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Depression: Helping Handout for Home

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INTRODUCTION

Sad. Empty. Hopeless. Unhappy. Miserable. Gloomy. These are words that might come to mind when thinking of a depressed child or adolescent. However, depression in youth also appears in other ways. For example, a child may be very irritable or angry, may move around more (rather than seem really tired), and might need less sleep and more food than we would think for a person who is depressed (American Psychiatric Association [APA], 2013). Feeling sad, hopeless, or miserable occasionally is an expected part of life; however, when these feelings don't lift after a few weeks, or they cause someone to not be able to participate successfully in life's activities, it is cause for concern.

Depression is defined as a period of two or more weeks with either "depressed mood" or "loss of interest or pleasure" in things a person previously enjoyed, plus at least four other symptoms that show a change from how the person normally is (APA, 2013). These problems are typically related to sleeping (changes in amount of sleep or problems with falling or staying asleep), eating (changes in weight or appetite), energy (changes in activity level), concentration difficulties, problems with self-image (feelings of worthlessness or inappropriate guilt), or suicidal thoughts and feelings (APA, 2013).

This illness is more common in youth than most people think. In 2015, the National Institute of Mental Health (NIMH) estimated about 3 million adolescents had a major depressive episode in the past year—approximately 12.5% of the U.S. population ages 12 to 17 (NIMH, n.d.). This means that about three or four teens in a typical classroom of 30 students may be experiencing depression.

When someone has depression, it is important to get help. Those who are depressed commonly describe suicidal thoughts and behaviors. Depression also affects critical long-term aspects of a child's life, such as friendships, romantic relationships, school, work, and physical health (Thapar, Collishaw, Pine, & Thapar, 2012). Unfortunately, other issues that often occur along with depression, such as acting out or behavioral problems, might hide it, meaning that youth do not get the help they need.

WHAT TO CONSIDER WHEN SELECTING INTERVENTIONS AND SUPPORTS

Although we usually think of depression as an individual and mostly personal experience, the child's environment can influence the depression and the child's depression can influence those in the environment. Helping a depressed child or adolescent involves both individual and environmental considerations.

Developmental and Gender Differences

Depression can occur in young children. When it begins in childhood, the likelihood of depression happening again in life is high (Thapar et al., 2012). Therefore, it is important to treat the signs and symptoms we see in childhood. Symptoms that occur more in children and might be overlooked include increased irritability, behavioral problems, and physical complaints (e.g., stomachaches; American Academy of Child & Adolescent Psychiatry, 2013). Young children can also experience the more classic form of depression, with symptoms of sadness, lack of energy, and loss of interest in things previously liked (Thapar et al., 2012). Parents or caregivers who see

such symptoms for more than 2 weeks should seek professional help.

With younger children, depression occurs at about the same rate in girls and boys; however, by puberty many more girls than boys report symptoms. Girls report more anxiety and atypical depressive symptoms (e.g., increased appetite, increased need for sleep, and relational sensitivity), whereas boys report more substance use or abuse as well as acting out and hyperactive types of behaviors (Thapar et al., 2012).

Additionally, youth with certain developmental experiences might require special consideration. For example, sexual minority youth (e.g., lesbian, gay, bisexual, transgender), children with trauma histories, those with disrupted caregiving experiences (e.g., foster children, those with a parent in jail and living with extended family), and youth who have been bullied at school report increased risk for depression (Thapar et al., 2012). Youth with such experiences should be watched carefully for signs of depression.

Biological and Genetic Considerations: Family History and Coexisting Problems

When a parent is depressed, the child is three to four times more likely to develop depression, providing support for the possibility that depression is biologically and genetically influenced (Thapar et al., 2012). Thus, a family that has a history of depression should pay particular attention to smaller signs of depression in their children. Moreover, it is important for parents to address their own depression, as it has been shown that a caregiver's mental health has long-term effects on children's depression (Thapar et al., 2012).

Although far less common, a child with depression may also show signs of manic episodes; therefore, it is important to consider whether the child may have a bipolar disorder. These diagnoses share the symptoms of depression; however, youth with bipolar disorder may show irritability that is more intense, frequent, aggressive, and out of control than the irritability seen in depression. Other symptoms that are common in manic episodes, such as elation or euphoria (e.g., Kowatch, Youngstrom, Danielyan, & Findling, 2005), are not typically found in youth with depression. Parents should take note of all of their child's symptoms and behaviors so that they can report these accurately to a physician or mental health professional.

Environmental Factors

Maintaining healthy relationships can be key to helping youth with depression. For example, teenagers who have good relationships with their parents and whose parents are involved in their lives are less likely to become depressed and more likely to get healthy if they become depressed (Murshid, 2017). The connection between depression and environmental factors such as bullying is stronger for children who have a genetic risk (Thapar et al., 2012). Chronic exposure to stress, such as that caused by bullying, increases the risk, but healthier friendships may protect youth from depression (Murshid, 2017). Therefore, treatments and strategies that improve both family and peer relationships are likely to be helpful.

RECOMMENDATIONS

It is frightening for parents to consider that their child may be experiencing depression, especially parents who have experienced depression themselves. However, there are strategies parents can use to support their children in becoming healthy, productive adults.

Using Home-Based Strategies

1. ***Familiarize yourself with the signs of depression and your child's experience with it.*** Knowing your child and how your child experiences depression is very important. Being attentive to the signs outlined above and being able to communicate those to others can be quite helpful for your child's treatment plan.
2. ***Try to keep conflict in the home low.*** Because your child might be acting in ways that are frustrating for you (e.g., changes in energy levels might be perceived as lazy), it can be easy to argue with or nag at your child. Try to not get involved in little battles, but think about the big picture in getting your child healthy. If possible, try to be even more nurturing, warm, and accepting. Also try not to argue with your partner or other adults in front of your child.
3. ***Destress together.*** Model positive ways to take care of yourself. For example, take a walk together in the evenings, or take part in visualization and deep breathing exercises (see Recommended Resources below).
4. ***Help your child shift negative thinking.*** Many children who are depressed see good things that happen as luck, yet they feel overly responsible for

bad things. They also might feel hopeless or feel that nothing good will ever happen. Try to listen—being truly heard is one of the best gifts we can give our children—yet help your child move these thoughts in a more positive direction.

5. ***Consider mindfulness strategies.*** Help your child learn to use other ways of thinking, such as acceptance and awareness in the present moment. These aspects of mindfulness and mindfulness-based therapies can be helpful with depression. Additionally, model these practices by accepting your child's more negative emotions, such as sadness and anger. Negative emotions can make us uncomfortable, so we try to move away from them when children express them. But it is important to acknowledge and accept negative emotions so that children feel heard and understood.
6. ***Develop a healthy lifestyle.*** Help your child get an appropriate amount of sleep and maintain a healthy diet. Managing a proper sleep cycle and eating healthy can protect your child's physical and mental health. For example, you may need to monitor your child's screen time to maintain a proper bedtime.
7. ***Help your child regulate social and extracurricular activities.*** Youth with depression can look very different in their levels of social and extracurricular activities. It is important to try to help your child find manageable levels of social activities—to not be overly scheduled (e.g., involved in too many things) but also not be overly reclusive (e.g., not wanting to leave the house).
8. ***Make your home safe.*** Lock up or secure any weapons, medicines, and alcohol to ensure your child's safety. If possible, change combinations on gun safes or remove weapons from the home altogether. Remember that youth can be impulsive, and their depression may lead them to engage in activities they never did before. Limiting the availability of weapons and drugs can make a big difference in preventing suicide.

Accessing Community Supports

9. ***Talk to the school psychologist and your child's pediatrician.*** Recognize that you are not alone and look for those who can support you. It usually takes a team approach to provide the help a depressed child needs. This team may include mental health workers, physicians, and school professionals. Stigma, or shame, can be associated with having a mental health challenge, and it is important to assure your child that asking for help is okay. School-based mental health professionals or your child's healthcare providers can provide guidance in understanding your child's symptoms and offer suggestions for next steps. The APA website offers a therapist locator service, which may be helpful.
10. ***Look for a therapist skilled in working with youth with depression.*** Don't be afraid to ask questions about the therapist's experience or familiarity with therapies that are shown to be effective in working with youth with depression, such as the following:
    - *Family-focused therapy.* FFT works with the understanding that environment is crucial in treating depression. It is intended to help families create healthy communication and problem-solving practices and improve relationships. FFT is a specific form of therapy, but there are other family-based counseling strategies that have also shown promise (e.g., attachment-based therapy).
    - *Cognitive–behavioral therapy.* CBT connects the idea that our thoughts influence our behavior and focuses on how youth think about the world, themselves, and their future. Many different strategies and programs exist for use with youth with depression, but this is typically an individual or group-based strategy; that is, your child meets one-on-one with a therapist or is with other children with depression.
    - *Dialectical behavior therapy.* DBT is a specialized form of CBT that focuses on improving emotions (and the ability to control one's emotions) and building tolerance to stress. DBT was created to work specifically with depressed or suicidal individuals.
    - *Interpersonal psychotherapy for adolescents.* IPT-A focuses on the idea that depression is a disturbance in the circadian rhythms, or the body's clock, and that it is through managing our activities and our mood that we can get our body and mind back on track. IPT-A is also typically individual or group-based.
11. ***Don't forget the importance of attending to your own mental health needs.*** Having a child with depression can be tough. Find support where you can to make sure you have the energy and ability to be there for your child. Remember also that if you are depressed, treating your own depression is critical to helping your child.

Considering the Use of Medications

12. ***Become informed about the costs and benefits of having your child take a medication.*** Antidepressants have been shown to be effective for youth with depression. However, many different types might be suggested by your child's physician, so don't be afraid to ask for information. Also, antidepressants do not work instantly, and they require a sustained plan of treatment. Be sure you understand the plan and your insurance coverage before beginning treatment. You may have concerns about adverse side effects from medications (e.g., weight gain), which can seem alarming. Discuss these effects with your child's health care provider.
13. ***After starting on medication, pay close attention to changes in your child's symptoms or behavior.*** In 2003, the U.S. Food and Drug Administration (FDA) recommended that individuals starting antidepressant medications should be closely monitored for worsening of symptoms, increases in suicidal thoughts and behaviors, or unusual changes in behavior (FDA, 2007). This warning occurred after some concerns were raised about individuals reporting increased suicidal thoughts and behaviors after starting antidepressants. However, these medications are prescribed in circumstances when there is already an increased risk, and depression remains the most important cause of these thoughts and behaviors. It has been shown that as the number of antidepressant prescriptions go up, suicide rates actually go down (Gibbons et al., 2007). Still, close monitoring for the first several weeks of treatment is recommended.

Developing a Long-Term Plan

14. ***Be patient.*** Regardless of the type of treatment started, be prepared for some lag time before you or your child start to see changes. Typically, it takes several weeks to see positive effects from therapy or medications.
15. ***Be prepared.*** Have a plan for what to do if you notice the signs of depression not getting better or becoming worse, especially if there are signs of suicidal thoughts or behaviors. Have a list of phone numbers to call (e.g., healthcare providers, National Suicide Hotline). Take note of symptoms and be sure to communicate what you're seeing with your child's healthcare provider and mental health professional so they can make the best treatment decisions.
16. ***Try to be open and communicate with your child.*** Give your child a voice in the decisions surrounding the treatment plan. However, safety should be a primary concern. Try to help your child understand that some decisions might need to be made by adults, but build in developmentally appropriate choices, where possible. For example, attending therapy may not be optional, but seek your child's views on which day of the week therapy sessions take place.

RECOMMENDED RESOURCES

Websites

www.apa.org/helpcenter.index.aspx

The help center portion of the American Psychological Association website has a number of resources, including a national therapist locator and a guide with questions to help you find a skilled therapist.

https://childmind.org/

This website from the Child Mind Institute is a very parent- and family-friendly resource with lots of great information about different parenting issues. For example, Topics A–Z offers resources on things like depression, behavioral disorders, mindfulness, and developmental milestones.

https://www.npr.org/sections/health-shots/2017/09/09/549133027/for-teens-knee-deep-in-negativity-reframing-thoughts-can-help

This online article by Mary K. Alvord, from the National Public Radio webpage Shots: Health News from NPR, summarizes how to help youth work on changing negative thinking.

https://suicidepreventionlifeline.org/

The National Suicide Prevention Lifeline website provides a 1-800 phone number that is answered 24 hours a day, 7 days a week. The website also provides many resources for those dealing with crisis, those trying to help someone in crisis, and survivors of suicide.

Books

Evans, D. L., & Andrews, L. W. (2005). *If your adolescent has depression or bipolar disorder: An essential resource for parents*. New York, NY: Oxford University Press.

This book provides information for parents about diagnosis, clinical treatment, and strategies for home and school to help your teen with depression.

Greenland, S. K. (2016). *Mindful games: Sharing mindfulness and meditation with children, teens and families*. Boulder, CO: Shambhala.

This book provides 60 different mindfulness activities that you can take part in with your child.

Irwin, C. (2007). *Monochrome days: A firsthand account of one teenager's experience with depression*. New York, NY: Oxford University Press.

This book is written for your teen in a way that is relatable (stories from teens) and in language that is developmentally appropriate. It addresses symptoms, different experiences (e.g., hospitalization), treatment and medication issues, and coping and recovery.

Related Helping Handouts

Depression: Helping Handout for School
Nonsuicidal Self-Injury: Helping Handout for Home
Nonsuicidal Self-Injury: Helping Handout for School
Suicidal Thinking and Threats: Helping Handout for Home

REFERENCES

American Academy of Child & Adolescent Psychiatry. (2013). *Depression in children and teens*. Retrieved from https://www.aacap.org/AACAP/Families_and_youth/Facts_for_Families/FFF-Guide/The-Depressed-Child-004.aspx

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

Gibbons, R. D., Brown, C. H., Hur, K., Marcus, S. M., Bhaumik, D. K., Erkens, J. A., … Mann, J. J. (2007). Early evidence on the effects of regulators' suicidality warnings on SSRI prescriptions and suicide in children and adolescents. *American Journal of Psychiatry*, *164*, 1356–1363. doi:10.1176/appi.ajp.2007.07030454

Kowatch, R. A., Youngstrom, E. A., Danielyan, A., & Findling, R. L. (2005). Review and meta-analysis of the phenomenology and clinical characteristics of mania in children and adolescents. *Bipolar Disorders*, *7*, 483–496. doi:10.1111/j.1399-5618.2005.00261.x

Murshid, N. S. (2017). Parents, friends, and depression: A multi-country study of adolescents in South Asia. *Children and Youth Services Review*, *79*, 160–165. doi:10.1016/j.childyouth.2017.06.018

National Institute of Mental Health. (n.d.). *Major depression among adolescents*. Retrieved from https://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adolescents.shtml

Thapar, A., Collishaw, S., Pine, D. S., & Thapar, A. K. (2012). Depression in adolescence. *The Lancet*, *379*, 1056–1067. doi:10.1016/s0140-6736(11)6087-4

U.S. Food and Drug Administration (FDA). (2007). *Revisions to product labeling*. Retrieved from https://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM173233.pdf

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