; immediately seek professional help.

—if depression persists: consult your family doctor for a complete medical exam; seek a referral to a psychologist or psychiatrist.

Resources

Depression and Its Treatment—by Drs. J. H. Greist and J. Jefferson, 1984. This is a very readable layman's guide to understanding and treating depression.

Stress, Sanity and Survival—by Drs. R. L. Woolfolk and F. C. Richardson, 1978. Numerous suggestions are given for dealing with worry, anger, anxiety, inadequacy and other signs of stress associated with depression.

Three Steps Forward: Two Steps Back—by C. R. Swindel, 1980. Written from a religious perspective, this book offers practical ways to face problems such as loss, anxiety, self-doubt, fear and anger.

Control Your Depression—by Dr. P. Lewinsohn, 1979. This leading expert offers meaningful and helpful suggestions based on his theory of depression.

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1a. Mood Disorders in Children and Adolescents

by Anne Brown

Adapted from an article of the same name in the NARSAD Research Newsletter, Winter 1996.



Many researchers believe that mood disorders in children and adolescents represent one of the most under diagnosed group of illnesses in psychiatry. This is due to several factors:

- (1) children are not always able to express how they feel,
- (2) the symptoms of mood disorders take on different forms in children than in adults,
- (3) mood disorders are often accompanied by other psychiatric disorders which can mask depressive symptoms, and
- (4) many physicians tend to think of depression and bipolar disorder as illnesses of adulthood.

Not surprisingly, it was only in the 1980's that mood disorders in children were included in the category of diagnosed psychiatric illnesses.

How Prevalent are Mood Disorders in Children and Adolescents?

- 7-14% of children will experience an episode of major depression before the age of 15.
- 20-30% of adult bipolar patients report having their first episode before the age of 20.
- Out of 100,000 adolescents, two to three thousand will have mood disorders out of which 8-10 will commit suicide.

Depression

There is emerging evidence that major depression can develop in prepubertal children and that it is a significant clinical occurrence among adolescents. Recent epidemiologic studies have shown that a large proportion of adults experience the onset of major depression during adolescence and early adulthood.

By studying high-risk populations for developing childhood mood disorders, researchers hope to learn more about the onset and course of depression. Myrna M. Weissman, Ph.D. of Columbia University (a NARSAD Established Investigator and 1994 Selo Prize Co-Winner) has found an increased prevalence of major depression as well as a variety of other psychiatric problems in the children of depressed parents compared with those of normal parents. Specifically, she has discovered that the onset of major depression was significantly earlier in both male and female children of depressed parents (mean age of 12.7 years) compared with those of normal parents (mean age, 16.8 years). She has also observed sex differences in rates of depression to begin in adolescence. Before 10 years of age, she found a low frequency and equal sex ratio, however by 16 years of age, there was a marked increase in major depression in girls, as compared to boys of the same age.

The essential features of mood disorders are the same in children as in adults, although children exhibit the symptoms differently. Unlike adults, children may not have the vocabulary to accurately describe how they feel and, therefore may express their problems through behavior. The following behaviors may be associated with mood disorders in children:

- *In Preschool Children:*

Somber Appearance, almost ill-looking; they lack the bounce of their nondepressed peers. They may be tearful or spontaneously irritable, not just upset when they do not get their way. They make frequent negative self-statements and are often self-destructive.

- *In Elementary School-Aged Children and Adolescence:*
Disruptive behavior, possible academic difficulties, and peer problems. Increased irritability and aggression, suicidal threats, and worsening school performance. Parents often say that nothing pleases the children, that they hate themselves and everything around them.

Bipolar Disorder

There has been a great deal of diagnostic uncertainty surrounding bipolar disorder in children. This may be caused by a major difference in the way mania is expressed in bipolar children versus adults. A look back at the histories of adults with bipolar symptoms often shows that mood swings began around puberty, however there is a frequent 5-to-10 year lag between the onset of symptoms and display of the disorder serious enough to be recognized and require treatment, resulting in the under diagnosis of bipolar disorder.

Unlike adult bipolar patients, manic children are seldom characterized by euphoric mood. Rather, the most common mood disturbance in manic children may be better described as irritable, with "affective storms" or prolonged and aggressive temper outbursts. For example, a study by Gabrielle A. Carlson, M.D. of State University of New York-Stony Brook, found that bipolar children under the age of 9 had more irritability, crying, and motor agitation as compared to older bipolar children, who were more likely to have "classically manic symptoms" such as euphoria and grandiosity. In addition, it has been suggested that the course of childhood-onset bipolar disorder tends to be chronic and continuous rather than episodic and acute, as is the adult form of the disorder.

Other aspects that make diagnosing bipolar disorder in children difficult is the frequency with which bipolar disorder is mistaken for attention-deficit hyperactivity disorder (ADHD), conduct disorder (which includes symptoms of socially unacceptable, violent or criminal behavior), or schizophrenia.

Bipolar Disorder vs. Other Childhood Disorders

ADHD and bipolar disorder have many overlapping features which include: distractibility, inattention, impulsivity, and hyperactivity. However, bipolar disorder has several differentiating features, which include:

psychosis, depression, aggression, excitability, rapid mood swings, inappropriate affect and disregard for feelings of others.

Conduct disorder overlaps with bipolar disorder on symptoms such as: impulsivity, shoplifting, substance abuse, difficulties with the law and aggressiveness. However, in bipolar disorder, some distinguishing factors include: antisocial behavior with elevated or irritable mood and lack of peer group influence.

When comparing schizophrenia and bipolar, their common symptoms include: grandiose and paranoid delusions and hallucinatory phenomena. However, in schizophrenia, differentiating features include: thought disorder and bizarre delusions.

The widely accepted belief that childhood-onset mania is rare has recently been challenged. Many researchers including Janet Wozniak, M.D. of Harvard Medical School (a NARSAD Young Investigator) have shown a major overlap in the symptoms of mania and ADHD. Dr. Wozniak believes that this overlap may be responsible for the under identification and misdiagnosis of bipolar disorder. In her study of clinically referred children, she found 16% to have mania with irritable and mixed moods (i.e. with symptoms of depression and mania occurring simultaneously). Also, she found that the children meeting the criteria for mania frequently also met the criteria for ADHD (the rate of ADHD in children with mania was 98%, while the rate of mania in children with ADHD was only 20%).

Schizophrenia has also been found to be mistaken for manic depression in adolescents. Despite the fact that psychotic features are a well-established part of adolescent manic-depressive illness, many clinicians continue to believe that thought disorder, grandiosity, and bizarre delusional and hallucinatory phenomena are distinctively characteristic of schizophrenia. Difficulties often arise in differentiating blunted from depressive affect and apathy from depression-induced delay in response time to questions.

Treatments

It is important for children suffering from mood disorders to receive prompt treatment because early onset places children at a greater risk for multiple episodes of depression throughout their life span. Children who

experience their first episode of depression before the age of 15 have a worse prognosis when compared with patients who had a later onset of the disorder.

At the present time, there is no definitive treatment for the spectrum of mood disorders in children, although some researchers believe that children respond well to treatment because they readily adapt and their symptoms are not yet entrenched. Treatment consists of a combination of interventions. Medications can be useful for cases of major depression or childhood onset mania, and psychotherapy can help children express their feelings and develop ways of coping with the illness. Some other helpful interventions that may be used are educational and family therapy.

Children suspected of mood disorders should be evaluated by a child psychiatrist, or if one is not available an adult psychiatrist who has experience in treating children. It is important that the clinician has had special training in speaking with children, utilizing play therapy, and can treat children in context of a family unit.

Suicide

An estimated 2,000 teenagers per year commit suicide in the United States, making it the leading cause of death after accidents and homicide. According to David Schaffer, M.D., of Columbia University (a NARSAD Established Investigator), suicidal behavior is uncommon before puberty, with the incidence of suicide attempts reaching its peak at around age 15 and becoming less common by the late teens. Studies of adolescent suicides in New York, Pittsburgh and Finland indicate that approximately 90 percent of the teenagers who commit suicide have a psychiatric diagnosis, most often a form of mood disorder and/or alcohol or substance abuse.

As in adults, suicide attempts occur more often in females (a ratio of 9 to 1), with overdose and wrist-cutting the most common means. Completed suicide occurs more often in males (a ratio of 3 to 1), usually white males, with shooting (62 percent) and hanging (19 percent) the most common means.

Biological Theories on Suicide

A number of biological theories are emerging to explain suicidal behavior. The available evidence points to

hyposerotonergic functioning in studies of both completers and attempters. In suicide victims' brains, an increase in postsynaptic 5-hydroxytryptamine type 2 (5-HT₂) receptors was found in the prefrontal cortex, suggesting that a compensatory increase in receptor density occurred in response to decreased serotonin release. The most robust findings in postmortem brains have been the measurements of low levels of serotonin (5-HT) and its major metabolite, 5-hydroxyindoleacetic acid (5-HIAA). Those findings were localized to the brainstem (the level of cell bodies) and were not found in the cortex. Completers have also shown alterations in noradrenergic (the activation of norepinephrine in the transmission of nerve impulses) but not cholinergic (of autonomic nerve fibers) pathways.

Several clinical studies have also found evidence of family histories of suicidal behavior, suggesting the likelihood of genetic factors playing a role in suicide. Twin studies provide evidence for genetic transmission of this vulnerability as twins share the same environment but differ in number of genes shared. Of 150 sets of twins reported in which at least one twin committed suicide, all 10 of the pairs in which both committed suicide were identical twins, and half of those were concordant for the same psychiatric illness.

Identifying the Vulnerable

Dr. Schaffer believes that screening out the vulnerable groups of children and adolescents for the risk factors of suicide and then referring them for treatment is the best way to lower the staggering teenage suicide rate. Students are regarded as high-risk if they have indicated suicidal ideation within the last three months, if they have ever made a prior suicide attempt, or if they indicate severe mood problems, excessive alcohol consumption or substance use.

In summary, mood disorders in children and adolescents are much more common than was originally estimated. This underestimation was primarily due to the diagnostic confusion surrounding overlapping symptoms from other childhood disorders and the difference in the expression of mania in children versus adults. Many research efforts are underway to better diagnose and identify the children and adolescents who are at risk for mood disorders. It is hoped that by identifying the most vulnerable individuals and providing them with treatment, we will finally start to see a decline in the staggering suicide rates for adolescents.

NIMH

National Institute of Mental Health

<http://www.nimh.nih.gov/healthinformation/childmenu.cfm>

1b. *Brief Notes on the* Mental Health of Children and Adolescents

Excerpt:

The future of our country depends on the mental health and strength of our young people. However, many children have mental health problems that interfere with normal development and functioning. A 1999 study estimated that almost 21 percent of U.S. children ages 9 to 17 had a diagnosable mental or addictive disorder that caused at least some impairment. When diagnostic criteria were limited to *significant* functional impairment, the estimate dropped to 11 percent. Moreover, in any given year, it is estimated that fewer than one in five of these youth receives needed treatment. Recent evidence compiled by the World Health Organization indicates that by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50 percent, internationally, to become one of the five most common causes of morbidity, mortality, and disability among children. The mental health problems affecting children and adolescents include the following:

Depressive Disorders

Depressive disorders, which include *major depressive disorder*, *dysthymic disorder*, and *bipolar disorder*, adversely affect mood, energy, interest, sleep, appetite, and overall functioning. In contrast to the normal emotional experiences of sadness, feelings of loss, or passing mood states, symptoms of depressive disorders are extreme and persistent and can interfere significantly with a young person's ability to function at home, at school, and with peers. Researchers estimate that the prevalence of any form of depression among children and adolescents in the U.S. is more than six percent in a six-month period, with almost five percent having major depressive disorder.

Major depressive disorder (major depression) is characterized by five or more of the following symptoms: persistent sad or irritable mood, loss of interest in activities once enjoyed, significant change in appetite or body weight, difficulty sleeping or oversleeping, psychomotor agitation or slowing, loss of energy, feelings of worthlessness or inappropriate guilt, difficulty concentrating, and recurrent thoughts of death or suicide. *Dysthymic disorder*, a typically less severe but more chronic form of depression, is diagnosed when depressed mood persists for at least one year in children and is accompanied by at least two other symptoms of depression (without meeting the criteria for major depression). Youth with dysthymic disorder are at risk for developing major depression.

Although *bipolar disorder* (manic-depressive illness) typically emerges in late adolescence or early adulthood, there is increasing evidence that this illness also can begin in childhood. According to one study, one percent of adolescents ages 14-18 were found to have met criteria

for bipolar disorder or cyclothymia, a similar but less severe illness, in their lifetime. Bipolar disorder beginning in childhood or early adolescence may be a different, possibly more severe form of the illness than older adolescent- and adult-onset bipolar disorder. Research has revealed that when the illness begins before or soon after puberty, it is often characterized by a continuous, rapid-cycling, irritable, and mixed manic and depressive symptom state that may co-occur with disruptive behavior disorders, particularly attention deficit hyperactivity disorder (ADHD) or conduct disorder (CD), or may have features of these disorders as initial symptoms.

The manic symptoms of bipolar disorder in children and adolescents may include the following: either extremely irritable or overly silly and elated mood; overly-inflated self-esteem; exaggerated beliefs about personal talents or abilities; increased energy; decreased need for sleep; increased talking; distractibility; increased sexual thoughts, feelings, behaviors, or use of explicit sexual language; increased goal-directed activity or physical agitation; and excessive involvement in risky behaviors or activities.

There is evidence that depressive disorders emerging early in life often continue into adulthood, and that early-onset depressive disorders may predict more severe illnesses in adult life. Diagnosis and treatment of depressive disorders in children and adolescents are critical for enabling young people with these illnesses to live up to their full potential.

Depressive disorders are associated with an increased risk of suicidal behavior. In 1999, suicide was the 3rd leading cause of death in 15-to 24-year-olds, following unintentional injuries (#1) and homicide (#2), and the 4th leading cause of death among 10- to 14-year-olds. Early identification and treatment of depressive disorders in young people may play an important role in reducing or preventing suicidal behavior.

Both medication and specialized forms of psychotherapy are prescribed to treat depressive disorders in children and adolescents. Recent studies indicate that certain selective serotonin reuptake inhibitor (SSRI) medications are safe and efficacious treatments for major depression in young people. In addition, cognitive-behavioral therapy (CBT) has proven effective for treating depression in adolescents. The ongoing Treatment for Adolescents with Depression Study (TADS), funded by NIMH, is comparing the effectiveness of an SSRI medication, CBT, and their combination to determine the best approach for treating major depression in teenagers. Other studies are evaluating the effectiveness of different individual, family, and group psychotherapies for treating depressive disorders in young people.

At present, the treatment of bipolar disorder in children and adolescents is based mainly on experience with adults, since as yet there are limited data on the safety and efficacy of treatments for this disorder in young people. The essential treatment in adults involves the use of mood-stabilizing medications, typically lithium and/or valproate, which are often very effective for controlling mania and preventing recurrences of manic and depressive episodes. However, because medications may have different effects in children than they do in adults, they should be carefully monitored by a physician. For example, there is some evidence indicating that valproate may cause hormonal problems in teenage girls. Antidepressant medication, if needed, generally must be used together with a mood stabilizer, since antidepressants taken alone may induce manic symptoms or rapid cycling in people with bipolar disorder. Current NIMH-funded studies are attempting to fill the gaps in knowledge about treatments for bipolar disorder in children and adolescents...

American Academy of Child & Adolescent Psychiatry

1c. THE DEPRESSED CHILD

No. 4 (10/92)

(<http://www.aacap.org/publications/factsfam/depressd.htm>)

(Updated 7/04)

Not only adults become depressed. Children and teenagers also may have depression, which is a treatable illness. Depression is defined as an illness when the feelings of depression persist and interfere with a child or adolescent's ability to function.

About 5 percent of children and adolescents in the general population suffer from depression at any given point in time. Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. Depression also tends to run in families.

The behavior of depressed children and teenagers may differ from the behavior of depressed adults. Child and adolescent psychiatrists advise parents to be aware of signs of depression in their youngsters.

If one or more of these signs of depression persist, parents should seek help:

- Frequent sadness, tearfulness, crying
- Hopelessness
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self esteem and guilt
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self destructive behavior



A child who used to play often with friends may now spend most of the time alone and without interests. Things that were once fun now bring little joy to the depressed child. Children and adolescents who are depressed may say they want to be dead or may talk about suicide. Depressed children and adolescents are at increased risk for committing suicide. Depressed adolescents may abuse alcohol or other drugs as a way to feel better.

Children and adolescents who cause trouble at home or at school may actually be depressed but not know it. Because the youngster may not always seem sad, parents and teachers may not realize that troublesome behavior is a sign of depression. When asked directly, these children can sometimes state they are unhappy or sad.

Early diagnosis and medical treatment are essential for depressed children. This is a real illness that requires professional help. Comprehensive treatment often includes both individual and family therapy. It may also include the use of antidepressant medication. For help, parents should ask their physician to refer them to a child and adolescent psychiatrist, who can diagnose and treat depression in children and teenagers. Also see the following Facts for Families: #8 Children and Grief, #10 Teen Suicide, #21 Psychiatric Medication for Children, and #38 Manic-Depressive Illness in Teens.



The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 7000 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

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2a. Assessment and Treatment of Childhood Depression

From the Clinical Child Psychology Newsletter, Volume 13, Number 3; Fall 1998

By: Wendy Bailey, M.A. and Nadine J. Kaslow, Ph.D ABPP

Emory University School of Medicine

» Definition and Prevalence of Unipolar Depression

For a child to receive a DSM-IV diagnosis of major depressive disorder, the child's symptoms must cause impairment of daily functioning, reflect a change from baseline, and may not be secondary to uncomplicated bereavement. The child must exhibit at least five of the following symptoms during the same two week period: (1) depressed or irritable mood (must be present for diagnosis); (2) anhedonia; (3) decreased weight or appetite or failure to make expected weight gains; (4) sleep disturbance; (5) psychomotor agitation or retardation; (6) fatigue or loss of energy; (7) feelings of worthlessness or inappropriate guilt; (8) concentration difficulties or indecisiveness; and (9) thoughts of death and/or suicide. Other depressive disorders that may be manifested in youth include dysthymic disorder and adjustment disorder with depressed mood. While the DSM-IV acknowledges the existence of depressive disorders in youth, DSM-IV criteria for mood disorders lack a developmental perspective, failing to account for children's cognitive, affective, and interpersonal competencies, and biological maturation (Cicchetti & Schneider-Rosen, 1986). As a result, the criteria for the diagnosis for children are almost identical to those for adults. Dissatisfaction with these criteria have led many to advocate for a developmental psychopathology perspective with regard to the diagnosis of mood

disorders in youth (Cicchetti & Schneider-Rosen, 1986).

No large scale epidemiological study has been conducted regarding the incidence and prevalence of mood disorders in youth. The available data, however, reveal prevalence rates ranging from 2-5% in community samples and 10-50% in psychiatric settings (Fleming & Offord, 1990; McCracken, 1992; Petersen et al., 1993). Prevalence rates for mood disorders increase with age (Fleming & Offord, 1990). Although there is no evidence of consistent sex differences in depression rates among pre-pubertal youth, by age 15, females are twice as likely as males to receive a depressive diagnosis (Angold, 1988; Nolen-Hoeksema & Girgus, 1994).

» Etiology

Multiple etiological models have been offered as explanations for depression in youth. The most commonly cited psychosocial models have emerged from psychodynamic, cognitive behavioral, and family systems theories.

Psychodynamic Perspective

Ego-analytic, object relations, and attachment theories offer the predominant current psychodynamic models of childhood depression. The ego-analytic model suggests that children with separation-individuation difficulties, and unrealistic expectations of themselves and others are at increased risk for depression (Sandler

& Joffe, 1965). Based on this model, depressed children's cognitive distortions reflect problematic parent-child interactions that produce low self-esteem, a perceived lack of instrumentality, dependence on others for gratification, and a negative frame of reference that often renders them unhappy (Bemporad, 1994). According to object relations and attachment theories, early disruptions in attachment predispose individuals to symptoms associated with depression such as the experience of emptiness, helplessness, and a negative perception of the world (Bowlby, 1981). Little research has been conducted to assess the validity of the psychodynamic perspectives on mood disorders in youth.

Cognitive-Behavioral Perspective

Researchers have extensively studied the cognitions of depressed children and adolescents. This research reveals that the cognitive patterns of depressed children are similar to their adult counterparts. Specifically, compared to nondepressed children, depressed youth have impaired information-processing; cognitive distortions; a negative view of themselves (low self-esteem), the world, and the future (hopelessness); a perception of themselves as helpless and unable to control the events in their lives; a depressogenic attributional style (attribute negative life events to more internal, stable, and global causes and positive events to more external, unstable, and specific

causes); and deficits in self-monitoring, self-evaluation, and self-reinforcement (Kaslow, Brown, & Mee, 1994). Despite the proliferation of research highlighting the cognitive deficits of depressed youth, the role of the negative cognitive style in the etiology of depression is only now beginning to be studied (Garber & Hilsman, 1992).

Family Systems Perspective

Depressed youth typically have a familial history of psychopathology, particularly mood and substance use disorders (Hammen, 1991). In addition, these children are often from families with a history of several negative life events; experiences with high levels of negative life events place a child or adolescent at risk for depression (for reviews see Compas, Grant, & Ey, 1994; Garber & Hilsman, 1992). The families of depressed youth typically are characterized by the following relational patterns: attachment problems (e.g., insecure attachment), low cohesion, low support, child maltreatment, inappropriate levels of family control, high levels of family conflict, ineffective conflict resolution, difficulties with affect regulation, impaired communication patterns, transmission of depressive cognitions, and a poorness of fit between the child's temperament and the family's style of relating (Kaslow, Deering, & Ash, 1996; Kaslow, Deering, & Racusin, 1994). Little effort has been made to date to examine empirically the role of family dysfunction in the etiology of depressive disorders in youth.

» Assessment

Psychosocial Approach

A psychosocial assessment of childhood depression uses a multi-trait, multi-method, multi-informant approach to examine individual and contextual factors. This method of assessment enhances diagnostic reliability and validity, addresses inter-informant discrepancies, and portrays youngsters' impairments and competencies across domains (e.g.,

cognitive, affective, and interpersonal functioning, adaptive behavior, negative life events) and settings. In brief, a thorough evaluation examines domains of functioning beyond mood related symptoms. Furthermore, a psychosocial evaluation involves interviews with the depressed child and primary caretakers and family members, completion of behavior ratings scales by multiple informants (e.g., child, parents, teachers, peers, clinicians), and when indicated, results from psychological testing. Given the potential contribution of family process, it can be valuable to assess interactional patterns.

Semi-structured interviews

Hodges (1994) suggests that diagnostic interviews are optimal assessment tools for the diagnosis of clinical depression as a syndrome, while symptom checklists and questionnaires yield information about individual symptoms and psychological distress. Semistructured diagnostic clinical interviews include the Diagnostic Interview Schedule for Children, the Child Assessment Scale, the Schedule for Affective Disorders and Schizophrenia in School-Age Children, the Diagnostic Interview for Children and Adolescents, and the comorbid disorders also can be diagnosed through the use of these semi-structured diagnostic clinical interviews. This standardized method of assessment facilitates differential diagnosis.

Self-report questionnaires

Self-report questionnaires are the most commonly used assessment tool for the determination of the severity of depressive symptoms. Reliable and valid self-report measures that are appropriate for children ages eight and older include: Children's Depression Inventory, Reynolds Child Depression Scale, Reynolds Adolescent Depression Scale, Depression Self-Rating Scale, Children's Depression Scale, Beck Depression Inventory, and the Center for Epidemiological Studies Depression Scale (for review, see Reynolds, 1994). Self-report measures are preferred over diagnostic clinical interviews because they are less lengthy, therefore they require less time to administer.

However, self-report questionnaires should be used in conjunction with clinical interviews that offer a more comprehensive diagnostic picture of the level of psychological distress experienced by the patient or client (Reynolds, 1994).

Medical Approach

Alcohol and illicit drugs as well as prescribed medication such as anticonvulsants, corticosteroids, and some antibiotics have depressive side-effects, therefore medical work-ups are helpful in ruling out depression due to organic causes. Medical work-ups should include a physical examination, a drug screen for the most commonly abused substances, and the gathering of information pertaining to familial history of depression. A laboratory work-up is also recommended in order to rule out infection, anemia, thyroid disease, parathyroid disease, kidney disorders, adrenal dysfunction and metabolic abnormalities, all of which are associated with depression.

» Treatment

Both psychosocial and psychopharmacological treatments are used with depressed children and adolescents. Although multiple treatment approaches have been advanced, few have been adequately evaluated (see Kaslow & Thompson, 1998 for review). The following section offers a brief overview of treatments with sound empirical support.

Empirically supported psychosocial interventions for children.

Multi-component treatments formulated from a cognitive-behavioral perspective, consisting of less than 20 sessions, and administered in group-format within a school setting have received the most consistent empirical support. These interventions (Stark, Reynolds, & Kaslow, 1987; Stark, Rouse, & Livingston, 1991) tend to consist of psychoeducational and cognitive-behavioral treatments that do not differ markedly from those that are commonly administered to adult

populations. Treatment components involve enhancing skills in cognitive restructuring, problem-solving, relaxation, self-control, social skills, and social competence among depressed youth (for review see Kaslow & Thompson, 1998).

Empirically supported psychosocial interventions for adolescents.

Similar to the psychosocial interventions for depression among children, most adolescent interventions consist of less than 20 sessions and are administered in a psychoeducational and group format. One well-designed adolescent intervention study, conducted by Lewinsohn, Clarke, Rohde, Hops, & Seeley (1996), suggests that cognitive-behavioral treatment is more effective at decreasing depressive symptoms among adolescents than a wait-list control condition. The cognitive-behavior intervention focused on increasing pleasant activities and enhancing skills in social competence, relaxation, conflict resolution, and controlling depressive thoughts. Lewinsohn and colleagues (1996) also found that cognitive behavioral treatment is equally effective in ameliorating depressive symptoms among adolescents when administered only to the adolescent in a group setting and when offered to the adolescent in a group setting combined with separate sessions for the parents.

Biological Interventions Pharmacotherapy.

Tricyclic antidepressants (TCAs) and specific serotonin reuptake inhibitors (SSRIs) are the most frequently prescribed antidepressants. Monoamine oxidase inhibitors (MAOIs) are not recommended for children and adolescents due to their level of lethality in overdose and stringent dietary restrictions (Ryan, 1992).

Research has yielded mixed results regarding the efficacy of tricyclic antidepressants (TCAs) and specific serotonin reuptake inhibitors (SSRIs) in depressed children and

adolescents. For example, open trial studies of TCAs, such as imipramine, amitriptyline, and nortriptyline, indicate that TCAs are effective in decreasing depressive symptoms among prepubertal youth (for review, see Harrington, 1993).

Similarly, open-trial studies of SSRIs, such as fluoxetine (prozac) and fluvoxamine (luvox), indicate that these medications are effective in decreasing depressive symptoms in adolescents (Harrington, 1993). However, double-blind studies do not support previous findings; TCAs (e.g. Geller, Fox, & Clark, 1994) and SSRIs (e.g., Apter, Ratzoni, King, Weizman, Iancu, Binder, & Riddle, 1994; Boulous, Kutcher, Gardner, & Young, 1992) have yielded similar results to placebo treatments.

While more methodologically sound pharmacological studies are needed to clarify the efficacy of antidepressants with various age groups, both TCAs and SSRIs are frequently used by child psychiatrists and pediatricians. While SSRIs are less lethal than TCAs in overdose and cause fewer harmful side effects, TCAs are less expensive and therefore more accessible to low-income youth (Rosenberg, Holtum, & Gershon, 1994).

»Prevention

Prevention trials for depression are recent, although a number of programs designed for youth following stressful events (e.g., divorce, death of a family member) have implications for preventing depression. Similar to childhood and adolescent depression interventions, in the area of the prevention of depression among youth, the most effective prevention programs have been psychoeducational. For example, in one of the most effective programs, conducted by Jaycox, Reivich, Gillham, and Seligman (1994), it was found that 10-to 13-year-olds who received didactic training focusing on social problem solving, cognitive restructuring, assertiveness, negotiation, and coping strategies reported fewer depressive symptoms at six-month and two-year follow-up than their waitlist control counterparts. Similarly, Hains and Ellmann (1994) reported that those adolescents who had received cognitive

restructuring, problem solving, and coping skills training reported fewer depressive symptoms than a wait-list control group at follow-up. More recently, Clarke and colleagues (1995) compared a 15 session group cognitive prevention program and a treatment-as-usual condition for adolescents with self-reported depressive symptoms who did not meet diagnostic criteria for a mood disorder. A survival analysis indicated that at 12-month follow-up, adolescents in the experimental group were less likely than controls to meet the diagnostic criteria for a mood disorder. These findings support the utility of prevention programs in reducing the risk for mood disorders in at-risk youth.

Related psychoeducational prevention efforts focus on children of depressed parents. Beardslee and colleagues (e.g., Beardslee, & MacMillan, 1993; Beardslee et al, 1993) found that families in a clinician-based format were more positive about the program and developed more adaptive attitudes and behaviors for coping with stress than did families in the lecture-based program. These changes may be associated with improved parental management of high-risk children and more adaptive child coping, both of which may decrease the child's risk for depression.

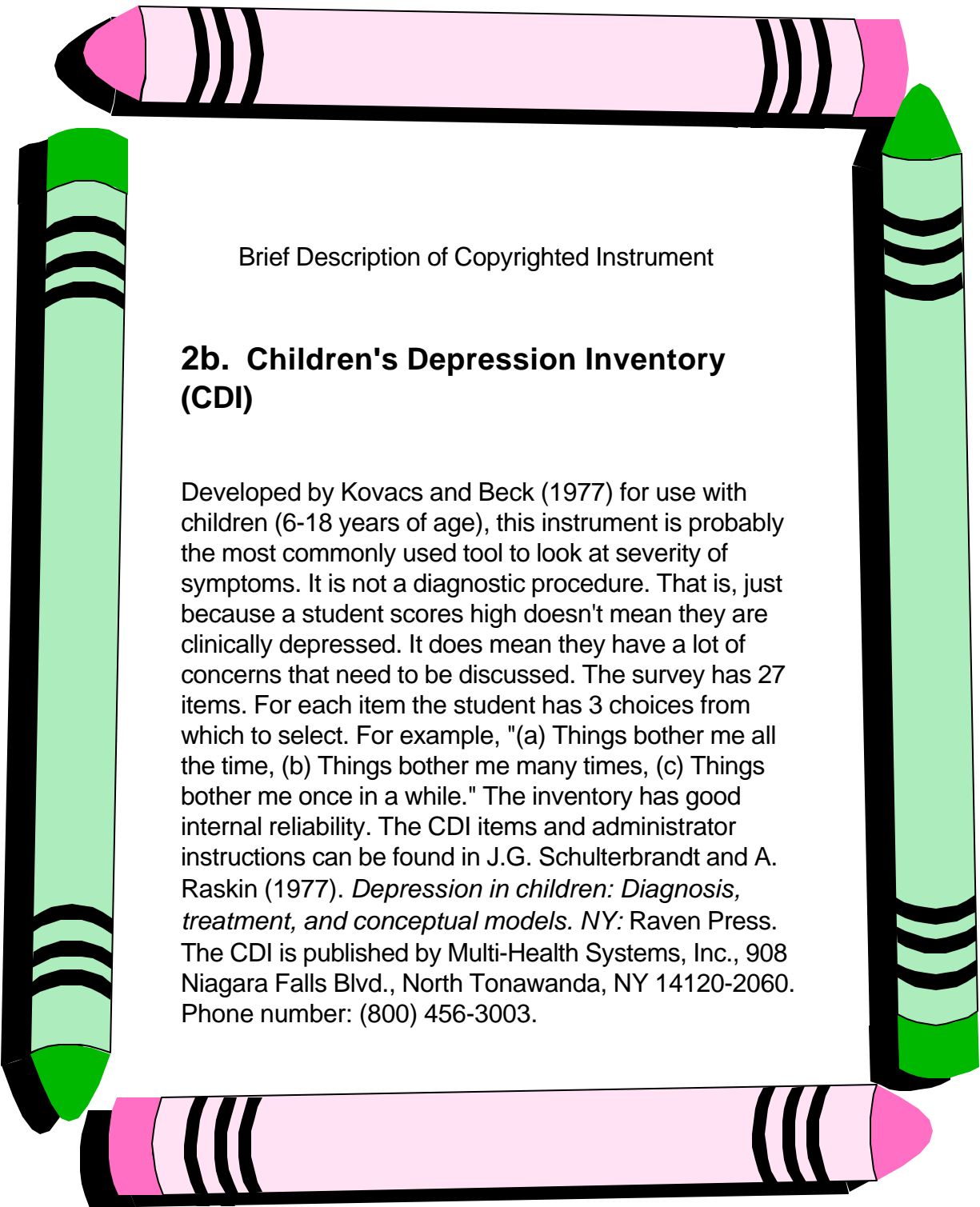
»Concluding Comments

Despite the proliferation of research on child and adolescent depression, research on effective treatments is only beginning to emerge. Initial results suggest that multi-component interventions guided by cognitive-behavioral principles produce significant reductions in depressive symptoms among children and adolescents. Other interventions may be effective, for example, family-based treatments, but few have received systematic empirical evaluation. Thus, given multiple etiologies among children and adolescents with depressive symptoms, it is premature to conclude that a single approach, or specific treatment component, will be uniformly effective across cases. Progress in this area will hinge on longitudinal investigations with an

explicit developmental focus that consider the cognitive, interpersonal, and neurobiological processes associated with depressive risk and course. Such research will provide the basis for the development and empirical validation of new interventions that aim to prevent or resolve depressive disorders.

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Brief Description of Copyrighted Instrument

2b. Children's Depression Inventory (CDI)

Developed by Kovacs and Beck (1977) for use with children (6-18 years of age), this instrument is probably the most commonly used tool to look at severity of symptoms. It is not a diagnostic procedure. That is, just because a student scores high doesn't mean they are clinically depressed. It does mean they have a lot of concerns that need to be discussed. The survey has 27 items. For each item the student has 3 choices from which to select. For example, "(a) Things bother me all the time, (b) Things bother me many times, (c) Things bother me once in a while." The inventory has good internal reliability. The CDI items and administrator instructions can be found in J.G. Schulterbrandt and A. Raskin (1977). *Depression in children: Diagnosis, treatment, and conceptual models*. NY: Raven Press. The CDI is published by Multi-Health Systems, Inc., 908 Niagara Falls Blvd., North Tonawanda, NY 14120-2060. Phone number: (800) 456-3003.

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**2c. Ten-year review of rating scales II:
scales for internalizing disorders.
(Research Update Review).**

Author/s: Kathleen Myers

Excerpt:

SUMMARY AND CONCLUSIONS

Depression-rating scales and anxiety-rating scales offer great utility for elucidating youths' internalizing psychopathology treatment planning, following treatment course, and assuring accountability in practice. However, they cannot be used casually. The potential user must consider a particular scale in relation to the problem to be assessed, characteristics of the sample, properties of the scale, and the goals of assessment. All of the reviewed scales have strengths and weaknesses. Depression-rating scales suffer predominantly from the lack of clear construct validity. Furthermore, several depression scales are waning in popularity, thereby reducing the number of available depression-rating scales and ongoing examination of their functioning. On the other hand, the most popular scales provide a wealth of information on their functioning.

Furthermore, these scales have parallel parent-report forms for collateral information and short forms to facilitate repeated evaluation. Older anxiety-rating scales also suffer from the lack of construct clarity and developmental relevance. However, newer scales appear to enjoy good construct validity and suitability for youths but have not been used long enough to draw conclusions regarding their overall appropriateness and validity. Most also have parallel parent forms and short screening forms. Their biggest challenge, and their greatest promise, is their ability to discriminate anxiety disorders from depressive disorders. In any event, no one scale is likely to provide all of the information desired. In general, more than one scale should be used to evaluate a specific internalizing construct, thereby assuring a more robust assessment of a youth's problem (Myers and Winters, 2002). This is especially important for scales assessing mood and anxiety disorders because they tend to overlap in their constructs and symptom profiles. Within these guidelines, rating scales for internalizing disorders can facilitate research and augment clinical practice.

EMPIRICALLY SUPPORTED TREATMENTS

In an effort to improve the quality of treatment, the mental health field is promoting the use of empirically supported interventions. The following pages contain *excerpts* from a 1998 report entitled “Applying the Criteria for Empirically Supported Treatments to Studies of Psychosocial Interventions for Child and Adolescent Depression” by T. H. Ollendick and N. J. King, which appears in the *Journal of Clinical Child Psychology*, 27, 156-167.

Excerpted here are the abstract, the authors’ conclusions, and their reference list.

Abstract of article by T. H. Ollendick and N. J. King, which appears in the *Journal of Clinical Child Psychology*, 27, 156-167.

Reviews the psychosocial treatment outcome studies for depressed children and adolescents and concludes that psychosocial interventions are effective at posttreatment and follow-up in reducing depressive symptoms/disorders in clinical and nonclinical samples of youth, regardless of treatment modality or extent of parental involvement. The article then examines the extent to which each study conforms to the guidelines set forth by the Task Force on Promotion and Dissemination of Psychological Procedures (1996) for well-established and probably efficacious interventions. Results of this analysis indicate only 2 series of studies that meet criteria for probably efficacious interventions and no studies that meet criteria for well-established treatments. Finally, the advantages and disadvantages of applying criteria for empirically supported treatments to identify good treatments for depressed youth are discussed, the importance of devising developmentally and culturally sensitive interventions targeted to the unique needs of each child is highlighted, and recommendations for future research that is informed by clinical practice and empirical findings are offered.

The following pages illustrate the gist of the article.

Criteria for Well-Established and Probably Efficacious Treatments

The following are the most recent criteria for ESTs (Chambless et al., 1996; see Lonigan et al., this issue). Because the child and adolescent depression intervention literature does not include a large series of single case design experiments, only criteria related to between-group design studies are delineated.

For an intervention to be deemed well established, there must be at least two good between-group design experiments demonstrating efficacy in one of the following ways: (a) superior to pill or psychological placebo or to another treatment, or (b) equivalent to an already established treatment in experiments with adequate statistical power ($n \geq 30$ per group). The experiments must be conducted in accordance with a treatment manual, sample characteristics must be detailed, and at least two different investigators or investigatory teams must demonstrate intervention effects. For an intervention to be classified as probably efficacious, either two experiments must demonstrate that the intervention is more effective than a wait-list condition or one or more experiments must meet all criteria for a well-established treatment, except for the requirement that treatment effects be shown by two different research teams...

...to date, none of the childhood depression intervention studies meet criteria for well-established treatments. The two studies conducted by Stark and colleagues (Stark et al., 1987, 1991), however, appear to meet criteria for probably efficacious treatments.

Because the investigations by Stark and colleagues represent the best available psychosocial treatment out-come studies for childhood depression, these studies are detailed. Stark et al. (1987) weighed the relative efficacy of 12-session group interventions involving self-control therapy, behavior problem-solving therapy, and a wait-list control for 29 fourth through sixth graders with elevated depression scores at two time points. The self-control intervention taught self-management skills (e.g., self-monitoring, self-evaluating, self-consequating, causal attributions). The behavioral problem-solving group intervention consisted of education, self-monitoring of pleasant events, and group problem solving directed toward improving social behavior. Postintervention within-group analyses found that participants in both active interventions reported fewer symptoms of depression and anxiety, whereas wait-list children reported minimal change. Between-group analyses revealed that children in the self-control condition showed relatively greater improvement in self-esteem and depressive symptoms, as measured by

the Children's Depression Inventory (CDI; Kovacs, 1985), than the youth in the other two groups. However, no between-group differences were noted on the other measures of depression according to child or mother ratings or on measures of self-esteem or anxiety. At 8-week follow-up, 88% of the children in the self-control condition and 67% of the children in the behavioral problem-solving condition obtained CDI scores below the cutoff for depression (i.e., <13), and none of the participants in either experimental group met criteria for clinically significant levels of depressive symptoms according to their responses on the Children's Depression Rating Scale-Revised (CDRS-R; Poznanski, 1984). Also at follow-up, the children in the self-control condition reported greater generalization of treatment effects according to their responses to the CDRS-R and the Coopersmith Self-Esteem Inventory (Coopersmith, 1975), but no differences in depression levels were noted between the children in the self-control and behavioral problem-solving conditions on the CDI or the Child Depression Scale (Reynolds, 1989). Also, there were no between-group differences at follow-up in terms of mother's ratings of their child's depression on the Child Behavior Check-list (Achenbach & Edelbrock, 1983) or in terms of children's reports of anxiety. Taken together, results revealed that both experimental interventions were relatively successful in reducing symptoms of depression. For the most part, findings regarding the comparison of the self-control and behavioral problem-solving group interventions were equivocal. However, the pattern suggested that the self-control intervention was more beneficial to the children.

Based on results from the aforementioned study, Stark et al. (1991) evaluated an expanded version of self-control therapy for 26 fourth through seventh graders who endorsed high levels of depressive symptoms. This research offers only a partial replication of Stark's earlier work (i.e., Stark et al., 1987), as the self-control therapies tested in the two different treatment outcome studies were similar but not identical, and there was no behavioral problem-solving condition in the second study. The experimental intervention in the second study was a 24- to 26-session cognitive-behavioral treatment that consisted of self-control and social skills training, assertiveness training, relaxation training and imagery, and cognitive restructuring. This experimental treatment was compared to a traditional counseling condition designed to control for nonspecific elements of the intervention. Monthly family meetings for the cognitive-behavioral group encouraged parents to assist their children in applying their new skills and to increase the frequency of positive family activities. Monthly family sessions associated with the traditional counseling condition addressed improving communication and increasing pleasant family

events. Postintervention and 7-month follow-up assessments revealed decreases in self-reported depressive symptoms for both groups of children. At postintervention, youth in the cognitive-behavioral intervention reported fewer depressive symptoms on a semistructured interview and endorsed fewer depressive cognitions.

The 1987 and 1991 outcome studies by Stark and colleagues come the closest of all of the child studies to meeting the criteria for probably efficacious treatments. Specifically, client characteristics were specified, a treatment manual was used, and two adequate group design studies demonstrated that a self-control intervention was superior to a placebo treatment. However, as noted previously, the self-control interventions used in the two studies were not identical in terms of length of treatment or material covered. With these qualifications, we view this research program as approximating that required for being a probably efficacious EST.

* * *

... The intervention research conducted by Lewinsohn and coworkers (i.e., Lewinsohn et al., 1990; Lewinsohn et al., 1996) represents state-of-the-art adolescent depression intervention research. These methodologically sophisticated studies meet criteria for probably efficacious treatments as client characteristics were specified, a treatment manual was used, and two adequate group design studies demonstrated that a coping skills program was more efficacious than a wait-list condition. Thus, a brief description of these studies is warranted. In the first study, Lewinsohn et al. (1990) randomly assigned 59 high school students, ages 14 to 18 years who met diagnostic criteria for depressive disorders, to cognitive-behavioral group treatment for the adolescent only, concurrent cognitive-behavioral treatment groups for the depressed adolescent and his or her parents, and a wait-list control condition. The cognitive-behavioral intervention, based on the Coping With Depression (CWD) course for adults, was adapted to address the concerns and competencies of adolescents. The CWD, a 14-session multiple component intervention, focuses on experiential learning and skills training, with attention to increasing pleasant activities, training in relaxation, controlling depressive thoughts, improving social interaction, and developing conflict resolution skills. The seven-session complimentary parent intervention program is designed to enhance parents' ability to reinforce their adolescent's adaptive changes, which should increase the maintenance and generalization of treatment effects. Postintervention assessment indicated that fewer adolescents in the two active treatment groups met diagnostic criteria for depression as compared to youth in the wait-list group. Also, compared to their nontreated counterparts, adolescents in the CWD adolescent-

only and the CWD for adolescent-and-parent evidenced greater reductions in self-reported depressive and anxious symptoms and maladaptive cognitions and evidenced more involvement in positive events. Treatment gains were maintained at 2-year follow-up. Although there were a few statistically significant differences between the adolescent-only CWD condition and the adolescent-and-parent CWD, no between-group differences were found on most variables, suggesting either that the outcome was similar for both groups or that with a larger sample, the adolescent-and-parent CWD would prove to be more effective than the adolescent-only condition.

The second study conducted by Lewinsohn et al. (1996) was a replication, with modifications, of the prior design. Skills training was interwoven throughout the CWD course rather than offered in single blocks in separate sessions. The other modification was the addition of random assignment to different conditions during the 2-year follow-up phase: (a) booster sessions plus assessment every 4 months, (b) assessment only every 4 months, and (c) annual assessment only. In a sample of 96 adolescents meeting diagnostic criteria for major depressive disorder or dysthymic disorder, recovery rates in the two active treatment conditions (i.e., CWD = 65%, CWD plus parent intervention = 69%) were greater than those for the adolescents in the wait-list control group (48%). No significant differences were found between the two experimental groups. Comparable recovery and relapse rates were reported for the three follow-up conditions. Of particular interest was that at the 2-year follow-up, 97.5% of adolescents who participated in an active treatment condition no longer met criteria for a depressive disorder.

Current Empirical Status of Psychosocial Interventions for Depressed Children and Adolescents

In summary, results from this review reveal that several psychosocial intervention programs, the majority of which are based on a cognitive-behavioral model, are effective in reducing depressive symptoms and alleviating depressive disorders in nonclinical samples of children and both clinical and nonclinical samples of adolescents. Positive treatment effects are noted regardless of treatment modality (group, individual, or family therapy) or nature or extent of parental involvement. Treatment effects generally are maintained at follow-up. However, because most of the studies were conducted in schools with nonreferred youth with depressive symptoms and used relatively inexperienced clinicians, the generalizability of the findings across populations, settings, and clinician-experience level remains unclear. Further, because few between-group design studies have compared

different interventions, it is premature to conclude that any specific intervention approach is most efficacious in reducing depression in youth. Given that the intervention literature on mood disorders in youth is in its infancy and most of the studies were conducted prior to the establishment of the criteria for ESTs, it is not surprising that none of the interventions met criteria for well-established treatments and only one series of child studies and one series of adolescent studies appear to meet the criteria for probably efficacious interventions.

Strengths and Weaknesses of the EST Approach

Our review of the child and adolescent depression treatment literature brings to the fore a number of advantages and disadvantages of the EST movement. There are enumerable methodological advantages to ascertaining the efficacy of an intervention based on its superiority to a pill, placebo, or other treatment or its equivalence to an already established treatment when a random assignment to control study is conducted. Only with random assignment can between-group differences in the reduction of depression and its sequelae be attributed to the intervention. However, a major clinical concern often emerges regarding random assignment to a placebo control condition. Some youth with significant problems (e.g., suicidal ideation) will not receive adequate and timely care in the control condition. Many researchers have handled this issue by eliminating children with elevated levels of suicidal ideation. This, however, limits the utility of the interventions to those depressed youth in greatest need.

The primary advantages of conducting treatments in accord with a manual are that such interventions (a) are systematic, focused, and goal-oriented; (b) enable more mental health professionals to be trained to provide effective psychosocial interventions for depressed youth; (c) increase our ability to detect differences between treatment conditions; and (d) have a greater likelihood for replication. A number of obstacles impede the use of treatment manuals for addressing child and adolescent depression. First, rigid application of a manualized treatment protocol may result in difficulty establishing rapport with a depressed youth and ineffective dissemination of psychological services due to the therapist's inability to attend to the distinctive mood or context of each session or the child's current concerns. Second, it is difficult for an intervention manual to address individual differences (e.g., depression symptoms and severity, comorbid conditions, education level, cognitive level, age, sex, family constellation, family income, attendance patterns). Third, most treatment manuals only address a singular problem (e.g., depression) rather than the comorbid psychological conditions and environmental

influences (e.g., poverty, physical/sexual abuse, parent and child substance abuse and psychiatric problems, parental cognitive limitations) that impact the child's adjustment and that often are of greater concern to the child or family than the child's depression. Finally, most treatment manuals lack systematic attention to the child's background (e.g., ethnicity, income level), belief system, and expectations of therapy.

The key advantage of specifying client characteristics is that this information is crucial to considerations regarding the generalizability of the findings. There are no disadvantages to informing the reader of the client characteristics. However, the issue of determining client characteristics for inclusion criteria often is a challenging one. Developing inclusion criteria comprehensive enough to promote participation of all youth who need the intervention results in considerable within-group variability. It is difficult to control for this variability when matching the experimental and control groups. Many researchers address this dilemma by providing relatively narrow inclusion criteria, which limits the generalizability of findings from research studies to actual clinical practice. Often treatment outcome researchers, in an effort to conduct methodologically sophisticated studies, place methodological rigor above clinical reality.

The merits of determining the efficacy of an intervention across research teams are without question, and there are no disadvantages of such a recommendation. The dilemma for researchers in achieving this goal is the limited research funding available for conducting psychosocial intervention studies for depressed youth.

A Look to the Future

In closing, a number of problems with the child and adolescent depression treatment literature are noteworthy and have implications for the development and implementation of future treatment outcome studies. First, most studies failed to accommodate developmental differences in children's competencies and did not assess the benefits of various intervention strategies for youth at different ages and developmental levels. The protocols often failed to incorporate the pertinent developmental psychology literature on cognitive and affective development, but rather appeared to be downward extensions of adult depression interventions. Thus, future research should integrate developmental research findings on the cognitive, affective, and social functioning of youth in devising and implementing therapies for depressed children and adolescents. Given that children are embedded within a family context, a developmental perspective also highlights the importance of active family involvement, including family therapy (Kaslow & Racusin, 1994).

A second problem is the lack of a culturally sensitive perspective. Most studies were conducted with middle-class, Caucasian youth, and little attention was paid to the cultural relevance of the materials used, the intervention strategies incorporated, and the cultural background and sensitivity of the therapists who administer the protocols. Thus, in the future, researchers should include diverse groups of children, the therapists should be cognizant of the child's sociocultural context and aware of their own ethnicity affects the therapeutic alliance, and culturally sensitive assessment and interventions should be incorporated.

Third, there are no data that indicate which treatments are most effective for which depressed children and adolescents, and none of the investigatory teams have examined which specific component(s) of the multifaceted interventions is most beneficial for which children. Future studies would be more informative if they examined which children benefitted most from which intervention components (e.g., social skills training, cognitive restructuring, family involvement).

This would help clinicians to target specific intervention components for different children and families. In addition, researchers need to ascertain which depressed children are most likely to benefit from cognitive-behavioral versus interpersonal versus family therapy versus pharmacology, or some combination thereof. Such information will enable clinicians and clinical researchers to provide the optimal treatment for each depressed child or adolescent.

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4a. GUIDELINES FOR SCHOOL BASED SUICIDE PREVENTION PROGRAMS

Prevention Division of the American Association of Suicidology
1999

(<http://www.suicidology.org/associations/1045/files/School%20guidelines.pdf>)

Excerpt:

Suicide prevention is competing for time and resources with many other initiatives in schools. We must have confidence in both the efficacy and efficiency of any program that we propose. While schools adopt many programs on the basis of packaging, programs generally are not retained in the absence of results. A sound conceptual grounding is necessary for achieving consistent results and makes it easier to update the program in light of experience and empirical findings.

Part of the effort to build the conceptual base for prevention in general has resulted in typology intended to clarify prevention methodology (Institute of Medicine, 1994) which included:

1. *Universal* interventions, which are directed at an entire population rather than selected subpopulations or individuals. Such interventions may include efforts to enhance the supportiveness of populations such as their ability and inclination to provide a helpful initial response to a troubled youth; or, they may include teaching generic coping skills to an entire population; or, they may seek to enhance the sense of connection and participation among members of an organization or community.
2. *Selective* interventions, which are targeted to subpopulations that are characterized by shared exposure to some epidemiologically determined risk factor(s). For example, students at critical transitional periods, such as entering middle school or high school, can be at greater risk for a variety of adjustment and/or academic problems.
3. *Indicated* interventions are targeted to specific individuals who are already preclinical levels of a disorder and who have been identified through screening procedures. For example, students who self identify or are identified by others as having suicidal thoughts or plans are referred for an appropriate treatment...

Universal Suicide Prevention Approaches

The goal of universal approaches is *to raise the overall supportiveness and responsiveness of the at risk youths' environment*. This approach is preferable when the causes of a risk behavior are not yet clear or easily attenuated. Many factors have been proposed to contribute to youth suicide. The best current risk factors produce high false positives, thus universal approaches that help school personnel to identify and get help for at risk youth represent an efficient approach. The role of the school is seen as critical, but limited. All schools are not assumed to possess the resources to treat suicidal or emotionally disturbed students. They *can* enhance their capacity to identify and get help for these students as part of their mandate to socialize and protect their students.

Following are empirical bases for the universal program that includes classes for students:

- Most suicidal youths confide their concerns more often to peers than adults.
- Disturbed youth (e.g. depressed, substance abusers) prefer peer supports over adults more than their non disturbed peers.
- Some adolescents, particularly some males, do not respond to troubled peers in empathic or helpful ways.
- As few as 25% of peer confidants tell an adult about their troubled or suicidal peer.
- School personnel are consistently among the *last* choices of adolescents for discussing personal concerns.
- Consistent reasons cited by students for reluctance to confide in adults in their schools include: confidentiality is not respected, and school schedules and conflicting adult roles (i.e. evaluative and disciplinary) prevent students from getting to know adults well enough to confide in them.
- The inaccessibility of, and reluctance of adolescents to seek out helpful adults is considered to be a *risk factor* that contributes to destructive outcomes associated with a variety adolescent risk behaviors.
- Conversely, research has shown that contact with helpful adults may be considered a *protective factor* for a variety of troubled youth.
- There is also evidence that *provision* of help by youths may be beneficial to them: participation in helping interactions can shape prosocial behaviors and reduce problematic behavior; and is related to indices of social competencies that can carry over to other challenging situations.

Therefore, the overall goals of the universal program are to increase the likelihood that school gatekeepers (administrators, faculty, and staff) and peers who come into contact with at-risk youth can more readily identify them, provide an appropriate initial response to them, will know how to obtain help for them, and are consistently inclined to take such action.

Protective Factors & Wellness Promotion

It should be noted within the context of universal prevention programs that research on resilient youth (those who fail to evidence risk behaviors such as poor social and school performance in spite of coming from difficult environments) and protective factors has identified characteristics of youth and their environments that can attenuate the likelihood that they will engage in a variety of risk behaviors such as delinquency, substance abuse, and suicidal thoughts. Some longitudinal research indicates that the presence of protective factors may have a stronger influence on the likelihood that risk behaviors will occur than the presence of risk factors. These protective factors include personal characteristics such as social problem solving competencies; and, environmental characteristics such as contact with a caring adult and a school climate that promotes students' involvement, contribution, and sense of connection with their school. Thus, there is evidence that universal,

empirically grounded, multigrade school programs that teach problem solving, decision making, and other competencies may attenuate the likelihood of a variety of risk behaviors. The multiple impacts of such programs makes them more efficient than categorical programs, and thus appealing to educators. Programs that increase the opportunities for students to participate in and contribute to their schools, as well as opportunities for outside of class interactions among students and adults in their school are also potentially powerful preventive interventions. One caveat concerning resilient youth is in order. Research indicates that youth who come from high risk environments and yet do well in school and peer relations still evidence a greater prevalence of anxiety and depression than peers who do not come from such environments. Anxiety and depression are significant risk factors for suicide, and these internalizing disorders are more likely to go undetected than the externalizing behaviors with which school must contend. Universal screening programs have been proposed for schools, but such programs are beyond the resources of schools and require parental consent. Moreover, students' self reports of suicidality have been shown to change on surveys a few weeks apart, so how often would schools have to conduct screening in order to obtain reliable results? At the very least, all school personnel should be aware of basic signs of depression and anxiety in students...

REQUIREMENTS FOR EFFECTIVE PREVENTION PROGRAMS

The following points have been gleaned from the literature on effective prevention, and the implementation and institutionalization of innovations in schools.

- Conceptually & empirically grounded goals and objectives.

Note: Clear, observable instructional objectives also serve as outcome or dependent program variables.

- Clearly articulated and packaged components.

Note: Teachers prefer to work with materials that include lesson outlines and plans, detailed instructor guidelines that include typical student responses and how to respond to these, all handouts, and references for additional materials. As they gain experience with the materials, they may adapt them to their students and their own teaching style.

- Appropriate instructional principles.

Note: these include participatory lessons that acknowledge and relate the material to students' experience; and the use of the demonstration, practice, feedback, practice sequence for teaching skills.

- Comprehensive: address all levels of targeted organization.

Note: School programs must include consults and training for administration, all faculty & staff, and students.

- Ecological: address the multiple contexts in which participants interact.

Note: Most school programs involve identification and referral of at risk students. Close working relationships must exist between the school and community gatekeepers and parents. Gatekeepers must be trained to work with suicidal youth; and parents must be informed about school programs and involved in supportive interventions.

- Conform to the context/culture/values of the target population and organization.

Note: programs must fit into the educational and protective mandate of schools, minimize disruption of school schedules, and minimize demand on other school resources such as personnel, time, space, and materials.

REQUIREMENTS FOR EFFECTIVE IMPLEMENTATION

No matter how well researched, designed, and packaged a program is, if it is not implemented as conceived, it will not have the desired impact. As with effective programs guidelines for effective implementation can be gleaned from the experience and research, including:

- **Pilot**

Note: piloting a program reveals the inevitable adaptations that must be made so it can work in different school contexts. Also, pilots show school personnel that you are taking their context and feedback into consideration and help to promote their ownership of the program.

- **Packaging**

Note: Programs must fit into the education, socialization, and protection mandates of the school (in that order of emphasis). They must also fit into the schedules and personnel/material resources of the school. If a program is a pull out, costs too much, or requires too much training and time of school staff, it won't be maintained. (One of the reasons that DARE is so widespread, even though controlled studies have failed to demonstrate impact, is that it is vigorously marketed *and* is provided by outsiders rather than school staff (low effort)). Be aware that if the program consists of a even a very detailed manual with no on site consultation, there can be considerable slippage in the implementation. That's why you want to avoid conclusions about a programs' efficacy if the implementation hasn't been checked.

- **Reconnaissance and relationship development.**

Note: spending time in the school also shows that you take their context and feedback seriously. Schools are inundated with "innovations". They will adapt those that come from a trusted source. You may start by meeting some other felt need of the school before introducing your program.

- **Similar models**

Note: school officials are swayed most by endorsements from colleagues in other schools/districts who have used the program.

- **Two-sided communication**

Note: provide opportunities for school personnel to voice and discuss concerns about the program. *Elicit* and address concerns.

- **Moderate fear arousal**

Note: school officials often hesitate to add more to their ever-expanding programming unless they are aware of negative consequences if they do not have a program or procedure in place (e.g. schools *have* been sued for providing an inadequate response to a suicidal student. Also, suicide is comorbid with other risk behaviors that are more evident to school officials, such as interpersonal violence and dropout).

- **WIIFM**

Note: "what's in it for me" must be addressed with school officials. (e.g. it is now recognized that emotional distress, and community and family stressors are barriers to learning; we cannot separate cognitive and emotional functioning. Collaboration with responsive community providers can assist schools in attenuating barriers to learning).

- **Plain language**

Note: even experienced consultants cannot recognize all of their profession's jargon. Program materials should be reviewed with school personnel. (e.g. don't use "comorbid").

- **Collegial**

Note: beware of "professional preciousness" evidenced by such statements as "you mean you let *coaches* provide the suicide classes?"

- **Listen**



- **Core & adaptable**

Note: guided by your conceptual basis, you must identify core features of your program that cannot be changed, such as minimum dosage (hours); or, media can be updated but not replaced by a lecture. Other features can be changed to fit the context (e.g. replacing a pull out program with an in-class program).

- **Train on site providers (using demonstration, practice, feedback)**

Note: turnkey programs that don't require outside personnel are more likely to be adopted and retained in schools. Outside consultants can provide ongoing or occasional follow up.

REQUIREMENTS FOR INSTITUTIONALIZATION (RETENTION OVER TIME) OF PROGRAMS

There is a considerable body of literature (as well as the experience of anyone who has worked with schools, corporations, and other institutions) that shows that few programs last long in a given setting. There are some strategies for increasing the likelihood that a program will be retained or institutionalized in schools. In addition to the variables associated with effective program design and implementation:

- **Supportive administration**

Note: program survival requires the principal's support of the particular program, as well as his/her support of the school's responsibility for prevention of risk behaviors and promotion of positive coping behaviors, student responsibility, and other principles contained in the program.

- **Identify responsible individual(s).**

Note: there must be an individual or group that assumes formal ownership of and responsibility for providing and sustaining the program. Some successful programs outlive the recollection of their original source or authors.

- **Provide ongoing consultation/support.**

If at all possible, this is helpful at least for the first two cycles of program implementation until school personnel not only gain ownership, but also gain familiarity with resource sources on the topic.

- **Identify a place in the curriculum or some other formal school structure such as a school based crisis team or youth service center.**

- **Create policies, procedures, structures to support innovation.**

- **Easy to administer assessments to check implementation and impact.**

Note: when educators can see results, they are more likely to retain and update the program. Remember, this is where clear, measurable program objectives come into play.

- **Educators feel stretched by the program.**

Note: school personnel will remain advocates when they are able to adapt the program based on their experience; enjoy mutual support; can bring to bear other skills/materials from their background; and, in general, experience involvement with the program as providing a useful addition to teaching repertoire...



4b. Behavioral Management: Suicide Crisis

In developing our Center's Resource Aid Packet on *Responding to Crisis at a School*, we were impressed by the good work being done by so many people around the country. The unfortunate fact that so many students feel despair and consider suicide has resulted in important common practices at school sites.

Changing systems in schools to support students and reduce unnecessary stress is the first line of defense.

However, when concerns arise about a specific student, school staff must be ready to respond. The suicide assessment and follow-through checklists in the next section are a compilation of best practices and offer tools to guide intervention.

When a Student Talks of Suicide . . .

You must assess the situation and reduce the crisis state (see Suicidal Assessment Checklist in section V). The following are some specific suggestions.

What to do:

- Send someone for help; you'll need back-up.
- Remain calm; remember the student is overwhelmed and confused as well as ambivalent.
- Get vital statistics, including student's name, address, home phone number and parent's work number.
- Encourage the student to talk. Listen! Listen! Listen! And when you respond, reflect back what you hear the student saying. Clarify, and help him or her to define the problem, if you can.

Consider that the student is planning suicide. How does the student plan to do it, and how long has s/he been planning and thinking about it? What events motivated the student to take this step?

- Clarify some immediate options (e.g., school and/or community people who can help).
- If feasible, get an agreement to no-suicide ("No matter what happens, I will not kill myself.")
- Involve parents for decision making and follow-through and provide for ongoing support and management of care (including checking regularly with parents and teachers).

What to avoid:

- Don't leave the student alone and don't send the student away
- Don't minimize the student's concerns or make light of the threat
- Don't worry about silences; both you and the student need time to think
- Don't fall into the trap of thinking that all the student needs is reassurance
- Don't lose patience
- Don't promise confidentiality -- promise help and privacy
- Don't argue whether suicide is right or wrong

When a Student Attempts Suicide . . .

A student may make statements about suicide (in writing assignments, drawing, or indirect verbal expression). Another may make an actual attempt using any of a variety of means. In such situations, you must act promptly and decisively.

What to do:

- Be directive. Tell the student, "Don't do that; stand there and talk with me." "Put that down." "Hand me that." "I'm listening."
- Mobilize someone to inform an administrator and call 911; get others to help you; you'll need back-up.
- Clear the scene of those who are not needed. An "administrator" should contact parents to advise them of the situation and that someone will call back immediately to direct the parent where to meet the youngster.
- Look at the student directly. Speak in a calm, low voice tone. Buy time. Get the student to talk. Listen. Acknowledge his or her feelings "You are really angry." "You must be feeling really hurt."
- Secure any weapon or pills; record the time any drugs were taken to provide this information to the emergency medical staff or police.
- Get the student's name, address and phone.
- Stay with the pupil; provide comfort.
- As soon as feasible, secure any suicidal note, record when the incident occurred, what the pupil said and did, etc.
- Ask for a debriefing session as part of taking care of yourself after the event.

What to avoid:

- Don't moralize ("You're young, you have everything to live for.")
- Don't leave the student alone (even if the student has to go to the bathroom).
- Don't move the student.

In all cases, show concern and ask questions in a straightforward and calm manner. Show you are willing to discuss suicide and that you aren't appalled or disgusted by it. Open lines of communication. Get care for the student.

Read Some More

Adolescent Suicide: Assessment and Intervention by A.L. Berman & D.A. Jobes (1991). Washington, D.C.: American Psychological Association.

Youth Suicide: A Comprehensive Manual for Prevention and Intervention by B.B. Hicks (1990). Bloomington, IN: National Educational Service

4c. SUICIDAL ASSESSMENT -- CHECKLIST*

Student's Name: _____ Date: _____ Interviewer: _____

(Suggested points to cover with student/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

Does the individual have frequent suicidal thoughts? Y N

Have there been suicide attempts by the student or significant others in his or her life? Y N

Does the student have a detailed, feasible plan? Y N

Has s/he made special arrangements as giving away prized possessions? Y N

Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife? Y N

(2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress? Y N

Have there been major changes in recent behavior along with negative feelings and thoughts? Y N

(Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant other to help the student survive? Y N

Does the student feel alienated? Y N

(4) HISTORY OF RISK-TAKING BEHAVIOR

Does the student take life-threatening risks or display poor impulse control? Y N

*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk also is associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time, and a location where it is unlikely the act would be disrupted. Further high risk indicators include the student having made final arrangements and information about a critical, recent loss. Because of the informal nature of this type assessment, it should not be filed as part of a student's regular school records.

FOLLOW-THROUGH STEPS AFTER ASSESSING SUICIDAL RISK -- CHECKLIST

- ___(1) As part of the process of assessment, efforts will have been made to discuss the problem openly and nonjudgmentally with the student. (Keep in mind how seriously devalued a suicidal student feels. Thus, avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.) If the student has resisted talking about the matter, it is worth a further effort because the more the student shares, the better off one is in trying to engage the student in problem solving.
- ___(2) Explain to the student the importance of and your responsibility for breaking confidentiality in the case of suicidal risk. Explore whether the student would prefer taking the lead or at least be present during the process of informing parents and other concerned parties.
- ___(3) If not, be certain the student is in a supportive and understanding environment (not left alone/isolated) while you set about informing others and arranging for help.
- ___(4) Try to contact parents by phone to
 - a) inform about concern
 - b) gather additional information to assess risk
 - c) provide information about problem and available resources
 - d) offer help in connecting with appropriate resources

Note: if parents are uncooperative, it may be necessary to report child endangerment after taking the following steps.
- ___(5) If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help. In high risk cases, if parents are unavailable (or uncooperative) and no one else is available to help, it becomes necessary to contact local public agencies (e.g., children's services, services for emergency hospitalization, local law enforcement). Agencies will want the following information:
 - *student's name/address/birthdate/social security number
 - *data indicating student is a danger to self (see Suicide Assessment -- Checklist)
 - *stage of parent notification
 - *language spoken by parent/student
 - *health coverage plan if there is one
 - *where student is to be found
- ___(6) Follow-up with student and parents to determine what steps have been taken to minimize risk.
- ___(7) Document all steps taken and outcomes. Plan for aftermath intervention and support.
- ___(8) Report child endangerment if necessary.

5. Affect regulation and addictive aspects of repetitive self-injury in hospitalized adolescents.

Journal of the American Academy of Child and Adolescent Psychiatry

Nov 2002 v41 i11 p1333(9)

Nixon MK, Cloutier PF, Aggarwal S.

Excerpt:

The association of SIB with stressful events and the endorsement of self-injury as a means to cope with dysphoric affect or express frustration, anger, or revenge support the affect regulation model as the primary function of SIB in hospitalized adolescents. The only other studies examining reasons for self-injury that we are aware of are those of Briere and Gil (1998), which examined a sample of self-referred, primarily abused women, and Herpertz (1995), who studied a psychiatric inpatient population of mostly women. The former gave self-punishment as the most commonly reported reason to self-injure, with affect regulatory being secondary, whereas the latter study, with a broader clinical sample, endorsed SIB'S tension-relieving effect in response to overwhelming affect. SIB as a means to regulate affect may be more predominant among those with psychiatric disorders. Zlotnick et al. (1997) noted that suicidal behavior in adolescent inpatients appeared related to a reduced capacity to manage internal states, with the suggestion that suicide attempts were a means to reduce intolerable emotional states. Whereas learning to modulate affect adaptively should lead to appropriate self-soothing strategies as the individual matures, the failure to regulate affect, due to either genetic or environmental factors, has been suggested as being central to the development of psychopathology (Bradley, 2000). Overall, much of our sample did not experience anger chronically, nor did a large proportion invest a great deal of energy in monitoring or preventing the experience or expression of anger. The equal distribution of those with clinically elevated internalizing anger and externalizing anger indicates that repetitive SIB is not exclusive to those who primarily suppress their anger. Nevertheless, adolescents with elevated internalized anger scores appear to have greater morbidity, with higher levels of both depression and self-reported rates of ever having had an eating disorder. SIB served most highly as a means to express frustration, in addition to being a means for expressing anger and revenge, releasing unbearable tension, and coping with feelings of depression...

NIMH

National Institute
of Mental Health

1. Child and Adolescent Bipolar Disorder: An Update from the National Institute of Mental Health (<http://www.nimh.nih.gov/publicat/bipolarupdate.cfm>)

Excerpt:

Research findings, clinical experience, and family accounts provide substantial evidence that bipolar disorder, also called manic-depressive illness, can occur in children and adolescents. Bipolar disorder is difficult to recognize and diagnose in youth, however, because it does not fit precisely the symptom criteria established for adults, and because its symptoms can resemble or co-occur with those of other common childhood-onset mental disorders. In addition, symptoms of bipolar disorder may be initially mistaken for normal emotions and behaviors of children and adolescents. But unlike normal mood changes, bipolar disorder significantly impairs functioning in school, with peers, and at home with family. Better understanding of the diagnosis and treatment of bipolar disorder in youth is urgently needed. In pursuit of this goal, the National Institute of Mental Health (NIMH) is conducting and supporting research on child and adolescent bipolar disorder.

A Cautionary Note

Effective treatment depends on appropriate diagnosis of bipolar disorder in children and adolescents. There is some evidence that using antidepressant medication to treat depression in a person who has bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer. In addition, using stimulant medications to treat attention deficit hyperactivity disorder (ADHD) or ADHD-like symptoms in a child with bipolar disorder may worsen manic symptoms. While it can be hard to determine which young patients will become manic, there is a greater likelihood among children and adolescents who have a family history of bipolar disorder. If manic symptoms develop or markedly worsen during antidepressant or stimulant use, a physician should be consulted immediately, and diagnosis and treatment for bipolar disorder should be considered.

Symptoms and Diagnosis

Bipolar disorder is a serious mental illness characterized by recurrent episodes of depression, mania, and/or mixed symptom states. These episodes cause unusual and extreme shifts in mood, energy, and behavior that interfere significantly with normal, healthy functioning.

Manic symptoms include:

- Severe changes in mood—either extremely irritable or overly silly and elated
- Overly-inflated self-esteem; grandiosity
- Increased energy
- Decreased need for sleep—ability to go with very little or no sleep for days without tiring
- Increased talking—talks too much, too fast; changes topics too quickly; cannot be interrupted
- Distractibility—attention moves constantly from one thing to the next
- Hypersexuality—increased sexual thoughts, feelings, or behaviors; use of explicit sexual language
- Increased goal-directed activity or physical agitation
- Disregard of risk—excessive involvement in risky behaviors or activities

Depressive symptoms include:

- Persistent sad or irritable mood
- Loss of interest in activities once enjoyed
- Significant change in appetite or body weight
- Difficulty sleeping or oversleeping
- Physical agitation or slowing
- Loss of energy
- Feelings of worthlessness or inappropriate guilt
- Difficulty concentrating
- Recurrent thoughts of death or suicide



Symptoms of mania and depression in children and adolescents may manifest themselves through a variety of different behaviors ^{1,2}. When manic, children and adolescents, in contrast to adults, are more likely to be irritable and prone to destructive outbursts than to be elated or euphoric. When depressed, there may be many physical complaints such as headaches, muscle aches, stomachaches or tiredness, frequent absences from school or poor performance in school, talk of or efforts to run away from home, irritability, complaining, unexplained crying, social isolation, poor communication, and extreme sensitivity to rejection or failure. Other manifestations of manic and depressive states may include alcohol or substance abuse and difficulty with relationships.

Existing evidence indicates that bipolar disorder beginning in childhood or early adolescence may

be a different, possibly more severe form of the illness than older adolescent- and adult-onset bipolar disorder. When the illness begins before or soon after puberty, it is often characterized by a continuous, rapid-cycling, irritable, and mixed symptom state that may co-occur with disruptive behavior disorders, particularly attention deficit hyperactivity disorder (ADHD) or conduct disorder (CD), or may have features of these disorders as initial symptoms. In contrast, later adolescent- or adult-onset bipolar disorder tends to begin suddenly, often with a classic manic episode, and to have a more episodic pattern with relatively stable periods between episodes. There is also less co-occurring ADHD or CD among those with later onset illness.

A child or adolescent who appears to be depressed and exhibits ADHD-like symptoms that are very severe, with excessive temper outbursts and mood changes, should be evaluated by a psychiatrist or psychologist with experience in bipolar disorder, particularly if there is a family history of the illness. This evaluation is especially important since psychostimulant medications, often prescribed for ADHD, may worsen manic symptoms. There is also limited evidence suggesting that some of the symptoms of ADHD may be a forerunner of full-blown mania.

Findings from an NIMH-supported study suggest that the illness may be at least as common among youth as among adults. In this study, one percent of adolescents ages 14 to 18 were found to have met criteria for bipolar disorder or cyclothymia, a similar but milder illness, in their lifetime ³. In addition, close to six percent of adolescents in the study had experienced a distinct period of abnormally and persistently elevated, expansive, or irritable mood even though they never met full criteria for bipolar disorder or cyclothymia. Compared to adolescents with a history of major depressive disorder and to a never-mentally-ill group, both the teens with bipolar disorder and those with subclinical symptoms had greater functional impairment and higher rates of co-occurring illnesses (especially anxiety and disruptive behavior disorders), suicide attempts, and mental health services utilization. The study highlights the need for improved recognition, treatment, and prevention of even the milder and subclinical cases of bipolar disorder in adolescence.



Once the diagnosis of bipolar disorder is made, the treatment of children and adolescents is based mainly on experience with adults, since as yet there is very limited data on the efficacy and safety of mood stabilizing medications in youth. The essential treatment for this disorder in adults involves the use of appropriate doses of mood stabilizers, most typically lithium and/or valproate, which are often very effective for controlling mania and preventing recurrences of manic and depressive episodes. Research on the effectiveness of these and other medications in children and adolescents with bipolar disorder is ongoing. In addition, studies are investigating various forms of psychotherapy, including cognitive-behavioral therapy, to complement medication treatment for this illness in young people.

American Academy of Child & Adolescent Psychiatry

2. BIPOLAR DISORDER (MANIC-DEPRESSIVE ILLNESS) IN TEENS

No. 38 Updated 5/2000

(<http://www.aacap.org/publications/factsfam/bipolar.htm>)

Teenagers with Bipolar Disorder may have an ongoing combination of extremely high (manic) and low (depressed) moods. Highs may alternate with lows, or the person may feel both extremes at the same time.

Bipolar Disorder usually starts in adult life. Although less common, it does occur in teenagers and even rarely in young children. This illness can affect anyone. However, if one or both parents have Bipolar Disorder, the chances are greater that their children will develop the disorder. Family history of drug or alcohol abuse also may be associated with Bipolar Disorder in teens.

Bipolar Disorder may begin either with manic or depressive symptoms.

The manic symptoms include:

- severe changes in mood compared to others of the same age and background - either unusually happy or silly, or very irritable, angry, agitated or aggressive
- unrealistic highs in self-esteem - for example, a teenager who feels all powerful or like a superhero with special powers
- great increase in energy and the ability to go with little or no sleep for days without feeling tired
- increase in talking - the adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted



- distractibility - the teen's attention moves constantly from one thing to the next
- repeated high risk-taking behavior; such as, abusing alcohol and drugs, reckless driving, or sexual promiscuity

The depressive symptoms include :

- irritability, depressed mood, persistent sadness, frequent crying
- thoughts of death or suicide
- loss of enjoyment in favorite activities
- frequent complaints of physical illnesses such as headaches or stomach aches
- low energy level, fatigue, poor concentration, complaints of boredom
- major change in eating or sleeping patterns, such as oversleeping or overeating



Some of these signs are similar to those that occur in teenagers with other problems such as drug abuse, delinquency, attention-deficit hyperactivity disorder, or even schizophrenia. The diagnosis can only be made with careful observation over an extended period of time. A thorough evaluation by a child and adolescent psychiatrist can be helpful in identifying the problems and starting specific treatment.

Teenagers with Bipolar Disorder can be effectively treated. Treatment for Bipolar Disorder usually includes education of the patient and the family about the illness, mood stabilizing medications such as lithium and valproic acid, and psychotherapy. Mood stabilizing medications often reduce the number and severity of manic episodes, and also help to prevent depression. Psychotherapy helps the teenager understand himself or herself, adapt to stresses, rebuild self-esteem and improve relationships.

V. B. 3. Interventions for Serious Problems: Bipolar Disorder: Sample Goals for Individualized Educational Program

3. Sample Goals for Individualized Educational Program

(from : NAMI – the National Alliance for the Mentally Ill <http://www.nami.org/youth/iep.html>)

Excerpt:

While preparing their book, *The Bipolar Child*, authors Janice and Demetri Papolos sent a description of "Elan," a hypothetical student with bipolar disorder and special education needs, Elan is a personable individual who shows good attention and task orientation for very short periods of time. Elan has been diagnosed with bipolar disorder. His emotions and his academic availability are variable and quite unpredictable. Physical complaints are often present both in and out of school. Presently, Elan has a difficult time getting up in the morning, and he is often late, or does not come to school at all. He can appear tired, bored, irritable, and explosive, and he has poor judgment and decision-making skills. Other times, Elan can be extremely energetic and need to move around quite a bit. He can be talkative, distractible, and extremely impulsive.

Elan has *difficulty expressing his feelings and frustrations*, and he often has negative and hopeless thoughts. When unable to do something others might consider simple, he feels a sense of failure. He does not have good problem-solving skills or stress-management techniques. He often resorts to self-inflicted wounds and talks of suicide.

Elan's *concentration and ability to focus can be extremely impaired* because of his limited alertness and attendance difficulties. His lack of interpersonal skills causes peer difficulties and limits his ability to establish healthy relationships with peers and adults.

At other times-usually when he has high energy levels and is becoming more manic-he feels his understanding is superior to that of his classmates and that this negates his need to complete assignments. During these times, he can be disrespectful to adults, oppositional, and provoking to his peers.

Currently, Elan is very compliant about taking his medications, and he has the desire to do what it takes to manage his disorder.

Consistent positive understanding and intervention is necessary for improving Elan's self-esteem and allowing him to be accepted through his good and bad times. Staying calm and speaking to him in a reassuring tone is a must.

Elan is in need of a smaller, very structured setting that would be sensitive to his psychosocial needs. He presently does not do well with change or too much environmental stimulation. Counseling and support services, such as a safe place and/or a person to go to when he feels overwhelmed or is having negative thoughts, is necessary. A support group with similar peers would be ideal, if available. Flexibility in this plan is a must.

Goal #1: Elan will learn and apply strategies to independently divert bad thoughts.

Objectives:

- Elan will go to the school counselor/psychologist twice a week (more frequently as needed).
- Elan will explore negative thoughts with the counselor and develop strategies for diverting them independently.
- Elan will tell an appropriate adult when he has negative feelings he cannot manage.
- Elan will use a variety of learned strategies and document results in a journal at least two times weekly.

Goal #2: Elan will develop other techniques to relieve anxiety rather than resort to harmful behaviors.

Objectives:

- When faced with a stressful situation, Elan will explore options with a counselor.
- Elan will address anxiety-causing topics, which may be suggested by staff, in a journal at least one time per week.
- Elan will talk to an adult when feeling explosive or becoming out of control. He will remove himself to a safe place/person before harming himself or others.
- Elan will identify triggers that contribute to harmful behaviors and problem-solve alternatives with a counselor.

Goal #3: Elan will increase his time on task with only one redirective from 2-3 minutes to 10-15 minutes.

Objectives:

- Elan will comply with all redirection (such as non-verbal cues) the first time.
- Elan will increase the number of daily assignments he completes within a specified amount of time, determined by the teacher and his ability for that day.
- Elan will stay focused for 10-15 minutes-or longer-on any given subject.
- Elan will use problem-solving strategies when needing a break to refresh and refocus.

Goal #4: Elan will increase his communication skills in a variety of settings.

Objectives:

- Elan will seek assistance with problem-solving from appropriate adults.
- Elan will practice communication skills at least one time per week with staff and in his journal.
- Elan will ask an adult when he needs to move around and/or go to a safe place.
- Elan will tell an adult when he feels he may be getting out of control.
- Elan will converse positively with a peer three times a week. He will note any positive changes he notices as a result of these interactions.

Goal #5: Elan will achieve grade-level work with a success ratio of four out of five assignments completed in all classes.

Objectives:

- When given an assignment, Elan will complete four out of five of them, accurately, legibly, and on time.
- Elan will ask for extended time, modified work, etc. when he feels overwhelmed. (Parent will have to do this initially.)
- Elan will accept redirection cues from the teacher when off task.
- Elan will use a homework notebook daily to record all assignments. Teachers will check for accuracy and sign. Parent will sign to verify homework is completed.



Modifications Necessary at This Time:

- Breaking down assignments into manageable parts with clear and simple directions, given one at a time.
- Preparing for transitions.
- Ensuring clarity of understanding and alertness.
- Allowing most difficult subjects to be taken in the afternoon when he is most alert.
- Granting extra time for tests, class work, and homework.
- Allowing for unpredictable mood swings and skill functioning.
- Training all staff involved with Elan on bipolar disorder.
- Ensuring awareness of potential victimization from other students.
- Providing positive praise and redirection.
- Reporting any suicidal comments to counselor/psychologist immediately.
- Providing home instruction to help him keep up with schoolwork if there are times when Elan's mood disorder makes it impossible for him to attend school for an extended period of time.
- Placing an aide in Elan's classroom to ensure his well-being and to assist the teacher with all the students who also need help.
- Having the aide accompany Elan as a buddy without drawing undue attention to him if he does not do well with unstructured times, such as lunch and recess.

Behavior Plan

Goal # 6: Elan will decrease explosive outbursts.

Objectives:

- Elan will seek adult assistance before lashing out with aggressive behaviors.
- Elan will remove himself and seek time out and/or a safe place when feeling explosive.
- Elan will learn and apply strategies for anger control.
- Elan will postpone making important decisions during a depressive state.
- Elan will recognize possible early signs of an impending manic or depressive cycle and talk about them to his psychiatrist.

Elan will earn points for all of the above. Points can be accumulated toward a day without homework or something special that will motivate this child.

Source: The Bipolar Child by Demetri Papolos, M.D., and Janice Papolos (Broadway Books, January 2000). Reprinted with permission of Broadway Books. Ms. Faustini will be making a presentation on IEP development at the NAMI Convention, June 14-18, 2000 in San Diego

4. Educator's Guide To Receiving Bipolar Students After Hospitalization

(2000) by Tracey Trudeau.

(From the Child & Adolescent Bipolar Foundation –
<http://www.bpkids.org/learning/reference/articles/015.htm>)

Tracey Trudeau is a Child & Adolescent Specialist at the Mood Disorders Association of Manitoba, Canada.

1. Erratic school attendance makes it difficult to assess academic potential or impairment, therefore awareness of lack of opportunity to learn as opposed to the inability to learn is important. Students require flexibility in their academic programming, including those capable of learning core subjects when well and stable. This ultimately becomes an attendance issue rather than a problem defined by a deficit in potential.
2. Premorbid cognitive assessment data provide a good baseline measure for illness-related changes, particularly when qualitative analyses of subtests are employed.
3. A strong supportive partnership between the disciplines of psychiatry and education where there is some common understanding of each other's roles, needs, and language is a prerequisite of successful transitioning. Information sharing that is full of discipline-related jargon confounds the end purpose - student well-being.
4. A special effort should be made by inpatient facilities to connect with rural school districts to minimize any feelings of geographical disconnection by receiving school staff or perception of diminished support.
5. Inpatient staff roles should include finding a supportive school and a primary liaison for the student, providing initial teacher education, program planning assistance, and post-placement support to the receiving school.
6. Predictable and consistent daily routines are ideal for recovering students - the idea of one room, one teacher, might be explored with appropriate students. Gradual or partial re-integration is usually recommended rather than returning with a full academic load.
7. Importance of finding a student's optimum learning style is stressed (i.e. auditory, visual, kinesthetic), as is the willingness of teachers to allow flexibility of the format of work product that would best represent the student's understanding of concepts.
8. Medication and treatment non-adherence difficulties are often timed around school and holiday transitions. Is there a role here for the school counselor in proactively seeking out the student and checking in?
9. Some students will struggle with learning in two languages after recovery despite excelling previously in bilingual education. Careful evaluation of student ability to continue in a demanding bilingual program will ensure that possible pressure to please parents or teachers does not sabotage the total academic program.

10. Students have a strong desire to return to community schooling. This is complicated by worry of ostracism or harassment by peers. These concerns should be raised proactively by parents, therapists, and school staff. Instances of bullying or ridicule about psychiatric hospitalization or diagnosis should be dealt with swiftly and seriously in a manner consistent with racial or sexual harassment.
11. Mental health units should be taught in the upper grades in the context of regular biology or health courses. It is important to begin to demystify these illnesses to the general public and to peers of recovering students rather than solely directing this information to educators, service providers and other helpers.
12. Hospital staff is encouraged to develop a personalized checklist for cues of illness relapse (such as particular symptom emergence) based upon an individual student's past history and current presentation. The student should collaborate in the creation of the checklist and know the steps a school staff member will take on his/her behalf. The use of a contract in the event of acute illness onset facilitates more efficiently timed emergency psychiatric services. Emergence of psychotic symptoms in school should be handled (if possible) discretely.
13. Medication education (especially the side effect profile and level of efficacy in controlling symptoms) should be provided to teachers. Evaluation of work product and performance must consider the limitations of residual illness symptoms and medication side effects: Poor penmanship due to hand tremor, awkward gait or rapid weight gain in physical education, dry mouth and increased fluid intake necessitating frequent bathroom trips, heightened sensitivity to noise and light, are all common in students treated with psychotropic medications.
14. Public school reintegration should be gradual (starting with half days) and working gradually towards a full load if the student is capable. Curriculums should be flexible and the preferred learning methods are co-operative learning and a module format. Mastery learning through module format will ensure that cognitive instability has not interfered with concepts previously taught. A module format may be helpful where a student can work at his or her own pace, or perhaps come back to the module after a hospitalization. Emphasis on mastery learning may be appropriate for students who have lost previous academic achievements/gains. Learning gaps (including concurrent high competencies and clear deficits) are common in bipolar students.
15. A peer mentor (ideally one grade older) may be assigned to the student at a new school. Conversely, a recovering bipolar student wishing to mentor younger peers may be important in developing self-competency. A peer mentor from a self-help or advocacy group may be one important step in understanding that it is possible to grow beyond persistent psychiatric illness, or conversely, share the realistic experiences of being treatment non-adherent and self-destructive.
16. Teachers and other staff should encourage a self-help philosophy with students through advocating for a life-management perspective. Such a philosophy includes self-challenge, self-acceptance, honesty, and especially humor. Typical classroom behavior management strategies are appropriate to use when the student is stable and in remission - they do not work when the student is becoming ill or is still in recovery. For example, during the depressive phase of the illness, bipolar students experience phenomena called 'anhedonia' or flat affect - the inability to experience pleasure or happiness. Consequently, the student has lost the reinforcement of satisfaction which comes from learning something new, so being praised and encouraged by teachers and parents may be ineffectual for behavioral reinforcement.
17. Special education staff are encouraged to design IEPs for students with bipolar disorder that allow for equal time to develop strengths and to follow creative projects as is given for addressing identified academic shortcomings. Students who see themselves as spending more time 'making up' and less time 'getting ahead'

may not develop an area of perceived competence. For example, these students show decline in math performance when comparing work pre- and post-illness. Remedial work in math is necessary, however bipolar disorder also increases the tendency of creative excellence in the visual and written arts. These strengths must be developed and even become a primary focus in an IEP.

18. Below average adaptive behavior skills (communication, daily living skills, socialization, motor skills) as measured by tools like the Vineland Adaptive Behavior Scale may identify target areas missed in more 'intellect-based' assessments (Shole-Martin & Alessi, 1988). Many students who are hospitalized frequently or for extended periods with serious psychiatric illnesses show significant to serious deficits in adaptive behavior skills. Consulting with an occupational therapist may identify problems which parents and/or teachers have attributed to 'motivational' factors.
19. If a student is capable or doing all academic work, but at a slower pace, or, in chunks due to regular and protracted school absences, an IEP that realistically plans for 1.5 academic years to complete each grade might be more helpful than a plan that 'hopes' the student will complete the work if he or she would just remain stable. This also brings forth the serious question of mandatory grade promotion. If the student can understand the work but simply requires the time to complete it, are educators creating ever-increasing cumulative deficits and setting these bipolar students up for later failure? Promoting these students just so that they may remain with their peers may not be a) what the student wants, b) an academically sound decision, or c) the best way to ensure that the student is given a chance to learn to his or her potential.
20. Inpatient staff must ask themselves if parents are making 'informed' decisions regarding educational and health concerns for their children. Parents must know, however hard it may be, the full extent of current and future impairment given what is known about the student's course of illness and history. This is neither the time to 'understate' the case nor to protect the student and the family from the expectation that relapse is not only likely but highly probable. The goal is to frankly communicate the serious nature of the disorder while ensuring that some optimism may be maintained. Contingency planning helps reduce the anxiety of impending relapse.
21. The most important goal for an educator of a bipolar student is to keep that student interested in learning and feeling welcome at school. This is even more important than teaching a prescribed number of concepts by June or in a manner that does not appear to 'bend the rules' too much for a particular child. If the primary measure of success in educating these students is how well they have been molded into the routine and rules of the school, then it is likely that the student's best interests have come second. This illness will go on far longer than the years spent in school. If the student leaves school loving to learn, (s)he will come back to it throughout the lifespan when well enough.
22. Remember that the student did not choose to have bipolar disorder any more than a child chooses to have Down's syndrome or profound deafness. The transition planning process and educational programming should be governed by compassion.

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1. Controlling Anger -- Before It Controls You

We all know what anger is, and we've all felt it: whether as a fleeting annoyance or as full-fledged rage. Anger is a completely normal, usually healthy, human emotion. But when it gets out of control and turns destructive, it can lead to problems——problems at work, in your personal relationships, and in the overall quality of your life. And it can make you feel as though you're at the mercy of an unpredictable and powerful emotion. This brochure is meant to help you understand and control anger.

What is Anger?



The Nature of Anger

Anger is "an emotional state that varies in intensity from mild irritation to intense fury and rage," according to Charles Spielberger, PhD, a psychologist who specializes in the study of anger. Like other emotions, it is accompanied by physiological and biological changes; when you get angry, your heart rate and blood pressure go up, as do the levels of your energy hormones, adrenaline, and noradrenaline.

Anger can be caused by both external and internal events. You could be angry at a specific person (Such as a coworker or supervisor) or event (a traffic jam, a canceled flight), or your anger could be caused by worrying or brooding about your personal problems. Memories of traumatic or enraging events can also trigger angry feelings.

Expressing Anger

The instinctive, natural way to express anger is to respond aggressively. Anger is a natural, adaptive response to threats; it inspires powerful, often aggressive, feelings and behaviors, which allow us to fight and to defend ourselves when we are attacked. A certain amount of anger, therefore, is necessary to our survival.

On the other hand, we can't physically lash out at every person or object that irritates or annoys us; laws, social norms, and common sense place limits on how far our anger can take us.

People use a variety of both conscious and unconscious processes to deal with their angry feelings. The three main approaches are expressing, suppressing, and calming. Expressing your angry feelings in an assertive——not aggressive——manner is the healthiest way to express anger. To do this, you have to learn how to make clear what your needs are, and how to get them met, without hurting others. Being assertive doesn't mean being pushy or demanding; it means being respectful of yourself and others.

Anger can be suppressed, and then converted or redirected. This happens when you hold in your anger, stop thinking about it, and focus on something positive. The aim is to inhibit or suppress your anger and convert it into more constructive behavior. The danger in this type of response is that if it isn't allowed outward expression, your anger can turn inward—on yourself. Anger turned inward may cause hypertension, high blood pressure, or depression.

Unexpressed anger can create other problems. It can lead to pathological expressions of anger, such as passive-aggressive behavior (getting back at people indirectly, without telling them why, rather than confronting them head-on) or a personality that seems perpetually cynical and hostile. People who are constantly putting others down, criticizing everything, and making cynical comments haven't learned how to constructively express their anger. Not surprisingly, they aren't likely to have many successful relationships.

Finally, you can calm down inside. This means not just controlling your outward behavior, but also controlling your internal responses, taking steps to lower your heart rate, calm yourself down, and let the feelings subside...

Anger Management

The goal of anger management is to reduce both your emotional feelings and the physiological arousal that anger causes. You can't get rid of, or avoid, the things or the people that enrage you, nor can you change them, but you can learn to control your reactions.



Are You Too Angry?

There are psychological tests that measure the intensity of angry feelings, how prone to anger you are, and how well you handle it. But chances are good that if you do have a problem with anger, you already know it. If you find yourself acting in ways that seem out of control and frightening, you might need help finding better ways to deal with this emotion.

Why Are Some People More Angry Than Others?

According to Jerry Deffenbacher, PhD, a psychologist who specializes in anger management, some people really are more "hotheaded" than others are; they get angry more easily and more intensely than the average person does. There are also those who don't show their anger in loud spectacular ways but are chronically irritable and grumpy. Easily angered people don't always curse and throw things; sometimes they withdraw socially, sulk, or get physically ill.

People who are easily angered generally have what some psychologists call a low tolerance for frustration, meaning simply that they feel that they should not have to be subjected to frustration, inconvenience, or annoyance. They can't take things in stride, and they're particularly infuriated if the situation seems somehow unjust: for example, being corrected for a minor mistake.

What makes these people this way? A number of things. One cause may be genetic or physiological: There is evidence that some children are born irritable, touchy, and easily angered, and that these signs are present from a very early age. Another may be sociocultural. Anger is often regarded as negative; we're taught that

it's all right to express anxiety, depression, or other emotions but not to express anger. As a result, we don't learn how to handle it or channel it constructively.

Research has also found that family background plays a role. Typically, people who are easily angered come from families that are disruptive, chaotic, and not skilled at emotional communications.

Is It Good To "Let it All Hang Out?"

Psychologists now say that this is a dangerous myth. Some people use this theory as a license to hurt others. Research has found that "letting it rip" with anger actually escalates anger and aggression and does nothing to help you (or the person you're angry with) resolve the situation.

It's best to find out what it is that triggers your anger, and then to develop strategies to keep those triggers from tipping you over the edge.



Strategies To Keep Anger At Bay

Relaxation

Simple relaxation tools, such as deep breathing and relaxing imagery, can help calm down angry feelings. There are books and courses that can teach you relaxation techniques, and once you learn the techniques, you can call upon them in any situation. If you are involved in a relationship where both partners are hot-tempered, it might be a good idea for both of you to learn these techniques.

Some simple steps you can try:

- Breathe deeply, from your diaphragm; breathing from your chest won't relax you. Picture your breath coming up from your "gut."
- Slowly repeat a calm word or phrase such as "relax," "take it easy." Repeat it to yourself while breathing deeply.
- Use imagery; visualize a relaxing experience, from either your memory or your imagination.
- Nonstrenuous, slow yoga-like exercises can relax your muscles and make you feel much calmer.

Practice these techniques daily. Learn to use them automatically when you're in a tense situation.

Cognitive Restructuring

Simply put, this means changing the way you think. Angry people tend to curse, swear, or speak in highly colorful terms that reflect their inner thoughts. When you're angry, your thinking can get very exaggerated and overly dramatic. Try replacing these thoughts with more rational ones. For instance, instead of telling yourself, "oh, it's awful, it's terrible, everything's ruined," tell yourself, "it's frustrating, and it's understandable that I'm upset about it, but it's not the end of the world and getting angry is not going to fix it anyhow."

Be careful of words like "never" or "always" when talking about yourself or someone else. "This !&*%@ machine never works," or "you're always forgetting things" are not just inaccurate, they also serve to make you feel that your anger is justified and that there's no way to solve the problem. They also alienate and humiliate people who might otherwise be willing to work with you on a solution.

Remind yourself that getting angry is not going to fix anything, that it won't make you feel better (and may actually make you feel worse).

Logic defeats anger, because anger, even when it's justified, can quickly become irrational. So use cold hard logic on yourself. Remind yourself that the world is "not out to get you," you're just experiencing some of the rough spots of daily life. Do this each time you feel anger getting the best of you, and it'll help you get a more balanced perspective. Angry people tend to demand things: fairness, appreciation, agreement, willingness to do things their way. Everyone wants these things, and we are all hurt and disappointed when we don't get them, but angry people demand them, and when their demands aren't met, their disappointment becomes anger. As part of their cognitive restructuring, angry people need to become aware of their demanding nature and translate their expectations into desires. In other words, saying, "I would like" something is healthier than saying, "I demand" or "I must have" something. When you're unable to get what you want, you will experience the normal reactions——frustration, disappointment, hurt——but not anger. Some angry people use this anger as a way to avoid feeling hurt, but that doesn't mean the hurt goes away.

Problem Solving

Sometimes, our anger and frustration are caused by very real and inescapable problems in our lives. Not all anger is misplaced, and often it's a healthy, natural response to these difficulties. There is also a cultural belief that every problem has a solution, and it adds to our frustration to find out that this isn't always the case. The best attitude to bring to such a situation, then, is not to focus on finding the solution, but rather on how you handle and face the problem.

Make a plan, and check your progress along the way. Resolve to give it your best, but also not to punish yourself if an answer doesn't come right away. If you can approach it with your best intentions and efforts and make a serious attempt to face it head-on, you will be less likely to lose patience and fall into all-or-nothing thinking, even if the problem does not get solved right away.

Better Communication

Angry people tend to jump to——and act on——conclusions, and some of those conclusions can be very inaccurate. The first thing to do if you're in a heated discussion is slow down and think through your responses. Don't say the first thing that comes into your head, but slow down and think carefully about what you want to say. At the same time, listen carefully to what the other person is saying and take your time before answering.

Listen, too, to what is underlying the anger. For instance, you like a certain amount of freedom and personal space, and your "significant other" wants more connection and closeness. If he or she starts complaining about your activities, don't retaliate by painting your partner as a jailer, a warden, or an albatross around your neck.

It's natural to get defensive when you're criticized, but don't fight back. Instead, listen to what's underlying the words: the message that this person might feel neglected and unloved. It may take a lot of patient questioning on your part, and it may require some breathing space, but don't let your anger—or a partner's—let a discussion spin out of control. Keeping your cool can keep the situation from becoming a disastrous one.

Using Humor

"Silly humor" can help defuse rage in a number of ways. For one thing, it can help you get a more balanced perspective. When you get angry and call someone a name or refer to them in some imaginative phrase, stop and picture what that word would literally look like. If you're at work and you think of a coworker as a "dirtbag" or a "single-cell life form," for example, picture a large bag full of dirt (or an amoeba) sitting at your colleague's desk, talking on the phone, going to meetings. Do this whenever a name comes into your head about another person. If you can, draw a picture of what the actual thing might look like. This will take a lot of the edge off your fury; and humor can always be relied on to help unknot a tense situation.

The underlying message of highly angry people, Dr. Deffenbacher says, is "things oughta go my way!" Angry people tend to feel that they are morally right, that any blocking or changing of their plans is an unbearable indignity and that they should NOT have to suffer this way. Maybe other people do, but not them!

When you feel that urge, he suggests, picture yourself as a god or goddess, a supreme ruler, who owns the streets and stores and office space, striding alone and having your way in all situations while others defer to you. The more detail you can get into your imaginary scenes, the more chances you have to realize that maybe you are being unreasonable; you'll also realize how unimportant the things you're angry about really are. There are two cautions in using humor. First, don't try to just "laugh off" your problems; rather, use humor to help yourself face them more constructively. Second, don't give in to harsh, sarcastic humor; that's just another form of unhealthy anger expression.

What these techniques have in common is a refusal to take yourself too seriously. Anger is a serious emotion, but it's often accompanied by ideas that, if examined, can make you laugh.

Changing Your Environment

Sometimes it's our immediate surroundings that give us cause for irritation and fury. Problems and responsibilities can weigh on you and make you feel angry at the "trap" you seem to have fallen into and all the people and things that form that trap.

Give yourself a break. Make sure you have some "personal time" scheduled for times of the day that you know are particularly stressful. One example is the working mother who has a standing rule that when she comes home from work, for the first 15 minutes "nobody talks to Mom unless the house is on fire." After this brief quiet time, she feels better prepared to handle demands from her kids without blowing up at them.

Some Other Tips for Easing Up on Yourself

Timing: If you and your spouse tend to fight when you discuss things at night—perhaps you're tired, or distracted, or maybe it's just habit—try changing the times when you talk about important matters so these talks don't turn into arguments.

Avoidance: If your child's chaotic room makes you furious every time you walk by it, shut the door. Don't make yourself look at what infuriates you. Don't say, "well, my child should clean up the room so I won't have to be angry!" That's not the point. The point is to keep yourself calm.

Finding alternatives: If your daily commute through traffic leaves you in a state of rage and frustration, give yourself a project—learn or map out a different route, one that's less congested or more scenic. Or find another alternative, such as a bus or commuter train.

Do You Need Counseling?

If you feel that your anger is really out of control, if it is having an impact on your relationships and on important parts of your life, you might consider counseling to learn how to handle it better. A psychologist or other licensed mental health professional can work with you in developing a range of techniques for changing your thinking and your behavior.

When you talk to a prospective therapist, tell her or him that you have problems with anger that you want to work on, and ask about his or her approach to anger management. Make sure this isn't only a course of action designed to "put you in touch with your feelings and express them"—that may be precisely what your problem is. With counseling, psychologists say, a highly angry person can move closer to a middle range of anger in about 8 to 10 weeks, depending on the circumstances and the techniques used.

What About Assertiveness Training?

It's true that angry people need to learn to become assertive (rather than aggressive), but most books and courses on developing assertiveness are aimed at people who don't feel enough anger. These people are more passive and acquiescent than the average person; they tend to let others walk all over them. That isn't something that most angry people do. Still, these books can contain some useful tactics to use in frustrating situations.

Remember, you can't eliminate anger—and it wouldn't be a good idea if you could. In spite of all your efforts, things will happen that will cause you anger; and sometimes it will be justifiable anger. Life will be filled with frustration, pain, loss, and the unpredictable actions of others. You can't change that; but you can change the way you let such events affect you. Controlling your angry responses can keep them from making you even more unhappy in the long run.



2. Helping Young Children Deal with Anger. ERIC Digest.

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Children's anger presents challenges to teachers committed to constructive, ethical, and effective child guidance. This Digest explores what we know about the components of children's anger, factors contributing to understanding and managing anger, and the ways teachers can guide children's expressions of anger.

THREE COMPONENTS OF ANGER

Anger is believed to have three components (Lewis & Michalson, 1983):

THE EMOTIONAL STATE OF ANGER. The first component is the emotion itself, defined as an affective or arousal state, or a feeling experienced when a goal is blocked or needs are frustrated. Fabes and Eisenberg (1992) describe several types of stress-producing anger provocations that young children face daily in classroom interactions:

- * Conflict over possessions, which involves someone taking children's property or invading their space.
- * Physical assault, which involves one child doing something to another child, such as pushing or hitting.
- * Verbal conflict, for example, a tease or a taunt.
- * Rejection, which involves a child being ignored or not allowed to play with peers.
- * Issues of compliance, which often involve asking or insisting that children do something that they do not want to do--for instance, wash their hands.

EXPRESSION OF ANGER. The second component of anger is its expression. Some children vent or express anger through facial expressions, crying, sulking, or talking, but do little to try to solve a problem or confront the provocateur. Others actively resist by physically or verbally defending their positions, self-esteem, or possessions in nonaggressive ways. Still other children express anger with aggressive revenge by physically or verbally retaliating against the provocateur. Some children express dislike by telling the offender that he or she cannot play or is not liked. Other children express anger through avoidance or attempts to escape from or evade the provocateur. And some children use adult seeking, looking for comfort or solutions from a teacher, or telling the teacher about an incident.

Teachers can use child guidance strategies to help children express angry feelings in socially constructive ways. Children develop ideas about how to express emotions (Michalson & Lewis, 1985; Russel, 1989) primarily through social interaction in their families and later by watching television or movies, playing video games, and reading books (Honig & Wittmer, 1992). Some children have learned a negative, aggressive approach to expressing anger (Cummings, 1987; Hennessy et al., 1994) and, when confronted with everyday anger conflicts, resort to using aggression in the classroom (Huesmann, 1988). A major challenge for early childhood teachers is to encourage children to acknowledge angry feelings and to help them learn to express anger in positive and effective ways.

AN UNDERSTANDING OF ANGER. The third component of the anger experience is understanding--interpreting and evaluating--the emotion. Because the ability to regulate the expression of anger is linked to an understanding of the emotion (Zeman & Shipman, 1996), and because children's ability to reflect on their anger is somewhat limited, children need guidance from teachers and parents in understanding and managing their feelings of anger.

UNDERSTANDING AND MANAGING ANGER

The development of basic cognitive processes undergirds children's gradual development of the understanding of anger (Lewis & Saarni, 1985).

MEMORY. Memory improves substantially during early childhood (Perlmutter, 1986), enabling young children to better remember aspects of anger-arousing interactions. Children who have developed unhelpful ideas of how to express anger (Miller & Sperry, 1987) may retrieve the early unhelpful strategy even after teachers help them gain a more helpful perspective. This finding implies that teachers may have to remind some children, sometimes more than once or twice, about the less aggressive ways of expressing anger.

LANGUAGE. Talking about emotions helps young children understand their feelings (Brown & Dunn, 1996). The understanding of emotion in preschool children is predicted by overall language ability (Denham, Zoller, & Couchoud, 1994). Teachers can expect individual differences in the ability to identify and label angry feelings because children's families model a variety of approaches in talking about emotions.

SELF-REFERENTIAL AND SELF-REGULATORY BEHAVIORS.

Self-referential behaviors include viewing the self as separate from others and as an active, independent, causal agent. Self-regulation refers to controlling impulses, tolerating frustration, and postponing immediate gratification. Initial self-regulation in young children provides a base for early childhood teachers who can develop strategies to nurture children's emerging ability to regulate the expression of anger.

GUIDING CHILDREN'S EXPRESSIONS OF ANGER

Teachers can help children deal with anger by guiding their understanding and management of this emotion. The practices described here can help children understand and manage angry feelings in a direct and nonaggressive way.

CREATE A SAFE EMOTIONAL CLIMATE. A healthy early childhood setting permits children to acknowledge all feelings, pleasant and unpleasant, and does not shame anger. Healthy classroom systems have clear, firm, and flexible boundaries.

MODEL RESPONSIBLE ANGER MANAGEMENT. Children have an impaired ability to understand emotion when adults show a lot of anger (Denham, Zoller, & Couchoud, 1994). Adults who are most effective in helping children manage anger model responsible management by acknowledging, accepting, and taking responsibility for their own angry feelings and by expressing anger in direct and nonaggressive ways.

HELP CHILDREN DEVELOP SELF-REGULATORY SKILLS. Teachers of infants and toddlers do a lot of self-regulation "work," realizing that the children in their care have a very limited ability to regulate their own emotions. As children get older, adults can gradually transfer control of the self to children, so that they can develop self-regulatory skills.

ENCOURAGE CHILDREN TO LABEL FEELINGS OF ANGER. Teachers and parents can help young children produce a label for their anger by teaching them that they are having a feeling and that they can use a word to describe their angry feeling. A permanent record (a book or chart) can be made of lists of labels for anger (e.g., mad, irritated, annoyed), and the class can refer to it when discussing angry feelings.

ENCOURAGE CHILDREN TO TALK ABOUT ANGER-AROUSING INTERACTIONS. Preschool children better understand anger and other emotions when adults explain emotions (Denham, Zoller, & Couchoud, 1994). When children are embroiled in an anger-arousing interaction, teachers can help by listening without judging, evaluating, or ordering them to feel differently.

USE BOOKS AND STORIES ABOUT ANGER TO HELP CHILDREN.

UNDERSTAND AND MANAGE ANGER. Well-presented stories about anger and other emotions validate children's feelings and give information about anger (Jalongo, 1986; Marion, 1995). It is important to preview all books about anger because some stories teach irresponsible anger management.

COMMUNICATE WITH PARENTS. Some of the same strategies employed to talk with parents about other areas of the curriculum can be used to enlist their assistance in helping children learn to express emotions. For example, articles about learning to use words to label anger can be included in a newsletter to parents.

Children guided toward responsible anger management are more likely to understand and manage angry feelings directly and nonaggressively and to avoid the stress often accompanying poor anger management (Eisenberg et al., 1991). Teachers can take some of the bumps out of understanding and managing anger by adopting positive guidance strategies.

SAMHSA's National Mental Health Information Center

The Center for Mental Health Services

(<http://www.mentalhealth.org/publications/allpubs/Ca-0032/default.asp>)

3. Helping the Child Who is Expressing Anger

When you hear about children killing other children, you may think, "I don't know a single child who could do such a thing."

Too often the daily news confirms that children and teens can be violent, even deadly. As parents, families, teachers and members of the community, what can we do to help children cope with angry feelings--from frustration to rage?

Some young people turn to violence, because they do not see other ways to endure what they are feeling at that moment. They may not anticipate the repercussions of their violence.

These tips may help when you recognize a child who is withdrawing or exploding over everyday frustrations:

- Listen to what the child is saying about his or her feelings and be willing to talk about any subject. Young people today are dealing with adult problems such as love, sex, relationships, failure and rejection. Unfortunately, their minds and bodies simply are not ready for these stresses.
- Provide comfort and assurance. Tell the child that you care about his or her problems. Show confidence in his or her ability to tackle life's ups and downs.
- Tell the child that everyone experiences anger. Tell him or her about the last time you felt really angry and how you dealt with that anger in a positive way.

- Encourage the child to shift gears—to spend some time doing things he or she really likes to do—playing sports, walking someone’s dog, or reading a book. A different activity can refocus thoughts and help alleviate some of the angry feelings.
- Teach basic problem-solving skills. When upsetting situations arise, the child who has practiced these skills will be more likely to think through the consequences of different actions and will, ultimately, make a better choice than violence.
- Look at how you handle your own anger. Are you setting a good example? Would you want to be imitated by a child who admires you?
- Acknowledge good behavior. When a child deals with his or her anger in a positive way, praise the positive choice. Take every opportunity to reinforce strengths. Build the child’s awareness of his or her own talents and abilities.



If none of these approaches seems to work, and the child stays angry or withdrawn for a long time, seek help. Talk to your family doctor or pediatrician. Together, you may decide that your child and family need help from someone with more mental health training.

Free information about children’s and adolescents’ mental health is available from the CARING FOR EVERY CHILD’S MENTAL HEALTH: Communities Together public education campaign of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Call 1.800.789.2647 or go to www.mentalhealth.samhsa.gov/child.

SAMHSA's National Mental Health Information Center

The Center for Mental Health Services

(<http://www.mentalhealth.org/publications/allpubs/SVP-0013/SVP-0013ch5.asp>)

4. Helping Your Children Navigate Their Teen Years: A Guide for Parents

Managing Anger: Theirs and Yours

Warm family relationships can help protect children from acting violently, abusing alcohol and other drugs, or engaging in other high-risk behaviors. But family members—even in the most loving families—get angry at one another from time to time. When families communicate well and work cooperatively, anger can be resolved without a problem. Handled poorly, however, anger gets in the way of good communication between parent and child. Anger without control can sometimes be dangerous and may even become violent.

Many adults are not good at managing anger, and expressing this emotion in a healthy way. Some adults see anger as an emotion that should be suppressed, because it leads to trouble. Some grew up in families in which anger generally led to explosive behavior and even violence. Others were taught that it is not “nice” to be angry. It’s important that parents know how to manage anger successfully in family life, at work, and in the community. And that same knowledge needs to be shared with children, so that they learn this important skill.

My teenage son doesn't know how to handle his intense feelings. He talks back to us and even swears at us. He doesn't do what we ask him to do. He seems to be trying to aggravate us. I get so angry I blow up. We end up screaming at each other and saying things we regret. I feel like things are out of control.

With the many changes that occur during adolescence, it’s not unusual for teenagers to feel anger and resentment toward parents. Adolescents struggle to establish prepare for adulthood. Sometimes anger is their way of asserting independence. This can wear thin on parents, who may fight back with their own anger, creating a vicious circle of escalating resentment.

The best solution to out-of-control anger—whether from a parent or from a teen—is to step back, and identify more positive, healthy ways to deal with strong feelings. We do this when we can calm down and respond in a disciplined and thoughtful way. By maintaining composure, parents can be good role models and open the door to constructive communication with their children.

But how do you keep calm when you feel pushed to the limit? Here are some suggestions:

Tips for Calming Down

- **Pick your battles.** Sometimes the issue is not worth the anger, or worth arguing about.
- **Take a deep breath; count to ten.** Think about the issue before a single word comes out of your mouth.
- **Go for a walk.**
- **Use “self-talk” to calm down.** That is, say something soothing to yourself such as: “I need to relax and stay calm. I can’t afford to blow up.”
- **Reframe the issue.** For example, when your son says something rude to you, it may be less a matter of him disrespecting you than a sign that he has a problem with his anger. “Framing” it this way, you focus on the fact that he needs your help in overcoming this problem.
- **Use humor.** Humor can sometimes be a good way to calm anger, but be sure not to use sarcasm, which can sometimes be hurtful.

Sometimes the hardest part of helping children learn to manage their anger is that parents have to look at their own practices. Parents need to ask:

- Do I express anger in positive and constructive ways?
- Do I resolve conflict well?
- Have I taught my children to accept and express their anger?

Resolving Conflict

Resolving conflict constructively may be a huge challenge, but it’s an absolute necessity for the sake of every member of your family.

Once you are calm, you are in a better position to address the issues that caused the conflict. Here are some tips:

- **Give your point of view.** State the problem as you see it; speak clearly and calmly— don’t yell.
- **Ask to hear your teen’s point of view.**
- **Pay attention, listen, and carefully consider what your teen is saying.**
- **Discuss ways to solve the dispute without a battle.**
- **Practice the art of compromise.** Find the middle ground you can both live with comfortably.
- **Assert your authority, when appropriate, but in a calm, yet firm manner.**

What If the Anger Doesn't Stop?

When anger becomes a chronic problem for someone in the family, the underlying issue may be larger than you or your teen can manage. If you even think your family is at this crisis point, or if you even think you or any member of your family has a serious problem with anger management, it’s time to seek help from a mental health professional. Recognize that this situation necessitates counseling, and sometimes that means the entire family will need help.

5. Model Programs

Aggressors, Victims, and Bystanders: Thinking and Acting to Prevent Violence, for middle schools, is a demonstrated curriculum for high-risk students. The curriculum is composed of 12 classroom sessions that deal with violence among peers and the separate but interrelated roles of aggressors, victims, and bystanders that youth play in potentially violent situations. The backbone of this curriculum is the four-step Think-First Model of Conflict Resolution. The model helps students to pause and keep cool, understand what is going on before jumping to conclusions, define their problems and goals in ways that will not lead to fights, and generate positive solutions. The curriculum has been tested in urban, suburban, and small-city school districts and has made students more supportive of resolving conflicts without aggression.

Contact: Christine Blaber Education Development Center, Inc., 55 Chapel Street, Suite 25, Newton, MA 02458, 800-225-4276 ext. 2364, E-mail: Cblaber@edc.org

To order the curriculum: Education Development Center, Inc., P.O. Box 1020, Sewickley, PA 15143-1020, 800-793- 5076, Fax: 412-741-0609, & Email: mcc@edc.org/mcc.

The Anger Coping Program, for middle schools, is a demonstrated model for selected male students. The program consists of 18 weekly small group sessions led by a school counselor and a mental health counselor during the school day. The lessons emphasize self-management and self-monitoring, perspective taking, and social problem solving skills. Aggressive boys who have been through the Anger Coping Program have been found to have lower rates of drug and alcohol involvement and higher levels of self-esteem and problem-solving skills than those who have not.

Contact: John E. Lochman, Professor and Saxon Chair of Clinical Psychology, Department of Psychology, Box 870348, The University of Alabama, Tuscaloosa, AL 35487, 205-348-5083, Fax: 205-348-8648, E-mail: jlochman@GP.AS.UA.EDU

BASIS, for middle schools, is a demonstrated model that focuses on procedures for discipline. Clarifying and consistently enforcing the school rules, improving classroom management and organization, tracking student behaviors (good and bad), reinforcing positive behaviors, and increasing the frequency of communication with parents about student behavior are emphasized. A multi-year, multi-site study found that classroom disruption decreased and attention to academic work increased significantly in the schools in which the program was well implemented.

Contact: Denise Gottfredson, University of Maryland, Department of Criminology, Lefrak Hall, Room 2220, College Park, MD 20742, 301-405-4717, Fax: 301-405-4733, E-mail: dgottfredson@crim.umd.edu

Conflict Resolution: A Curriculum for Youth Providers, for secondary schools, is a demonstrated model. Key elements include helping students define conflict, teaching three types of conflict resolution, and reviewing basic communications behavior. Each session contains at least one skills-building exercise and lasts from 15 to 50 minutes. This program has reduced violence and the frequency of fights resulting in injuries that require medical treatment.

Contact: National Resource Center for Youth Services, College of Continuing Education, University of Oklahoma, 4502 E 41st Street Building 4 West, Tulsa, OK 74135-2512, Phone: 918/660-3700, Fax: 918/660-3737, Web site: www.nrcys.ou.edu

Positive Adolescent Choices Training (PACT), for middle and high schools, is a demonstrated model for high-risk African American youth and other high-risk youth selected by teachers for conduct problems or histories of victimization. Using videotaped vignettes and role playing, students learn social skills such as giving positive and negative feedback, accepting feedback, negotiation, problem-solving, and resisting peer pressure in small groups of 10-12. Students who have been through PACT have exhibited 50 percent less physical aggression at school and more than 50 percent fewer violence-related juvenile court charges than a comparable group who did not receive PACT.

Contact: Betty R. Yung, Ph.D., Director, Center for Child and Adolescent Violence Prevention, Wright State University, School of Professional Psychology, Ellis Human Development Institute, 9 North Edwin C. Moses Boulevard, Dayton, OH 45407, 937-775-4300, Fax: 937-775-4323, E-mail: betty.yung@right.edu

Promoting Alternative Thinking Strategies (PATHS), for grades K-5, is a demonstrated model designed to promote emotional competence through expression, understanding, and regulation of emotions. Cognitive problem-solving skills are also taught. The main objectives are for students to learn new skills and be able to apply those skills in daily life. Improvements have been found in students' hyperactivity, peer aggression, and conduct problems.

Contact: Dan Chadrow, Developmental Research and Programs, 800-736-2630, Web site: www.drp.org, E-mail: moreinfo@drp.org. (Developer) Mark Greenberg, Ph.D., Prevention Research Center, S110 Henderson Building, Pennsylvania State University, University Park, PA 16802, 814-863-0112 Fax: 814-865-2530, Email: mxg47@psu.edu

Peace Builders®, for grades K-5, is a demonstrated model for students of mixed ethnicity that has been tested in urban and suburban elementary schools. Peace Builders should be viewed as a way of life rather than a program because it attempts to change the characteristics of the school setting that trigger aggressive, hostile behavior. This program seeks to increase the availability of pro-social models to enhance social competence and decrease the frequency and intensity of aggressive behaviors. Researchers found that this program improved students' social competence (especially if students had two years of exposure to the program) and buffered expected increases in their aggressive behavior.

Contact: Jane Gulibon, Heartsprings, Inc., P.O. Box 12158, Tucson, AZ 85732, 800-368-9356, Web site: www.peacebuilders.com, E-mail: custrel@heartsprings.org

Second Step, for pre-K through middle schools, is a demonstrated curriculum designed to insert skills-based training into existing school curriculums and encourage the transfer of skills to behavior at school and at home. The pre-K through grade 5 versions of Second Step also have a 6-week parent education component. The elementary program teaches empathy, impulse control, and anger management. The middle school program covers understanding the violence problem, empathy, anger management, problem solving, and applying skills to everyday situations. A study showed that physical aggression decreased from autumn to spring among students who were in the program but increased among students who were in a comparison group.

Contact: Committee for Children, 2203 Airport Way South, Suite 500, Seattle, WA 98134, or 172 20th Avenue, Seattle, WA 98122, 800-634-4449 ext 6223, Fax: 206-438-6765, Web site: www.cfchildren.org

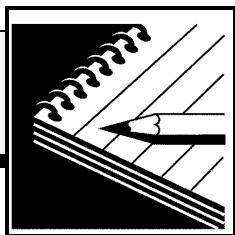
The School Safety Program, for high schools, is a demonstrated model for identifying violence problems and devising effective responses. The program's main component is a curriculum integrated into a required 11th grade social studies course that trains students to be problem solvers, engages students in solving their school's problems, identifies problem students through reviews by teachers and police, and sponsors regular meetings among school teachers, school administrators, and the police. An evaluation found a 50 percent reduction in incidents requiring calls to the police (mainly assault-related behaviors) at an intervention school but only a small reduction at a comparison school. In addition, threats to teachers decreased 17 percent in an intervention school but increased by five percent in a comparison school.

Contact: Lori Fridell, Director of Research, Police Executive Research Forum, 1120 Connecticut Avenue NW, Suite 930, Washington, DC 20036, Phone: 202-454-8318, Fax: 202-466-7826, Web site: www.policeforum.org, Email: lfridell@policeforum.org

VI. References and Resources

- A. References
- B. Agencies and Online Resources
- C. Center Resources
 - 1. Consultation Cadre
 - 2. Quick Finds on Anger and on Depression
 - 3. Center Materials

VI. A. References and Resources: References



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* See references in previous excerpted articles.



B. Agencies and Online Resources Relevant to Affect and Mood Problems

American Association of Suicidology

The American Association of Suicidology is a nonprofit organization dedicated to the understanding and prevention of suicide. This site is designed as a resource for anyone concerned about suicide, including AAS members, suicide researchers, therapists, prevention specialists, survivors of suicide, and people who are themselves in crisis.

Contact: M. David Rudd, Ph.D., Executive Director, 4201 Connecticut Avenue, N.W. Suite 310 Washington, DC 20008

Voice: (202) 237-2280

Fax: (202) 237-2282

E-Mail: m_rudd@baylor.edu

Web: <http://www.suicidology.org>

Center for Suicide Research and Prevention

Rush-Presbyterian-St. Luke's Medical Center, 1725 West Harrison Street, Suite 995, Chicago, IL 60612

Voice (312) 942-5000

Fax: (312) 942-2177

D/ART: Depression/Awareness, Recognition and Treatment

(D/ART), DEPRESSION; Awareness, Recognition, and Treatment is a federal government program to educate the public, primary care providers, and mental health specialists about depressive illnesses--their symptoms, diagnosis, and treatment. Sponsored by the National Institute of Mental Health (NIMH) and based on more than 50 years of medical and scientific research, D/ART is a collaboration between the government and community organizations to benefit the mental health of the American public.

Contact: D/ART, 5600 Fishers Lane, Rockville, MD 20857

Phone: 1-800-421-4211

Website: <http://www.brooklane.org/whtepgs/depression.geninfo.html>

Depression Resource List

An easy to use site with lists of resources online related to depression, suicide, manic depression, panic and anxiety and treatment. Several support group websites listed for each topic.

Email: corbeau@execpc.com

Web: <http://www.execpc.com/>

Depression.com

The editorial staff of Depression.com screens the latest news and research, reviews the dozens of depression-related sites in cyberspace, and provides an interactive forum for people who deal with it. Also provides quizzes and numerous topics filled with information about depression.

Website: <http://www.depression.com/>

DRADA (Depression and Related Affective Disorders Assn)

DRADA's mission is to alleviate the suffering arising from depression and manic depression by assisting self-help groups, providing education and information, and lending support to research programs. DRADA works in cooperation with the Department of Psychiatry at the Johns Hopkins University School of Medicine, which helps us ensure that our materials are medically accurate, as well as co-sponsoring our annual mood disorders research/education symposiums.

Contact: 600 N. Wolfe St., Baltimore, MD 21287-7381

Phone: (410) 955-4647 or (202) 955-5800

Email: drada@jhmi.edu

Website: http://www.hopkinsmedicine.org/specialprojects/drada_draft/

MDSG-NY (Mood Disorders Support Group, Inc.)

This site is Internet's central clearing house for information on all types of depressive disorders and on the most effective treatments for individuals suffering from Major Depression, Manic-Depression (Bipolar Disorder), Cyclothymia, Dysthymia and other mood disorders.

Contact: P.O. Box30377, New York, NY 10011

Phone: (212) 533-MDSG;

FAX: (212) 475-5109.

Email: info@mdsg.org

Website: <http://www.mdsg.org>

Mental Health Net (MHN)

Mental Health Net (MHN) is a comprehensive, fun, and useful guide to every mental health topic imaginable, with over 3,000 individual resources listed. The information found here is for everyone associated with mental health. Topics covered on MHN range from disorders such as depression, anxiety, and substance abuse, to professional journals and self-help magazines that are available online.

Website: <http://www.mentalhelp.net>

Moodswing org.

Online resources for people with Bipolar (and friends and family). Home of the Bipolar Disorder Frequently asked Questions.

Website: <http://www.moodswing.org>.

Also, don't forget to check with our Sister Center:

Center for School Mental Health Assistance (CSMHA) at the University of Maryland at Baltimore

Contact: Mark Weist, Ph.D. (Director)

Sharon Hoover (Program Director)

University of Maryland at Baltimore

680 W. Lexington St. 10th fl

Baltimore, MD 21201-1570

Ph: (888)706-0980

Fax: (410)706-0984

Email: csmha@psych.umaryland.edu

Website: <http://csmha.umaryland.edu>

Depressive and Bipolar Support Alliance

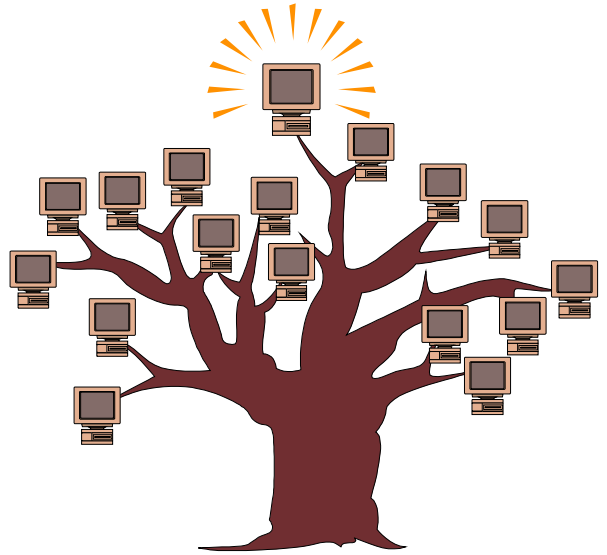
The mission of the National Depressive and Manic-Depressive Association is to educate patients, families, professionals, and the public concerning the nature of depressive and manic-depressive illness as treatable medical diseases; to foster self-help for patients and families; to eliminate discrimination and stigma; to improve access to care; and to advocate for research toward the elimination of these illnesses.

Contact: 730 N. Franklin, #501, Chicago, IL 60610

Phone: 800-826-3632 or (312) 42-0049;

FAX: (312)642-7243.

Website: <http://www.dbsalliance.org/>



The Samaritans

A non-religious charity that has been offering emotional support to the suicidal and despairing for over 40 years by phone, visit and letter. Callers are guaranteed absolute confidentiality and retain the right to make their own decisions including the decision to end their life. The service is available via E-mail, run from Cheltenham, England, and can be reached from anywhere with Internet access. Trained volunteers read and reply to mail once a day, every day of the year.

Contact: 10 The Grove, Slough, Berkshire SL1 1QP

Phone: 01753 216500

Fax: 01753 775787

Email: jo@samaritans.org

Website: <http://www.samaritans.org.uk/>

SA\VE: Suicide Awareness \ Voices of Education

This website provides educational materials on suicide prevention and untreated depression.

Contact: Joseph H. Talley, M.D., 9001 E. Bloomington Fwy Suite #150, Bloomington, MN 55420

Phone: (952) 946-7998

Email: save@save.org

Website: <http://www.save.org>

Teens-Depression and Suicide Prevention

This website provides information and resources on depression and suicide prevention.

Phone: (800) 554-8336

Email: whitel@trfn.clpgh.org

Website: <http://trfn.pgh.pa.us/Populations/ya/depression.html>

VI. C. References and Resources: Center Resources: Consultation Cadre

Affect and Mood Problems Related to School to School aged Youth Consultation Cadre List

Professionals across the country volunteer to network with others to share what they know. Some cadre members run programs, many work directly with youngsters in a variety of settings and focus on a wide range of psychosocial problems. Others are ready to share their expertise on policy, funding, and major system concerns. The group encompasses professionals working in schools, agencies, community organizations, resource centers, clinics and health centers, teaching hospitals, universities, and so forth.

People ask how we screen cadre members. We don't! It's not our role to endorse anyone. We think it's wonderful that so many professionals want to help their colleagues, and our role is to facilitate the networking. If you are willing to offer informal consultation at no charge to colleagues trying to improve systems, programs, and services for addressing barriers to learning, let us know. Our list is growing each day; the following are those currently on file related to this topic. Note: the list is alphabetized by Region and State as an aid in finding a nearby resource.

Updated 09/13/04

Central States

Iowa

Pam Bleam
Elementary Counselor
Manson Northwest Webster School
Manson, IA 50563
Phone: 712/469/3598

Kaye Grossnickle
Program Director
School Based Youth Services Program
Fort Dodge Senior High School
819 N. 25th St.
Fort Dodge, IA 50501
Phone: 515/955-1770
Fax: 515/955-3374
Email: kgrossnickle@aea5.k12.ia.us

Raymond Morley
Consultant- Homeless Children & Youth At-Risk
Students
Iowa Department of Education
Grimes State Office Building
Des Moines, IA 50319-0146
Phone: 515/281-3966
Email: ray.morley@iowa.gov

Janet R. Scurr
At-Risk Coordinator
East Marshall Schools
201 N. Franklin
Le Grand, IA 50142
Phone: 515/479-2785

Pamela Tekippe
Clinical Social Worker
Mental Health Clinic of Tama Co.
1309 S. Broadway
Toledo, IA 52342
Phone: 614/484-5234
Fax: 614/484-5632

Michigan

Arthur Ashford
Supervisor
New Center Community Mental Health
Children's Unit
2051 West Grand Blvd.
Detroit, MI 48208
Phone: 313/895-4000
Fax: 313/961-3502

Michael Murphy
Prevention Supervisor
Washtenaw Co. Human Services
Address: 555 Towner, P.O. Box 915
Ypsilanti, MI 48197
Phone: 313/484-6620
Fax: 313/484-6634

Adnan Hammad
Director, Community Health & Research Center
Arab Community Center for Economic and Social
Services (ACCESS)
6450 Maple St.
Dearborn, MI 48120
Phone: 313/216-2239
Fax: 313/548-3078

Minnesota

Glenna Gentile
Adapt Clinical Supervisor
Range Mental Health Center
504 North 1st St.
Virginia, MN 55792
Phone: 218/741-4714
Email: glennagentile@hotmail.com

Jose Gonzalez
Interpreter / Supervisor
Minneapolis Dept. of Health & Family Support
250 4th St. So., Rm 401
Minneapolis, MN 55415
Phone: 612/673-3815
Fax: 612/673-2891

Charlotte Ryan
Consult. for Youth w/ Emotional or Beh. Disorders
Department of Children, Families, & Learning
Office of Special Education
1500 Highway 36 West
Roseville, MN 55113
Phone: 651/582-8645
Fax: 651/582-8725
Email: char.ryan.state.mn.us

Missouri

Angela Borisch
Program Director
Kids Under Twenty One
2718 South Brentwood Blvd.
St. Louis, MO 63144
Phone: 314/963-7571
Fax: 314/963-7574
Email: info@kuto.org

Andrea Woodward
Clinical Director
Counseling Association Network
1734 East 63rd Street, Suite 446
Kansas City, MO 64110
Phone: 816/523-6990
Fax: 816/523-7071
Email: clgascentwk@hotmail.com

North Dakota

Gaylynn Becker
Asst. Dir.: Counseling, Testing, Career Development,
and Middle level
ND Dept. of Public Instruction
600 East Blvd Ave.
Bismarck, ND 58505-0440
Phone: 701/328-2755
Fax: 701/328-4770
Email: griz@karlbecker.com

Connecticut

Thomas Guilotta
CEO
Child & Family Agency
255 Hempstead Street
New London, CT 06320
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A Center Response:

The following reflects our most recent response for technical assistance related to ANGER MANAGEMENT. This list represents a sample of information to get you started and is not meant to be an exhaustive list.

(Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one).

Center Developed Resources and Tools

- [Quick Training Aid: Behavior Problems at School](#)
- [Introductory Packet: Violence Prevention and Safe Schools](#)
- [Resource Aid Packet: Responding to Crisis at a School](#)
- [Problem Response and Prevention](#)
- [Guides to Practice: Common Psychosocial Problems of School-Age Youth](#)
- [Hotline Numbers](#)

Relevant Publications on the Internet

- [Anger and Aggression Management Techniques](#)
- [Anger Might Be a Symptom of Depression in Children and Adolescents](#)
- [Anger Management](#)
- [Anger Management Resources](#)
- [Controlling Anger: Before It Controls You](#)
- [Helping Young Children Deal with Anger](#)
- [Lesson Plan: "Managing Anger"](#)
- [Managing and Coping with the Angry Child](#)
- [Methods for Handling Our Own Aggression/Anger](#)
- [Some Model Programs with Contact Information](#)

Selected Materials from our Clearinghouse

- [Anger and Aggression Management Techniques through the "Think First" Curriculum](#)
- [Everyday School Violence: How Disorder Fuels It](#)
- [Preventing and Managing Conflict in Schools](#)
- [Skills for Living: Group Counseling Activities for Young Adolescents](#)

Relevant Publications That Can Be Obtained at Your Local Library and Other Sources

- Cross-Cultural Perspectives on Anger. By, J. Tanaka-Matsumi. In: Howard Kassinove, Ed; et al. *Anger disorders: Definition, diagnosis, and treatment*. Taylor & Francis: Washington, DC, USA, 1995. p. 81-90.
- A Preliminary Evaluation of the Colorado "Rethink Parenting" and Anger Management Program. By, R. J. Fetsch, C. J. Schultz, & J. J. Wahler. In: *Child Abuse & Neglect*. 1999 Apr. 23 (4): p. 353-360.
- Adolescent Anger-Management Groups for Violence Reduction. By, E. L. Feindler, & M. Scalley. In: Karen Callan Stoiber, Ed; Thomas R. Kratochwill, Ed; et al. *Handbook of group intervention for children and families*. Allyn & Bacon, Inc: Boston, MA, USA, 1998. p. 100-119.

Related Agencies and Websites

- [Anger Main Page--Controlling the Volcano Within](#)
- [Anger Management suggested reading list \(angrykids.com\)](#)
- [The Anger Management Counselling Practice of Toronto™](#)
- [Anger Management Services](#)
- [Anger Management for Youth Program--School Mediation Center](#)
- [Center for the Study and Prevention of Violence](#)
- [Ohio Commission on Dispute Resolution & Conflict Management](#)

Shortcut Text	Internet Address
Quick Training Aid: Behavior Problems at School	http://smhp.psych.ucla.edu/dbsimple2.asp?primary=2107&number=9998
Introductory Packet: Violence Prevention and Safe Schools	http://smhp.psych.ucla.edu/dbsimple2.asp?primary=2108&number=9999
Resource Aid Packet: Responding to Crisis at a School	http://smhp.psych.ucla.edu/dbsimple2.asp?primary=2107&number=9999
Problem Response and Prevention	http://smhp.psych.ucla.edu/conted2/part12b.htm
Guides to Practice: Common Psychosocial Problems of School-Age Youth	http://smhp.psych.ucla.edu/dbsimple2.asp?primary=3013&number=9998
Hotline Numbers	http://smhp.psych.ucla.edu/hotline.htm
Anger and Aggression Management Techniques	http://www.indiana.edu/~safeschl/AngerManagement.pdf
Anger Might Be a Symptom of Depression in Children and Adolescents	http://www.angrykids.com/sdca.htm
Anger Management	http://www.wsd1.org/PC_LMS/pf/angermgmt.htm
Anger Management Resources	http://www.indiana.edu/~safeschl/resources_anger.html
Controlling Anger: Before It Controls You	http://www.apa.org/pubinfo/anger.html
Helping Young Children Deal with Anger	http://www.ed.gov/databases/ERIC_Digests/ed414077.html
Lesson Plan: "Managing Anger"	http://www.pbs.org/inthemix/educators/lessons/schoolviol3/
Managing and Coping with the Angry Child	http://www.angermgmt.com/children.html
Methods for Handling Our Own Aggression/Anger	http://www.mentalhelp.net/psyhelp/chap7/chap7n.htm
Some Model Programs with Contact Information	http://www.ed.gov/pubs/AnnSchoolRept98/aggression.html
Anger and Aggression Management Techniques through the "Think First" Curriculum	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=2108DOC23
Everyday School Violence: How Disorder Fuels It	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=2108DOC70
Preventing and Managing Conflict in Schools	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=2108DOC13
Skills for Living: Group Counseling Activities for Young Adolescents	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=2304DOC24
Anger Main Page--Controlling the Volcano Within	http://www.anger-management.net/
Anger Management suggested reading list (angrykids.com)	http://www.angrykids.com/books.html
The Anger Management Counselling Practice of Toronto™	http://www.angeronline.com/html/aboutus.html
Anger Management Services	http://www.angermgmt.com/
Anger Management for Youth Program--School Mediation Center	http://www.csmmp.org/programs/anger_mgt.htm
Center for the Study and Prevention of Violence	http://www.colorado.edu/cspv/
Ohio Commission on Dispute Resolution & Conflict Management	http://www.disputeresolution.ohio.gov/schools/resourcescm.htm
search	http://smhp.psych.ucla.edu/search.htm
technical assistance page	http://smhp.psych.ucla.edu/techreq.htm
Center for School Mental Health Assistance	http://csmha.umaryland.edu/
"The fine Art of Fishing"	http://smhp.psych.ucla.edu/selfhelp.htm

A Center Response:

The following reflects our most recent response for technical assistance related to CHILDHOOD AND ADOLESCENT DEPRESSION. This list represents a sample of information to get you started and is not meant to be an exhaustive list.

(Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one).

Materials produced by Our Center

- [Resource Aid Packet: Screening/Assessing Students: Indicators and Tools](#)
- [Resource Aid Packet: Student Psychotropic Medication: The School's Role](#)
- [Addressing Barriers to Learning: New Directions for Mental Health in Schools](#)
- [Introductory Packet: Assessing to Address Barriers to Learning](#)
- [Introductory Packet: Affect and Mood Problems related to School Aged Youth](#)
- [Featured Newsletter article \(Summer, '99\): Youth Suicide/Depression/Violence](#)
- [Quick Training Aid: Suicide Prevention](#)

Relevant Publications on the Internet

- [Adolescent Depression: Helping Depressed Teens](#)
- [Affect and Mood Problems Related to School Aged Youth](#)
- [Brighter Futures: Improvements in Depression Care Pay for Themselves](#)
- [British Warning on Antidepressant use for Youth](#)
- [Depression Quick Find](#)
- [Depression in Children and Adolescents](#)
- [Depression in Children and Adolescents](#)
- [Depression in Children and Adolescents: A Fact Sheet for Physicians](#)
- [The Depressed Child](#)
- [Difference in Early Childhood Risk Factors for Juvenile- and Adult-onset Depression](#)
- ["Educator's Guide to Receiving Bipolar Students After Hospitalization"](#)
- ["An Explosive Debate: The Bipolar Child" Educational Leadersip, November, 2001.](#)
- [General and Specific Childhood Risk Factors for Depression and Drug Disorders by Early Adulthood](#)
- [The Hopelessness Theory of Depression: A Test of the Diathesis--Stress and Causal Mediation Components in Third and Seventh Grade Children \[1\].\(Statistical Data Included\)](#)
- [Major Depression in Children and Adolescents](#)
- [Management of Bipolar Disorder](#)
- [Mental Health: Culture, Race, and Ethnicity - A Supplement to Mental Health: A Report of the Surgeon General](#)
- [Mental Health, Education, and Social role outcomes of Adolescents with Depression](#)
- [National Trends in Outpatient Treatment of Depression \(pdf document\)](#)
- [NIMH: Depression in Children and Adolescents: A Fact Sheet for Physicians](#)
- [Practice Parameters for the Assessment and Treatment of Children and Adolescents with Depressive Disorders](#)
- [Reporting on Suicide: Recommendations for the Media](#)
- [School Associated Violent Deaths in the United States, 2001](#)
- [Screening for Depression: Recommendations and Rationale](#)
- [Treatment of Bipolar Disorder: A Guide for Patients and Families](#)
- ["Teen Homicide, Suicide, and Firearm-Related Death"](#)
- ["The Treatment for Adolescents with Depression Study Team" \(2003\) Journal of the American Academy of Child and Adolescent Psychiatry, 42\(5\), 531-542](#)
- [Treatment for Adolescents with Depression Study Team](#)
- [What to do When a Friend is Depressed...](#)

Selected Materials from our Clearinghouse

- [Applying the Criteria for Empirically Supported Treatments to Studies of Psychosocial Interventions for Child and Adolescent Depression](#)
- [Assessment and Treatment of Depression in Children and Adolescents](#)
- [Beck Depression Inventory](#)
- [Bipolar Disorder](#)
- [Childhood Depression: Is it on the Rise?](#)

- [Depression in Childhood](#)
- [Handbook of Depression in Children and Adolescents: Ch 24: Suicide and Suicidal Behavior in Children and Adolescents](#)
- [Interviewing the Suicidal/Depressed Child](#)
- [Practitioners' Corner: Manualized Treatments for Youth Depression: Suggestions for Practitioners in Managed Care Era](#)
- [Promoting Resilience: Helping Young Children and Parents Affected by Substance Abuse, Domestic Violence and Depression in the Context of Welfare Reform](#)
- [Should we Screen for Depression? Caveats and Potential Pitfalls](#)
- [Treating Depression in Children and Adolescents](#)

Related Agencies and Websites

- [Teens-Depression and Suicide Prevention](#)
- [SAVE: Suicide Awareness](#)
- [American Academy of Child & Adolescent Psychiatry Website on Children and Depression](#)
- [Clinical Trials: Child and Adolescent Depression](#)

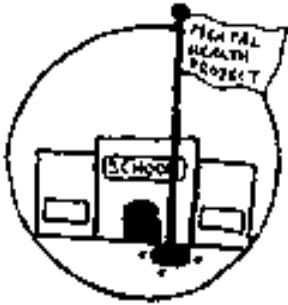
Relevant Publications That Can Be Obtained at Your Local Library

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Shortcut Text	Internet Address
Resource Aid Packet: Screening/Assessing Students: Indicators and Tools	http://smhp.psych.ucla.edu/dbsimple2.asp?primary=2301&number=9999
Resource Aid Packet: Student Psychotropic Medication: The School's Role	http://smhp.psych.ucla.edu/dbsimple2.asp?primary=2305&number=9999
Addressing Barriers to Learning: New Directions for Mental Health in Schools	http://smhp.psych.ucla.edu/dbsimple2.asp?primary=2312&number=9998
Introductory Packet: Assessing to Address Barriers to Learning	http://smhp.psych.ucla.edu/dbsimple2.asp?primary=2301&number=9998
Introductory Packet: Affect and Mood Problems related to School Aged Youth	http://smhp.psych.ucla.edu/dbsimple2.asp?primary=3013&number=9995
Featured Newsletter article (Summer, '99): Youth Suicide/Depression/Violence	http://smhp.psych.ucla.edu/dbsimple2.asp?primary=3002&number=9997
Quick Training Aid: Suicide Prevention	http://smhp.psych.ucla.edu/dbsimple2.asp?primary=3002&number=9998
Adolescent Depression: Helping Depressed Teens	http://www.nmha.org/infoctr/factsheets/24.cfm
Affect and Mood Problems Related to School Aged Youth	http://smhp.psych.ucla.edu/intropak.htm
Brighter Futures: Improvements in Depression Care Pay for Themselves	http://www.rand.org/publications/randreview/issues/rr.12.01/brighter.html
British Warning on Antidepressant use for Youth	http://www.mhra.gov.uk/
Depression Quick Find	http://smhp.psych.ucla.edu/qf/depression.htm
Depression in Children and Adolescents	http://www.baltimorepsych.com/cadepress.htm
Depression in Children and Adolescents	http://www.findarticles.com/cf_0/m3225/10_62/67164195/print.jhtml
Depression in Children and Adolescents: A Fact Sheet for Physicians	http://www.nimh.nih.gov/publicat/NIMHdepchildresfact.pdf
The Depressed Child	http://www.aacap.org/publications/factsfam/depressd.htm
Difference in Early Childhood Risk Factors for Juvenile- and Adult-onset Depression	http://archpsyc.ama-assn.org/cgi/content/full/59/3/215?submit.y=13&submit.x=49&gca=59%2F3%2F
"Educator's Guide to Receiving Bipolar Students After Hospitalization"	http://www.bpkids.org/learning/reference/articles/015.htm
"An Explosive Debate: The Bipolar Child" Educational Leadership, November, 2001.	http://www.ascd.org/publications/ed_lead/200211/schlozman.html

Shortcut Text	Internet Address
General and Specific Childhood Risk Factors for Depression and Drug Disorders by Early Adulthood	http://www.psych.uic.edu/pmdc/childhoodrisk.htm
The Hopelessness Theory of Depression: A Test of the Diathesis--Stress and Causal Mediation Components in Third and Seventh Grade Children [1].(Statistical Data Included)	http://www.findarticles.com/cf_0/m0902/3_29/76558497/p1/article.jhtml
Major Depression in Children and Adolescents	http://www.mentalhealth.org/publications/allpubs/CA-0011/default.asp
Management of Bipolar Disorder	http://www.aafp.org/afp/20000915/1343.html
Mental Health: Culture, Race, and Ethnicity - A Supplement to Mental Health: A Report of the Surgeon General	http://www.surgeongeneral.gov/library/mentalhealth/cre/
Mental Health, Education, and Social role outcomes of Adolescents with Depression	http://archpsyc.ama-assn.org/cgi/gca?sendit=Get+All+Checked+Abstract%28s%29&SEARCHID=1059683793311_1029&FULLTEXT=Mental+Health%2C+Education%2C+and+Social+role+outcomes+of+Adolescents+with+Depression+&JOURNALCODE=&FIRSTIN2F3%2F225
National Trends in Outpatient Treatment of Depression (pdf document)	http://jama.ama-assn.org/cgi/reprint/287/2/203.pdf
Practice Parameters for the Assessment and Treatment of Children and Adolescents with Depressive Disorders	http://www.guideline.gov/resources/summaryarchive.aspx#1531
Reporting on Suicide: Recommendations for the Media	http://www.afsp.org/education/newrecommendations.htm
School Associated Violent Deaths in the United States, 2001	http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5322a3.htm
Screening for Depression: Recommendations and Rationale	http://www.ahrq.gov/clinic/3rduspstf/depression/depressrr.htm
Treatment of Bipolar Disorder: A Guide for Patients and Families	http://www.psychguides.com/bp2000ho.pdf
"Teen Homicide, Suicide, and Firearm-Related Death"	http://www.mchlibrary.info/alert/alert120602.html#3
"The Treatment for Adolescents with Depression Study Team" (2003) Journal of the American Academy of Child and Adolescent Psychiatry, 42(5), 531-542	http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12707557&d
Treatment for Adolescents with Depression Study Team	http://rtckids.fmhi.usf.edu/rctpubs/datatrends/summary_87.pdf

Shortcut Text	Internet Address
What to do When a Friend is Depressed...	http://www.nimh.nih.gov/publicat/friend.cfm
Applying the Criteria for Empirically Supported Treatments to Studies of Psychosocial Interventions for Child and Adolescent Depression	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC44
Assessment and Treatment of Depression in Children and Adolescents	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC36
Beck Depression Inventory	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC11
Bipolar Disorder	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC38
Childhood Depression: Is it on the Rise?	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC43
Depression in Childhood	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC21
Handbook of Depression in Children and Adolescents: Ch 24: Suicide and Suicidal Behavior in Children and Adolescents	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC37
Interviewing the Suicidal/Depressed Child	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC15
Practitioners' Corner: Manualized Treatments for Youth Depression: Suggestions for Practitioners in Managed Care Era	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC41
Should we Screen for Depression? Caveats and Potential Pitfalls	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC2
Treating Depression in Children and Adolescents	http://smhp.psych.ucla.edu/smhp.exe?ACTION=POPUP&ITEM=3002DOC8
Teens-Depression and Suicide Prevention	http://www.aap.org/advocacy/childhealthmonth/prevteensuicide.htm
SAVE: Suicide Awareness	http://www.save.org/
American Academy of Child & Adolescent Psychiatry Website on Children and Depression	http://www.aacap.org/publications/dprchild/
Clinical Trials: Child and Adolescent Depression	http://www.centerwatch.com/patient/studies/cat43.html
search	http://smhp.psych.ucla.edu/search.htm
technical assistance page	http://smhp.psych.ucla.edu/techreq.htm
Center for School Mental Health Assistance	http://csmha.umaryland.edu/
"The fine Art of Fishing"	http://smhp.psych.ucla.edu/selfhelp.htm



Related Packets from Our Center

UCLA Center for Mental Health in Schools

» **A Resource Aid Packet on Student and Psychotropic Medication: The School's Role**

This sample packet is divided into three sections. Section 1 provides an overview perspective, guidelines, and tools related to a school's role in administering and monitoring medication, educating school staff about medication, and providing guidance for students on medication. Section 2 highlights major medications and their side effects. And Section 3 outlines resources for more information and support.

Keywords: psychotropic medication, attention deficit hyperactivity disorder, conduct disorder, anxiety disorder, depression, bipolar disorder, Tourette's syndrome, psychoses, pervasive developmental disorders, case monitoring, case management, affective disorders, behavioral problems, children, medicine, psychiatry

» **Center Guidebook: Common Psychosocial Problems of School Aged Youth Developmental Variations, Problems, Disorders and Perspectives for Prevention and Treatment**

This resource provides frameworks and strategies to guide schools as they encounter common psychosocial problems. It is designed as a desk reference aid. After an introductory overview of mental health in schools, Part I stresses ways to keep the environment in perspective as a cause of certain types of problems. Part II frames the full range of programs that allow a school and community to address psychosocial problems. Part III covers five of the most common “syndromes” students manifest and schools agonize over: attention problems, conduct and behavior problems, anxiety problems, affect and mood problems, social / interpersonal problems. Part IV explores ways to increase a school’s capacity to prevent and ameliorate problems. part V provides additional sources of information, including agencies and organizations that can provide further information and support.

» **A Resource Aid Packet on Responding to Crisis at a School**

Provides a set of guides and handouts for use in crisis planning and as aids for training staff to respond effectively. Contains materials to guide the organization and initial training of a school-based crisis team, as well as materials for use in ongoing training and as information handouts for staff and in some cases for students and parents.

Keywords: crisis response, school-based intervention, training, crisis, resources, students, family-school interactions, staff development, education/training of school staff members, program design and implementation, coping, crisis assistance, violence, death, family violence, domestic violence, grief, sexual assault, gangs, violent behavior, sexual abuse, behavioral initiatives, suicide

» **A Resource Aid Packet on Screening/Assessing Students: Indicators and Tools**

Designed to provide some resources relevant to screening students experiencing problems. In particular, this packet includes a perspective for understanding the screening process and aids for initial problem identification and screening of several major psychosocial problems.

Keywords: screening and assessment, resources, social problems, academic problems, substance abuse, childhood depression, suicide, drugs, behavioral initiatives

» **An Introductory Packet on Assessing to Address Barriers to Learning**

Discusses basic principles, concepts, issues, and concerns related to assessment of various barriers to student learning. It also includes resource aids on the types of procedures and instruments to measure psychosocial, as well as environmental barriers to learning.

Keywords: screening and assessment, reducing barriers to learning, resources, learning resources, learning disabilities, intervention, cultural diversity, depression, childhood-depression, suicide, multi-cultural, behavioral initiatives

For ordering information contact:
School Mental Health Project; Dept. of Psychology/UCLA; Los Angeles, CA,
90095-1563;
Phone: 310-825-3634; FAX: 310-206-8716;
<http://smhp.psych.ucla.edu>

Quick Training Aids



School Interventions to Prevent and Respond to Affect and Mood

Periodically, windows of opportunities arise for providing inservice at schools about mental health and psychosocial concerns, When such opportunities appear, it may be helpful to access one of more of our Center's *Quick Training Aids*.

Each of these offer a brief set of resources to guide those providing an inservice session. (They also are a form of quick self-tutorial and group discussion.)

Most encompass

- key talking points for a short training session
- a brief overview of the topic
- facts sheets
- tools
- a sampling of other related information and resources

*In compiling resource material, the Center tries to identify those that represent "best practice" standards, If you know of better material, please **let us know** so that we can make improvements.*

This set of training aids was designed for free online access and interactive learning. It can be used online and/or downloaded at <http://smhp.psych.ucla.edu> - go to Quick Find and scroll down in the list of "Center Responses to Specific Requests" to Depression. Besides this Quick Training Aid, you also will find a wealth of other resources on this topic.

Quick Training Aids



Suicide Prevention

Periodically, windows of opportunities arise for providing inservice at schools about mental health and psychosocial concerns. When such opportunities appear, it may be helpful to access one or more of our Center's *Quick Training Aids*.

Each of these offers a brief set of resources to guide those providing an inservice session. (They also are a form of quick self-tutorial and group discussion.)

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<http://smhp.psych.ucla.edu>



Technical Assistance Sampler on:

School Interventions to Prevent Youth Suicide



This document is a hardcopy version of a resource that can be downloaded at no cost from the Center's website <http://smhp.psych.ucla.edu>

This Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspice of the School Mental Health Project, Dept. of Psychology, UCLA.

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Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Both are agencies of the U.S. Department of Health and Human Services.



*We hope you found this to be a useful resource.
There's more where this came from!*

This packet has been specially prepared by our Clearinghouse. Other Introductory Packets and materials are available. Resources in the Clearinghouse are organized around the following categories.

Systemic Concerns

- » Policy issues related to mental health in schools
- » Mechanisms and procedures for program/service coordination
 - Collaborative Teams
 - School-community service linkages
 - Cross disciplinary training and interprofessional education
- » Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- » Issues related to working in rural, urban, and suburban areas
- » Restructuring school support service
 - Systemic change strategies
 - Involving stakeholders in decisions
 - Staffing patterns
 - Financing
 - Evaluation, Quality Assurance
 - Legal Issues
- » Professional standards

Programs and Process Concerns

- » Clustering activities into a cohesive, programmatic approach
 - Support for transitions
 - Mental health education to enhance healthy development & prevent problems
 - Parent/home involvement
 - Enhancing classrooms to reduce referrals (including prereferral interventions)
 - Use of volunteers/trainees
 - Outreach to community
 - Crisis response
 - Crisis and violence prevention (including safe schools)
- » Staff capacity building & support
 - Cultural competence
 - Minimizing burnout
- » Interventions for student and family assistance
 - Screening/Assessment
 - Enhancing triage & ref. processes
 - Least Intervention Needed
 - Short-term student counseling
 - Family counseling and support
 - Case monitoring/management
 - Confidentiality
 - Record keeping and reporting
 - School-based Clinics

Psychosocial Problems

- » Drug/alcohol abuse
- » Depression/suicide
- » Grief
- » Dropout prevention
- » Gangs
- » School adjustment (including newcomer acculturation)
- » Pregnancy prevention/support
- » Eating problems (anorexia, bulimia)
- » Physical/Sexual Abuse
- » Neglect
- » Gender and sexuality
- » Self-esteem
- » Relationship problems
- » Anxiety
- » Disabilities
- » Reactions to chronic illness
- » Learning, attention & behavior problems