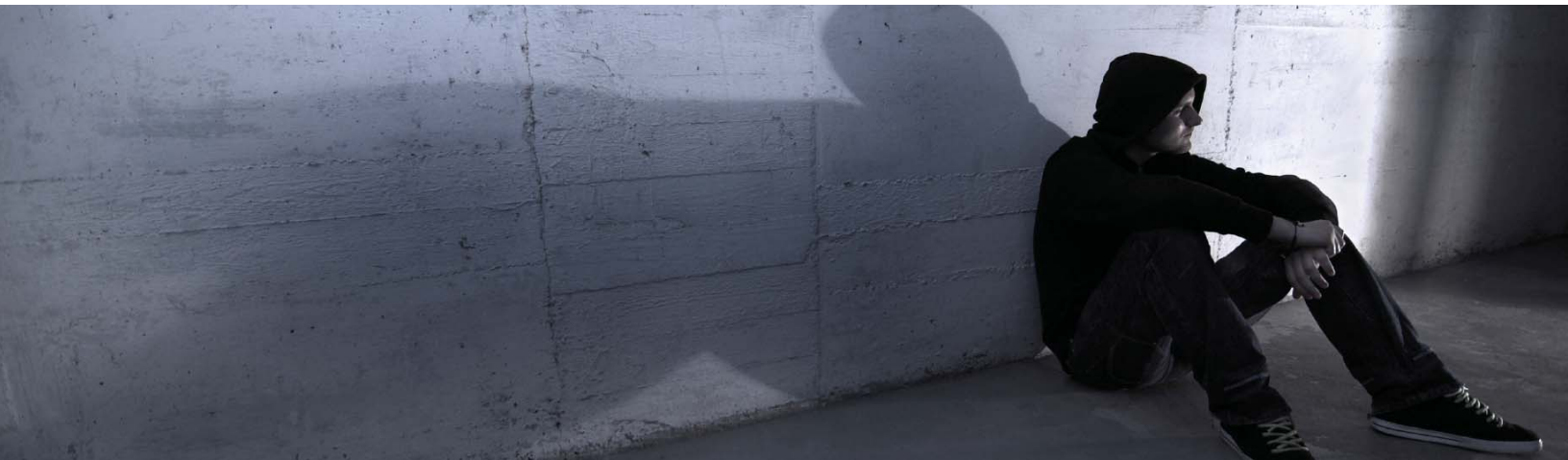


# GUIDE TO UNDERSTANDING ADOLESCENT MAJOR DEPRESSIVE DISORDER



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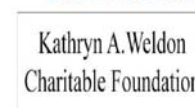
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For further information about the Chair and its programs, projects, activities and access to materials created by the Chair team visit: [www.teenmentalhealth.org](http://www.teenmentalhealth.org).

## (1) DEFINITION OF DEPRESSION

A Clinical Depression is a medical diagnosis and is comprised of a number of symptoms (what the person experiences) and signs (what another person observes). The collection of symptoms and signs that make up a diagnosis are determined through research and are identified as a medical diagnosis by international classifications (such as the Diagnostic Statistical Manual and the international Classification of Diseases). Depression as a mental disorder should not be confused with the word “depression” used to describe common reaction to life experiences. There will be more about this distinction later.

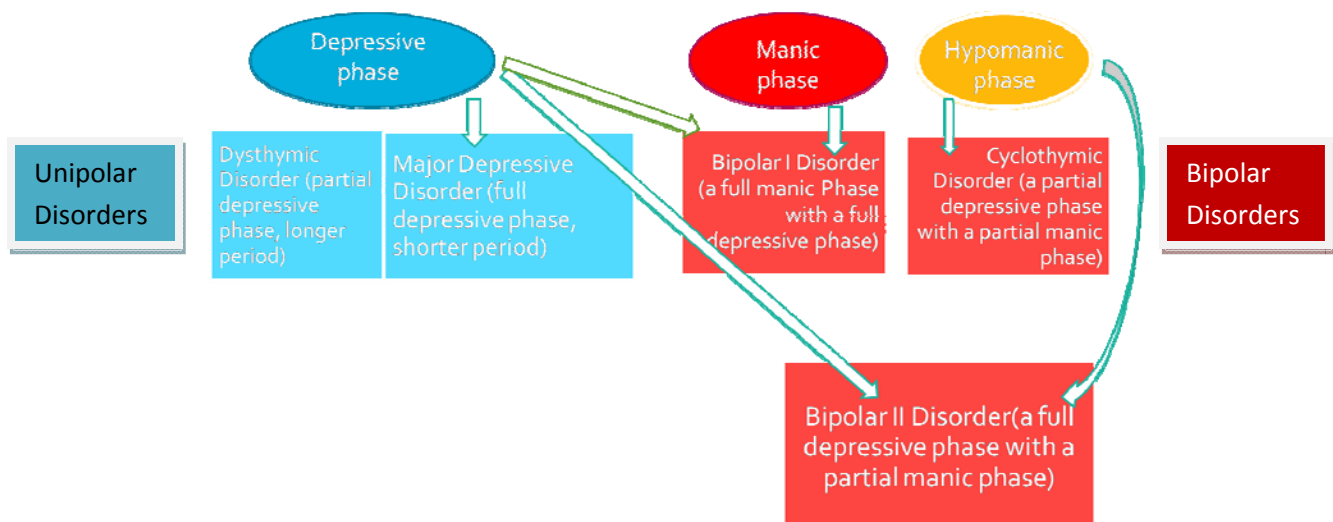
The word “depression” is often used by people to describe feelings of sadness or unhappiness, which all people experience at sometime in their lives. Depression is a word that has many meanings. In everyday language it often means feelings of sadness, distress, dismay, unhappiness, demoralisation and more. These meanings of “depression” can be confused with the word “depression” used to denote a serious mental disorder. In this case we are using the word Depression to describe Clinical Depression. Here Depression is used to describe a medical condition affecting the way mood is controlled by the brain and in turn creating the signs and symptoms used in diagnosis.

The term Clinical Depression describes not just one disorder, but a group of disorders that have a negative impact on a person’s life. Clinical Depression is often accompanied by feelings of anxiety, and is always accompanied by significant problems with family, friends, work or school.

Whatever the causes of Clinical Depression, there are many treatment options which can help, and if Clinical Depression is recognized and treated soon after it begins outcomes are better.

## (2) TYPES OF DEPRESSIVE DISORDERS

There are two main categories for Clinical Depression, these include: Unipolar and Bipolar. Unipolar Depression will be our focus here but more information about Bipolar can be found [here](#).



Unipolar Depression means one or more episodes of low mood but no episodes of high (or manic) mood. Major Depressive Disorder (MDD) and Dysthymia are the two most common forms of Unipolar Depression. Major Depressive Disorder is the disorder that most people are talking about when they discuss Clinical Depression. The symptoms and signs of Major Depressive Disorder are listed in [table 1](#).

Dysthymia is similar to Major Depressive Disorder but tends to be longer lasting and not as severe. The symptoms and signs of Dysthymia are found in [table 2](#).

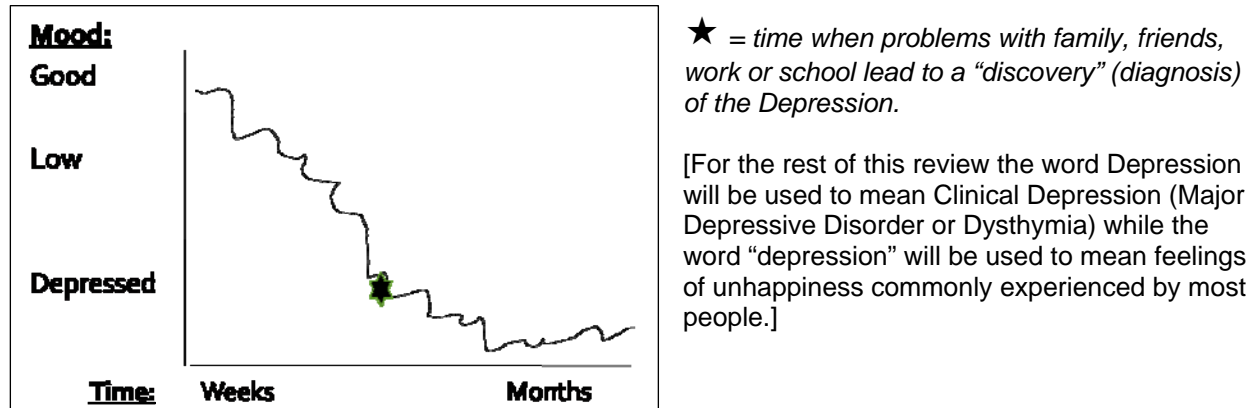
### (3) COMMON SYMPTOMS OF CLINICAL DEPRESSIONS

TABLE 1: Major Depressive Disorder Diagnostic and Statistical Manual for the Diagnosis of Mental Disorders (DSM-IV-TR)	
<ul style="list-style-type: none"> <li>• Five of the following symptoms are required for a diagnosis and of the five one should be depressed mood, loss of pleasure or interest, or irritable mood in children.</li> <li>• Symptoms should last for two or more weeks.</li> </ul>	
Adults	Adolescents or Children
<ul style="list-style-type: none"> <li>• Depressed mood</li> <li>• Decrease in interest or pleasure in most or all (once enjoyable) activities</li> <li>• Weight gain or loss without dieting or change in appetite</li> <li>• Unable to get sufficient sleep or too much sleep (<b>Insomnia</b> or <b>Hypersomnia</b>)</li> <li>• Slow movements or purposeless movements that are a result of mental tension such as, nervousness or restlessness (<b>psychomotor agitation</b> or <b>retardation</b>)</li> <li>• Feeling tired or loss of energy</li> <li>• Feelings of worthlessness or guilt</li> <li>• Unable to concentrate, or indecisiveness</li> <li>• Thoughts of death, (<b>suicidal ideation</b>), suicide plan, or <b>suicide attempt</b>.</li> </ul>	<ul style="list-style-type: none"> <li>• Can be cranky and annoyed (irritable mood)</li> <li>• Failure to meet expected weight gains should be considered (Should be measured by a doctor)</li> </ul>
<p>In both children and adults the Depression must also:</p> <ol style="list-style-type: none"> <li>1) Be substantially different from the usual mood state.</li> <li>2) Be accompanied by significant problems with friends, family, work or school that happen <u>because of</u> the Depression.</li> </ol>	

Symptoms in Clinical Depression may differ between children and adults. It is more difficult to diagnose Depression in children.

Most Depressions come on gradually, usually over a period of months (see figure one). Because of this it is sometimes hard to tell when the Depression starts. That is also why sometimes young people, parents, friends, teachers or other do not realize something is wrong until the Depression becomes severe or until problems with friends, family, work or school call attention to the Depression.

Figure 1. Typical Onset of a Clinical Depression



Major Depressive Disorder (MDD) is an episodic disorder — that means it can come and go over time. When a person is in an episode of MDD she/he is said to be Depressed, when the episode ends the person is said to be “euthymic” (which means usual mood) — see figure 2. On average a typical Depressive episode can last for 8 to 10 months.

Many people who develop a Depression prior to age 25 will have another episode within 5 years of the ending of the first episode. Treatment (we will discuss this later) is provided to decrease the length and severity of the Depressive episode AND to prevent other episodes from happening.

Figure 2. Depressive Episode and Euthymia (usual mood)

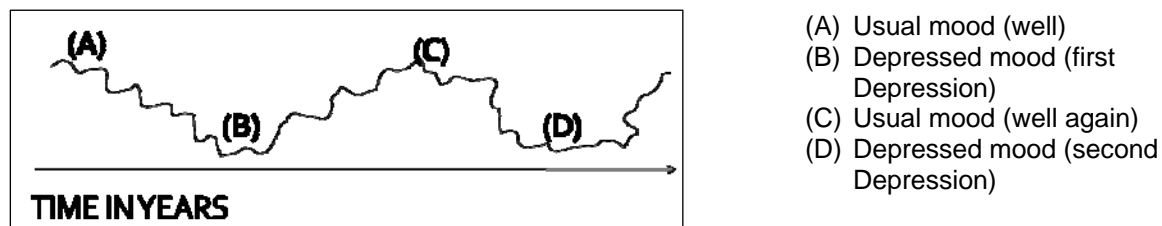


TABLE 2: Dysthymic Disorder Symptoms	
Adults	Adolescents and Children
<ul style="list-style-type: none"> <li>• Two or more of the following symptoms should be present for at least two years for a diagnosis in adults</li> <li>• Depressed mood for most of the day, for more days than not</li> </ul>	<ul style="list-style-type: none"> <li>• Two or more of the following symptoms should be present for at least one year for a diagnosis in adolescents or children.</li> <li>• Depressed OR irritable mood for most of the day, for more days than not</li> </ul>
Shared Symptoms	
<ul style="list-style-type: none"> <li>• Poor appetite or overeating</li> <li>• Diminished amount of sleep or increased amount of sleep</li> <li>• Low energy or feeling tired</li> <li>• Low self-esteem</li> <li>• Poor concentration or difficulty making decisions</li> <li>• Feelings of hopelessness</li> </ul>	
<p>In both children and adults the Depression must also:</p> <ol style="list-style-type: none"> <li>1) Be substantially different from the usual mood state.</li> <li>2) Be accompanied by significant problems with friends, family work or school that happen <u>because of</u> the Depression.</li> </ol>	

Dysthymia is less common than MDD in children and adolescents. Although it typically lasts much longer than an episode of MDD (more than 1 year) it may also be less severe in its signs and symptoms.

Depression is not common before puberty. Most Depressions begin in the 10 to 15 years following the beginning of puberty—not because of hormones, by the way!

Depression at different ages may look somewhat different. The older someone is when they get Depressed the more “adult” like the Depression will be.

There are some definitions that you should understand before we compare adult to child and adolescent MDD.

- Anxiety: is a negative mood which is characterized by physical tension, worry, and apprehension
- Hypersomnia: a sleep disorder characterized by too much sleep
- Insomnia: a sleep disorder characterized by an inability to fall asleep
- Psychomotor agitation: inner tension, feelings of agitation and movements that happen because of mental tension. For example, pacing back and forth or peeling or biting skin around fingers
- Psychomotor retardation: thoughts or movements that are slowed down
- Dysphoric – negative, sad, unhappy



<b>Matching Adult Symptom</b>	<b>How the symptom may look at the ages of 3-12yrs</b>
Dysphoric mood	Rapidly changing low irritable moods, apathy
Loss of pleasure or interest	Decreased socialization
Appetite or weight change	Eating Problems
Insomnia or hypersomnia	Sleep problems
Psychomotor Agitation	Irritability, tantrums, aggressive behaviour
Psychomotor Retardation	Lethargy
Loss of energy	Lethargy
Feelings of Worthlessness	Low self-esteem, guilt
Diminished Concentration	Difficult to assess, may show poor school performance
Recurrent thoughts of death or suicide	Accident proneness
Anxiety	Fear of separation from parents
Physical Complaints	Present – (stomach aches, headaches).

<b>Matching Adult Symptom</b>	<b>How the symptom may look at the ages of 13-18 yrs</b>
Depressed mood	Sad expression, apathy, irritability, depressed mood
Loss of pleasure or interest	Same as adult Presentation
Appetite or weight change	Same as adult Presentation or failure to meet expected weight gains
Insomnia or hypersomnia	Same as adult Presentation
Psychomotor Agitation	Aggressive behaviour
Psychomotor Retardation	Same as adult Presentation
Loss of energy	Same as adult Presentation
Feelings of Worthlessness	Guilt, low self esteem
Diminished Concentration	Poor school performance
Recurrent thoughts of death or suicide	Same as adult Presentation
Anxiety	Same as a dult Presentation
Physical Complaints	Same as adult Presentation

### Quick Check for Depression:

The following questions may help you identify if you or your child may have Depression. This QUICK CHECK is **NOT** a diagnostic test. If after taking the QUICK CHECK you are concerned about the possibility of Depression, please see your doctor and tell her/him about your concerns.

- Are you feeling down and unhappy most of the time?
- Are you being bothered by small things that don't usually bother you most of the time?
- Does nothing seem fun anymore?
- Do you find yourself not very hungry, or don't feel like eating most of the time?
- Do you find it hard to pay attention to what you are doing?
- Is it harder to go to sleep at night than it used to be?
  - OR do you find that even though you get a lot of sleep it doesn't feel like enough?
- Are you too tired to do things most of the time?
- Do you feel scared without anything really scary around?
- Are you becoming quieter than you usually are?
- Do you feel lonely most of the time, even around other people?
- Do you feel like the other children/teenagers don't like you or not want to be with you?
- Do you feel like crying more often than you usually do?
- Do you have difficulty getting started doing things most of the time?

[Modified from the self-report Center for Epidemiological Studies Depression Scale for Children (CES-DC).]

## Do I have Depression? (For adolescents)

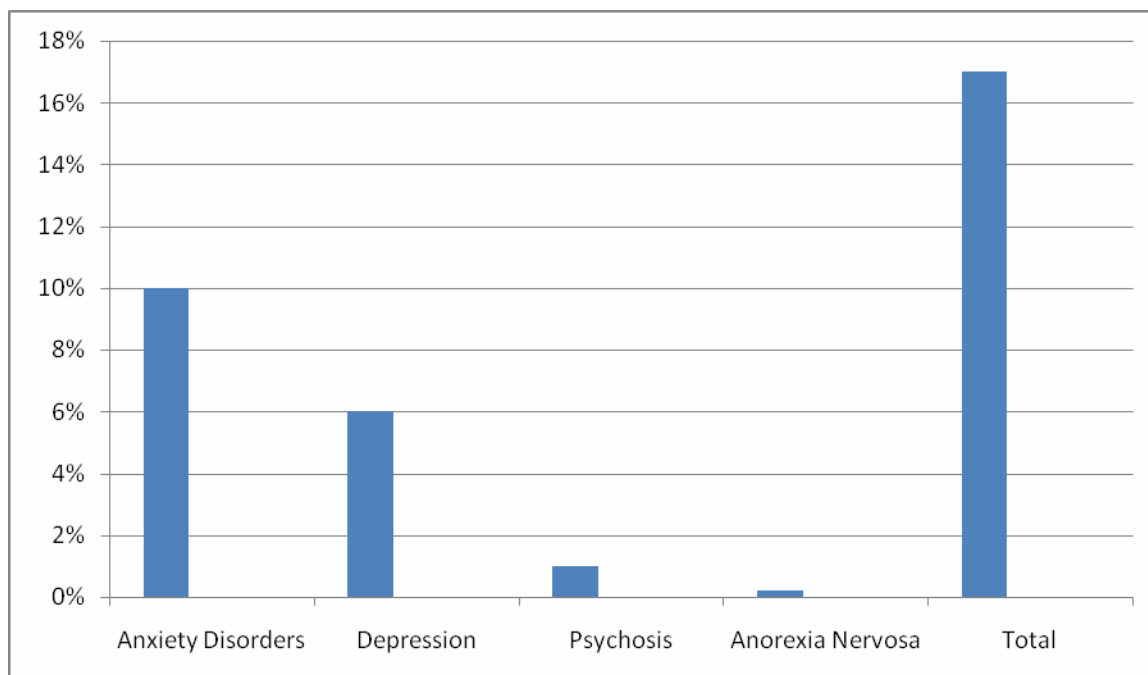
- Are you experiencing low mood, sadness, feeling blah or down, depressed, or just can't be bothered?
- Do you feel worthless, hopeless or like you are letting people down or like you are not being a good person?
- Are you feeling tired, low in energy, or want to rest or lie down a lot?
- Is it hard for you to get motivated or do you have to push to get things done?
- Does life not seem like much fun anymore?
- Do the things you used like to do not make you feel good anymore?
- Are you worried, nervous, panicky, tense, keyed up, anxious?
- Do you ever feel like not living anymore?
- Have you ever thought about, planned or attempt suicide or self-harm?

*[The above questions have been modified from the Kutcher Adolescent Depression Scale (KADS).]*

## (4) LEARNING MORE ABOUT DEPRESSION

Depression is the second most common mental disorder in young people—affecting up to six percent of youth between ages of 18 years.

**Figure 3. Common Mental Disorders by later Adolescence**



Other common types of mental disorders that may occur alongside Depression include:

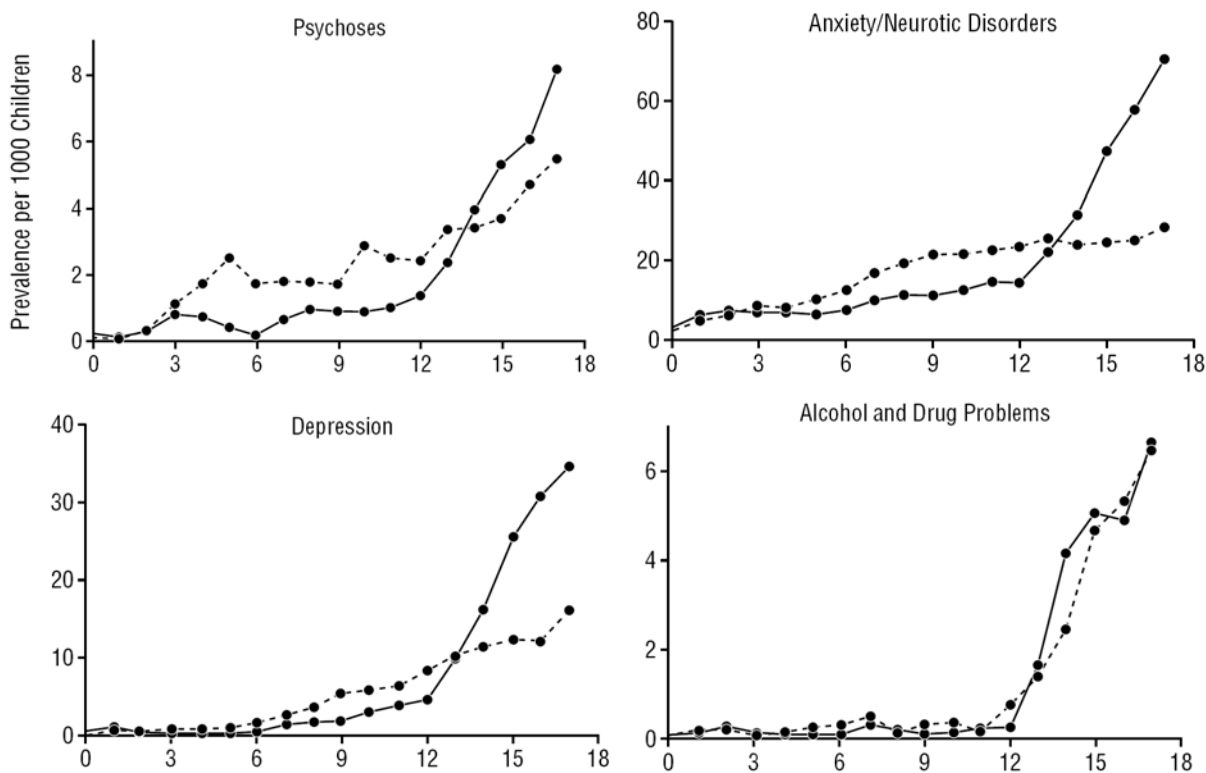
- Alcohol and Drug Abuse (Substance abuse)
- Eating Disorders
- Anxiety Disorder
  - Social Phobia
  - Panic Disorder

The adolescent years (13 to 25) are a time when many mental disorders begin for the first time. Figure 4. and table 3 show some of the most common of these.

### Age of Onset of Mental Disorders Graphs

**Figure 4.** Selected examples of patterns of mental disorders in children living in Alberta, Canada, stratified by type of disorder and sex, April 1, 1995, through March 31, 1996. The vertical scale varies for each graph, thus rates are not directly comparable.

*Spady DW, Schopflocher DP, Svenson LW, Thompson AH. Arch Pediatr Adolesc Med. 2001 Oct;155(10):1153-9.*



Age	Gender	Anxiety D.	Psychosis	Alcohol & Drug	Depression
0 yrs					
	Males	>0.5%	n/a	>0.1%	>0.2%
	Females	>0.5%	n/a	>0.1%	>0.2%
3 yrs					
	Males	0.6%	>0.1%	>0.1%	>0.1%
	Females	0.6%	0.1%	>0.1%	>0.1%
6 yrs					
	Males	0.9%	0.2%	>0.1%	0.1%
	Females	0.6%	>0.1%	>0.1%	0.1%
9 yrs					
	Males	2.1%	0.2%	>0.1%	0.5%
	Females	1%	0.1%	>0.1%	0.2%
12 yrs					
	Males	2.5%	0.25%	>0.1%	0.9%
	Females	0.7%	0.15%	>0.1%	0.4%
15 yrs					
	Males	2.2%	0.4%	0.5%	1.2%
	Females	5%	0.6%	0.5%	3%
18 yrs					
	Males	2.5%	0.5%	0.7%	1.5%
	Females	7%	0.8%	0.7%	3.5%

**Table 3.** Retrieved from: <http://www.who.int/whr/2001/en/index.html>

MDD is more common in girls than in boys. Important risk factors (things which increase the likelihood of getting Depression in the adolescent years) are:

1. Family history of MDD or bipolar disorder
2. Childhood history of Depression or Anxiety Disorder (especially separation anxiety disorder)
3. Alcohol or other substance abuse.

Remember—a Clinical Depression (MDD or Dysthymia) **IS NOT THE SAME THING** as “being depressed” as part of usual life.

## (5) BEING CLEAR WITH THE WORDS

The word “depression” or “depressed” is often used to describe someone who is unhappy, or distressed. This does not mean that she/he would be diagnosed with Clinical Depression. Depression is a common (up to 6 % of adolescents), but serious, mental disorder. It is easy to be confused about the difference between everyday sadness, distress, unhappiness, etc., that comes from common everyday problems such as difficulties at schools, arguments with family, disagreements with friends, etc., with the symptoms of Clinical Depression.

It is important to know the difference! Clinical Depression can cause many problems in a person's everyday life at school, home, or with the community. Clinical Depression has a set of symptoms and signs, and depressed mood is only one out of many possible symptoms. These are found in [Table 1](#) and [Table 2](#). Depression is **ALWAYS** accompanied by substantial functional impairment.

Everyone experiences sad things in their lives, such as a loved one dying, relationship breakups, disappointment or frustration and nobody gets by without feelings of unhappiness or sadness, because they are normal emotional reactions to everyday life. It can be useful to think about the differences between normal depressive feelings and Depression by comparing “distress” (normal emotional reactions to usual life) to “disorder” (a mental disorder).

## Distress versus Disorder

Distress	Disorder
<ul style="list-style-type: none"> <li>Always because of a bad or negative event</li> </ul>	<ul style="list-style-type: none"> <li>May or may not be because of a bad or negative event—often comes on by itself</li> </ul>
<ul style="list-style-type: none"> <li>Does not have a huge and prolonged impact on daily life</li> </ul>	<ul style="list-style-type: none"> <li>Usually has a substantial and prolonged negative impact on daily life and can cause negative events</li> </ul>
<ul style="list-style-type: none"> <li>Will go away when the environment changes or when the person adapts to what has happened</li> </ul>	<ul style="list-style-type: none"> <li>Environment may change but symptoms will persist</li> </ul>
<ul style="list-style-type: none"> <li>Do not usually need to talk to a mental health professional—support from friends and family is usually enough.</li> </ul>	<ul style="list-style-type: none"> <li>Usually need help or treatment from a health or mental health professional</li> </ul>
<ul style="list-style-type: none"> <li>Does not meet diagnostic criteria for a Clinical Depression</li> </ul>	<ul style="list-style-type: none"> <li>Meets diagnostic criteria (DSM or ICD) for a Clinical Depression</li> </ul>

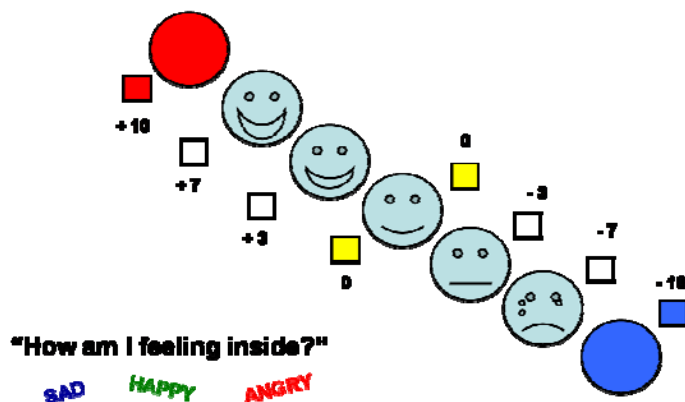
Depression is a disorder of mood and mood is one of the six [functions of the brain](#). So to understand Depression you need to know about mood. Mood is the subjective experience (what a person experiences) of an inner state (how we “feel inside”). Mood is complex and multifaceted, ranging from calm or quiet to irritable or excited and can exist all by itself (e.g., “I feel calm”; “I feel excited”) or because something has happened and we are reacting to that (e.g., “I feel excited because I am going to the movies”; “I feel happy because I got a good mark on my test”; “I feel unhappy because my friends are going away for the summer”).

Here are some words that describe moods commonly experienced by many teenagers:

Happy  
Excited  
Angry  
Frustrated

Calm  
Irritable  
Expansive  
Petulant

Depressed  
Elated  
Pensive  
Quiet



## What is Mood? - Normal Mood Verses Problem Mood (Depression)

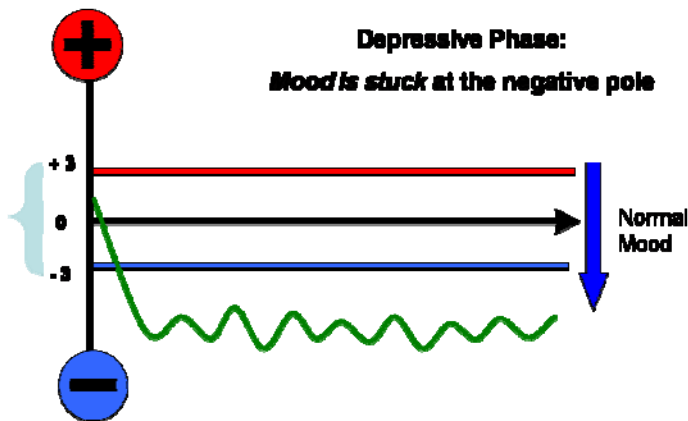
### “Normal” Mood Graph

Mood is always changing. Sometimes you'll feel happy and sometimes you'll feel sad. It is normal to feel this way. Think of mood like a wave. It goes up and down all by itself and also in reaction to changes in your life. Most of the time your mood stays within certain limits (both up and down) that are part of your personality.



### Problem Mood Graphs: Mood during a Depressive Phase

The problem of Depression comes when you feel sad or down all the time no matter what is going on in your life. You barely ever feel happy and a lot of the time may also be cranky, irritable, or angry for no reason.

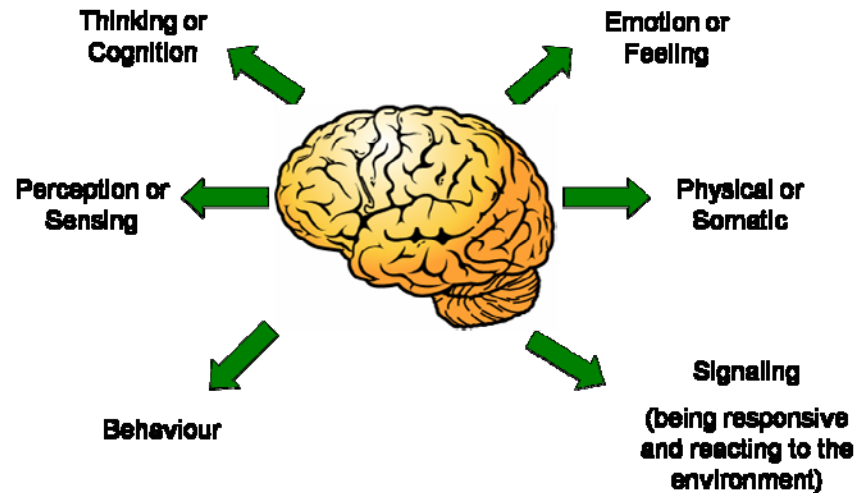


### What is a Problem Mood? (Depression)

- Changes to low when it should not
- Lasts much longer in the low phase than it should
- Negative effects on daily life and how we deal with different situations

## (6) THE SIX FUNCTIONS OF THE BRAIN

To help understand what happens when someone becomes depressed it is important to know how the brain usually functions. The diagram below shows the six different functions of the brain (to learn more about the teen brain click [here](#))



### Thinking or Cognition

A quick definition of thinking and cognition is: the way we think and process information. For example how we think about different things in our lives such as picking out your clothes in the morning OR how you solve a problem (whether it's mathematics or what to do if you have hurt your friends' feelings).

There are many different thinking/cognition activities. Here are some examples:

- Immediate memory: what just happened?
- Short-term memory: what happened this morning or last night?
- Long-term memory: what happened a year ago?
- Attention: being aware of what is going on around you.
- Concentration: working hard to pay attention to one really important thing.
- Comprehension: understanding what you are reading.
- Sorting: separating objects by size, shape, or by something they share in common.
- Organizing: putting things into categories, placing items of events in a logical or time-related sequence
- Planning: deciding how you are going to do things ahead of time.
- Problem solving: coming up with a solution to a problem.

### Emotion or feeling

- How we are feeling at any time
- Usually doesn't require thinking, but is linked to thinking—for example, thinking positive/negative thoughts can have a positive/negative impact on your mood.
- Our ability to experience 'feelings' and express those feelings to others. These are two key components of 'Emotion':

## Perception or Sensing

- How the brain takes in information about your surroundings.
- Hearing, seeing, smelling, feeling, tasting and knowing where your body is in space (proprioception).
- Proprioception: sensing the position, location, and movement of the body parts. One example of your sense of proprioception is when you are able to close your eyes and touch your nose.

Knowing where your body is in space is called proprioception. Here is how it works. Stick your right arm out and extend your index finger. Then shut your eyes and touch your nose with your index finger. Then do the same with your left arm and index finger. Easy! That is proprioception. How did your brain do that?

## Physical

- Movement of all of your body parts
- How the body feels inside of itself (e.g., sore muscles, a full bladder).
- How the body performs voluntary or involuntary functions.
  - Voluntary functions: when you see the ball coming and catch it; when you bend down and pick a peanut off the floor, etc.
  - Involuntary functions: breathing; digesting food; heart beating; etc.

## Behaviour

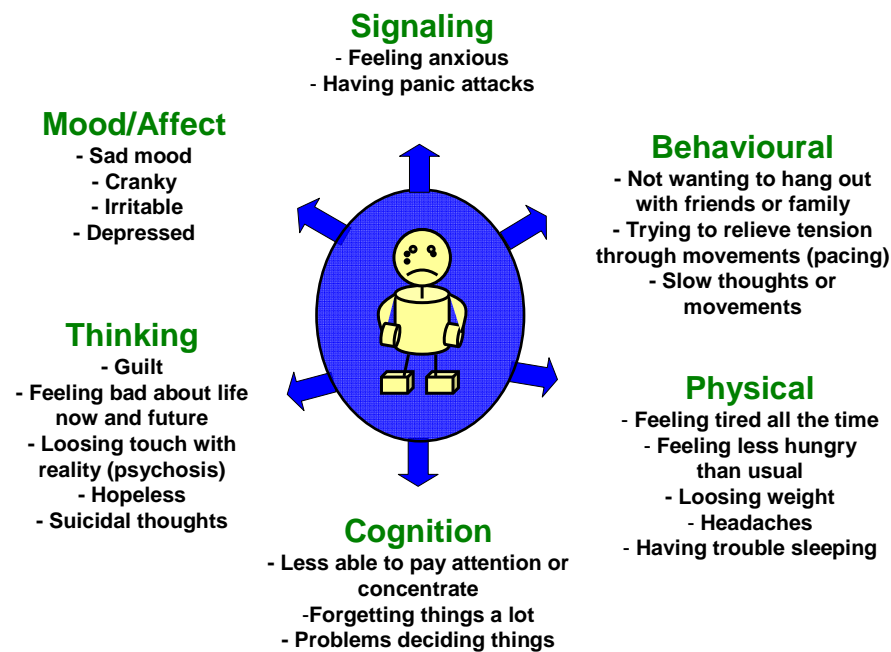
- Behaviors are actions that allow us to interact with others and our environment through 'doing'.
- Eating, playing, speaking, fighting, walking, running, driving, and other activities are examples of behaviours.

## Signalling

- When the brain senses danger from signals received from the environment through our senses. It causes physical and emotional reactions designed to protect us from harm
- As soon as the brain senses danger it turns on our 'adrenaline tap'... This activates a cascade of reactions that results in our bodies being prepared to react to danger.
- This results in:
  - Increased heart rate
  - Sweating
  - Tension/ anxiety
  - Increased delivery of blood to the muscles
  - Sharpened sight and hearing
  - Extreme alertness



When a person becomes Depressed many of the brain's usual functions can be disturbed. For example:



### Mood/Affect

- A typical symptom of Depression is depressed or irritable mood.
- How these symptoms can have a negative influence on your life:
  - A depressed mood can be hard to deal with for the person feeling it and for other people around the person feeling it. It can make others not want to be around him/her. Your feelings and moods can really affect your friends and family.

### Behaviours

- If some activities do not feel as fun anymore, then you may feel like you do not want to spend time with your friends or family. Some people withdraw or isolate themselves.
- If you do not feel like hanging out with friends or family, you may start to feel more lonely and alone. You may feel you have nobody to talk to. This adds to your depressed mood and you can get into a negative spiral.

### Thinking

- Feeling guilty when you should not.
- Negative thoughts about yourself, life and your future.
- Hopelessness.
- Thinking life is not worth living, thoughts of suicide.
- Guilt or hopelessness or low self-esteem.
- Psychosis: very rarely a Depression can become so severe that the depressed person loses touch with reality.

## Cognition

- Problems with concentrating or paying attention.
- Trouble remembering things.
- Trouble making decisions.
- You may have trouble studying and concentrating on school assignments.
  - Taking tests can be affected by trouble remembering and making decisions. This can lead to poor grades or even school failure, which can then make you feel even more depressed.

## Effects on the Body (Physical)

- Problems sleeping
- Changes in appetite
- Losing weight
- Less energy
- Headaches, stomach aches, or other types of aches and pains.
- Can leave you feeling lethargic and less likely to participate in your usual activities

## (7) How Does Depression Happen

The short answer to this question is that we really don't know for sure. The encouraging part however is that we are learning more about this all of the time and we now understand that simple explanations of what causes Depression (such as "it's caused by stress"; "it's due to genes") are not correct. We know that the brain controls mood and that for a Depression to happen the usual brain processes of mood control are likely to be disrupted.

We also know that these control processes depend both on the genetic program of brain development (determined at the time of conception) and factors in the environment (from conception afterwards). Because these control processes are chemical we know that both genetic and environmental influences on mood control are chemically mediated in the brain. That does not mean that only a chemical (such as medicine) can work to change how the brain controls mood. All environmental effects are changed into chemical processes in the brain.

This means that many different kinds of inputs can affect how the [brain](#) controls mood (for example: exercise can affect mood by its actions or one or more specific brain chemical pathways).

### Altered brain chemistry

Many different chemicals are involved in the brain's control of mood. Here are some of the most common. Serotonin is a brain chemical involved in regulating mood, emotion, sleep and appetite. For many people, Depression may be associated with problems in the way the serotonin system works. "Selective Serotonin Reuptake Inhibitors" are medications for Depression and act by improving the functioning of the serotonin system.

Dopamine is a brain chemical involved in regulating how you behave, think, and move, in motivation, and reward (such as when we get something we want or that makes us feel good), sleep, mood, paying attention, and learning. For some people with Depression, their dopamine systems may not be functioning as they should.

Norepinehrine is a brain chemical involved in body responses such as heart rate and sweating. It is also important in learning, remembering, and paying attention. Like serotonin and dopamine it is also thought

that some people with Depression suffer from problems in the way their norepinephrine systems are functioning.

### **Altered brain-hormone systems**

Females are about twice more likely to suffer from Depression than males beginning at puberty. At puberty males and females go through major and different hormonal changes. Males have an increase in testosterone and females have an increase in estrogens and progesterones and start their menstrual cycle. It has been suggested that the increased rate of Depression in females may be associated with the interaction of these hormones on brain functioning.

Cortisol is a stress hormone that can be found in people who endure stress for a longer period than the stress of a big test or confronting a problem for the first time. High levels of cortisol have been found in patients with Depression. This has led scientists to speculate that some people with Depression may have problems in their brain's stress response system.

### **Inherited Vulnerability**

Research studies on identical twins and non-identical twins show that identical twins share Depression much more often than non-identical twins. Since identical twins have almost the exact same genes and non-identical twins have the genetics of non-twin brothers and sisters, the difference in rates is thought to be largely due to genetic factors. Also, Depression runs in families. If a parent has had Depression the risk of one of their children having Depression is greater than the risk of the child of a person who has never had Depression. (This is also true in Bipolar Depression). However, just because Depression runs in a family does not mean that a child will necessarily become Depressed!

It is important to know that increased genetic risk does not necessarily lead to Depression. The environment also plays an important role. Recent research has focused on the way that the environment can influence how genes work. This type of study is called epigenetics and new findings suggest that we need to change our simplistic and likely incorrect ideas about nature (such as genes and things we are born with) and nurture (such as how or where we are raised). Both nature and nurture interact in complicated processes that we are only now just beginning to sort out. Some recent research for example suggests that genetic factors can both influence how a person will create specific life events and how they will react also to them! We have a long way to go before we really understand the complex interactions involved. Given what we currently know it is reasonable to conclude the following:

- 1) Genetic factors increase risk for Depression but do not predict who will become Depressed.
- 2) Environmental factors can influence who may become Depressed
- 3) We need to pay attention to both genetic and environmental factors when we try to promote good mental health and when we treat Depression.
- 4) Sometimes the Depression itself can lead to negative environmental effects that may worsen the Depression or increase the risk for Depressions in the future.

We know that there are factors in a child's environment that may increase or decrease their risk for Depression. For example, prolonged abuse in childhood or poor social/family supports both increase the risk for Depression. However, just as we have seen above for genes, a particular environment does not necessarily lead to Depression.

In fact, most people exposed to significant environmental stresses never become Depressed. We also know that when someone is Depressed the environment can often help them get well faster or conversely, make it harder for them to get well. For example, good social/family support are helpful while poor social/family support are unlikely to help and may indeed make things worse.

## (8) TREATMENT

### Finding Depression before Treating It

A diagnosis of Depression is made by a doctor or other health professional who is an expert in diagnosis. At this time there is no biological “test” for Depression (such as a blood test of sugar for diabetes). Once a diagnosis of Depression is made, there are a number of treatments that can be considered.

### What are the Treatments and How Do I Choose?

There are basically two different kinds of treatments for Depression:

- 1) Psychotherapy (talk therapy)
- 2) Medications (antidepressant medications)

There are also other treatments which may be additionally helpful for some people, depending on their environment and circumstances, such as:

- 1) Family Therapy
- 2) Social Skills Therapy

There are also a number of wellness enhancing activities that may be additionally helpful for many people, such as:

- 1) Exercise
- 2) Diet
- 3) Social activities
- 4) Good sleep & hygiene
- 5) Education/ schooling assistance

There are also a few dietary choices that may also be helpful for some people:

- 1) Foods rich in Omega3
- 2) Vitamin D (800 IU per day)

There are also things that should be avoided, such as:

- 1) Drugs (examples: marijuana, alcohol, cocaine, etc.) This is because drugs and alcohol can have a negative impact on the brain chemical systems we discussed earlier.
- 2) Isolation from friends/family

Not all treatments for Depression will work for everyone. Treatment needs to be selected following a thorough discussion of the various treatment options involving the person with Depression, his or her parents or caretakers, and the health provider (doctor, psychiatrist, psychologist, nurse, etc.). It is important to know that all treatments have potential risks and potential benefits, and that not all treatments have had the same amount of solid scientific evidence to support their use. Before selecting a treatment it is important that you understand the following:

To help you to better understand treatments and to help you make the best informed decision about treatment we have created this section on Key Questions to Ask Your Health Provider about your Treatment. We suggest you read those sections prior to discussing treatment options with your health provider.

### **Key Questions to Ask Your Health Provider about Your Treatment**

- 1) What are all the treatment options?
- 2) For each option:
  - a. What is the scientific evidence for its benefits?
  - b. What is the scientific evidence for its risks?
  - c. What are its costs?
- 3) How will the treatment be given and for how long?
- 4) How will you know that you are getting well?
- 5) What will happen if you are not getting well?

At this point in time, your treatment provider cannot know what treatment will be best for you before you take it, so you will need to discuss the options. Sometimes two treatments given together is a possibility- such as a medicine plus a psychotherapy. It may be useful to write these questions down and take them with you to your appointment.

[To find out more see the Evidence-Based Medicine Guide for Patients.](#)

## Types of Treatments

The following is a brief overview of treatments for Depression in young people for which there is reasonable current scientific evidence for positive effect. More information on specific treatments can be found following the links identified in each section.

### **Psychotherapy**

#### **Cognitive Behavioural Therapy (CBT)**

This is a therapy that focuses on changing how people think about themselves, their past, their present and their future. It can be provided by anyone trained in its use and can be given in a group or individually. It often requires homework between therapy sessions and a usual "course" of CBT is 10 to 12 one hour long sessions over a period of 2 to 3 months. Recent research suggests that computer assisted CBT may also be effective.

#### **Interpersonal Therapy (IPT)**

IPT is a therapy which focuses on forming positive relationships and improving social functioning. It has not received the same depth or scope of research as Cognitive Behavioural Therapy and is usually given in hourly segments over a period of 2-3 months (often once weekly). IPT can be given by anyone specifically trained in its use.

Currently there is no evidence that either CBT or IPT is "better", more effective or has fewer risks in comparison to the other. Some researchers suggest that they both share similar elements so that it may be their common components rather than their theoretical differences which are important. Given the scientific information available at this time, we recommend that a young person with Depression strongly consider taking CBT or IPT as a treatment for their Depression.

## Medication (Anti-depressant medications)

There are many antidepressant medications available but only a few have received sufficient study in young people to support their use in the treatment of Depression. There are fluoxetine (Prozac); citalopram (Celexa); sertraline (Zoloft). All of these are from the class of antidepressant called Serotonin Specific Reuptake Inhibitors (SSRI) which means that they likely exert their treatment effects through the serotonin chemical system of the brain. The best available evidence is for fluoxetine. More detailed useful information about other medicines can be found in [Child and Adolescent Psychopharmacology News](#).

At this time, the strongest scientific evidence for what works in treating Depression in young people is for fluoxetine combined with CBT, followed by fluoxetine and usual medical care. Fluoxetine and other SSRI medicines received warnings from regulatory agencies (Food and Drug Administration, Health Canada, etc.) because studies showed that more young people taking the medications demonstrated suicidal ideas or self harm than those taking placebos (placebos are inert substances given to individuals being tested in a study). The real difference in these events was about 0.2 percent compared to 0.1 percent. Recent scientific evidence has demonstrated the following regarding the use of antidepressant medications and suicide in young people:

- 1) Antidepressant medication use is linked with significantly fewer suicides and fewer suicide/self harm events
- 2) Decreases in antidepressant use are [linked with increased rate of youth suicide](#)

It is important to remember that Depression is the most significant risk factor for suicide in young people living in North America. Every treatment for Depression – medication or psychotherapy – must include evaluation and monitoring of suicide risk. For more information on suicide in young people see the [Understanding Adolescent Depression and Suicide Education Training Program](#).

Some antidepressant medications commonly used in adults should generally not be used in young people, either because they have not been shown to be effective or because they have unacceptable side-effect risks.

They include: Venlafaxine (Effexor); any Tricyclic Antidepressant-TCA (Imipramine, Desipramine, etc) or any Mono-Amine Oxidase Inhibitor (MAOI).

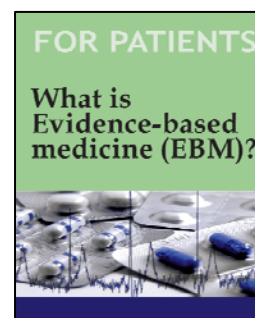
## Treatment in Youth Depression—what the current Scientific Evidence Shows is Effective

- Strongest evidence – medication (fluoxetine) plus CBT, fluoxetine plus usual medical care
- Second strongest evidence – psychotherapy (CBT, IPT)
- Using both Fluoxetine (Prozac) and cognitive-behavioural therapy (CBT) is the treatment with the best evidence to support its use and may also offer the best approach to decrease suicide risk

### Evidence-Based Medicine Guide for Patients

Developed by the Sun Life Financial Chair in Adolescent Mental Health, this guide provides patients with a comprehensive understanding of the scientific basis for medical treatments (biological, psychological, social) and how to communicate with your healthcare provider when discussing medication and other treatment options.

[Download the EBM Guide Here](#)



## Activities to Improve Overall Mental Health

Below is a chart that outlines some strategies that you can use to improve your mental health and to help you recover from Depression when used in addition to the treatments discussed above. It may be a good idea to take this chart to your family doctor and ask questions about how to go about each activity. How often to do the activity? With whom you should be doing the activities? Your doctor should be able to help you develop a diet and exercise plan. You should also find a buddy who will follow the diet and exercise with you. Having another person next to you gives you support you may need to follow your plan.

Activity	Plan (What to do? How often? With whom?)
Exercise	Example: Running. Four times a week. With your best friend.
Eating well	Example: Eating a healthy breakfast. Making sure you are getting enough protein, carbs, and healthy fats from foods such as cereals, nuts, milk, etc. Should be eating healthy foods most of the time.
Sleeping well	Example: Should be getting 8-9 hours of sleep every night.
Problem solving	Example: How to deal with stress at home: learning how to talk to mom when she is annoying you. How to deal with stress at school: when others are saying nasty things about you, learn how to keep calm and stay out of conflicts and away from negative people.
Being socially active	Example: Getting involved in sports, clubs, group hobbies, going to the mall, exercising with a group, dances, movie nights, etc.

## Activities That Should Be Avoided to Improve Mental Health

In general there are things that make us upset and will put us in a bad mood. Overall if there are things that you know make you feel badly, even if you like doing them from a force of habit, they should be avoided and you should stop. Below are some specific examples of things that should be avoided in order to avoid a negative mood.

- Using illegal drugs
- Too much alcohol (e.g., "getting wasted")
- Spending your day in a dark room
- Listening to really negative music...Music can have a HUGE influence on your mood!
- Avoid spending time with negative people.

## (9) MYTHS AND FACTS

**Depressive disorders cannot exist in children.** Depressive Disorders can and DO exist in children. Although childhood Depression exists, it is less common and Depression can look differently in children than adults, and makes it harder for mental health professionals to diagnose.

**Parents are to blame for their children's Depression.** If bad parenting caused Depression, then all people who have experienced bad parenting would have Depression. But a link between bad parenting and childhood Depression has not been established.

**People with Depression are to blame for their own disorder.** It is true that people with Clinical Depression often have a negative outlook about themselves, others, and their world. However, this is the result of and not the cause of their Depression.

**Depression only occurs when something bad happens in your life.** Depression may arise from life stressors, however, most people weather stress without becoming Depressed. Frequently Depression occurs for no apparent reason.

**Some one who is smart and successful would never commit suicide.** Be careful... remember, suicidality is often kept secret. 'Suicide' has no cultural, ethnic, racial or socioeconomic boundaries. Suicide and Depression can affect anybody, they do not target specific groups of people.

**Suicide is an expected or natural response to stress.** Suicide is an abnormal outcome of stress. Everybody experiences stress and hardships, but everybody does not attempt suicide. If you or someone you know is thinking of suicide it is important to seek help and treatment because there is hope.

## (10) Roles for Parents, Friends and Families

### For the Parents

Children depend upon their parents for help and usually often look to parents for advice and care. This is why it is important that parents are informed about Depression, so that if their child is having difficulties that might be due to Depression, they can help by involving professionals who know about this issue. This is a very important role! If you believe something is wrong with your child, do not ignore the problem and hope that it goes away. Depression identified and treated at an early age predicts a better long-term outcome.

### Dealing with his or her Depression

I know you are probably wondering what you can do to help. There are things that *can* help and here are helpful tips that will help you deal with your child, relative, or friend.

### Tips for Helping your Relative or Friend

1. **Be Patient.** Treatment can take time and many people with Depression try many different medications and treatments before they get better so it is important not to get frustrated or give up hope.
2. **Don't Blame Yourself.** Remember you can make someone unhappy, but Depression isn't just being unhappy so you can't "make" Depression happen.



3. **Take Care Of Yourself.** It is important that a person with Depression have the best help and supportive people around him or her. You need to be well in order to be able to give them the best support you can.
4. **Get Involved in his or her Life.** Take him or her out to do things he or she loves and that you also love. Encourage your child to participate in the activities he or she used to enjoy. Be patient, it may take time before he or she is as enthusiastic as you would like.
5. **Listen to Them.** Listen to his or her thoughts, worries, and problems. Supportive listening helps.
6. **Don't Judge.** Judging him or her could make him or her withdraw. Not having someone to turn to could make them feel alone and make his or her depressive symptoms worse. Listening helps!

## (11) SUICIDE

Suicide is a leading cause of death among Canadian youth, second only to motor vehicle collisions. Suicide rates vary across regions in Canada. The lowest youth suicide rates are found in Atlantic Canada while the highest are found in Northern regions and Quebec. Suicide attempts are also a health problem among Canadian youth. About twelve times as many young people make suicide attempts as those who actually die by suicide. Youth who survive a suicide attempt are at increased risk for completed suicide, as well as other types of violent death. They are also at risk for poor mental and physical health.

**Table 1. Suicide rate per 100,000 population, age 15-19, both sexes, 2000-2004**

Province/Territory	Overall	Male	Female
British Columbia	7.0	10.6	3.1
Alberta	11.5	17.4	5.4
Saskatchewan	15.3	20.8	9.5
Manitoba	16.9	24.1	9.4
Ontario	6.5	9.5	3.3
Quebec	14.6	21.2	7.7
New Brunswick	9.4	14.5	4.1
Nova Scotia	4.4	6.8	1.9
Newfoundland and Labrador	9.9	15.3	4.2
Northwest Territories	36.9	68.4	0
Nunavut	364.4	577.1	147
Canada	10.2	15.0	5.1

**Source:** Statistics Canada (2007). *CANSIM Table 102-0551: Deaths, by selected grouped causes, age group and sex, Canada, provinces and territories, annual.* Statistics Canada: Ottawa.

**Table 2. Methods of attempted and completed suicide**

Method	% of cases*	
	Attempted suicide	Completed suicide
Poisoning (i.e., drug overdose)	83	26
Cutting or piercing	9	2
Hanging, strangulation or suffocation	2	39
Firearms (i.e., guns)	--	22
Other	5	13

\*There were no data found for the Yukon Territory

## Mental Illness: A risk factor for Suicide

The most significant risk factor for youth suicide is mental disorder: research has shown that over 90% of suicide victims suffer from a mental disorder. A history of previous suicide attempts, substance abuse, and family history of suicide all increase the risk of suicide for young people.

Other risk factors for youth suicide include socioeconomic factors (e.g. social disadvantage and non-intact family of origin), parental mental illness, personal history of childhood physical or sexual abuse, and dysfunctional parent-child relationships. However more research is required to determine to what extent if any, each of these factors actually contributes to causing suicide.

### **Suicide Warning Signs**

The following is a list of warning signs that could indicate that a young person is thinking about or planning suicide. While signs are not in and of themselves indicative of a youth who is suicidal, when they occur in the presence of a change in usual social or academic functioning they should raise concern – concern that results in a professional assessment for suicide risk.

In fact, many youth at one time or another express or experience these “signs”. However, where the warning sign shows up as a clear change in an individuals’ personality, behaviour, or functioning, it may be a sign of a more serious problem.

- Depressed or lethargic or sad mood
- Hopelessness or despair
- Withdrawal from family
- Withdrawal from friends and usual social activities
- Loss of interest in activities once enjoyed
- Neglect of personal appearance
- Persistent self-deprecating comments
- Increased use of drugs and/or alcohol
- Preoccupation with death or people who have died by suicide
- Suicide or death as the theme of conversation, schoolwork or artwork
- Giving away valued possessions

### **Where to Get Help:**

If a youth (or anyone else) you know speaks to you about committing suicide, makes threats to end their life, or attempts suicide they should be taken to the closest emergency medical service. Once there, it is critical that the health professional meeting with the youth obtains all the information needed to make a proper assessment of suicide risk. This may include asking about previous suicidal attempts or thinking, current or past mental illness, presence of medical disorder, presence of substance use or abuse, presence of psychosocial stressors, and an assessment of the youth’s coping capacity and problem solving skills.

## (12) LINKS TO RESOURCES

Below is a list of electronically accessible resources that you may find useful for more information on adolescent mental health.

- National Institute of Mental Health: [www.nimh.nih.gov](http://www.nimh.nih.gov)
- American Academy of Child & Adolescent Psychiatry: [www.aacap.org](http://www.aacap.org)
- National Alliance on Mental Illness: [www.aacap.org/](http://www.aacap.org/) (easy to find information with their site search)
- The Dana Foundation: [www.dana.org](http://www.dana.org)
- Canadian Academy of Child and Adolescent Psychiatry: [www.cacap-acpea.org](http://www.cacap-acpea.org)
- Canadian Mental Health Association: [www.cmha.ca](http://www.cmha.ca)
- Sun Life Financial Chair in Adolescent Mental Health: [www.teenmentalhealth.org](http://www.teenmentalhealth.org)
- Mind Your Mind: [www.mindyourmind.ca](http://www.mindyourmind.ca)
- To Write Love on Her Arms: [www.twloha.com](http://www.twloha.com)

## (13) GLOSSARY OF TERMS

**Agoraphobia:** fear and avoidance of situations in which one would feel unsafe if they began to experience a panic attack.

**Anhedonia :** is symptoms which some people with Depression or with schizophrenia experience, which refers to a lack of pleasure experienced by the individual.

**Anxiety:** is a negative mood which is characterized by physical tension, and apprehension about the future.

**Anxiety Disorders:** a group of mental illnesses which are characterized by physical tension, and apprehension (negative expectations) about the future.

**Attention Deficit Hyper-Activity Disorder (ADHD):** is a mental illness that has three categories: (1) Predominantly Hyperactive-Impulsive; (2) Predominantly Inattentive; (3) Combined Type (both hyperactive and inattentive). Children with ADHD usually have many problems in school and focusing on work. One task at a time is hard for them to do. Inattentive means not being able to pay attention for long, so it is hard for them to focus on school work. Hyperactive-Impulsive means always wanting to be on the go and not being able to think things through before they act. This is why many children with ADHD can't sit still, which can annoy others around them (i.e., their teacher, and their parents).

**Cognition:** The way one thinks and processes thoughts and information. For an example, memory is a part of cognition.

**Completed Suicide:** is a purposeful self inflicted act that is fatal and is associated with implicit or explicit intent to die.

**Conduct Disorder (CD):** a mental disorder in which the individual has a long pattern of aggressive behaviours that are unacceptable in society.

**Depression:** a clinical term used to describe a mental illness which is characterized by depressed mood, loss of interest, change in sleep and weight or appetite, and other specific symptoms.

### **Depressive Phase (Episode):**

- Depressed mood
- Marked decrease in interest or pleasure in most or all (once favourable) activities
- Significant weight gain or loss without dieting or change in appetite
- Unable to get sufficient sleep or too much sleep (**Insomnia** or **Hypersomnia**)
- Slow movements or purposeless movements that are a result of mental tension such as, nervousness or restlessness, which is observable by others (**psychomotor agitation** or **retardation**)
- Fatigue or loss of energy
- Feelings of worthlessness or excessive inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death, **suicidal ideation**, suicide plan, or **suicide attempt**.

**Diagnosis:** a description that classifies a medical or mental disorder or illness.

**Diagnostic Criteria:** Criteria that has to be fulfilled before a person can be placed in a particular category of medical or mental disorder.

**Distress:** Distress always has a causal event, functional abilities are only affected mildly, will disappear with a change in the environment, and professional intervention is not usually necessary.

**Double Depression:** a mental illness which is characterized by a presence of both major depressive disorder and dysthymic disorder in one individual but not necessarily at the same time.

**Generalized Anxiety Disorder:** a mental illness which is characterized by excessive anxiety and worry about a number of possible events (not any single, specific event) that leads to functional impairment.

**Grandiosity:** having an exaggerated belief in one's importance or abilities.

**Hypomanic Phase:** similar to a manic phase, except fewer signs are present and are less severe.

**Manic Phase:**

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting one week
- Three of the following (four if mood is only irritable) symptoms have been present during the time of the first symptom:
  - Inflated self-esteem or **grandiosity**
  - Decreased need for sleep
  - More talkative than usual or pressure to keep talking
  - Flight of ideas or thoughts are racing
  - Distractability
  - Increase in goal-directed activity or psychomotor agitation
  - Excessive involvement in pleasurable activities that have a potential for painful consequences

**Mental Disorder:** A mental illness which makes the things you do in life hard, like work, school, and socializing with other people. Must meet recognized diagnostic criteria (DSM or ICD).

**Mental Health Professional:** a person who works to help other people with their mental state or mental illness.

**Mood:** is the ongoing inner feeling experienced by an individual.

**Neurodevelopment:** Development of the brain.

**Neuroscience:** Science of the brain.

**Obsessive-Compulsive Disorder:** a mental illness characterized by obsessions, intrusive and mostly nonsensical thoughts, images, or urges that an individual tries to eliminate, and compulsions, thoughts or actions used to suppress the obsessions and provide relief. Examples of obsessions include repetitive thoughts of germs or contamination. Examples of compulsions include repetitive touching or counting to avoid obsessions.

**Panic Disorder:** a mental illness which the person has panic attacks and anticipates and fears the attacks.

**Perception:** the way we understand information that comes from the five senses.

**Posttraumatic Stress Disorder (PTSD):** This will sometimes happen to people who experience a really scary, painful, or horrific (traumatic) event in which they felt scared, helpless, or horror. People who experience this will have flashback memories (or nightmares) of the event and will avoid things that remind them of the event.

**Prognosis:** an educated guess (based on previous evidence) of how the illness in the individual will turn out in regards to length of time it will be present and how it will affect the person.

**Psychomotor agitation:** movements that happen because of mental tension. It is a way of relieving mental tension. For example, pacing back and forth and peeling or biting skin around fingers.

**Psychomotor retardation:** thoughts or movements that are slowed down.

**Psychosis:** The term psychosis is used to describe the state of a person who projects unusual behaviours, delusions (irrational beliefs) and hallucinations (sensory experiences that are not really happening)

**Remission:** when an individual returns to a normal state after having an active phase of a mental disorder.

**Social Phobia:** the fear of having to be in social situations, like performing in front of other people. For example, the fear of public speaking, the fear of going to a party because other people are “judging” them.

**Somatic:** physical.

**Self-harm:** refers to any self-inflicted destructive behaviours not associated with an implicit or explicit intent to die.

**Specific Phobia:** any specific fear of an object or situation. Examples: the fear of heights, the fear of snakes, spiders, or bugs.

**Suicidality:** refers to any thoughts or actions associated with an implicit or explicit intent to die.

**Suicidal Attempt:** a purposeful self-inflicted act that is non-fatal and is associated with implicit or explicit intent to die.

**Suicidal Ideation:** refers to thoughts, images or fantasies of harming or killing oneself.

**Suicidal intent:** The conscious decision to take one’s life—to commit suicide.

**Suicidal Plan:** The considered events leading to the attempt on one’s life.

**Symptom:** an inner experience that comes with a certain disease, illness, or disorder.

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