

## Tutorial: Depression and Depression Management

### WHAT IS DEPRESSION?

Depression is the most common mental health disorder in both adults and children/adolescents. A depressed person experiences intense emotional distress for a period of days, weeks, months or years. There are differing severities of depression with differing psychiatric diagnoses given to each:

- An *Adjustment Disorder* is the most common type of depressed mood. A person admits to depressed feelings. These feelings are short lived (less than 6 months) and usually occur in response to some negative experience, such as rejection, a let down or a loss.
- A *Major Depression* is a serious depressive disorder in which a person experiences a severely depressed mood for periods as long as 7-9 months or greater. Depressive symptoms are similar for both adults and older children and include a sense of intense sadness, a loss of interest in formerly pleasurable activities, self-criticism, feelings of pessimism, a sense of hopelessness, increased fatigue, difficulty with concentration, impaired decision-making skills, lack of energy or motivation, and altered sleep patterns. Anxiety symptoms may be present. In more severe depression, the individual might think life is not worth living and/or have suicidal thoughts. In younger children, anxiety and depression symptoms are often seen as increased fears of separation, reluctance to meet new people, vague physical complaints such as general aches and pains, stomachaches, headaches, and acting-out behaviors. It is not uncommon to have repeat bouts of major depression. The younger the age of a child at the time of the first depressive episode, the greater the risk of repeat bouts of depression as the child matures.
- In *Dysthymia*, a person has fewer and less severe depressive symptoms than in a major depression; however the depression last longer, sometimes years. Children and adolescents often experience dysthymia, with the child depressed for most of the day, on most days, with symptoms continuing for several years. Because of its persistent nature, dysthymia is especially likely to interfere with normal adjustment.
- In a *Bipolar Disorder*, a person has dramatic changes in mood which alternate between spans of hyperactivity, or mania, and depression. Symptoms of mania are very different from depression. During a manic episode, a person feels overly energetic, confident and "special" and may report racing thoughts. During these hyperactive states, the person may do tasks too quickly and in a disorganized chaotic fashion; numerous projects may be started but few completed. Typically, the person has difficulty sleeping but denies feeling tired, and often has pressured or loud speech. Finally, the person may have exaggerated ideas about actual capabilities, may become "fresh" and uninhibited with others, and engage in reckless, risky or promiscuous behaviors. This mood disorder typically starts during adolescence with the onset of a depression; the hyperactive or manic symptoms typically do not occur until many months or years after the depression has resolved.

### WHY IS DEPRESSION AND ITS MANAGEMENT IMPORTANT FOR MANY STUDENTS AFTER TBI?

Children and their families often experience a wide range of emotional reactions during the initial few months after a brain injury. Initially, there is relief that a child has survived. Early recovery of physical abilities often inspires hope that the student will be fine with a return to normal day-to-day activities in the near future. For many students and their families, there is a gradual realization that some changes in thinking and behaviors may indeed persist. These changes often occur in the larger context of the students mourning their very real and potentially permanent losses in their thinking, physical abilities, and behaviors.

A student needs to mourn these losses; sometimes, this mourning leads to depression. This is particularly the case when mourning is experienced at the same time as the student is experiencing academic difficulties, losing friendships, and becoming more isolated. Thus, all students with brain injury are at increased risk of an adjustment disorder with a gradual onset over the months post injury. Unless treated, the adjustment disorder can worsen into a major depression or a dysthmia.

Research has shown that the majority of children with severe brain injuries, and a considerable minority of children with less severe injuries, are at risk of developing a new and significant depression post injury. Research also suggests that males injured before the age of 15, children with emotional problems prior to their brain injury, and children in families who are having difficulty coping with the brain injury are at increased risk of developing a depression. Finally, depressive disorders post brain injury are, in part, due to specific damage to part of the brain that controls our emotional responses – the bottom sides of the prefrontal parts of the brain. Thus, there is a neurological basis to post brain injury depression.

### **WHAT ARE THE CLINICAL SUPPORTS AND INSTRUCTION NEEDED FOR STUDENTS WITH BRAIN INJURY WHO ARE DEPRESSED?**

Supports for students to address depression include timely identification of the problem, accurate diagnosis of the depression and implementation of mental health and medication as well as support in the school and home. Each of these areas is addressed below:

#### **Identification of Depression**

The initial step in dealing with depression is to recognize that a child is depressed. The first step in identifying depression is to ensure that it is truly depression that we are dealing with. Parents and school staff are keen observers of a child's behaviors and often the "front line" identifiers of the child's depressed mood. Consultation with parents, the school psychologist and teachers may be helpful to determine if the student presents as depressed in all settings. For example, a young child may be acting out or an adolescent may be increasingly irritable in the home setting but not the classroom or with friends. These behaviors would suggest situation specific issues rather than a sign of depression in the student.

#### **Timely Assessment of the Student's Mood**

Referral to a physician or other mental health professional to assess the severity of a child's depression is the next step in obtaining needed treatment. In children, the diagnosis of depression is more difficult, since younger children may be unable to verbalize thoughts and feelings. Clinicians by necessity need to rely on parents, teachers, and other professionals to assess mood and behavior change particularly in younger students.

#### **Starting Needed Medications or Therapy**

Management of depression depends on the severity and type of depressive disorder. Typical management includes mood medications prescribed by a physician and/or supportive therapy offered alone or in combination.

- Mood medications are likely to be used when a child has either a major depression or a bipolar disorder. Typically, antidepressants (usually serotonin reuptake inhibitors (SSRI) or mood stabilizers) are selected. Family and school staff will need to ensure that the student complies with prescribed medications.
- Psychological interventions or "talk therapy" is considered for older children either by themselves, with family members or in structured group settings. Most psychotherapy approaches use a

cognitive behavioral therapy (CBT) model in which a child is taught how to alter faulty (or negative) self-thoughts that are maintaining their depression and to learn new coping and problem solving skills. In younger children, play therapy may be utilized instead of talk therapy.

### **Helping students manage their own depression**

There are many ways that teachers and parents can help students handle and or minimize their depression:

- a. Limit comparisons of before and after injury:** A student with brain injury has experienced real losses in his/her thinking, physical and behavioral abilities. The older the child at time of onset of injury, the more aware the student is of these difference before and after injury; this discrepancy often fuels depression and anxiety. Parents and teachers can help the student by modeling less critical statements about a student's abilities, with the goal of minimizing negative comparisons which serve to maintain the student's depressed mood. For example, the student might describe his current abilities as "I was really good at spelling before, but now I am really dumb"; the parent/teacher could reframe the same statement to a less critical response such as "You didn't do a bad job on the spelling test today, and your grade was higher than last week"
- b. Limit situations that trigger depressive thoughts:** Teachers and parents should be aware of situations, people, or events (triggers) that typically provoke depressive reactions (crying, irritability, or withdrawal) in the student. For example, modifying gym class activities so the student is not confronted with current physical limitations, or matching a student with a new student for an assignment rather than a former friend who knew the student's former abilities. Whenever possible, attempts should be made to remove triggers proactively from the student's daily routines. As the student becomes aware of what these "triggers" are, the student should be empowered to removal himself from these events.
- c. Help the student re-interpret social cues:** Students with brain injury often have decreased ability to correctly "read" social situations and the intent of others behavior. For example, when social cues are misread – for example, a student perceives someone making insulting remarks when none was intended – the student will feel rejected based on this incorrect interpretation. This rejection is magnified when a student is depressed, resulting in an increase in the depression and further social withdrawal. Parents and teachers can help the student reframe the social interaction and rethink the social situation in a less critical fashion. This reframing will help to limit the negative emotional response by the student. [See Tutorial on Social Perception]
- d. Ensure that strategies are in place to enhance a student's self-esteem and self-concept:** Depressed students develop a sense of self that includes a strong sense of failure and futility. The student tends to think of self in terms of "failure", "helpless" or "hopeless". For these students, it is essential that they be provided ample opportunities to contribute to helping others, thus rebuilding optimism about their own abilities rather than continued focus on enhancing and maintaining "learned helplessness". Depression can also reduce a student's already taxed cognitive abilities. Parents and teachers should ensure that the students are provided academic tasks within his current abilities to ensure feelings of mastery and allow for a slow rebuilding of self esteem. [See Tutorials on Instructional Routines; Apprenticeship Teaching; Sense of Self]
- e. Help the student learn to "reframe" critical self-statements:** Overly critical and negative self-statements make a depressed student further distance himself from his peers. The student typically internalizes and believes these self-statements, thus maintaining his depression. Similarly, the student frequently "catastrophizes", that is, makes small issues into major problems without realizing that he is doing this. Alternatively, the student may use extreme terminology when describing his situation, "I never get a chance" "She always makes fun of me" "I never do anything right" and so on. In such situations, adults can

model “reframing” a negative self-statement into a less critical response. With modeling, the student can learn to reframe critical self-statements into less critical and more positive messages to self.

**f. Help the student learning to identify depressive feelings:** Young children and older students with significant brain injuries may experience bodily symptoms of depression without knowing what the emotion underlying these symptoms is. The feelings are simply nameless feelings that lead to negative and regressive behaviors. These students need help in identifying depressive feelings, giving these feelings a name, and understand that these symptoms can be addressed in order to regain better control of their mood. For example, when a young child suddenly withdraws from an activity, the teacher may ask the child to think about what she is feeling inside (bodily symptom) that made her remove herself from the activity. Often providing suggestions of possible reasons (e.g., fear, a sense of doom, rejection, failure, etc.) will help the child associate words with the feelings.

**g. Help the student to “self-motivate”:** Depressed students often over-react to challenging situations, minor annoyances or unexpected changes in their daily routines with immediate refusal to engagement in a task or activity. Their refusal only fuels their feeling of failure and leads to further isolation. In such situations, it is helpful to provide the student with a “self-script”, a series of questions that he can ask himself in order to evaluate the relative merit and limitations of a task or activity, thus encouraging him to think more flexibly about the specific task. For example, the student can ask “Is this really a big deal or a little deal to do the activity?” or “If I start this task, will there be any benefit to me?” or “What will be the down side of not doing this activity?” These self-regulation scripts can be practiced by the student across a variety of tasks, allowing the student to gradually internalize the self-script, thus minimizing rejection, failure, and isolation. [[See Self-Regulation Scripts](#)]

#### **EVIDENCE SUPPORTING THE USE OF INTERVENTION APPROACHES FOR CHILDREN AND ADOLESCENTS WHO EXPERIENCE DEPRESSION AFTER TBI**

This summary of evidence is written for teachers, mental health clinicians, and others who may be required to support their intervention practices with evidence from the research literature or who may simply be curious about the state of the evidence. This summary was written in early 2008. Evidence continues to accumulate.

The research literature contains no reports of studies of the effectiveness of intervention specifically for children or adolescents who experience depression after TBI. Findings from studies of other populations are relevant in making evidence-based clinical decisions, but should be interpreted with caution. In particular, the memory problems, difficulty with abstract reasoning, and self-regulatory impairments of many students with TBI may require modification of clinical approaches validated with other populations.

Carr (2008) reviewed several reviews of evidence based on studies of alternative approaches to intervention for depression in varied populations of children and adolescents. Causes of depression that Carr considered in the review include genetic factors (e.g., neurobiological factors that control relevant neurotransmitter systems) and environmental factors (e.g., loss of important relationships, injuries, illnesses, disruptive life transitions, and experiences of failure and bullying). Non-optimal parenting received special attention.

Psychological therapies that have been studied in children and adolescents with depression include cognitive behavior therapy (CBT), psychodynamic therapy, interpersonal therapy, and family therapy. One review and two meta-analyses have demonstrated the effectiveness of CBT with these populations. The effect sizes in the two meta-analyses (focused on adolescents) were both large (1.27 and 1.02). In one comparative trial, outcome following cognitive behavior therapy was superior to that following family therapy or supportive therapy. These results support several of the practical suggestions offered in this tutorial.

Carr identified only two published reports of studies of psychodynamic therapy. Both had positive

outcomes, offering preliminary support for that approach. Interpersonal therapy is supported by five studies with adolescents, four of which were controlled. Interpersonal therapy focuses on (1) grief associated with loss of a loved one, (2) role disputes among family and friends, (3) transitions within roles (e.g., new peer groups), (4) social skills, and (5) other relationship difficulties. The literature includes six studies of family therapy for this population (especially depressed adolescents). This literature supports the use of cognitive-behavioral approaches to family therapy.

In a comprehensive meta-analytic review of components of psychotherapeutic interventions for depressed and anxious children, Spilmans and colleagues (2007) concluded that, although bona fide cognitive and behavioral treatments are superior to interventions that are not bona fide, evidence does not exist to support specific components of the successful interventions. Rather it is likely that nonspecific components, such as a strong therapeutic alliance, are most influential in determining the outcome of therapy. A similar conclusion about the importance of a therapeutic alliance was reached by Judd and Wilson (2005) in their review of psychotherapeutic interventions for adults with TBI.

Common themes in outcome and life after pediatric TBI make the procedures of CBT, relationship therapy, and family therapy worth recommending in many cases. As always, specific decisions about interventions and supports must be made on the basis of an analysis of the often complex factors in individual cases.

With respect to psychopharmacologic interventions, Carr cited one comprehensive review that showed that tricyclic antidepressants are ineffective, and two reviews that demonstrated positive effects of selective serotonin reuptake inhibitors (SSRIs) for children and adolescents with depression. However, SSRIs should be used with caution because of some evidence that they increase suicidal ideation.

Carr, A. (2008). Depression in young people: Description, assessment and evidence-based treatment. *Developmental Neurorehabilitation*, 11(1), 3-15

Judd, D., & Wilson, S.L. (2005). Psychotherapy with brain injury survivors: An investigation of the challenges encountered by clinicians and their modifications to therapeutic practice. *Brain Injury*, 19(6), 437-449.

Spilmans, G.I., Paseka, L.F., & McFall, J.P. (2007). What are the active ingredients in cognitive and behavioral psychotherapy for anxious and depressed children? A meta-analytic review. *Clinical Psychology Review*, 27(5), 642-654.

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