

Consider the prevalence of childhood depression, giving specific reference to psy...



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Consider the prevalence of childhood depression, giving specific reference to psychological treatments for depressed students. Depression in childhood or adolescence may be one of the most overlooked and undertreated psychological disorders within the field of mental health. Depression in children and adolescents has become an important issue in research due to its many emotional forms, and its relationship to self-destructive behaviours. Furthermore, depression in childhood or adolescence may be a particularly distressing experience for both the young person and family members or care givers involved. Unfortunately, there does not seem to be a positive outcome for children and adolescents who are suffering with depression. Available evidence suggests that while the majority of adolescents recover from a depressive episode within a year, they do not grow out of their mood disorder completely (Harrington, 1993). Major depression is a recurrent condition and depressed adolescents are more likely than their non-depressed peers to develop episodes of depression in adulthood.

Most experts in childhood psychopathologies (e. g. Achenbach, 1995) agree that there are three main categories of psychological disorders in children and adolescents. The first two are attention problems which impair the ability to concentrate, also externalising problems including both delinquency and excessive aggressiveness or defiance, in which the deviant behaviour is directed outward. The third category, internalising problems include problems of depression, anxiety or eating disorders, in which unusual behaviour is largely directed internally.

Children and adolescents who show internalising forms of psychopathology often display signs of having different developmental problems than children with conduct disorders. The symptoms of depression amongst children and adolescents are persistent feelings of sadness accompanied by impairment in daily functions, such as interacting with family, friends and doing schoolwork. The present work sets out to explore the extent to which childhood mood disorders are considered significant, and the currently available therapies used to treat these problems.

Researchers have found abundant evidence that depression is actually quite common in adolescents and it occurs a lot less among younger children. It is estimated that 10% of preadolescent and 30-40% of adolescents experience a significant short term depressed mood or unhappiness (Compas, Hinden, & Gerhardt, 1995). When a depressed mood lasts 6 months or longer and is accompanied by other symptoms, such as disturbances of sleeping and eating and difficulty concentrating, it is usually referred to as clinical depression or a major depressive disorder. An approximation of the frequency of clinical depression among children and adolescents vary somewhat, the best studies suggest that at any given time about 1.0% of preadolescents and between 1.6% and 8.0% of adolescents are suffering from long-term depression (Cicchetti & Toth, 1998).

Conceivably twice as many young people will experience serious depression at some time in adolescent years (Compas, Ey, Grant, 1993; Merikangas & Angst, 1995). They last on average for 7 to 9 months, but they are highly likely to recur: As many as 90% of those who suffer a major depressive

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episode, experience a recurrence within 2 years (Cicchetti & Toth, 1998). Furthermore, depression can have serious consequences. For one thing, depression can interfere with learning by slowing down the speed at which the brain processes information (Calhoun & Dickerson Mayes, 2005). Depressed adolescents are more likely than their non-depressed peers to use drugs (Rey, Sawyer, Raphael, Patton, & Lynskey, 2002).

Also, a significant proportion of depressed adolescents have stated that they think about suicide (Fennig, Geva, Zalzman, Weitzman, & Apter, 2005). In accordance with this ChildLine.org.uk (2011), have stated that between 2005-2006 the majority of their calls were about depression and predominantly from young people aged 12 and over, with children under 12 accounting for only 5 per cent of calls (as compared to 23 per cent of total calls to ChildLine about all issues). Girls accounted for more than three quarters (77 per cent) of calls about depression.

??? Figure 1. 1 | ChildLine Calls Received | Girls | Boys | Total || April 2005 ???
 March 2006 | | | || Depression | 1, 609 | 476 | 2085 || Self-Harm | 1, 854 | 158
 | 2, 012 || Suicide | 1, 009 | 256 | 1, 265 || Eating Problems | 631 | 94 | 725 ||
 Total Calls | 5, 103 | 984 | 6, 087 | As we can see from the ChildLine figure 1. 1, sex differences in the distribution of depression have consistently been found. Depression is more common amongst adolescent girls than boys. This prevalence of depression among teenage girls than boys is similar to the sex distribution of depression among adults (Carr, 1999). The relative contribution of; ??? Biological factors (brain function, the influence of neurotransmitters and hormones).

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??? Psychosocial factors (interpersonal relationships; the social environment where differences in ethnicity and social class come into play; and interactions between genders across age groups for both females and males). Even with the biological and psychosocial factors addressed, it still seems that sex difference in prevalence is unclear. Hypothesis about the discrepancy of hormonal changes in puberty on boys and girls and differing role demands on male and female adolescents deserve exploration (Carr, 1999). In one longitudinal study of youths growing up in a working class neighbourhood in the United States, one-fifth of those who had a period of serious depression by the age of 18 had also attempted suicide (Reinherz, Giaconia, Pakiz, Silverman, Frost, & Lefkowitz, 1993).

Interestingly, during the preadolescent years, boys and girls are equally likely to be unhappy or depressed; however, between the ages of 13 and 15, girls are twice as likely to report high or chronic levels of depression. This sex difference persists throughout adulthood and has been found in a number of industrialised countries and among African Americans, Hispanic Americans and Caucasian Americans (Culbertson, 2001). Evidence suggests that the percentage of girls experiencing depression is much higher than with boys, but why is this Research proposes that children growing up with depressed parents are much more likely than those growing up with non-depressed parents to develop depression themselves (Merikangas & Angst, 1995). Evidentially, this finding could indicate a genetic factor; a possibility supported by studies of twins and adopted children (Petersen et al, 1993). Alternatively, the connection between parental and childhood depression

could be explained in terms of changes the parent-child relationship having suffered a breakdown due to the parents depression.

Consequently, depressed mothers are much more likely than non-depressed mothers to have children who are insecurely attached, as the mother is often so non-responsive to her child that her behaviour seems to promote in the child a kind of helpless acceptance. Such a sense of helplessness has been found to be strongly related to depression in both adults and adolescents (Dodge, 1990). Evidently, not all children of depressed parents are themselves depressed. About 60% show no abnormality at all (Dodge, 1990). Whether a child follows the pathway toward depression seems to be influenced by a number of other stresses that are present in their life such as family arguments, domestic violence, alcoholic parents or family members, serious illness, parental work stress, loss of income or marital separation. The major role of the stressors in the emergence of depression is clear among children whose parent or parents are not depressed. Any combination of stressors ??” such as the parental divorce, the death of a parent or another loved one, a parent??™s loss of job, a move or change of schools ??” increases the likelihood of depression in the child (Chang, 2001; Compas et al., 1993).

Indeed, the role of such individual life stresses may help to explain the sex differences in depression among adolescents. Petersen proposed that ??? girls are more likely to experience simultaneous stressful experiences in adolescence, such as pubertal changes combined with a shift in schools (Petersen et al, 1993). A longitudinal study conducted Petersen, found that

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depression was not more common among girls than among boys when both groups had encountered equal levels of life stress or comparable simultaneous stressful experiences. (Nolan-Hoeksema & Girgus, 1994) agree with Petersen that one of the keys is that teenage girls face more stresses than boys. Although, (Nolan-Hoeksema & Girgus, 1994) argue that girls respond to their down moods quite differently than boys do. Girls are more likely to dwell on their sadness or distress; this coping strategy actually accentuates the depression, producing longer-lasting depressive episodes. Boys on the other hand are more likely to use distraction ??“ exercising, playing games, or working to deal with their own moods, a coping strategy that tends to reduce depression.

A study conducted by (Hartgers & Whitsell, 1996) revealed that adolescents who feel that they do not measure up to their own standards are much more likely to show symptoms of clinical depression. In fact, high self-esteem and a strong sense of identity seem to protect teens from the potential effects of life stresses (Chang, 2001). Developmental psychologists have identified that adolescents are much more likely than younger children to define themselves and others in comparative terms ??“ to judge themselves against some standard or to see themselves as ??? less than??? or ??? more than??? some other person (Chang, 2001).

Also, in adolescence physical appearance becomes highly important, and a numerous teenagers are convinced that they do not live up to culturally defined appearance standards. Self esteem thus drops in early adolescence, and depression rises (Carr, 1999). The research conducted by developmental

psychologists has enabled others such as school psychologists to understand the increase in depression in adolescence and the noticeable difference in rates of depression.

Depressive disorders are of particular importance to school psychologists, who are often placed in the best position to identify, refer, and treat depressed children/adolescents. Within the school setting, depression in students has become difficult to treat due to a lack of referrals for treatment ??? parental denial and insufficient symptom identification training??™ (Ramsey, 1994). In addition, recognising and diagnosing childhood depression is not a simple task. According to Janzen and Saklofske (1991), depression can develop either suddenly, or over a long period of time, ??? it may be a brief or long term episode, and may be associated with other disorders such as anxiety???. The presence of a couple of symptoms of depression is not enough to provide a diagnosis.

A group of symptoms that co-occur, and accumulate over time should be considered more serious. Depression is classified by severity, duration, and type according to the DSM-IV-TR, published by the American Psychological Association (2000). According to Callahan and Panichelli-Mindel (1996), many School Psychologists are not required to diagnose affective disorders in students, but do need to assess and develop interventions for them. The DSM IV appears to provide much help to school psychologists to determine the symptoms that indicate a particular disorder, and to relay that information to professionals outside of the school. According to Callahan and Panichelli-Mindel (1996), it may be difficult to provide a diagnosis when

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symptoms do not easily fit any categories. Consequently, when children/adolescents do not fit into a diagnostic category they may go without treatment when treatment is needed (Callahan & Panichelli-Mindel, 1996). While equal numbers of children develop mood problems, in adolescence there is a sharp rise in the prevalence of depression among girls.

Prevalence rates may be as high as 8% among teenage girls. Within DSM IV and ICD-10 the main distinctions are between primary and secondary mood disorders; recurrent major and persistent minor mood problems. In a study conducted by Dubuque (1998), specific guidelines are provided to help school staff generate awareness and support for depressed students. Furthermore, Dubuque (1998) reported that training programs can be implemented for school staff about childhood/adolescent depression, which will enable staff to recognise the symptoms. To assist in identification of children/adolescents in need of intervention, a variety of instruments to assess depression are available, including: ??? The Children??™s Depression Inventory (CDI), The Children??™s Depression Scale (CDS), The Reynolds Adolescent Depression Scale (RADS), The Reynolds Child Depression Scale, and The SAD Persons Scale??? (Ramsey, 1994).

Reynolds (1990) reports that although School Psychologists do not usually use clinical interviews, even though they are most effective means of assessment of depression. Clinical interviews allow an exploration of symptoms and information regarding whether possible symptoms are related to depression, or other factors (Reynolds, 1990). According to Dixon, (1987),

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there are four types of depression: normal, chronic, crisis, and clinical. The four types are distinguished by degree, intensity, duration, cause, hopefulness, response to treatment and level of functioning (Dixon, 1997). Normal depression is defined as mild periods of depression, linked to certain events that affect a student's mood periodically (Ramsey, 1994). Chronic depression involves frequent bouts of depression, often without an identifiable cause (Ramsey, 1994). Depression in a crisis state usually reflects a lack of problem-solving skills, and can be accompanied by feelings of sadness, and despair (Ramsey, 1994). Clinical depression involves a predisposition in personality paired with a crisis state (Ramsey, 1994).

Clinical depression is considered as having most severe prognosis due to the fact that after a long period of therapy, a clinically depressed student may or may not return to their normal level of functioning (Ramsey, 1994). In addition to a clear diagnosis, it is important to consider a child's or adolescent's cognitive and emotional level when deciding a treatment approach (Sung & Kirchner, 2000). The same study showed that treatment that is inappropriate for a child's level of cognitive functioning can foster negative outcomes. According to Sung and Kirchner (2000), psychotherapy can be an effective method of intervention for children with mild to moderate depression, and can be combined with medication for children that experience more severe depression. Sung and Kirchner (2000) suggest that the majority of available research on children ten years old and older deals with cognitive behavioural therapy, to help patients alter negative cognitions about themselves and the world. Cognitive behavioural therapy with

depressed children and adolescents has been shown to be productive over <https://assignbuster.com/consider-the-prevalence-of-childhood-depression-giving-specific-reference-to-psychological-treatments-for-depressed-students/>

both long and short-term treatment because of a high degree of cognitive distortions that contribute to depression in children (Sung & Kirchner, 2000). A meta-analysis of various studies revealed that cognitive behavioural therapy was shown to be more effective with depressed children than ??? nondirective supportive therapy, and systematic family therapy??? (Sung & Kirchner, 2000). Shure (1995) suggests that cognitive behavioural therapy teaches children and adolescents how to think for themselves.

Shure (1995) recommends a cognitive approach to treatment named ??? Interpersonal Cognitive Problem Solving also known as (ICPS)??? which is appropriate for children and adolescents of various ages and IQ levels. Shure (1995) suggests that lesson based games can be applied as early as preschool. The games are designed to help children get in touch with their feelings, as well as the feelings of others (Shure, 1995). According to Shure, ICPS can help children learn to generate or apply more than one solution for a problem, learn to create dialogues to express their feelings, and increase coping skills (Shure, 1995). Family intervention also appears to be beneficial in order to address parental self-blame.

Education of the child and adolescent as well as the family enhances both understanding, and compliance with treatment (Sung & Kirchner, 2000). Reynolds (1990) suggests that no one should ever engage in the treatment of a depressed child without proper training and knowledge of affective disorders, models, and treatment for several reasons. The treatment of a distressed child or adolescent with a combination of symptoms, and potential suicidal ideation is a very serious task. Reynolds (1990) suggests that if

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treatment fails, the child could be faced with increased feelings of helplessness, or despair. In a study by Fitts and Landau (1998), brief therapy is regarded as inappropriate for children and adolescents with depression. Fitts and Landau (1998) suggest that these young people are in need of ??? longer-term therapy??? that provides extensive emotional guidance and support to make a lasting improvement to child??™s quality of life.

It is also suggested, based on research, that people who are ??? extremely self-critical??? require long-term therapy (Fitts & Landeu, 1998). Fitts and Landeu (1998), clearly point out that despite these circumstances, ??? managed care??? manages costs by endorsing brief therapy regardless of the circumstances. Therefore, because a school psychologist makes a referral outside of the school system does not necessarily mean that a child will receive the long-term therapy needed. In conclusion, because of the complexity of mood disorders and depression and the uniqueness of each case intervention programmes should be based on comprehensive case formulation arising from a thorough multi-systemic assessment. Available evidence suggests that children and adolescents, multi-systemic intervention based on the principles of cognitive-behavioural therapy, family systems therapy, and social learning theory is the treatment of choice. Few, adolescents respond to anti-depressant medication, and so medication should only be considered if psychological therapy has been ineffective (Carr, 1999). Cognitive behavioural therapy appears to be the orientation most frequently endorsed by research on treatment of depressed students.

Materials can be used in therapy to actively engage students who are reluctant to comply with treatment. The materials available can present as a fun activity to students, and help the therapist gather information, and establish rapport. Stimulating activities are also suggested for use with symptom specific interventions (Ramsey, 1994). It appears that the most troublesome aspect of the treatment of childhood depression is the fact that many children remain untreated, or misdiagnosed. Education and an increase in awareness of the signs of childhood/adolescent depression can help reduce the amount of children that are left untreated. Coincidentally, the National Mental Health Association, holds Childhood Depression Awareness Day on May 9th 2011 in the UK and various other dates throughout May in America, this day is symbolised wearing by a green ribbon, consequently this event is held to help spread awareness, and education regarding the seriousness of childhood depression.

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