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COMBATING DEPRESSION

Alan Carr

INTRODUCTION

Major depression is an episodic disorder characterized by major depressive episodes and intervening periods or normal mood. This is distinguished from dysthymia, which is a milder but more persistent mood disorder, characterized by chronic low mood for at least a year in young people, accompanied by fewer additional cognitive or behavioural symptoms than are required for a diagnosis of major depressive disorder. The diagnostic criteria for a major depressive episode are described in ICD-10 (World Health Organization, 1992) and DSM –IV-TR (American Psychiatric Association, 2000).

Epidemiology, course and sex differences

In a review of 18 epidemiological studies Costello et al. (2004) found prevalence rates of major depression in youngsters under 18 to range from 0.2-12.9%, with a median of 4.7%. Depression is more common among young people than children; more common among teenage girls than boys; and very common among clinical populations (Costello et al., 2002).

The majority of youngsters recover from a depressive episode within a year; about a tenth relapse during the following year; about a third relapse within 4 years; and inter-episode intervals decrease as more episodes occur (Lewinsohn et al., 1994). Depression often persists into adulthood, and it is a risk factor for suicide (Harrington & Dubicka, 2001). Treatment of depressed young people with tricyclic antidepressants (TCAs) is ineffective (Hazell et al., 2002). Treatment with selective serotonin reuptake inhibitors (SSRIs) is effective in some cases (Cheung et al., 2005), but there is still controversy about the potential for SSRIs to increase suicide risk in young people (Gibbons et al., 2006). Children and young people with depression are at a higher risk of suicide than youngsters with other disorders, so the assessment and management of suicide risk is a priority when dealing with depressed young people (NICE, 2004).

Aetiology

Environmental factors which place undue stress on youngsters; which outstrip their coping capacities; and which occur in the absence of social support, interact with genetic factors and may initially render youngsters psychologically vulnerable to depression. Later they may precipitate the onset of depressive episodes and prevent recovery or precipitate relapse (Goodyer, 2001). Loss of important relationships, failure experiences, bullying, illnesses and injuries, and disruptive life transitions such as moving house or the onset of puberty all constitute stressful life events. Non-optimal early parenting environments are particularly important sources of environmental stress, and deserve special mention. Non-optimal parenting environments include those characterized by lack of parental attunement, parental psychopathology (notably maternal depression and paternal substance use), family conflict, stressful parental separation, domestic violence, and child maltreatment, all of which may be influenced by wider sociocultural factors such as poverty and social isolation (Short & Spence, 2006).

On the positive side, personal and contextual protective factors may reduce the likelihood of depression or contribute to recovery. These include intelligence, problem-solving skills, an active coping style, the capacity for self-reflection, self-esteem, an internal locus of control and sense of mastery, higher levels of physical activity, good social skills, a supportive cohesive family, a

positive school environment, supportive peer relationships, and a supportive community (Shortt & Spence, 2006)

PREVENTION OF DEPRESSION IN YOUNG PEOPLE

In a systematic review of the primary prevention programmes for depression in young people aged 5-19 years old, Merry et al. (2004) identified 21 well designed studies. They found that the psychological, but not the educational prevention programmes showed some evidence of efficacy. In the studies of psychological interventions a range of programmes were evaluated, including the PENN Resiliency Programme (Freres et al., 2002); the Coping with Stress Course (Clarke & Lewinsohn, 1995); the Resourceful Adolescent Programme (Shochet, 2002); the Problem Solving for Life programme (Sheffield et al., 2006); and the FRIENDS programme (Barrett et al., 2000). These programmes share a number of features in common. They are brief (under 20 sessions), manualized, structured interventions that can be delivered to groups of young people in classroom settings. They are all theoretically-based, and draw on social learning theory, cognitive behaviour therapy, and a diathesis-stress model of depression. They all involve skills training, as well as didactic teaching methods, and group-discussion. Within these courses, young people learn a coherent framework, within which to conceptualise factors affecting low mood and the self-regulation of emotional states. They also learn and practice skills for self-monitoring of mood, and related thoughts, behaviour patterns, interpersonal transactions, and stressful events. The development of a variety of coping skills and strategies for regulating negative mood states are also central to all of these programmes, although the precise subset of skills varies from programme to programme. These skills and strategies include challenging depressive and pessimistic thinking styles; using relaxation skills to control anxiety; using systematic problem-solving skills to manage stressful situations; soliciting social support from family and friends; scheduling pleasant events; and preventing the build-up of life stresses.

Merry et al. (2004), found that psychological prevention programmes led to significant reductions in depressive symptoms in studies which targeted youngsters at risk for depression (effect size = .26), but to non-significant reductions in depressive symptoms in those delivered to whole populations (effect size = .21). They also found that averaging across all types of studies, prevention programmes had significant short-term effects and reduced depressive symptoms (effect size = .26) or rates of depressive syndromes, when improvement was assessed immediately after programme completion. However, over follow-up periods of 1 to 3 years, these positive effects 'washed-out', and programmes, overall, did not have a significant long-term benefit for young people in terms of reducing depression.

ASSESSMENT AND TREATMENT OF DEPRESSION

When young people present with low mood, a preliminary assessment is essential to determine if depression is the core issue.

Assessment

Assessment for depression should begin with a broad screening for psychological difficulties. If this suggests that there are mood problems, a more detailed assessment of depressive symptoms may be conducted. If appropriate, this may be followed by structured interviewing about depressive syndromes. Then a wider interview covering risk and protective factors mentioned in the previous section, along with suicide risk assessment should be conducted. Guidelines for such broader interviews are given in Carr (2006).

For screening school-aged young people for any type of psychological disorder, including depression, the Achenbach System of Empirically Based Assessment (ASEBA, Achenbach & Rescorla, 2001) and the Behavioural Assessment System for Children (BASC, Reynolds & Kamphaus, 2004) are very useful. If youngsters screen positive for mood disorders on the brief

BASC or ASEBA depression scales, a more detailed assessment of depressive symptoms may be obtained with more comprehensive mood evaluation instruments, such as the Beck Depression Inventory for Youth (BDIY, Beck et al., 2005). Where elevated scores occur on depressive symptom assessment instruments, it is appropriate to conduct a structured interview with schedules such as the Development and Well-being Assessment (DAWBA, Goodman et al., 2000) or the Diagnostic Interview Schedule for Children (DISC-IV, Shaffer et al., 2000) to assess depression from a syndromal perspective.

TREATMENT EFFECTIVENESS

In a comprehensive meta-analysis of 35 randomized controlled studies of psychotherapy for depression in young people, Weisz et al. (2006) found that the average treated case fared better than 63% of untreated cases. Weisz et al. also found that there were no significant differences in outcome between cognitive behavioural treatments and other treatments, or between treatments conducted under optimal or routine clinical conditions. Treatment gains were maintained at six months, but not at one year follow-up.

Cognitive behaviour therapy

There is evidence from reviews by Harrington et al. (1998), Lewinsohn and Clarke (1999), and Reinecke et al. (1998) to support the effectiveness of cognitive behaviour therapy in the treatment of depression in young people. Collectively results from these reviews indicate that just over 60%, to just over 70% of young people diagnosed with a depressive disorder benefited from cognitive behaviour therapy.

Cognitive behaviour therapy for depression rests on the hypothesis that low mood is maintained by a depressive thinking style and constricted lifestyle that entails low rates of response contingent positive reinforcement. Cognitive behaviour therapy programmes for young people evaluated in treatment trials have two main components which target these two maintaining factors: behavioural activation and challenging depressive thinking (Compton et al. 2004). In challenging depressive thinking, youngsters learn mood monitoring, and how to identify and challenge depressive negative automatic thoughts and cognitive distortions that accompany decreases in mood. With behavioural activation youngsters re-organize their daily routines so they involve more pleasant events, physical exercise and social interaction. They also develop skills to support this process including social skills, relaxation skills, communication and problem-solving skills, and relapse prevention skills. Some cognitive behavioural programmes for depression in young people include concurrent intervention with parents, which helps them understand factors that maintain depression and support youngsters in following through on the behavioural activation and cognitive components of the child-focused part of the programme. Cognitive behaviour therapy usually spans 10-20 young person-focused sessions and may be offered on an individual or group basis. Where concurrent parent sessions occur, usually about 5-10 of these are offered. Stallard's (2002, 2005) *Think Good - Feel Good programme* is a useful clinical resource that combines many aspects of effective cognitive behavioural approaches to depression in young people.

In an important comparative trial Brent and his team found that immediately after treatment, more youngsters who received cognitive behaviour therapy (60%) were in remission compared with those who received family therapy (38%) or supportive therapy (39%) (Weersing & Brent, 2003). However, at two years follow-up there were no significant differences between the outcomes of the 3 groups. The positive effects of cognitive behaviour therapy arose predominantly from changes in depressive cognitive distortions. However the results of this study suggest it may be worthwhile combining individually-oriented, cognitive behaviour therapy and family therapy to aim to address both intrapsychic and interpersonal depression maintaining factors, and to extend therapy beyond 16 sessions so that additional services are not required.

Psychodynamic therapy

Only a single randomized controlled trial provides evidence for the effectiveness of psychodynamic psychotherapy with depressed young people. In a randomized controlled study of 72 youngsters aged 9-15 assigned to psychodynamic or family therapy, Trowell et al. (2007) found that about 75% of cases in both groups were fully recovered after therapy. 100% of those who received psychodynamic therapy and 81% of those who received family therapy were fully recovered at 6 months follow-up (but this group difference was not significant). Psychodynamic and family therapy also led to a significant reduction of double depression (major depression with co-morbid dysthymia) and rates of other co-morbid conditions. In this study psychodynamic therapy involved an average of 25 individual sessions and 12 concurrent parent sessions spanning 9 months, following a manual based on Malan's (1995) model of brief psychodynamic psychotherapy. In this model, the focus is on interpreting the links between defences, anxiety and unconscious feelings and impulses, within the context of the transference relationship with the therapist, the relationship with significant people in the young person's current life, and early relationships with parents or caregivers. Family therapy involved an average of 11 sessions spanning 9 months.

Interpersonal therapy

There is evidence from a number of studies that interpersonal psychotherapy is an effective treatment for adolescent depression which leads to recovery in more than 75% of cases. Interpersonal therapy for depression in young people targets five interpersonal difficulties which are assumed to be of particular importance in maintaining depression: (1) grief associated with the loss of a loved one; (2) role disputes involving family members and friends; (3) role transitions such as starting or ending relationships within family, school or peer group contexts, moving houses, graduation, or diagnosis of an illness; (4) interpersonal deficits, particularly poor social skills for making and maintaining relationships; and (5) relationship difficulties associated with living in a single parent family. In interpersonal therapy the specific focal interpersonal factors that maintain the youngster's depressive symptoms are addressed within a series of child-focused and conjoint family sessions. Mufson et al.'s (2004) *Interpersonal Psychotherapy For Depressed Adolescents* provides detailed guidance on this approach to therapy.

Family therapy

There is evidence from several studies of the effectiveness of family therapy for treatingdepression and suicidality in young people.(Curry et al., 2003; Diamond et al., 2002; Sanford et al., 2006; Trowell et al., 2007; Weersing & Brent, 2003),

In a comparative study, Trowell et al. (2007) found that 11 sessions of family therapy was as effective as a programme which included 25 sessions of psychodynamic therapy coupled with 12 adjunctive parent sessions. Therapy helped families understand the links between the youngster's depression, problematic family scripts and insecure family attachment patterns.

In another comparative study, Weersing and Brent (2003) found that only 38% of depressed young people recovered immediately after family therapy, but at two years follow-up 77% no longer met the criteria for depression. Family therapy was less effective in the short-term, but as effective in the long-term as cognitive behaviour therapy. Improvements in family functioning accounted for the youngsters' recovery. A behavioural systems approach to family therapy was used in this trial. This involved using family-based behavioural interventions such as problem monitoring, communication and problem-solving skills training, contingency contracting, and relapse prevention to reduce family conflict, enhance family relationships and promote better mood management.

In a controlled study of attachment-based family therapy for depression with 32 young people, Diamond et al. (2002) found that after treatment 81% of treated cases no longer met the criteria for depression, whereas 47% of the waiting list control group did. At six months follow-up 87% of

cases were not depressed. Attachment-based family therapy involves the following sequence of interventions: relational reframing, building alliances with the young person first and then with the parents, repairing attachment relationships between parents and young people, and building family competency (Diamond, 2005).

In a controlled trial involving the families of 31 young people, Sanford et al. (2006) evaluated the incremental benefit of adding psychoeducational family therapy to a routine treatment programme involving predominantly supportive counselling and SSRI antidepressant medication. Three months after treatment 75% of the family therapy group and 47% of controls no longer met the criteria for depression, and relationships between parents and the young person in the family therapy group were significantly better than in the control group. A 13 session, home-based family therapy model was used in this study, which included psychoeducation about depression, communication and problem-solving skills training, and relapse prevention.

In a single group outcome study for young people with co-morbid depression and substance abuse, found that after a combined programme of cognitive behaviour therapy and family therapy, 50% of cases recovered from depression and 66% from substance abuse. The programme spanned 10 weeks, with weekly family therapy sessions and twice weekly cognitive behaviour therapy group sessions. Robin and Foster's (1989) model of family therapy for negotiating -conflict between parents and young people was used in this programme.

Collectively these studies lend support for both attachment-based, and psychoeducationally-oriented cognitive-behavioural approaches to family therapy, as effective treatments for depressed young people.

CONCLUSIONS

Depression is a problem for a significant minority of young people. It is caused and maintained by both biological and psychosocial factors. Prevention programmes that facilitate the development of mood-management and self-regulation skills, which target young people shown to be at risk for depression, have significant positive short-term effects. Such programmes may be offered within a school context. In clinical settings, where youngsters present with low mood, psychological treatment may be offered following a through assessment. Effective protocols for mild to moderate depression have been developed within the cognitive-behavioural, interpersonal, psychodynamic and family therapy traditions. These protocols should be flexibly applied in clinical practice, taking due account of clinical formulations of clients' unique profiles of personal and contextual predisposing, precipitating, maintaining and protective factors. In light of such clinical formulations, a case may be made for combining components of treatment protocols for the young person and the family that have been shown to be effective, to address specific elements within a client's formulation (Carr, 2006). Available evidence suggests that family-based intervention for depression in young people includes family psychoeducation; facilitating family understanding and support of the depressed youngster; and organizing home-school liaison to help the youngster re-establish normal home and school routines. Available evidence suggests that interventions focused on the young person involve exploration of contributing factors, some of which may be outside the youngsters' awareness; facilitating mood-monitoring; increasing physical exercise, social activity and pleasant events; modification of depressive thinking styles, depression maintaining defence mechanisms and depression maintaining patterns of social interaction; the development and use of social problem-solving skills; and the development of relapse prevention skills. The evidence also suggests that a dozen family sessions and twice as many individual sessions are probably necessary for treating mild to moderate depression in young people. With severe depression, where clients show no response to a brief trial of psychotherapy, a trial of SSRIs combined with psychotherapy may be appropriate. However, caution is warranted in using SSRIs with youngsters, since they may

increase suicide risk. These conclusions are broadly consistent with international guidelines for best practice (American Academy of Child and Adolescent Psychiatry, 1998; NICE, 2005)

RESOURCES

Therapy manuals

Byng-Hall, J. (1995). *Rewriting Family Scripts. Improvisation and Change.* New York: Guilford. A family therapy approach that may be used for child and adolescent depression.

Langelier, C. (2001). *Mood Management Leader's Manual : A Cognitive-Behavioural Skills-Building Program for Adolescents.* Thousand Oaks, CA: Sage

Malan, D. (1995). *Individual Psychotherapy and the Science of Psychodynamics* (Second Edition). London: Butterworth- Heinemann. A psychodynamic approach that may be used for adolescent depression.

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Stallard, P. (2002). *Think Good - Feel Good: A Cognitive Behaviour Therapy Workbook for Children and Young People.* Chichester, UK: Wiley.

Stallard, P. (2005). *A Clinicians Guide To Think Good Feel Good: The Use of CBT With Children And Young People.* Chichester, UK: Wiley.

Self-help books

Fitzpatrick, C. (2004). *Coping with Depression in Young People. A Guide for Parents.* Chichester, UK: Wiley.

Langelier, C. (2001). *Mood Management : A Cognitive-Behavioural Skills-Building Program for Adolescents. Skills Workbook.* Thousand Oaks, CA: Sage

Websites

Adolescent Coping with Stress Programme. http://www.kpchr.org/public/acwd/CWS_MANUAL.pdf

Brent's therapy manuals. www.wpic.pitt.edu/research/star/ or BrentDA@upmc.edu

FRIENDS Programme. http://www.friendsinfo.net/

Problem Solving for Life Programme. jeanie@psy.uq.edu.au

Resourceful Adolescent Programme. http://www.hlth.qut.edu.au/psyc/rap/

Weisz's therapy manuals. weisz@psych.ucla.edu

KEY POINTS

- depression is more common among young people than children and among teenage girls than boys, and very common in clinical populations
- genetic factors interact with environmental factors to give rise to depression
- primary prevention programs that are psychological rather than educational have shown evidence of efficacy
- where mood problems are identified a more detailed assessment of depressive symptoms may be indicated
- research had shown that psychotherapy for depression can produce positive outcomes
- cognitive behavioural therapy, psychodynamic therapy, interpersonal therapy, and family therapy have all been demonstrated as being useful for some young people with regard to treating depression

QUESTIONS FOR DISCUSSION

1. Why do you think research has shown that depression is not exclusively due to either biological factors or psychosocial factors?
2. In light of what we know about sex differences in depression, what should be the differences in our approaches (if any) to treating depressed male and female adolescents?

3. Why do you think prevention programmes have a significant short-term effect on adolescents at risk of depression, but less effect on populations that are not at risk, and little effect in the long-term?
4. Why do you think cognitive behaviour therapy, interpersonal therapy, family therapy and psychodynamic psychotherapy all 'work' for adolescent depression, when they are so different?

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