Living with Depression

A Survival Manual for Families

(Third Edition)

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University of Pittsburgh Health Systems

Services for Teens at Risk

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Foreword

STAR-Center is a treatment, training, outreach, and research program of the division of Child Psychiatry, University of Pittsburgh School of Medicine. We acknowledge with gratitude the funding of the Pennsylvania General Assembly, which makes our services possible.
Introduction to this Manual

Services for Teens at Risk (STAR-CENTER) is a specialty research program designed to address the increasing problems related to adolescent suicide and depression. Our program was founded by David Brent, MD and Mary Margaret Kerr, ED.D in 1986. STAR-CENTER is funded by the Pennsylvania General Assembly with the primary mission, the prevention of adolescent suicide.

Our program provides individual assessment and treatment to teens who are experiencing depression and suicidality. Much of our work is done one-on-one with the adolescent. However, we also realize how essential it is to work as partners with parents, in a collective effort to help the adolescent overcome the problems that brought he/she to the STAR-CENTER.

Over the years, the families who have been treated in our program have helped us learn much of what we currently know about adolescent depression and suicide. We have learned that it is normal for family members of the depressed person to sometimes feel helpless and frustrated. It is common to experience feelings of anger, guilt, and fear. It may be difficult to understand how it is that your child is depressed or could consider taking his or her own life by suicide. Additionally, it can be extremely difficult to live with a family member who is experiencing depression. We have come to know that similarly to when a family has someone afflicted with a serious physical illness, depression affects the whole family.

We have learned that it is important to recognize when another family member is also experiencing depression, including yourself. Since depression does run in families this is not an uncommon occurrence. Experiencing depression makes it harder for the individual to cope with the depression in the child. A recent study of depressed teens and their families, indicated that one essential factor for successfully treating the depressed teen, is to help parents recognize and seek effective treatment for their own depression. We recommend that parents speak with us about concerns related to their own depressive symptoms or any other family members who may be depressed. Please let us know how we can help.

This manual was written for families. Our intent is to help you gain a better understanding of an extremely complicated issue by providing the most updated information on depression and suicide. We also hope to offer helpful coping strategies for your family. We have learned that by partnering with parents, we increase our chances of helping your adolescent overcome the depression. We hope you find this information helpful, and we look forward to working with you.
Introduction to Depression

Identifying Depression

Depressive disorders are among the most prevalent of the mental illnesses. Depression occurs among people of all ages, socioeconomic classes, ethnic groups, and cultures. The term illness implies a decline in one’s health or a change in one’s previous functioning, with an onset of symptoms that follow an identifiable course. Illnesses can be treated. Despite the fact that depression is considered an illness, individuals afflicted with a depressive disorder, can learn new skills and behaviors that will help with their recovery.

The depressive disorders are very responsive to treatment. Despite this, only an estimated 25% of the 15 million Americans with depression seek help. Many people suffer with their depressive symptoms unaware of their illness. Others fail to seek treatment because they believe their symptoms will go away spontaneously. Some people do not get help because they are so depressed that they cannot find the energy necessary to make the contact for help, while others may feel so hopeless that they do not think anyone can help them. Children and adolescents often do not understand or know what is happening to them and will often respond, "I don't know", or "nothing", to inquiries about what is troubling them.

The person suffering from a clinical depression does not function as usual. The key feature of clinical depression is a sad, angry, or irritable mood. Children often report being "bored", whereas the key feature for adolescents often is irritable/angry mood. The symptoms of depression such as low mood, disrupted sleep, changes in appetite patterns, and loss of interest may continue for months and even years if untreated. This presentation will describe the pictures of depression as well as possible causes, treatments, and ways in which you, the family members, can both help the depressed person and cope with the effects of living with a depressed relative.

The Symptoms of Depression

The "warning signs" of depression include:

- **Mood** - Persistent sad, anxious, or bored mood.

- **Irritability and anger** - Feeling of irritability or anger, as manifested by a "short fuse," feeling on edge, easily annoyed, "grouchy." Sometimes this irritability is more prominent than a sad mood.

- **Changes in energy** - Decreased energy. Frequent complaints of being tired, even after sleeping. Spending more time resting.

- **Psychomotor agitation** - Refers to feeling restless, inability to sit still, pacing, fidgeting.
- **Psychomotor retardation** - Slowing down of body movements, reacting slowly, slowed speech, decreased amount of speech.

- **Loss of interest and pleasure** - Feeling uninterested in things that were previously of interest. Feeling bored a lot and a loss of ability to experience pleasure, enjoy and have fun during activities. May appear to be "going through the motions."

- **Changes in sleeping patterns** - Initial insomnia (difficulty falling asleep), middle insomnia (difficulty staying asleep), terminal insomnia (waking up early), circadian reversal (for example, goes to bed no earlier than 4 a.m. and wakes up at noon), hypersomnia (sleeping more hours than usual).

- **Changes in eating patterns** - Appetite loss (eating less, not feeling hungry) or increased appetite as compared to usual (feeling hungry all of the time). If persistent, will be accompanied by unintentional weight change.

- **Changes in socializing patterns** - Less contact/involvement with family and friends compared to usual, preferring to be alone, avoiding social contacts, not going out to activities, and avoiding phone calls.

- **Inability to concentrate or slowed thinking** - Symptoms include difficulty paying attention, diminished ability to concentrate, forgetfulness, taking longer to do things, and decreased grades or work performance.

- **Hopelessness and discouragement** - Negative outlook toward the future regarding life and current problems. Feeling like giving up on things. Feeling like he/she can't be helped. Lack of care of personal appearance and poor self-esteem. Feeling like he/she will always feel this way. Hopelessness is linked with suicidality.

- **Guilt/worthlessness** - Feelings of worthlessness or excessive or inappropriate guilt.

- **Suicidal ideation and behavior** - Preoccupation with thoughts of death or suicide. Actual suicide attempts.

**Myths about Depression**

The word depression has been used by many people to describe any "down" mood they experience. Therefore, many people put off getting help because they expect their symptoms to go away, as have their "blue" moods in the past. Thinking that depression "will go away on its own" is a common myth.
While some people do recover spontaneously from depression, untreated depression can persist for months and even years.

Another common misconception about depression occurs when people believe that "everyone feels this way." Depressive disorders should not be confused with the occasional feelings of unhappiness that everyone experiences from time to time, such as periods associated with unhappy events and failures. Depressive disorders should also not be confused with the intense grief brought about by the loss of a loved one. Sadness and grief are normal and temporary reactions to life stresses, and will lift as time passes and the person is able to function normally again. However if the grieving person experiences persistent and severe depression symptoms, treatment may be necessary.

A common myth of depression is centered around the idea that the person afflicted with depression can control it and should be able to "pull himself/herself up by the boot straps" and feel better on his/her own. In fact, the person can often not control the depression, at least not without some professional help.

Getting help for depression is not a sign of weakness, but is an important step for the depressed person's recovery. Without treatment, the symptoms may continue and may even become more severe. Depression is not a sign of weakness. The depressed person is in pain and needs understanding and help, and is not to blame for his or her symptoms. No person or specific event can cause it. Family members or friends cannot cause a person's depression. Stressors can definitely affect or trigger the depression, but no one event can cause the depression. It is important for the depressed individual and the family to remember that depression is an illness and that with proper treatment the individual will learn the skills to cope with the illness and return to their previous level of functioning. It is also important to recognize that living with a depressed family member can be quite difficult for the whole family, often leading to additional stress.

Another common misconception centers around the idea that if a person talks about suicide this means the person would not go on to attempt suicide. It is untrue, as many people often believe, that a person who talks about suicide will not attempt it. Quite often those who do attempt suicide will often first threaten to do so. Suicidal threats should not be ignored. Even when there seems to be little or no danger of suicide, a mental health professional should be consulted.

Another misconception exists regarding the possibility of suicide when a depression is mild. Though a depression may appear mild, this does not exclude the possibility of suicide.

A great deal of confusion and misunderstanding exists about depression in children and adolescents. In the past, many people believed that children and adolescents could not suffer from depression and mislabeled a depressed child as "bad" or "lazy" and in need of "strict discipline." Decisions were often made to
send a child to a strict school for the purpose of "straightening the child out," based on this misconception. Similarly, people often attributed mood swings to the supposed normal moodiness of adolescents. In fact, clinical research shows that adolescents who experience persistent mood swings associated with functional impairment should be referred for a psychiatric evaluation. In summary, clinical depression does occur in children and adolescents, often making them unable to function as expected in their roles.
Types of Depression

Major Depression

According to the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, DSM-IV), a Major Depression is defined as a disorder with at least five of the following symptoms. These symptoms have been present during the same two-week period and represent a change from previous functioning.

- At least one of the symptoms is either 1) depressed mood - sad, mad, irritable or bored, and/or 2) loss of interest or pleasure.
- Depressed mood most of the day, nearly every day, as indicated by subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: in children and adolescents, can be irritable mood.
- Markedly diminished interest and pleasure in all, or almost all activities most of the day, nearly every day (as indicated either by subjective account or observation made by others).
- Significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: in children, consider failure to make expected weight gains.
- Insomnia (trouble falling asleep) or hypersomnia (sleeping too much).
- Psychomotor agitation or retardation.
- Fatigue or loss of energy.
- Feelings of worthlessness or excessive or inappropriate guilt.
- Diminished ability to think or concentrate, or indecisiveness.
- Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Not due to the direct effects of a substance (e.g., drugs of abuse, or prescribed medication) or a general medical condition (e.g., hypothyroidism).
- Not occurring within two months of the loss of a loved one (except if associated with marked functional impairment).

Almost one-third of young, prepubertal clinically referred children with depression experience either hallucinations or delusions related to their
depression. For example, they may hear voices telling them that they are worthless, commanding them to kill themselves, they may be convinced that the world is coming to an end, or that they have an incurable medical illness. These symptoms are usually associated with more severe depression and diminish as the depression remits.

Between 10% and 15% of people with Major Depressive Disorder will have additional episodes that will involve manic or hypomanic symptoms at which point they would be reclassified as having a Bipolar Disorder. This reclassification occurs less frequently as people become older and have an increased number of depressive episodes. Conversely, a much higher proportion of patients who have their onset of depression prior to adulthood eventually develop a bipolar illness. Research indicates that up to 50% of people with Major Depressive Disorder with psychotic features will have additional episodes that will involve manic or hypomanic symptoms.

**Bipolar Disorder (Manic-Depressive)**

Bipolar Disorder, sometimes called manic-depressive illness, is characterized by episodes of mania alternating with episodes of depression. The periods of depression are similar to the ones described above. In a manic episode, the person's mood is elevated and "high". Irritability may also be present. People in a manic state are hyperactive and often get by on very little sleep. Getting less sleep than normal can lead to additional difficulties related to sleep deprivation, which in turn can contribute to the cyclic nature of the illness. In other words, sleep deprivation can be a result of the mania or may trigger mania. Sleep problems may occur due to the mania, or due to other factors such as stress, medical problems, or jet lag. This points to the importance of maintaining regular sleep patterns.

People in a manic state may have an inflated or a grandiose mood and can be vastly overconfident. Their speech can be pressured and their thoughts can hop very quickly from one topic to another. They are often quite easily distractable, impulsive, and show very poor judgement. They become more energetic, sociable, and may engage in behaviors with potentially painful consequences, such as promiscuity, gambling, or impulsive spending. There are sometimes psychotic symptoms such as hallucinations, paranoia and delusions. The delusions are often of a grandiose variety - such as when the manic person claims to have special talents or a messianic mission (going to save the world, etc.). The symptoms can range from moderate to severe. With only a moderate level of symptoms (called hypomanic), a stranger may not recognize the condition as a problem, but those who are close to the individual may see the behavior as excessive and unusual. Manic episodes usually begin suddenly and symptoms increase over a few days. They can last for a few days to a few months, but usually are much briefer than depressive episodes.

In Bipolar Disorder, the first episode may be manic. A very few people have only manic episodes and most people will alternate between manic and
depressive episodes. Frequently, an episode of one type is followed immediately by an episode of the other type. Sometimes, particularly in young people, both manic and depressive symptoms may coexist simultaneously. This is known as a "mixed state," and is more difficult to treat. Sometimes episodes of mania and depression alternate very quickly. This is referred to as "rapid cycling" and is also difficult to treat. Often both "mixed states" and "rapid cycling" are associated and perhaps caused by coexisting substance abuse.

Adolescents with a diagnosis of Major Depression with severe psychomotor retardation, overeating, sleeping too much, psychosis, a family history of Bipolar Disorder or develop hypomania while being treated with antidepressant medications, are at risk to develop a manic episode in the future.

**Dysthymic Disorder**

This condition is characterized by chronic, longstanding depressed mood or loss of interest in usual pleasures and activities, along with other symptoms of Major Depression, but without the severity of a Major Depressive Disorder. For adults, the condition must have been present for **two years** to be considered a Dysthymic Disorder. For children and adolescents the condition must have been present for **one year**. The condition persists yet at times the symptoms may be "on and off" with normal moods returning for short periods of a few days to a few weeks. The diagnosis should not be made if the return of normal mood lasts for more than a few months. Psychotic symptoms are not present. Dysthymic Disorder can be described as a mild to moderate depression is both chronic and intermittent. (If depression is a "gray sky about to rain", dysthymia is "partly cloudy.")

Dysthymia is a serious condition due to its chronicity and may often lead to significant long-term impairment for the individual. Children may experience social and academic delays due to the Dysthymic condition. Individuals with Dysthymic Disorder symptoms are at higher risk of developing multiple depressive episodes and their depressive episodes tend to last much longer. Those with "double depression" (experiencing both Major Depressive Disorder and Dysthymic Disorder) may be at high risk for developing Bipolar Disorder, and are much less likely to respond to a brief course of cognitive therapy.

**Cyclothymic Disorder**

This condition is characterized by a chronic mood disturbance of at least two years duration, involving numerous periods of dysthymia and hypomania (mild manic symptoms). Symptoms are not as severe or long-lasting as symptoms in a manic or a depressive episode. In Cyclothymic Disorder the depression and hypomanic periods may be separated by normal moods lasting for months at a time or the two types of mood may be occurring at the same time or may alternate with each other. In a Cyclothymic Disorder there are no psychotic symptoms. In children and adolescents, Cyclothymic Disorder may progress to full-blown Bipolar Disorder.
Seasonal Affective Disorder

Seasonal affective disorders are characterized by affective episodes (depression, hypomania, or mania) recurring regularly during certain seasons. One form of the condition that has received most of the clinical and research attention, is the condition where fall-winter depressions alternate with nondepressed periods in the spring and summer. Seasonal affective disorder is thought to be related to decreased sunlight during the winter months. Individuals affected with this condition who are living in the northern hemisphere, experience an onset of the depressive symptoms between the beginning of October and the end of November and regular remission of symptoms from mid-February to mid-April. Depression symptoms are frequently mild to moderate but may be severe. Commonly reported symptoms are decreased activity, increased eating, carbohydrate craving, weight gain, oversleeping, sadness, irritability, anxiety and decreased sex drive. Social withdrawal and impaired work functioning are also common symptoms. It is important to diagnose this particular type of depression because a specific form of treatment called "light therapy" may be helpful.

Depressive Disorder Not Otherwise Specified (NOS) ("Atypical Depression")

The Depressive Disorder Not Otherwise Specified diagnosis includes disorders with depressive features that do not meet the criteria for Major Depression, Dysthymia, or Adjustment Disorders. For example, the individual may be experiencing depressive symptoms for at least two weeks, however the number of depressive symptoms are less than that indicative of a Major Depression.

Co-Existing Conditions

Many individuals with a depressive disorder also meet full criteria for an additional, co-existing condition such as anxiety. In a recent study of depressed adolescents it was found that a co-existing condition such as anxiety will impede the individuals recovery, often increasing the length of treatment. It was discovered that if the anxiety disorder is not targeted, the depression is likely to persist. Other disorders such as Attention Deficit/Hyperactivity Disorder may be present.
Natural History/Course of Depression

Remittance and Persistence

According to a longitudinal study of children with depressive disorders, the mean length of an untreated episode of depression was 8 months (32 weeks) and of untreated dysthymia 17 months (68 weeks). Children with untreated Major Depression were quite unlikely to recover spontaneously. By 18 months after the initial onset of the depression, almost all (92%) were recovered. The course of recovery is much more prolonged for children with Dysthymic Disorder, with average duration of 45 months. This particular study also suggested earlier age of onset predicts a prolonged recovery for children with Major Depression and Dysthymic Disorders. Children with Dysthymic Disorder may develop Major Depression symptoms that are "superimposed" on the Dysthymic Disorder. This condition is often referred to as a "double depression".

Children/adolescents in treatment with either medication or therapy, may experience initial improvement within 4 weeks and substantial clinical improvement in 8-12 weeks.

Recurrence (including risk factors for recurrence)

Recurrence refers to a new episode that follows a complete recovery that has lasted for at least two months. Some people have only a single episode of Major Depression and will have a full return to normal functioning. However, it is estimated that over 50% of people who have a single Major Depression episode will eventually have another Major Depressive episode. Recurrence rates are very high (up to 80%) among people who have already had three episodes, who have an early age of onset, double depression (dysthymia and major depression), bipolar disorder, and other psychiatric problems in addition to the depression. In clinically referred children, 40% of those with a depressive disorder will have a recurrence within two years and 70% within five years. The further away from the episode, (without recurrence), the lower the chance of a recurrence. Approximately 20% of patients with Major Depression become chronically depressed; 80% recover fully. For most individuals, Major Depression is an episodic illness. Outside of the episode, the individual may function normally.

In summary, Major Depression is an episodic illness that may recur. In treatment studies of adolescents with Major Depression, approximately 60% achieve clinical remission with cognitive-behavioral therapy or pharmacotherapy. In adolescents, comorbid anxiety, longer episode length, and parental anxiety or depression predicted poorer response to psychotherapy. Of those who recover, approximately 40% experience a recurrence within two years (Kovacs, 1984; Brent, 1995).

Family members should be aware of all the symptoms of depression, as depressive illnesses do run in families. It is not uncommon to have more than
one family member with a depressive illness. Therefore, it is important that the person with depression and the family be fully aware of the risk factors for recurrence:

- Signs or symptoms of depression (even "low-grade" symptoms) and or functional impairment.
- Long duration of depressive episode.
- History of dysthymia (chronic depression).
- Co-existing condition of Anxiety Disorder.
- Increased fighting/conflict in the family.
- Untreated depression or other psychiatric illness in parent.
- Alcohol/substance use or abuse in patient or parent.
Functional/Social Impairment

In major depressive episodes, there is always some decline in social and occupational functioning for the depressed individual. If severe impairment occurs, the person may not be able to take care of their own personal needs. Decreased ability to function in specific roles of spouse, parent, employee, student, family member, and friend may occur. The depressed individual will experience decreased effectiveness and interest in their roles. They may avoid responsibilities, including refusing to help with the household, refusing to make decisions, not doing homework, and not attending school or work.

In manic episodes, there is usually a marked impairment in social and occupational functioning for the individual. Due to the person's agitation and poor judgment, family members are often required to protect the person from negative consequences of their actions. During a manic episode, an individual may spend money impulsively, take unplanned trips, make unrealistic financial commitments, become increasingly aggressive, engage in promiscuous sexual behavior, and make poor social and occupational judgments. These actions may create major stress and serious consequences for the family.

Additional functional impairment may occur for the person who experiences anxiety symptoms or psychotic features during their episode.

For some individuals with Recurrent Depression, the intervals between episodes are marked by no symptoms or impairment in social functioning. Between episodes they return to their normal level of functioning. Other individuals may have more subtle onset of episodes as well as less complete recovery from symptoms. There is evidence that children who were depressed continue to show functional impairment, even after symptoms have improved. Children who have been depressed from an early age, often experience social delays/deficits that may continue to be evident in adolescence and adulthood.

The relationship between depression and social and interpersonal functioning has been studied in adults and children. Depressed adult women had lower levels of social involvement, were withdrawing, and viewed themselves to be socially inadequate, as compared to nondepressed adults. Children with Major Depression showed impairment in their relationships with mother, father, and siblings as compared to nondepressed children. Children who have had prolonged experiences with depression may need help catching up with their peers with regard to social skills. These social difficulties may continue to be evident after the episode of depression. A follow-up of high school students with depressive symptoms indicated that they were much more likely than a non-depressed comparison group of peers to have substance abuse, delinquent behaviors, unstable work histories and poor marital relationships. This follow-up illustrates some of the potential social costs of untreated depression in children and adolescents.
Suicide and Suicidal Behaviors

Suicide is the most serious complication of depressive disorders. Feelings of worthlessness and hopelessness may overcome the depressed person, which may lead to suicidal thoughts and at other times, suicidal acts. While all suicides are not committed by those who are clinically depressed and most clinically depressed people do not attempt or commit suicide, there is a strong connection between depression and suicide. Recent studies show that adolescents with depression are 30 times more likely for completed suicide. Recurrent thoughts of death, suicidal thoughts, and attempts are specific symptoms of Major Depressive Disorder. According to the National Institute of Mental Health, they estimate that between 30 and 70 percent of suicides are completed by people having a major depression. For those who are hospitalized for suicidality, the greatest risk period is during or immediately following the psychiatric hospitalization. Suicide may occur very early in a depressive episode, or after a chronic course. For this reason, it is important to insure continuity of care for your child if he/she is being discharged from an inpatient psychiatric unit.

Researchers indicate that more women attempt suicide, but more men actually complete suicide. These findings are similar for adolescents and young adults.

Risk Factors for Adolescent Suicide:

- Depression or Bipolar Disorder
- High hopelessness
- Drug and alcohol abuse
- Availability of firearms
- High suicidal intent
- Previous suicide attempt
- Co-existing condition such as anxiety
- Talking about death or suicide; saying "good-by," giving away possessions, making wills
- Engaging in self-destructive behavior
- Behavior problems
- Physical or sexual abuse
- In the midst of a legal or disciplinary crisis
- Lack of treatment
- Exposure to completed suicide
Suicide is one of the leading causes of death in the United States. According to the National Institute of Mental Health, the total number of completed suicides in the U.S. for 1994 was 31,142. Of the 31,142 completed suicides, 318 were individuals between the ages 10-14; 4,956 were in the age range 15-24; and 25,868 were individuals above the age of 24. However, researchers think the rate could be much higher due to unreported suicides. Suicide is the third leading cause of death for persons between the ages 15-24, behind only unintentional injuries and homicide. The suicide rate among teens and young adults has been on the rise. In the last 25 years, the suicide rate of adolescents and young adults between the ages of 10-14 and 15-24 has increased three-fold. There is substantial evidence that the increase in the suicide rate among young people may be associated with an increase in the prevalence of alcohol abuse and availability of firearms. It is also suggested that an association exists between alcohol intoxication and suicide by firearms.

Due to this high correlation between completed suicides and gun availability - it is strongly recommended that all firearms be removed from the home, especially if a family member is experiencing current depression and or a past episode of depression. Research indicates that it is crucial to remove firearms from the home, even if the firearms are locked and ammunition is unavailable. Availability of firearms in the home may be a risk factor for teen suicide even if the teen shows no obvious signs of mental disorder.
Causes of Depression

There is no single cause for clinical depression. Rather, there are a variety of interrelated factors, some of which may have more weight in certain depressions than others. Among these factors are genetic predisposition, biological imbalances, personality characteristics, learned behavior or thought patterns, and stressful life events.

Genetic/Familial Factors

It has long been known that depression runs in families. Because children of depressed parents tend to become depressed even when raised by nondepressed, adopted parents, it is felt that there is a genetic aspect to depression. Genetic factors are those inherited traits under biological control (e.g. hair color or eye color). In addition, there may be nongenetic factors within the family that influence the chance a child will develop depression.

Biochemical Factors

Several years ago physicians noted that certain medications had strong mood-altering effects, leading to the idea that mood disorders could be a function of a biochemical disturbance that could be stabilized by drugs. The results of many clinical studies have revolutionized the treatment of psychiatric disorders. Five main types of drugs, the tricyclic antidepressants, the selective serotonin reuptake inhibitors of (SSRI), the monoamine oxidase inhibitors (MAOI's), lithium carbonate and some medications commonly used to treat seizures are now available to treat depression. Most of these medications have been very effective and can be seen as further evidence that biochemical disturbances are present in some depressed people. Research involved in the study of animal and human brain tissue has also added to the evidence that biochemical imbalances exist that contribute to some types of depression. A group of chemical compounds, the biogenic amines, have been shown to regulate mood. These chemical messengers or neurotransmitters transmit electrochemical signals from one nerve cell in the brain to another. These neurotransmitters (messengers) set in motion the complex chemical interactions that control our behaviors, feelings, and thoughts. Studies suggest that too much, too little, or an improper balance of these messengers may be why a person experiences depression and mania. These important amines are concentrated in areas of the brain that also control drives such as hunger, sex, and thirst. Serotonin and norepinephrine are two of these neurotransmitters thought to be related to depression. Serotonin is believed to be associated with energy level, sleep, and aggression. It may be that a genetic predisposition to depression leads to an alteration in certain biological factors, since non-depressed youth whose parents have depression show very similar biological
changes in serotonin, to those who are actually depressed (Birmaher et al., in press).

**Cognitive Distortions and Social Skills**

Cognitive theories of depression maintain that distorted thinking is central to clinical depression. This type of thinking can be described briefly as a view of the world as cruel, the self as deficient and unworthy, and the future as hopeless. Cognitive distortions include logical errors, dichotomous (black and white) misinterpretation of events, and overgeneralization. The cognitive model suggests that this type of negative thinking is developed early in life and can lead to depression. When under stress, a person with a tendency to negative thinking is more likely to become depressed. For example, if a vulnerable person fails a test, he/she may respond by thinking, "I'm a failure." If a boy/girl is rejected by a girl/boyfriend, he/she may think, "without him/her, I'm nothing." These views lead to worsening self-esteem and increasing depression.

There is evidence that parental and child cognitive style are related, which could be due to either modeling or genetics.

**Environmental and Other Factors (Loss, Stress, Life Events, Chronic Illness)**

Researchers have found that certain kinds of life events including a serious loss, death of a loved one, a divorce, the loss of a job or the move to a new home can trigger depression, especially in those that are vulnerable. Chronic illness may also be a precipitant to the onset of depression. A number of studies have shown more "exit" events (divorce or loss), more undesirable events, more "severely threatening" events, and more uncontrollable events in the six months prior to the onset of depression.
Types of Treatment

Effective treatments are available now, despite the enormous amount that still remains to be learned about the causes and treatments of depression.

Psychotherapy

Psychotherapy involves the presence of an interested, but objective person (therapist) and the use of talking to define and resolve problems. There are many types of psychotherapy but only a few are designed to specifically treat depression. These are usually short-term therapies with a typical duration of six months or less. All psychotherapies aim at improving the person's social and personal functioning. Some therapies are designed to help the depressed person alter ways of thinking and viewing, while other therapies deal more with changing behavior and interaction patterns with others.

Psychotherapy is useful for the depressed person, but not for the person who is so troubled they can't talk or for the person with psychotic or manic symptoms. Psychotherapy is often used in combination with medication therapy (pharmacotherapy). The six most commonly used psychotherapies with depressive illness include cognitive, supportive, family, behavioral, interpersonal and psychodynamic psychotherapy.

Cognitive Therapy

This treatment focuses on the depressed person's negative or distorted thinking patterns. It is often a characteristic of the depressed person to minimize good events and overemphasize bad ones. For example, a person may do well on a test, but attribute it to "luck" or may fail one out of seven exams and focus unduly on the one failure. Depressed people may also overgeneralize or think that a single event will happen over and over again. For example, consider the boy who asked a girl for a date and was turned down. An example of overgeneralization would be to conclude, "I'm never going to get a date; girls are always turning me down." Another cognitive distortion is that of "all or nothing", black/white categories. "All or nothing" thinking is clearly illogical because things are not usually completely one way or the other. This type of thinking causes people to fear any mistake or imperfection because they will then see themselves as a complete zero and feel inferior, worthless and depressed.

Cognitive therapy assumes that negative thought patterns like the examples just mentioned lead to depressed feelings and that the way to change the depressed feelings is to help the depressed individual to monitor and modify the thoughts. The emphasis is on the depressed person's learning to correct the disturbed thought patterns through various exercises, such as keeping daily records of activities and negative thoughts. The therapist helps the person develop skills to continue self-correction and evaluation that can be used long
after the therapy has ended. Extensive evidence now exists in depressed adults and adolescents that this is an efficacious treatment for depression.

**Supportive Therapy**

In this approach, the focus is upon developing a helpful working relationship with a therapist who can assist people to clearly review and then better understand the problems that they may have experienced. The therapist and the person, then, work closely together by forming a relationship based on trust, mutual respect and genuine concern, in which they review the person's problems and coping abilities. The therapist tries to help the person to decide on more constructive ways of dealing with stressful circumstances. Time is devoted to allowing persons to discuss their feelings and beliefs about different experiences. This therapy assumes that by developing a special relationship with the therapist and by allowing the person to determine what takes place during the session, a person will be more optimistic about a specific problem and will show improvements in handling similar problems. Supportive treatment is an important element of all treatment, including pharmacotherapy, but probably is not sufficient as a sole mode of therapy for depression.

**Family Therapy**

Family therapy actively involves other family members in the treatment of the depressed adolescent. This form of treatment strengthens communication skills between parents and children and teaches problem solving strategies that can be helpful in reducing stress and frustration and ultimately depressive symptomatology. Families learn how to recognize symptoms of depression; how to identify sources of stress or conflict; and how to improve strategies to negotiate their differences. It is believed that by helping the parents and children to be more aware of each others' ideas and feelings, mutual support will increase and that this will help reduce the depressed adolescent's tendency toward isolation and negative interactions. In this way the treatment can enhance the recovery process and reduce the likelihood of future depressive symptoms. In general, cognitive therapy was shown to be superior to one form of family therapy for adolescent depression, but family therapy was shown to be particularly helpful if the patient was very impaired.

**Behavioral Therapy**

This therapy assumes that depressive behaviors are learned and reinforced in the environment. An example would be the shy, awkward woman who doesn't get asked to dance at a party. She may drop her head and her shoulders may hunch, and her own behavior may discourage any other people from asking her to dance. Given enough of this negative reinforcement, the pattern becomes fixed. Behavior therapy focuses on changing the person's behaviors and their environment. The person can be taught to monitor their events, decreasing the unpleasant ones and increasing the pleasant ones. Changing the person's environment by encouraging close associates to pay
attention to the depressed person's positive behaviors would be another intervention of some behavioral therapies. Specific social skills are taught and self-reward after positive behavior is encouraged. Behavioral techniques are an important component of cognitive therapy, particularly in those who are more severely depressed.

**Interpersonal Therapy**

This particular therapy focuses on disturbances in functioning between the depressed person and others in his/her life. Depressed symptoms are assumed to arise as a result of grief, normal life changes, role transitions and problematic or unfulfilled personal relationships. This approach deals with the current life situation of the patient and tries to resolve current problems. The therapist will teach the person about depression and how their feelings connect with important events within their environment. They may also focus on changing behavior and social skills. This form of treatment has been shown to be efficacious in adults and is currently being tested for adolescent depression.

**Psychodynamic Psychotherapy**

This approach involves seeing depression as a symptom of a complex set of character problems stemming from the person's early childhood experiences. Psycho-dynamic therapies aim to treat the "whole person" instead of the "symptoms" such as depressed mood. Psychodynamic therapies focus on the unconscious conflicts which are thought to be central to the depressed state of the person. A key element in psychodynamic treatment is "transference," a situation where the individual in treatment "transfers" perceptions and feelings about important childhood figures onto the therapist at therapy sessions. The therapist helps the patient change relationship patterns that are carried from the past. Currently, there is no empirical evidence to support the use of psychodynamic psychotherapies in treating adolescent depression.

**Medication**

There are five major types of drugs used to treat mood disorders:

**Selective Serotonin Reuptake Inhibitors (SSRI's)**

Examples of these medications are Fluoxetine (Prozac), Sertraline (Zoloft) and Paroxetine (Paxil). These medications work by increasing the brain's supply of the neurotransmitter called serotonin (Table 2-a,b,c). These medications are very selective towards the serotonin. This selectivity may explain why these medications tend to cause fewer of the disturbing side effects, such as drowsiness and dry mouth, seen with some other antidepressants. The most common side effects include nausea, stomachache, diarrhea, nervousness, suppressed sexual desire and enjoyment, insomnia or in some individuals sleepiness and lack of appetite.
Some depressive symptoms may improve after 1 or 2 weeks of taking these medications. However, it can take 4 to 6 weeks to notice significant improvement. Occasionally these medication (also the tricyclics) may induce symptoms of mania. In this case, the medication must be discontinued.

There have been several news media reports about Fluoxetine (Prozac). Many of the positive and negative reports have been distorted and sensationalized. The scientific data and worldwide medical opinion support the view that Fluoxetine (Prozac) does not cause suicide. On the contrary, Fluoxetine (Prozac) is seen as a very effective choice of treatment for depression and the risk of suicide is lower than in the standard tricyclic antidepressants. Prozac has been shown to be more efficacious than placebo in child and adolescent depression.

**Tricyclic Antidepressants**

Some examples of tricyclic antidepressants are Imipramine, Amitriptyline, Desipramine, Doxepin, Nortriptyline, and Amoxapine. Tricyclics act in relieving such depressive symptoms as loss of appetite/weight, loss of energy, decreased ability to feel pleasure, psychomotor retardation, suicidal thoughts, hopelessness and guilt. In general, depressive symptoms can be alleviated in 4-6 weeks. All tricyclics work similarly but they differ in their side effects. They may alter different neurotransmitters, usually some combination of serotonin and norepinephrine. A person may tolerate one antidepressant but not another. This is the reason that different antidepressants may be used with a particular individual. As mentioned, the side effects of tricyclics vary but the most common are dry mouth, constipation, dizziness, drowsiness, low or high blood pressure, rapid heart beat and problems with the electric conduction of the heart. Due to these side effects, the person taking this group to medications needs careful monitoring including measuring blood pressure, heart rate and electrocardiograms. These side effects generally lessen and disappear as treatment continues or after the dose of the medication is reduced or discontinued. The tricyclics have not been shown to be more efficacious than placebo in child and adolescent depression and can be fatal if taken in overdose. Therefore, these medications are not used as first choice drugs.

**Monamine Oxidase Inhibitors (MAOI’s)**

The other group of antidepressants, MAOI’s, are more likely used with people who have depressive symptoms such as overeating and or oversleeping. Symptoms such as anxiety, phobia, and obsessive/compulsive tendencies also respond to MAOI’s. MAOI’s are frequently used if a person has not responded positively to the use of other antidepressants. They have been shown to be particularly effective for depression associated with bipolar disorder and mood instability, or the pattern of “atypical” depression (mood reactivity, overeating, sleeping too much, fatigue).

The greatest problem with using certain types of MAOI’s is the diet and drug restrictions a person must follow while using the MAOI’s. Only people who
are willing to follow the strict restrictions can use MAOI's. Foods that are prohibited include processed meats, cheese, pickles and pickled foods, red wines and sherry, certain drugs such as amphetamines, barbiturates, some cough medicines, nasal decongestants and certain other antidepressants. Please consult your physician prior to beginning any additional medications. The interaction of MAOI's with any of these substances can cause quick and severe rise in blood pressure, accompanied by severe headaches and other symptoms.

Mood Stabilizers

There are three mood stabilizing agents in wide use - Lithium, Valproic Acid (Depakote) and Carbamazepine (Tegretol). These medications are used at various points in the treatment of Bipolar Disorder including, as part of the acute treatment of manic symptoms; once stabilizd, as way to "prevent" against future episodes of mania and depression; and to augment treatment of refractory depression.

Lithium Carbonate

Lithium Carbonate was the first of the mood stabilizers to achieve wide use. Use of Lithium has been shown in adults to be quite helpful in preventing subsequent episodes of mania and in treating episodes of acute mania. In general, Lithium, like the other mood stabilizers is a real antidepressant in its own right. Lithium is taken daily to achieve a certain blood level that is effective in preventing wide mood swings. A balance must be struck between effective "prevention" and "flattening" out the bipolar patients personality and flair, which may lead to non-compliance. In adolescents with mania, Lithium may be ineffective, particularly in those with prepubertal onset, comorbid externalizing disorders and mixed state/rapid cycling. For those conditions, Valproic Acid or Carbamazepine may be superior. In adults, the co-occurrence of depression and mania responds better to Valproic Acid/Valproate than to Lithium.

Lithium is a naturally occurring element that contains many properties in common with the electrolytes present in body tissue and fluids. Initial side effects may include nausea, stomach cramps, thirstiness, hand tremors, weight gain, and feelings of being slightly tired. These effects are usually transient, but some may persist for the entire treatment. Regular blood tests are always given during lithium treatment to ensure that the level of the drug is within the therapeutic range. High levels of lithium in the blood may be dangerous. When lithium levels are high, symptoms such as slurred speech, confusion, unable to walk well, vomiting, diarrhea, and/or severe tremors, serve as a warning to the patient and relatives to be seen immediately by their physician or the local emergency room. Individuals taking lithium should not be on sodium (salt) restricted diets. Also, if the patient is not going to have enough liquids, or has an illness that produces diarrhea or vomiting he/she should contact their physician.
If you or your child/teen are on medication and become or suspect you may be pregnant, please notify your physician immediately. Lithium is associated with serious birth defects in babies exposed to Lithium in utero.

Valproic Acid (Depakote)

Valproic Acid is a medication that has been used to treat epilepsy but is quickly becoming a first-line drug for the treatment of Bipolar Disorder. As noted, Valproic Acid may be especially helpful for bipolar youth with rapid cycling or mixed state.

Among the possible side effects of Valproic Acid (Depakote) are nausea, vomiting, drowsiness, and sometimes hair loss. The person taking this medication needs careful monitoring including blood levels to monitor liver functions. These side effects do not occur for most individuals but if they do occur, the psychiatrist should be notified immediately.

Carbamazepine

Medications such as Carbamazepine (Tegretol) are used to treat epilepsy, also have been used successfully for the treatment and prevention of Bipolar illness. Carbamazepine is used alone or in combination with Lithium. The possible side effects of Carbamazepine are occasional dizziness, drowsiness, double vision, rashes, nausea and difficulty in coordination. With this medication there is the possibility of a reduction in white blood cells and platelets, therefore requiring occasional blood tests. If there are signs of infection, the psychiatrist should be consulted.

In research studies, Carbamazepine alone, or in combination with Lithium, has been shown to be helpful for adolescents with Bipolar with Mixed States.

How these drugs work

The drugs discussed earlier, work by correcting the imbalances among neurotransmitters. The tricyclics and MAOI's appear to affect the symptoms of depression by increasing the availability of neurotransmitters. Selective Serotonin Reuptake Inhibitors (SSRI's) increase the availability of a specific neurotransmitter, serotonin and probably secondarily affect other neurotransmitters. Lithium seems to control mania by stabilizing the amount of transmitters.

Many families become concerned that their child will become addicted to these medications. Anti-depressant medications and mood stabilizers are not addictive.

Combination of Medication and Psychotherapy

Medications may improve the depressed person's mood and can effectively treat the person's sleep and appetite problems, however, they cannot
augment social skills that may be deficient from chronic effects of depression. Therefore, beneficial outcomes usually can be achieved by simultaneously reducing symptoms with the medication and promoting learning through psychotherapy. Usually it is recommended to begin with one treatment, such as psychotherapy, and add additional treatments as needed.

Light Therapy

Individuals affected with seasonal affective disorder indicate a marked responsiveness to changes in climate and light conditions. Many have noted improvement in depressive symptoms following moves to warmer, sunnier climates. Light therapy consists of sitting for 30-40 minutes, once or twice per day, in front of a special lamp which provides a measured amount of full spectrum or specific wavelength light equivalent to standing outdoors on a clear spring morning. The light, unlike regular light, replicates the natural daylight without the dangerous ultraviolet.
Course of Treatment

The course of treatment for depression varies based on the severity and chronicity of the illness, co-existing conditions, treatment model, and preference of the therapist, patient and family.

Phase of Treatment

Generally, treatment of adolescent depression can be considered to occur in three phases. The first phase includes assessment of symptomatology including suicide risk and providing psychoeducation to the patient and family about the disorder and treatment of choice. Prior to beginning treatment, the therapist should also conduct a careful review of associated problems such as social, academic and family functioning. The second phase is active treatment directed at symptom improvement. The acute treatment of depressed adolescents usually begins with 12-16 weeks of weekly therapy and or medication checks. Once improvement has been established, the frequency of sessions usually begins to taper off to every other week. Symptoms should continue to be monitored. If progress continues, session frequency could decrease to monthly, then every two months. For most depressive episodes, treatment and monitoring should continue for at least 6-9 months, once symptoms have begun to remit. The third phase of treatment involves evaluating progress, revising treatment goals and establishing a plan for maintenance. Parents and patients are encouraged to monitor for recurrence and to come back to treatment even with mild depressive symptoms. The return of mild symptoms could be a signal of recurrence and can be more efficiently treated at the early stage.

For individuals with multiple episodes of depression, chronic maintenance treatment is recommended. Individuals experiencing "double depression" (Major Depression and Dysthymia) the course of treatment may be prolonged. The course of treatment for Bipolar Disorder also tends to be longer due to the chronic nature of the disorder.
The Family and Depression

Impact of Depression on the Family
- Changes in routines for the family due to the depressed person's impaired functioning.
- Increase in anger, frustration, and irritability for family members because of the disruption.
- Feelings of guilt and blame occur for family members.
- Feeling resentful and ashamed of the depressed person and what's happening in the family.
- Experiencing anxiety and fear about the illness, wondering when it will go away, or who else will become depressed.
- Feeling the need to "walk on eggshells" around the depressed person.

Common Responses and Feelings of Family Members

It is very normal for family members to try and help the depressed person with common-sense solutions. Reassuring the person that the depression will go away, giving the person advice to become active, ignoring the problem, or advising the depressed person to logically view his or her problems are all normal responses; however, this advice is often brushed aside by the depressed person because of his or her inability to hear the support or to view situations in a logical fashion. These ordinarily helpful techniques do not usually work because the depression is actually blocking the process. These methods of reassuring the person that everything will work out and advising them to pull themselves together are not usually effective because they are based on the assumption that the person has the ability to "turn on and off" their illness. The depression is a major influence on the child's behavior.

It is normal for family members of the depressed person to sometimes feel helpless and frustrated. It is common to experience feelings of anger, guilt, and fear. Other family members will often become tired of hearing about the depression or having to deal with the depressed person's irritability, hopelessness and rejection of help.
Helping the Depressed Person

Continued Functioning of the Family

It is important for the family members of a depressed individual to take care of themselves and try to go on with their own lives. It is important to go places, see friends, and enjoy yourselves even if the depressed individual does not want to. Family members are long-term support resources for the person, therefore, to be helpful, you must be functioning well yourselves. Although it is very difficult, you must try to not allow the depression to control the whole family or completely disrupt your lives. It is also important to keep the family functioning normal. Do not become dominated by the depressed person’s needs and demands or allow yourselves to feel guilty for not responding to his/her every need. It is crucial that parents of the depressed child or teen, take time for themselves. As we are routinely reminded by the flight attendant on an airplane, "If you are traveling with a child and an emergency situation would arise, please place the oxygen mask on yourself first, before placing it on your child." "You will be unable to take proper care of the child unless you are first taken care of."

It is essential for family members to recognize depressive symptoms if they are occurring for themselves. As we have described, depressive conditions do tend to run in families. In a recent study of depressed adolescents, it was found that a high percent of the depressed teens, also had at least one parent who was actively depressed. The study noted that untreated parental depression and/or anxiety were predictors for poor treatment outcome for the depressed teen. If you suspect that you or someone else in your family is experiencing depression, please let us know and we will assist you in seeking an appropriate referral. Your treatment is an important part of your child's treatment and you can help your child get well by getting well.

Communication

Communication between parents and teenagers can breakdown during times of high stress. Depression, like other illnesses, can be very stressful for everyone in the family and very often lead to more arguments. Although it is not always easy, it is during these times of greater stress that family members need to talk with each other in helpful ways. The following guidelines may be helpful:

First try to talk directly with your child about the things that concern you. If possible, address small issues as they come up rather than letting small irritations build to a point of great tension. Teenagers like a parent who can listen but very often react negatively to advice. It can be helpful to ask your child first if they want suggestions before offering alternatives. It is inevitable that you and your child will disagree about a variety of issues. Clear, simple rules and reasonable expectations will make it easier for your child to know what to expect. Some parents are afraid to praise their children but praise and positive feedback are very important. Criticism and negative remarks are best delivered in a calm tone of voice. Remember that improvement is a gradual process and parents
who notice small positive changes and comment positively on those changes can aid their child's recovery greatly. Lastly, as a parent you may need a supportive person who will listen to your worries. Sometimes children inappropriately try to serve as a parent's main support but over the long run this can lead to too much stress for the child and ineffective support for the parent. Communicate your needs to other adult family members or friends who can provide the support you deserve.

It is important for family members to say what they feel directly to the depressed person, even when the feeling being experienced is anger. However, it is one thing to tell someone you are angry, and another to shout or lose your temper. Tell the person when you are unable to be supportive to them. It is acceptable to say you can't deal with something at a particular time. Be truthful and direct about negative feelings. You cannot protect the person from your negative feelings. It is especially important that you express your positive feelings about the person. Let them know when you notice improvements in their mood or behavior.

The tone of voice and facial expressions used when communicating is very important. How you say something to the depressed individual is often as important than actually what you say. If you are experiencing frustration and a lot of blowups at home, then having a therapist help improve communication between you and your teen should be a part of the treatment.

Family Members as Partners in the Treatment

Family members are partners in the depressed person's treatment. It is important to encourage the person to use the psychotherapy sessions to work on problems and concerns. Encouraging the person to take the medication as directed is an essential way of helping. Learning to recognize depressive and manic signs, for example, subtle changes in motivation, sleep, concentration and mood, will help significantly so that the individual may seek treatment before the illness worsens.

Changing Expectations

While it is not appropriate to "baby" the depressed person, it is important to recognize that symptoms of depression may limit performance in such areas as schoolwork and interpersonal relationships. The depressed person is not to blame for his/her situation and neither are you. Accepting that the family member is experiencing a legitimate medical illness is essential to their recovery. Be hopeful about the person's outcome because depression is very treatable, however, it may be necessary to modify one's expectations of the depressed person. Recognizing that the recovery is gradual and supporting their improvements along the way are especially important. You may work with the therapist to set reasonable expectations for your depressed child/teen.
Coping with Depression

Dealing with Emergencies/Suicidality

Families can learn to detect slight changes or early symptoms that occur at the beginning of episodes. Recognizing the symptoms early and seeking treatment at that time is essential. One of the most important factors for prevention of suicide in children and adolescents rests on the ability to recognize individuals at risk for suicidal behavior. Though a depression may appear mild, it does not exclude the possibility of suicide. Remember that it is not true, as many people believe, that a person who talks about suicide will not attempt it. Those who attempt suicide often appeal first for help by threatening to do so.

If the depressed person begins talking about death or suicide, it is crucial to contact the professionals involved in his or her treatment. If the individual has talked about suicide, it is essential to ask for specific information about their immediate safety. Making or reaffirming the “safety plan” is crucial. The safety plan is a plan for coping with suicidal thoughts and urges (Table 3). If the person is not actively involved in treatment, or is unable or unwilling to respond to your inquiry about his or her immediate safety, it is appropriate to contact your local hospital or emergency room. **Take seriously any suicidal talk or behavior by the person.** **Remove all available methods, such as firearms and medications.** There are emergency procedures that can be utilized to hospitalize the person if they are at immediate risk to harm themselves or others.

Effective Coping Strategies

- Be hopeful - depression can be treated.
- Encourage person to remain in treatment.
- Encourage person to take medication as prescribed, even if beginning to feel better. Parents should maintain control of the medication supply.
- Take care of yourself, go on with your life
- Be direct in communicating.
- Provide feedback about positive changes you noticed. Always take suicide talk seriously - let us know.
- Make school aware of what is occurring - they can be supportive.
- Remember the illness is causing the person's changes - avoid taking angry comments personally.
- Look for gradual improvement.
- Encourage the person to follow through with specific plans or steps, but avoid overprotecting or overdoing for the person. Gentle
assertiveness may be required to assist the depressed person, especially if they are withdrawn.

• Get treatment for self if needed.
• Please call us with any questions or concerns.

Depression is one of the most treatable of all the mental illnesses. Progress in research in all areas related to the depressive illnesses has been made and is continuing. Although there remains a lot we do not know yet, we look to the promise of continued research. After having read this manual, you will now be familiar with the basic features, types, and treatment approaches for depression. We hope you find this information helpful, and we look forward to working with you.
References


Hypomania

Atypical Bipolar

Children and Teens

Bipolar

Manic Depressive

Unipolar

Major Depression

Table 1
In Many Depressed Patients, Certain Chemicals in the Brain May Be in Short Supply

- Chemicals in the brain—like serotonin and norepinephrine—are known as “neurotransmitters”
- Neurotransmitters help to transmit messages between nerve cells
- Depression may be associated with reduced availability of the serotonin neurotransmitter in the synapse between these nerve cells

Hypothesized model of serotonin neurotransmission
DEPRESSION AS A CHEMICAL IMBALANCE

- Sometimes these neurotransmitters are reabsorbed by one nerve ending before they have had a chance to make contact with the next nerve cell; as a result, they cannot perform their function.

In depression there may be a shortage of the neurotransmitter serotonin in the synapse.
TREATMENT OF DEPRESSION

Many Depressed Patients Respond Well to Medication

- Antidepressant drugs work by helping to restore the brain's chemical balance
- Blocking the mechanism of reabsorption may lead to an increase in the availability of serotonin neurotransmitter

Antidepressant drug blocking reabsorption of serotonin neurotransmitter

- Drug therapy for depression may take up to 1 month or more to become fully effective—so don't expect overnight success
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<th>SAFETY PLAN</th>
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<td>SETTING THE STAGE</td>
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| Identifying Warning Signs |
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<th>SAFETY PLAN</th>
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| Step 2: External Strategies – People who can help distract me: |
| 1. |
| 2. |
| 3. |

| Step 3: External Strategies – Adults who I can ask for help: |
| 1. |
| 2. |
| 3. |

| Professionals who I can ask for help: |
| Therapist Name _______________________/Number _______________________

Star Clinic Main Number: 412-246-5619
WPIC (Hospital ER) 412-624-2000 (24 hours)
RESOLVE 1-888-796-8226 (24 hours)
Table 3

What is a Safety Plan?

Review with the teen and later teen and parents:

Plan for coping with suicidal thoughts and urges:
1. Teen commits to family and clinician not to engage in suicidal behavior
2. Teen agrees to implement safety plan if become suicidal
3. Safety plan is based on review of precipitants, vulnerabilities, cognitions, emotions leading to behavior
4. Review barriers to implementation with patient and parents

Safety Plan: Strategies*
*Samra & Bilsker, 2007; Stanley & Brown, 2008
1. Avoid activities or situations that may trigger suicidal thoughts (“Truce”)
2. Review Reasons for Living
3. Personal: Emotion regulation, distraction, exercise
4. Interpersonal: Contact friend, parent
5. Professional: Contact therapist, crisis line, ER
6. Write it down
7. **Assess confidence to implement, anticipate barriers**

- If you are having thoughts of hurting yourself go through these steps
- Remember suicidal thoughts usually pass with time
- Let’s make a written copy of this plan for **you to take home with you today**:
Safety Plan

- Activities that can calm/comfort me

- Truce/distance from stressors

- Review reasons for living

- Call friend/family member

- Call professional, crisis line
  Resolve: 1-888-796-8226
  WPIC ER: 412-624-2000

- Go somewhere safe

- Go to ER/call for transport

(Samra & Bilsker, 2007)*