DEPRESSION IN YOUNG CHILDREN: INFORMATION FOR PARENTS AND EDUCATORS

By Ralph E. Cash, PhD, NCSP
Nova Southeastern University

NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS

Depression in young children is a difficult topic for most of us to contemplate or to comprehend. Although children have always been vulnerable to a host of mental disorders, many children suffering from undiagnosed depression have been accused of being shy, lazy, stubborn, or disobedient. More recently, as awareness of emotional problems has increased, depressed children have often been diagnosed with a temporary response to stress (adjustment disorder), Attention Deficit Hyperactivity Disorder (ADHD), oppositional-defiant disorder, or some other problem. Although a number of children do have these other disorders, they often coexist with or are misdiagnosed instead of depression.

What Is Childhood Depression

Depression is a serious mental health issue that can affect even very young children. Depressed children are generally lacking in energy and enthusiasm. They often become withdrawn and are unable to concentrate or to enjoy life. If they are in school, they usually perform poorly. Sometimes they are irritable and sulky or even belligerent. If they are old enough to talk, they may refer to themselves as stupid and ugly, friendless, unloved and unlovable, worthless, or even hopeless. They may be preoccupied with themes of death and dying, and, occasionally, they may contemplate or even attempt suicide. Yes, even small children may do reckless, dangerous things designed to hurt or to kill themselves, although their concepts of death are quite different from those of adults.

Characteristics and Prevalence of Depression in Young Children

The prevalence of depression is increasing in successive generations with onset at earlier ages. Although adolescent and adult females are diagnosed with a depressive disorder twice as often as males, boys up to age 12 are as likely to suffer from depression as girls.

Types of depression. Children can suffer from mood disorders such as *dysthymia, major depression,* or *bipolar disorder* much like adolescents and adults, although less frequently. *Major depressive disorder,* the most severe and most disabling form of depression, occurs in episodes that affect approximately 1% of preschool children and 2% of pre-pubertal school-aged children at any given time. Moreover, approximately 2% of children suffer from *dysthymia,* a milder but more chronic form of depression. More than two thirds of children with dysthymia develop major depression within 5 years.

Presence of other disorders. More than half of depressed children also have at least one other psychological disorder, usually an anxiety disorder, attention deficit, conduct or oppositional-defiant disorder, or eating disorder. Almost one third of children diagnosed with Attention Deficit Hyperactivity Disorder and 20–30% of those who are initially diagnosed as depressed eventually turn out to have bipolar disorder, which is characterized by extreme mood swings from unrealistic elation to severe depression.

Risk Factors

For children of a depressed parent, the risk of depression is much higher than average. From studies with identical and fraternal twins as well as other siblings reared together and apart, it is estimated that 50% or more of the risk of childhood depression is inherited. Children under stress, those who have experienced a loss, those who abuse substances (including tobacco), those with chronic illnesses, and those who have attention, learning, or conduct disorders are at a higher risk for depression.

Although we do not know all of the factors that cause a genetically vulnerable child to develop a depressive disorder, it is likely that major contributing factors include death or the divorce of parents; a child's inability to conform to an unattainable ideal or live according to rigid moral convictions instilled

by parents; failure to establish solid emotional bonds in infancy because of rejection or neglect; an excess of punishment and criticism with too little reward and praise; ineffective means for expressing angry feelings; physical, emotional, or sexual abuse; bullying; and traumas such as terrorism or natural disasters.

Signs and Symptoms

Recent studies indicate that many of the major symptoms of depression in adolescents and adults—anhedonia (inability to experience pleasure from normally pleasurable activities), sadness and grouchiness, low energy level, recent changes in energy level, low self-esteem, crying, hyperactivity that begins after age 2, and playing or talking about themes involving death—are also characteristic of depression in children. Difficulty experiencing joy when exposed to the pleasurable aspects of daily life is especially characteristic of most depressed children. There are, however, important age-related differences in the signs and symptoms of depression.

- *From birth to age 3:* Depression may be reflected in feeding problems, failure to thrive that has no identifiable physical cause, tantrums, lack of playfulness, apathy, and less expression of positive feelings in general.
- *Age 3–5:* May be accident-prone, subject to phobias and exaggerated fears, likely to exhibit delays or regression in important developmental milestones such as toilet training, and inclined to apologize excessively for minor mistakes and problems such as spilling food or forgetting to put away toys.
- *Age 6–8:* Expresses vague physical complaints, aggressive behavior, clinging to parents, and avoidance of new people and challenges.
- *Age 9–12:* Expresses morbid thoughts, extreme worry about school work, insomnia, and blaming themselves for disappointing their parents and teachers.

Just because a child exhibits some or even all of these characteristics does not necessarily mean that that child has a depressive disorder. When these signs and symptoms are present, however, particularly if the symptoms are severe and/or persist most of the time for a month or more, it is important to have the child evaluated by a mental health professional who specializes in children, especially if the child has other risk factors. Early diagnosis and treatment can shorten depressive episodes, help to avoid future episodes, and prevent potentially dangerous or disastrous results such as school failure, self-injury, or suicide.

Evaluation and Treatment

Seeking diagnosis. Fortunately, depression and bipolar disorder can be identified and effectively treated even in very young children. Unfortunately, diagnosis and treatment of childhood depression require very specialized training and skills. For example, infants and preschoolers rarely have the ability to express feelings well using language. So depressive symptoms must be inferred from overt behavior, information gleaned from interviewing parents and other caregivers, observation of the child's interactions with other people, and play interviews. Only child psychiatrists, child psychologists, school psychologists, and other mental health professionals with specific training in working with young children are likely to have the expertise necessary to conduct such evaluations appropriately.

Comprehensive evaluation. As is the case with adolescents and adults, a thorough evaluation should begin with a physical examination to rule out identifiable physical causes for the behavior patterns that suggest depression. This should be carried out by a pediatrician or other physician trained to work with children. The physical exam usually includes assessment of the child's visual and auditory acuity. Undiagnosed vision and/or hearing impairment can cause a child to appear depressed or even trigger depression. For older children the examination should also include screening for drug and alcohol use, since this is occurring in our society at earlier and earlier ages and the use can mimic or bring on depressive episodes.

After the physical examination and any necessary medical treatment, qualified, child-oriented mental health professionals should see the child. They should interview the parents and other caregivers as necessary and then consult with other professionals including the pediatrician, teachers, and other school or daycare personnel. They then choose evaluative tests and observational procedures as needed, inform the parents of the results of the evaluation, and then formulate a comprehensive treatment/intervention plan in collaboration with the parents.

Treatment plan. To be most effective the plan must involve family, school or daycare personnel, medical specialists, and community resources as warranted. Comprehensive treatment of depressive disorders or bipolar disorder usually involves a combination of psychotherapy or counseling, pharmacotherapy (medication), school or daycare intervention planning, family education, and ongoing evaluation and monitoring. All of these must take into account and be sensitive to the values, cultural background, language, and other special circumstances of the child and his or her family.

What School Personnel Can Do

- Learn the signs and symptoms of depression at various ages and developmental levels.
- Consult with the school psychologist or other mental health professional in the school if a child is suspected of being depressed.
- Report suspected abuse or neglect to the appropriate authorities.
- Inform the parents of any concerns about their child, and help link them with resources for effective follow up.
- Encourage parent-school collaboration.
- Have a carefully crafted suicide prevention plan in place in the school and implement it.
- Have an effective suicide postvention plan in place in the school, and work to ensure that it never has to be implemented.
- Have a comprehensive crisis intervention plan in place in the school.
- Have clear anti-bullying policies in place in the school and implement the policies consistently.
- Cooperate with mental health professionals by providing data for evaluations with parent permission.
- Collaborate with treatment providers to implement treatment plans and to collect data to evaluate progress with parent permission.
- Use evidence-based programs to prevent substance abuse, strengthen problem solving, improve social skills, and teach alternatives to violent and self-destructive behavior.
- Take steps to ensure that every student feels welcome and safe in the school.

What Parents Can Do

- Know your child and your child's friends.
- Be actively involved with your child's school, preschool, or daycare program.
- Learn the signs and symptoms of depression, and monitor your child.
- Take your child to school or community health care/mental health screenings when these are offered.
- Participate in parent training sessions offered by the school or by community agencies.
- Learn about the school's violence, suicide, and bullying prevention plans.
- Learn about school and community resources for obtaining an evaluation if you suspect a problem.
- Cooperate fully in the evaluation process if your child needs to be evaluated.
- Be an active participant in developing a treatment plan if your child is diagnosed with depression.
- Monitor your child carefully for suicidal thoughts, statements, or plans.
- Make sure that guns, medications, and other potentially lethal implements are not accessible to children.
- Do not hesitate to ask your child directly about suicidal thoughts, drug involvement, alcohol use, or problems with bullies.
- Learn about the diagnosis and treatment options if your child has been diagnosed and use resources like those listed below.

Resources

Ingersoll, B., & Goldstein, S. (2001). *Lonely, sad, and angry.* North Branch, MN: Specialty Press. ISBN: 1886941459.

Merrell, K. W. (2001). *Helping children overcome depression and anxiety: A practical guide.* New York: Guilford. ISBN: 1-57230-617-3.

National Institute of Mental Health. (2001). *Depression in children and adolescents (Fact Sheet for Physicians).* Bethesda, MD: Author (NIH Publication No. 00-4744). Available: *www.nimh.nih.gov/publicat/depchildresfact*

U.S. Public Health Service. (1999). *Mental Health: A report of the Surgeon General.* Washington, DC: Author. Available: *www.surgeongeneral.gov*

U.S. Public Health Service. (1999). *The Surgeon General's Call to Action to prevent suicide.* Washington, DC: Author. Available: *www.surgeongeneral.gov*

U.S. Public Health Service. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A national action agenda.* Washington, DC: Author. Available: *www.surgeongeneral.gov*

World Health Organization. (2000). *Preventing suicide: A resource for teachers and other school staff.* Geneva: Mental and Behavioral Disorders, Department of Mental Health (WHO). Available: *www.who.int/en*

Websites/Organizations

American Academy for Child and Adolescent Psychiatry, 3615 Wisconsin Avenue, NW, Washington, DC 20016; *www.aacap.org*

American Academy of Family Physicians, P.O. Box 11210, Shawnee Mission, KS 66207; (800) 274-2237; *www.aafp.org*

American Association of Suicidology, Suite 310, 4201 Connecticut Avenue, NW, Washington, DC 20008; (202) 237-2280; *www.suicidology.org*

American Psychological Association, 750 First Street, NE, Washington, DC 20002; (202) 336-5500; *www.apa.org*

American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005; (202) 682-6000; *www.psych.org*

National Association of School Psychologists, Suite 402, 4340 East West Highway, Bethesda, MD 20814; (301) 657-0270; *www.nasponline.org*

National Institute of Mental Health, Office of Communications and Public Liaison, Information Resources and Inquiries Branch, Room 8184, 6001 Executive Boulevard, MSC 9663, Bethesda, MD 20892; (310) 443-4513; *www.nimh.nih.gov*

National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314; (800) 969-NMHA; *www.nmha.org*

Ralph E. "Gene" Cash, PhD, NCSP, is on the faculty of the School Psychology program at Nova Southeastern University in Ft. Lauderdale, FL.

The National Association of School Psychologists (NASP) offers a wide variety of free or low cost online resources to parents, teachers, and others working with children and youth through the NASP website ***www.nasponline.org*** and the NASP Center for Children & Families website ***www.naspcenter.org.*** Or use the direct links below to access information that can help you improve outcomes for the children and youth in your care.

About School Psychology—Downloadable brochures, FAQs, and facts about training, practice, and career choices for the profession.
www.nasponline.org/about_nasp/spsych.html

Crisis Resources—Handouts, fact sheets, and links regarding crisis prevention/intervention, coping with trauma, suicide prevention, and school safety.
www.nasponline.org/crisisresources

Culturally Competent Practice—Materials and resources promoting culturally competent assessment and intervention, minority recruitment, and issues related to cultural diversity and tolerance.
www.nasponline.org/culturalcompetence

En Español—Parent handouts and materials translated into Spanish. ***www.naspcenter.org/espanol/***

IDEA Information—Information, resources, and advocacy tools regarding IDEA policy and practical implementation.
www.nasponline.org/advocacy/IDEAinformation.html

Information for Educators—Handouts, articles, and other resources on a variety of topics.
www.naspcenter.org/teachers/teachers.html

Information for Parents—Handouts and other resources a variety of topics.
www.naspcenter.org/parents/parents.html

Links to State Associations—Easy access to state association websites.
www.nasponline.org/information/links_state_orgs.html

NASP Books & Publications Store—Review tables of contents and chapters of NASP bestsellers.
www.nasponline.org/bestsellers
Order online. ***www.nasponline.org/store***

Position Papers—Official NASP policy positions on key issues.
www.nasponline.org/information/position_paper.html

Success in School/Skills for Life—Parent handouts that can be posted on your school's website.
www.naspcenter.org/resourcekit