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Depression in Children and Adolescents: Identification, Assessment, and Treatment

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Depression in children and adolescents is a mood (affective) disorder whose magnitude and clinical importance has only recently permeated the concern of educators. Once considered exclusively the domain of psychiatrists, depression can and should be considered by school personnel in identification, assessment, and treatment (Reynolds, 1984). Unfortunately, professionals in special education have been slow to recognize that depression affects a wide range of school-related functioning (Maag & Rutherford, 1987, 1988). A survey by 47 nationally recognized experts in education of the behaviorally disordered, for instance, did not even mention depression as an important research issue in the field (Epstein & Cullinan, 1984). Youngsters with behavioral disorders are not the only handicapped group at risk for developing depression. Depression has been identified in children and adolescents with mild mental retardation, learning disabilities, and speech and language disorders (e.g., Cantwell & Baker, 1982; Reynolds & Miller, 1985; Stevenson & Romney, 1984).

Depression may be overlooked as a potentially important area of concern in special education, in part, because of its colloquial presence and associated ambiguity (Kendall, Hollon, Beck, Hammen, & Ingram, 1987). At one end of the spectrum, depression is a commonly used term to denote "feeling a little bummed out." At the other end of the spectrum, depression refers to a clinical syndrome or disorder. Kazdin (1990) provides the following distinction:

> As a *symptom*, depression refers to sad affect and as such is a common experience of everyday life. As a *syndrome* or *disorder*, depression refers to a group of symptoms that go together. Sadness may be part of a larger set of problems that include the loss of interest in activities, feelings of worthlessness, sleep disturbances, changes in appetite and others. (p. 121)

These distinctions are more than a matter of semantics—different definitions and uses of the label "depression" have important implications (Kendall et al., 1987). The syndrome of depression can be present, in secondary ways, in other disorders. For example, a schizophrenic individual may manifest depressive symptomatology without meeting diagnostic criteria for major mood disorder (American Psychiatric Association, 1987).

In this article we are providing only a brief overview of the current status of knowledge in the area of child and adolescent depression. For in-depth reviews, see Dolgan (1990), Kazdin (1990), and Reynolds (1985). We describe diagnostic criteria and identification procedures as well as assessment methodology and intervention strategies. The focus is on depression in handicapped populations in school settings and the implications for special educators.

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CURRENT PERSPECTIVES

For many years, controversy has surrounded the nature of depression in children and adolescents (Kaslow & Rehm, 1991). For example, conventional psychoanalytic doctrine postulates that depression cannot exist until the onset of adolescence and the development of the superego (Rie, 1966; Rochlin, 1959). A popular view during the 1970s reflected the belief that depression in children was "masked" and must be inferred from underlying behaviors such as hyperactivity, aggression, irritability, delinquency, and poor school performance, to name a few (e.g., Cytryn & McKnew, 1974; Malmquist, 1977). Lefkowitz and Burton (1978) suggested that depression represents a transitory developmental phenomenon which abates spontaneously without intervention; and Seifer, Nurcombe, Scioli, and Grapentine (1989) currently suggest that depression is but one symptom usually found in a pattern of other symptoms that seem to cluster together in children.

The current consensus among researchers and clinicians, however, is that depression in children and adolescents parallels that found in adults. Consequently, the diagnostic criteria for diagnosis of depression in adults also is appropriate and applicable to children and adolescents (Carlson & Cantwell, 1980; Chambers et al., 1985; Chiles, Miller, & Cox, 1980; Kashani, Barbero, & Bolander, 1981; Mitchell, McCauley, Burke, & Moss, 1988).

Diagnostic Criteria

The primary diagnostic system that researchers and clinicians currently use is the *Diagnostic and Statistical Manual for Mental Disorders–Revised* (DSM-III-R) (American Psychiatric Association, 1987). The DSM-III-R criteria for all mood disorders in adulthood, including depression, are applied to children as well. Although depression is a clinical condition that can be diagnosed in children, adolescents, and adults, its specific symptoms, associated features, and clinical course can vary as a function of development (Kazdin, 1990). DSM-III-R provides a standardized nomenclature, but this system does not help to identify developmental differences. Cicchetti and Schneider-Rosen (1986) have suggested that depression becomes a problem when it interferes with social, cognitive, or emotional competencies

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DSM-III-R *Criteria for Major Depressive Disorder*

At least five of the following symptoms must be present during the same 2-week period; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure.

- Depressed mood most of the day, nearly every day (either by subjective account; e.g., feels "down" or "low" or is observed by others to look sad or depressed)
- Loss of interest or pleasure in all or almost all activities nearly every day (either by subjective account or is observed by others to be apathetic)
- Significant weight loss or weight gain (when not dieting or binge-eating) (e.g., more than 5% of body weight in a month) or decrease or increase in appetite nearly every day (in children consider failure to make expected weight gains)
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) (in children under 6, hypoactivity)
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt (either may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- Diminished ability to think or concentrate, or indecisiveness nearly every day (either by subjective account or observed by others)
- Thoughts that he or she would be better off dead or suicidal ideation, nearly every day; or suicide attempt

necessary for the successful resolution of developmental tasks. A developmental perspective complements DSM-III-R criteria by providing a broader framework for understanding the nature of depression in children and adolescents (Carlson & Garber, 1986).

Depressive symptoms may be included in other types of disorders. Separation anxiety disorder, adjustment disorder with depressed mood, and uncomplicated bereavement are conditions associated with depressive symptoms such as sadness and loss of interest in usual activities. Severity, duration, and precipitants of the symptoms are major determinants of the type of depressive disorders diagnosed (Kazdin, 1990). A scheme depicting a continuum of mood disorders and selected differential problems is presented in Table 1.

TABLE 1
Classification Scheme for Mood Disturbances

Pathology	*Unipolar*	*Bipolar*
Severe	Major depression: Single episode* Recurrent**	Bipolar disorder: Manic Depressed Mixed
Moderate	Dysthymia***	Cyclothymia***
Mild	Atypical depression	Atypical bipolar disorder
	Adjustment disorder: Depressed mood Withdrawal	Adjustment disorder with anxious mood
Differential	Schizophrenia Schizoaffective disorder Separation anxiety	Paranoia Schizoaffective disorder
Nonpathological	Demoralization Bereavement	(no equivalent)

*Estimates are that more than 50% of individuals having a first single episode will eventually have recurrent episodes.
**Major depression, recurrent, may predispose to development of bipolar disorder.
***Dysthymia and cyclothymia may predispose to development of a major mood disorder.

Distinctions should be made between depression and dysthymia. The latter is seen as relatively less severe but recurring over a longer period, often punctuated by periods of normal mood that may last for days or even weeks. Another important distinction is between unipolar and bipolar depressive disorders. Unipolar depressive disorders consist of continuous or intermittent periods of dysphoric mood or anhedonia (inability to have fun), whereas bipolar disorders involve alternating episodes of depression and inappropriate euphoria, excessive energy, grandiosity, impulsivity, and poor judgment (Rizzo & Zabel, 1988). Common conditions of both differential pathological and nonpathological origin are noted in Table 1 as well; the former are those of similar severity but different pathological nature, and the latter are within the range of normal emotional responses.

Little is known about manic conditions in children, as they are believed to be rare and difficult to diagnosis in this age group (Kovacs, 1989). Criteria for major depressive disorder and dysthymia generally are necessary in the diagnosis of bipolar disorder and cyclothymia, respectively, along with specific criteria for alternating manic features. It is interesting to speculate whether the episodic nature of a bipolar disorder could render an afflicted child ineligible for special education in that he or she would fail to meet consistently the criterion of a "pervasive mood of sadness or depression" even though bipolar disorder is possibly more debilitating than depression per se (Forness, 1988).

Subtypes of Childhood and Adolescent Depression

The classification scheme illustrated in Table 1 represents a continuum of mood disorders, from the DSM-III-R, that may be present in children and adolescents. Childhood depression can further be classified into several distinct subtypes, each positing a slightly different etiological base and, therefore, having implications for identification, assessment, and treatment (Maag & Rutherford, 1988). Different subtypes of depression are presented in Table 2.

Several important distinctions exist between each subtype. *Anaclitic depression*, also termed the "deprivation syndrome" (Spitz & Wolf, 1946), develops in an infant after loss of a caregiver and no provision of a substitute. *Reactive depression* differs from anaclitic depression in that loss of the caregiver does not invariably lead to anaclitic depression; poor parent-child relationships have the most impact on development of reactive depression (Abrahams & Whitlock, 1969). *Acute depression* develops in response to some traumatic event, such as the loss of a loved one, and the prognosis for recovery is good (Cytryn & McKnew, 1972). *Chronic depression*, in contrast, is more extreme and has no immediate precipitating events but is punctuated by repeated separations from the caregiver during early infancy. Finally, *endogenous depression* is thought to be genetic or biochemical in nature, and possibly related to learning disabilities in some children (Brumback & Stanton, 1983).

TABLE 2
Subtypes of Childhood and Adolescent Depression

Subtype	*Characteristics*
Anaclitic Depression	Loss of caregiver with no provision for a substitute; period of misery followed by loss of interest in environment.
Reactive Depression	Trauma or loss frequently accompanied by feelings of guilt for past failures; poor parent-child relationship is important factor.
Acute Depression	Onset occurs after some traumatic event; prognosis for recovery is good if relationship with caregiver is healthy.
Chronic Depression	Repeated separations from caregiver beginning in infancy; presence of depression in mother; no immediate precipitating event; periodic recurring emotional-depriving experiences; suicidal ideation early in childhood.
Endogenous Depression	Genetically or biochemically determined; no identifiable stressors; believed to exist, to some degree, throughout life of child; may reach psychotic or suicidal proportions.

IDENTIFICATION AND ASSESSMENT

Upon examining prevalence figures of depression in children and adolescents, the importance for educators to identify this disorder becomes alarmingly apparent. The extent to which children and adolescents experience depressive symptomatology has been studied in school-based and clinical populations. Prevalence estimates usually are determined either through DSM-III diagnostic criteria or rating scales in which a score is translated into levels ranging from nondepressed to severely depressed (Reynolds, 1985). Because DSM-III focuses on clinical syndromes or symptom-clusters, prevalence estimates using this approach tend to be more conservative than those obtained for rating scales that provide only global indicators of symptom-severity. In fact, children obtaining rating scale scores in the severe range occasionally fail to meet DSM-III diagnostic criteria for depressive disorders (Kazdin, Colbus, & Rodgers, 1986).

Prevalence Estimates

Using DSM-III criteria, about 2% of school-based children (Kashani et al., 1983; Kashani & Simonds, 1979) and 10% to 20% of clinic-based children (Puig-Antich & Gittelman, 1982) have been diagnosed as depressed. When depression is identified using extreme scores on self report scales, between 2% and 17% of students attending general education school classes manifested moderate to severe levels of depressive symptomatology (Friedrich, Jacobs, & Reams, 1982; Kaplan, Hong, & Weinhold, 1984; Lefkowitz & Tesiny, 1985; Reynolds, 1983; Smucker, Craighead, Craighead, & Green, 1986; Teri, 1982a). Special education populations tend to have a much higher prevalence: Between 14% and 54% of learning disabled (LD) and seriously emotionally disturbed (SED) students manifested severe depressive symptomatology (Maag & Behrens, 1989a; Mattison et al., 1986; Stevenson & Romney, 1984).

A summary of selected prevalence studies is presented in Table 3. Only fairly recent studies employing large samples are included because they tend to be more accurate; however, considerable variability is evident, often depending on choice of diagnostic criteria and instrumentation.

Another reason prevalence estimates tend to be somewhat inchoate stems in part from the failure of researchers to consider variables such as gender and age. Gender differences in prevalence of depression usually do not surface until adolescence, when more females than males experience severe symptomatology (Angold, Weissman, John, Wickramaratne, Drusoff, 1991; Kashani et al., 1983; Lefkowitz & Tesiny, 1985; Lobovits & Handal, 1985; Mezzich & Mezzich, 1979; Reinherz et al., 1989; Reynolds, 1985). Similar results have been obtained with LD and SED adolescents; females are three times more likely to report severe depressive symptomatology than their male counterparts (Maag & Behrens, 1989b).

In regard to age, except for very young children (aged 1-6), who have low rates of depression (Kashani, Cantwell, Shekim, & Reid, 1982; Kashani, Ray, & Carlson, 1984), age differences in both handicapped and nonhandicapped populations tend to be mediated by gender (e.g., Fleming & Offord, 1990; Maag & Behrens, 1989a; Rutter, 1986). Adolescents in general, however, seem to experience higher rates of depression than children do (Forness, 1988; Kazdin, 1990).

Educators' Perspectives on Depression

Given the unsettling prevalence of depression in school-based populations, educators clearly should play a strategic role in early identification. Youngsters spend more time in school than in most other structured settings outside the home, and their most consistent and extensive contact is with educators (Grob, Klein, & Eisen, 1983). Consequently,

TABLE 3
Selected Prevalence Findings in Childhood and Adolescent Depression

Study	*Sample Type*	*Percent Depressed*
School-Based General Education Samples		
Lefkowitz & Tesiny (1985)	3,020 3rd-, 4th-, & 5th-grade children, mean age 9.8	5.2%
Reynolds (1983)	2,874 adolescents, ages 13–18	7%
School-Based Special Education Samples		
Maag & Behrens (1989a)	465 LD and SED adolescents ages 12–18 attending resource programs	21%
Mattison et al. (1986)	109 students ages 6–18 referred for SED placement	18% (ages 6-12) 51% (ages 13-18)
Stevenson & Romney (1984)	103 LD students ages 8–13 attending resource programs	14%
Clinic-Based Samples		
Cantwell & Baker (1982)	600 children and adolescents ages 2–16 presented to a community clinic for speech and language evaluation	4%
Carlson & Cantwell (1980)	102 children and adolescents ages 7–17 presented for psychiatric evaluation to an outpatient department	58%
Colbert, Newman, Ney, & Young (1982)	282 children and adolescents ages 6–14 admitted to a child and family practice unit	54%

school personnel may be the first professionals to notice developing problems (Powers, 1979). To facilitate the identification process, school personnel must be knowledgeable of depression and sensitive to students who might exhibit it. Although school personnel possess some general knowledge of depression, they cleave to several misconceptions.

Maag, Rutherford, and Parks (1988) had a sample of regular education teachers, special education teachers, and school counselors complete a questionnaire assessing their ability to identify characteristics of depression. Their answers were coded into similar response categories and compared to information about depression drawn from empirical research. School counselors possessed the greatest knowledge of depression, whereas general and special educators identified only global characteristics. Of particular note, special educators tended to identify characteristics related to externalizing problems (e.g., disobedience, aggression) more frequently than internalizing problems (e.g., sadness, loneliness, crying). Externalizing behaviors tend to correlate more highly to depression scores for males, and internalizing problems and negative view of self correlate more highly with depression scores for females (Smucker et al., 1986). More males than females typically receive special education services, so the belief in masked depression should not be resurrected.

In a similar study, Clarizio and Payette (1990) surveyed school psychologists. Although the school psychologists in the study possessed considerable knowledge of depression, their responses diverged relative to the literature in two important areas. *First*, a substantial number of school psychologists believed that childhood depression was substantively different from adult depression. They almost unanimously agreed that masked depression exists, even though this conceptualization has been discounted for several years (Kaslow & Rehm, 1991). *Second*, projective techniques (e.g., TAT, sentence completion) were one of the most frequently named methods for assessing depression. This finding contradicts evidence that projective tests are not sensitive enough to identify specific psychiatric conditions in childhood, including depression (Gittelman, 1980).

More alarmingly, some evidence suggests that educators may respond more negatively to depressed students than to their nondepressed peers. Peterson, Wonderlich, Reaven, and Mullins (1987) had teachers rate their feelings in response to four films in which a child was portrayed as either depressed or nondepressed and as having experienced either high or low life stress. The children who were both depressed and stressed received the most negative reactions from educators; the children who were either depressed or stressed were viewed less negatively; and the children who were neither depressed nor stressed received the most positive reactions. Depression clearly influenced educators' responses in ways that could serve to maintain a child's depression. Educators who communicate less positive and more negative behavior to a depressed child may enhance feelings of low self-esteem, dysphoria, inadequacy, and helplessness.

Because the risk of suicide also is greatly heightened with depression (Myers et al., 1991), educators have a partic-

ular need to be sensitive to this disorder. Guetzloe (1989) discusses issues of suicidality in school settings.

Early Identification

Early identification of depressed children and adolescents in school settings is desirable, but Reynolds (1986a) recognized several factors that make this goal problematic:

1. Prevalence figures may be somewhat misleading as depressive symptomatology tends to be overendorsed on the first administration of a self-report measure of depression. A second administration of the same measure shortly thereafter may not show depressive symptomatology. What happens is that a specific event or stressor may trigger a depressive episode, which may account for many cases of depression identified in prevalence surveys.
2. School personnel often have difficulty identifying specific symptom clusters associated with depression. To complicate matters, secondary teachers have limited contact with students.
3. Depressed students rarely refer themselves for help.
4. Some parents deny that their child may be suffering from a mood disorder.

On the basis of findings from prevalence studies of depression in children and adolescents and the lack of self-referral, teacher referral, or parent referral, Reynolds (1986a) developed a three-stage screening program to identify depressed children and adolescents in school settings: (a) conducting large-group screening with self-report depression measures; (b) 3 to 6 weeks later retesting children who, on the basis of the large-group screening in Stage 1, meet cutoff score criteria for depression; and (c) conducting individual clinical interviews with children who manifest clinical levels of depression at both Stage 1 and Stage 2 evaluations.

Classroom teachers can conduct group assessment of students, utilizing a self-report depression measure appropriate for children or adolescents. Self-report is particularly important in assessing depression because primary symptoms such as sadness, feelings of worthlessness, and loss of interest in activities reflect subjective feelings and self-perceptions (Kazdin, 1990). Common self-report measures for children and adolescents are given in Table 4.

Reynolds (1986a) has suggested that teachers avoid telling students they are being tested for depression because this information may induce lower levels of mood awareness. Instead, students can be informed that the school is interested in how they are feeling about themselves. This information can be restated to students involved in a second screening. The second screening serves to weed out students who experienced a transient depressed mood during the initial screening or exaggerated their depressive symptomatology. During the last stage, individual clinical interviews are conducted with students who met depression criteria at both previous stages. Common interview schedules also are presented in Table 4. Obtaining measures other than self-reports is important as some students consistently overestimate or underestimate depressive symptomatology or misinterpret items or response format.

To screen initially for only a single disorder may be neither desirable nor efficient sometimes, especially given limited resources in some school psychology or consulting services budgets. As an alternative to screening only for depression, Walker and Severson (1990) have developed a multi-stage procedure to screen for both internalizing and externalizing disorders. In this process, teachers are asked to nominate and rank order pupils who demonstrate characteristics of these broad-band disorders in their classroom (Stage 1) but then also rate only the top three pupils in each category on brief measures of adaptive and maladaptive behavior as well as on critical events or symptoms (Stage 2). A school psychologist then conducts brief observations of classroom attention and playground social interaction on two different occasions (Stage 3) for any pupils who exceed critical cutoff scores in the first two stages. Although this procedure is not specific to depression, it may identify children with a potential diagnosis of this disorder, which then can be verified using the techniques described above.

Depression-Related Characteristics

Depression influences a wide range of behavioral, cognitive, and affective functioning (Maag & Rutherford, 1987). Many depression-related characteristics vary as a function of developmental level (Kazdin, 1987). For example, infants have not acquired the ability to verbalize and have not experienced the world and therefore express depression through eating and sleeping disorders (Evans, Reinhart, & Succop, 1980). Because preschoolers are motor-oriented, much of their mood is expressed through behavior such as night terrors, enuresis, and encopresis. Older school-age children may become more outwardly aggressive, anxious, and antisocial (Kazdin, French, & Uniš, 1983). Depression becomes more overt in adolescents as their better-developed conscience exacerbates feelings of guilt and low self-esteem (Teri, 1982b).

TABLE 4
Commonly Used Measures for Childhood and Adolescent Depression

Measure	*Response Format*	*Description*
Self-Report (Child)		
Children's Depression Inventory (Kovacs, 1985)	27 items, each rated on a 0-2 point scale	Derived from Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Items reflect affective, cognitive, and behavioral symptoms.
Reynolds Child Depression Scale (Reynolds, 1986b)	30 items, each rated on a 1-5 point scale	Items selected to measure depression in school characteristics (e.g., suicide) are replaced by less severe behavior (e.g., hurting oneself).
Self-Report (Adolescent)		
Beck Depression Inventory (modified for adolescents) (Chiles et al., 1980)	33 items, each on a scale varying from 0 to 2, 3, or 4 points	Changes in language, not content of Beck Depression Inventory (Beck et al., 1961).
Reynolds Adolescent Depression Scale (Reynolds, 1986c)	30 items, each rated on a 4-point scale	Items derived from symptoms included in major, minor, and unipolar depression.
Clinical Interviews (Child)		
Bellevue Index of Depression (Petti, 1978)	40 items, each rated on a 4-point scale of severity and 3-point scale for duration	Administered separately to child, parents, and others; helpful to combine scores from different sources.
Children's Depression Rating Scale (Poznanski, Cook, & Carroll, 1979)	16 items scored after interview; symptoms rated on a 6-point scale for severity	Derived from Hamilton Depression Rating Scale (Hamilton, 1967) for adults. Administered also to parents and others to combine different sources.
Schedule for Affective Disorders for School-Age Children (Chambers et al., 1985)	Multiple items for mood disorders; depressive symptoms rated for degree of severity for scales varying in point values	Patterned after adult Schedule for Affective-Disorders (Endicott & Spitzer, 1978) based on Research Diagnostic Criteria (Spitzer, Endicott, & Robins, 1978). Parent and child are interviewed.
Clinical Interviews (Adolescent)		
Hamilton Depression Rating Scale (Hamilton, 1967)	17-item semi-structured interview with probes	Measures severity of depression and probes for psychotic symptoms; translates well for use with adolescents.
Research Diagnostic Criteria (Spitzer et al., 1978)	11 depression subtypes (e.g., simple, recurrent, unipolar, agitated)	Provides greater specificity than DSM classification; primarily used in research.

Note. For an in-depth review of the characteristics of individual assessment techniques, see Kazdin (1988).

A number of salient characteristics correlate with, if not contribute directly to, depression. Although the range of domains is quite large, several key characteristics occur quite frequently with depression. For example, low self-esteem is likely to be part of the symptom picture of depression. Hopelessness, or negative expectations toward the future, correlates with depression, suicidal ideation and behavior, and low self-esteem (DiGangi, Behrens, & Maag, 1989; Kazdin, Rodgers, & Colbus, 1986).

In addition to cognitive disturbances, social skill deficits often are associated with depression (Helsel & Matson, 1984). Environmental events that induce stress can contribute to the development and maintenance of depression as well (Compas, 1987). These depression-related characteris-

tics often reflect specific theoretical models of depression including social skill deficits, cognitive theory, learned helplessness theory, self-control deficits, and deficits in problem solving.

Descriptions of the relevant models are presented in Table 5. A number of measures focus on key areas related to depressive symptoms based on these theoretical models. Table 6 lists common measures that are used to assess areas central to current conceptual views of depression and convey areas reflecting specific theoretical models.

Categorizing Problems Associated with Depression

Based on current theoretical models, depression may result from social skill deficits, self-control deficits, learned helplessness attributions, or cognitive distortions or deficits. Interpersonal problem-solving skills contribute to both cognitive and behavioral conceptualizations (Braswell & Kendall, 1988; Nezu, Nezu, & Perri, 1989). Systematically approaching and evaluating problem situations represents a general orientation common to most intervention approaches. In addition, environmental factors, such as inappropriate or absent reinforcement contingencies, inhibit expression of healthy and positive functioning or promote depression and related characteristics.

Figure 1 illustrates a four-category conceptualization of problems associated with depression. According to this model, depression can be conceptualized as resulting from

Interpersonal Problem Solving	Environment Inhibiting Skill Acquisition or Performance: yes	Environment Inhibiting Skill Acquisition or Performance: no
present	Social Skill Deficit	Self-Control Deficit
absent	Cognitive Distortion or Deficit	Learned Helplessness

FIGURE 1
Model for Determining the Nature of Depression Deficits

TABLE 5
Theoretical Models Accounting for Depression

Model	*Description*
Social Skill Deficits	Depression results from a lack of social skills necessary to obtain reinforcement from the environment (Lewinsohn, 1974) Low rates of response-contingent positive reinforcement results in reduced activity levels. Punishing and aversive consequences (unpleasant outcomes) may result from person-environment interactions and lead to symptoms of depression.
Self-Control Model	Maladaptive or deficient self-regulatory processes in coping with stress cause depression (Rehm, 1977). Self-regulatory processes include self-monitoring, self-evaluation, and self-reinforcement. Individuals with self-regulatory deficits focus on negative events, set overly stringent criteria for evaluating their performance, and administer little reinforcement to themselves.
Learned Helplessness	Depression results from individuals' experiences and expectations that their responses do not influence events in their lives. Perfidious attributional style filters experiences in such a way as to produce deficits in affect, motivation, and self-esteem associated with depression (Abramson, Seligman, & Teasdale, 1978).
Cognitive Triad of Depression	Depressed individuals have a systematically negative bias in their thinking, which leads them to have a negative view of themselves, the world, and the future (Beck, 1967). Negative cognitions are considered to affect the individual's judgment about the world and interpersonal interactions, and to account for affective, motivational, and behavioral symptoms of depression.
Interpersonal Problem-Solving Deficits	Inability to generate alternative solutions to social problems, engage in means-end thinking, and make decisions exacerbate effects of negative events (Nezu, Nezu, & Perri, 1989). Depression emerges in response to problems of daily living.

TABLE 6
Common Measures for Assessing Depression-Related Characteristics

Measure	***Description***
Social Skills	
Matson Evaluation of Social Skills with Children (Matson, Rotatori, & Helsel, 1983)	Items pertain to social skills, assertiveness, jealousy, and impulsiveness as related to interpersonal interaction. Self-report and teacher-report forms rated on 5-point scale.
Walker-McConnell Scale of Social Competence and School Adjustment (Walker & McConnell, 1988)	Teacher-rated scale consisting of 43 descriptions of peer-related interpersonal social skills and adaptive behavior required for success within classroom instructional settings.
Cognition	
Children's Attributional Style Questionnaire (Seligman & Peterson, 1986)	Self-report measure consisting of 48 forced-choice items that permit assessment of three attributional dimensions considered important in a learned helplessness model of depression: internal-external characteristics, stable-unstable characteristics, and good-bad outcomes.
Children's Negative Cognitive Error Questionnaire (Leitenberg, Yost, & Carroll-Wilson, 1986)	Self-report measure consisting of 24 items presenting hypothetical situations or events followed by a statement about the event that reflects cognitive errors (catastrophizing, overgeneralizing, personalizing, and selective abstraction). Children rate degree of similarity to their own thoughts. This measure is based on Beck's cognitive therapy of depression.
Problem Solving	
Problem Solving Measure for Conflict (Lochman & Lampron, 1986)	Six means-end stories with each stem describing a problematic situation and a conclusion in which the problem was no longer occurring. Children provide the middle. Scores are based on children's responses on three content areas: verbal assertion, direct action, and physical aggression. This measure is based on Shure and Spivack's (1972) means-ends problem-solving test.
Simulated Problem Situations (Gesten et al., 1982)	Measures of children's natural problem-solving behavior when confronted with a simulated problem situation. Interactions between confederates and target children are observed. Scoring is based on number of alternative solutions generated, number of solution variants offered, number of irrelevant solutions generated, total number of solutions generated excluding irrelevant solutions, and effectiveness of solutions.
Stressful Events	
Life Events Checklist (Johnson & McCutcheon, 1980)	Self-report measure consisting of 46 items that list stressful events. Children indicate whether the event occurred in the past year, whether it was bad or good, and degree of impact on their lives.
Life Events Record (Coddington, 1972)	Stressful events varying as a function of age whose occurrence is rated according to life change units. Parents complete the form for young children; older children complete the scale themselves.
Activities and Reinforcers	
Pleasure Scale for Children (Kazdin, 1989)	Children report on a 3-point scale the extent to which 39 items would make them happy. The instrument measures degree of anhedonia.
Adolescent Activities (Carey, Kelley, Buss, & Scott, 1986)	Adolescents rate the frequency of occurrence of 100 activities for degree of pleasantness and unpleasantness experienced during the last 2 weeks. The measure is based on Lewinsohn's work.
Children's Reinforcement Schedules (Cautela, Cautela, & Esonis, 1983)	Children identify events that can be used as reinforcers. Helpful as a method to assess pleasure children report in response to a variety of events.
Adolescent Reinforcement Survey Schedule (Cautela, 1981)	Parallels Children's Reinforcement Schedules.

*Although many problem-solving measures have been reported in the literature, none are ideally suited for either research or practice (Butler & Meichenbaum, 1981).

TABLE 7
Treatment Strategies Following Theoretical Models of Depression

Model	*Description*
Social Skill Strategies	Main strategies include shaping procedures that use adult reinforcement, modeling or combined modeling and reinforcement procedures, and direct training procedures to make use of the child's cognitive and verbal skills. Specific training techniques include instructions, modeling, role playing, rehearsal, feedback, and self-management techniques. Verbal-cognitive approaches emphasize teaching specific social skills and general problem-solving techniques.
Self-Control Strategies	Self-management strategies including self-monitoring, self-evaluation, self-reinforcement, and self-instruction would be appropriate for remediating self-control deficits. Intervention should take into account children's cognitive developmental capacities and require the practitioner to play an active role in effecting the desired change by utilizing action-oriented techniques and concrete tasks.
Helplessness Strategies	Strategies follow an attribution retraining conceptualization in which children are taught to take responsibility for their failure and to attribute success or failure to effort. Adaptive coping responses are substituted for attributions of helplessness.
Cognitive Strategies	Treatment focuses on determining the meaning of the child's nonverbal and verbal communication. Any distorted cognitions the child expresses must be challenged. Bestowing acceptance and affection are important, as is assigning tasks that ensure success experiences. Techniques are designed to help the child identify, reality-test, and modify distorted conceptualizations and dysfunctional attitudes and beliefs.

social skill deficits, self-control deficits, cognitive distortions or deficits, and learned helplessness attributions. The presence of interpersonal problem-solving skills and environmental factors allows the categorization of depression for the basis of developing appropriate interventions. For example, poor social skills may result from erroneous problem solving or environmental factors. A child who is encouraged by his or her peers to participate in a game and is capable of performing the requisite behaviors but is unable to strategically select them probably indicates erroneous problem solving. Conversely, if the child lacks the behavioral requisites to participate in the game, social skill deficits may be targeted for intervention. Similarly, cognitive disturbances and misattributions may result from the child's inability to evaluate situations appropriately or perform the requisite behaviors.

TREATMENT OF CHILDHOOD AND ADOLESCENT DEPRESSION

The model depicting problems associated with depression presented in Figure 1 can be used to develop intervention programs for depressed youth. When developing a treatment program, the first consideration is whether depressive symptomatology represents a primary condition, (e.g., mood disorder) or is a byproduct of other behavior problems (Kaslow & Rehm, 1991). For example, youngsters who are hyperactive, aggressive, school phobic, or socially incompetent may experience depressive symptomatology and related dysfunctional cognitions as a result of these problems (Maag, Behrens, & DiGangi, 1991). If conventional treatments for these behavior problems are ineffective for ameliorating the primary problem and related depressive symptomatology, specific treatment strategies for depression should be employed.

Table 7 presents a summary of treatment approaches relative to theoretical models of depression. Intervention strategies generally reflect either behavioral or cognitive-behavioral orientations. Although techniques based on these models seem promising, only a few studies have investigated their efficacy with children and adolescents (see Maag, 1988a; Stark, 1990). In addition, Kazdin (1990) raises the issue of *comorbidity* (the individual meets criteria for more than one disorder). Several researchers have found that depression coexists with attention deficit disorders, conduct disorders, anxiety disorders, autism, and mental retardation (e.g, Anderson, Williams, McGhee, & Silva, 1987; Bernstein, 1991; Bernstein & Garfinkel, 1986; Bird et al., 1988; Fendrich, Weissman, & Warner, 1991; Forness & Kavale, in press; McClellan, Rupert, Reichler, & Sylvester, 1990; Strauss, Last, Hersen, & Kazdin, 1988).

Ironically, the phenomenon of comorbidity has led some researchers to suggest that it may be more meaningful

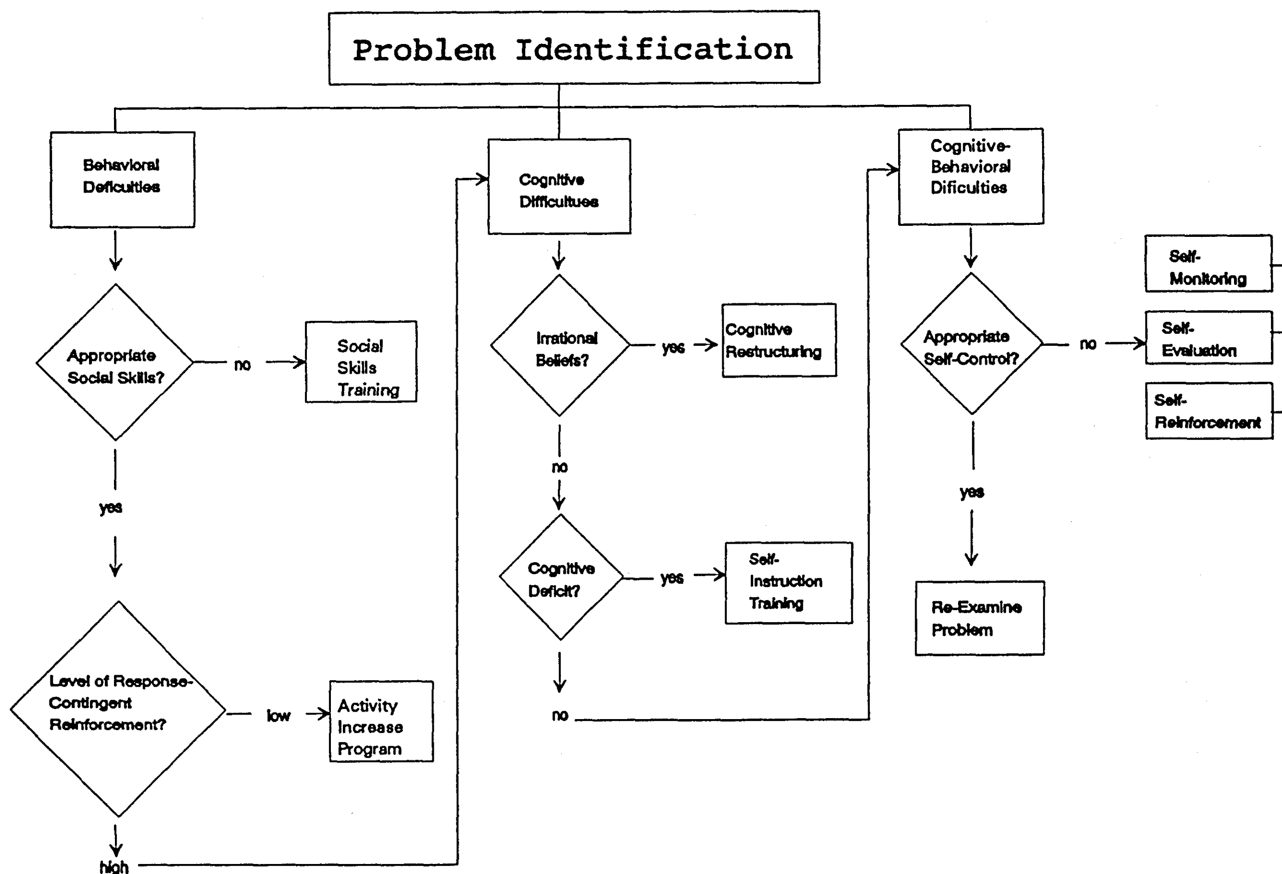

FIGURE 2
Flowchart for Determining Choice of Intervention Strategy

to conceptualize depression in terms of the broader classification of internalizing symptoms rather than the more specific symptomatology of depression, which is more difficult to distinguish (Wolfe et al., 1987). This finding is particularly germane to special educators, as problems of an internalizing nature tend to be frequent in children with learning problems (Thompson, 1986).

Determining Choice of Strategies

Given the range of deficits associated with depression, and their implications for treatment, it is important to determine which factor(s) seem most responsible for the development and maintenance of this disorder (Kaslow & Rehm, 1991). Attempting to assess youngsters' relative skills in each area is a tedious and exacting process. Nevertheless, to enhance treatment efficacy, intervention techniques should be matched to identified, specific problems (Maag, 1989).

In this regard, Kaslow and Rehm (1991) suggest sequencing potential intervention strategies and then making decisions on which ones to use in which order, depending on the results of assessment information. For example, if depression is secondary to a conduct or oppositional disorder, social skills training may be essential for the child to obtain an adequate level of response-contingent positive reinforcement in the environment. If the student's social skills are adequate, however, a more appropriate initial technique would be to modify the child's activity level.

Kaslow and Rehm (1991) also stressed the importance of eliciting overt behavior change prior to targeting cognitive factors, because overt behavior is easier to assess than self-reports of children's cognitions. In addition, obtaining an accurate sampling of the child's self-reported cognitions is

easier once behavior has been modified. Figure 2 presents a modified version of the flowchart developed by Kaslow and Rehm (1991) for determining choice of intervention strategies. This figure is based on the need to accurately identify and define the problem using assessment measures previously described. Targets for intervention reflect three general areas: behavior, cognitive, and cognitive-behavioral. As with any aspect of depression in children and adolescents, care must be taken to modify intervention strategies based on the child's developmental level and level of cognitive, affective, and behavioral functioning (Cole & Kaslow, 1988).

Developing a Conceptual Model for Intervention

Although the treatment literature for childhood and adolescent depression is relatively sparse compared to other areas such as conduct disorders or attention deficit disorders, several new studies have investigated a variety of training techniques. Table 8 provides a summary of recent treatment studies for childhood and adolescent depression. One of the difficulties encountered when treating depression is organizing and integrating the various techniques into a structured training format (Maag, 1988a). Attempting to implement all available techniques would be cumbersome and time-consuming. Yet, many depressed youths exhibit a variety of deficits, and employing a single intervention technique may not be sufficient.

A comprehensive training format would provide a structured system for employing various techniques systematically. One conceptual format is offered in the stress inoculation training (SIT) paradigm. SIT is a multi-component intervention format that combines elements of didactic teaching, Socratic discussion, cognitive restructuring, problem solving, relaxation training, behavioral and imaginal rehearsal, self-monitoring, self-instruction, self-reinforcement, and environmental manipulation (Meichenbaum, 1985). SIT should not be viewed as a loose compendium of unrelated methods, but, rather, a set of interconnected techniques that can be combined in a systematic way.

SIT is implemented in three phases: (a) *conceptualization*; (b) *skills acquisition and rehearsal*; and (c) *application and follow-through*. In Phase I, youngsters are educated about the causes, consequences, and alternative methods of handling depression. Phase II involves training youngsters in relevant skills for coping with depression. In Phase III, youngsters practice applying coping skills *in vitro* and *in vivo* during exposure to regulated doses of stressors that arouse but do not overwhelm their coping skills. SIT has been used to treat depression (Maag, 1988b) and for aggression and anger management (Feindler & Fremouw, 1983; Maag, Parks, & Rutherford, 1988) (see Maag, 1988a for an in-depth description of using stress inoculation training for treating depressed youths).

Pharmacological Treatment

Pharmacotherapy is an essential adjunct to behavioral and cognitive-behavioral interventions, particularly in cases with vegative symptomatology and family history of mood disorders (Cantwell & Carlson, 1983; Gadow, 1986; Klein, Gittelman, Quitkin, & Rifkin, 1980). Five classes of psychotropics are used in depression; these are depicted in Table 9 in terms of their uses, side effects, and related considerations (see Gadow, 1986; Greist & Greist, 1979; Kazdin, 1990; and Petti, 1983 for reviews of pharmacological interventions). Imipramine seems to be the drug of choice for children and adolescents alike (Esman, 1981; Kashani, Shekim, & Reid, 1984; Petti & Law, 1982; Preskorn, Weller, & Weller, 1982; Puig-Antich, 1982); but other drugs, such as lithium and tegretol, are widely used for adolescents who have variant forms of mood disorders (Campbell, Schulman, & Rapoport, 1978; Kishimoto, Ogura, Hazama, & Inoue, 1983).

Although pharmacotherapy is prescribed by psychiatrists, school personnel should be aware of the types of drugs used and their potentially serious side effects. A classroom observation study documenting single-subject classroom effects of imipramine and lithium suggests important considerations for teachers (Forness, Akiyama, & Campana, 1984). Educators need to become much more involved in evaluating effects of such medication on classroom-based measures of treatment outcome (Forness & Kavale, 1988).

Integrating Treatment

Even as treatment of childhood and adolescent depression seems promising, factors external to the child should be considered. Because of parents' influence over their children, Kazdin (1990) suggests that family-based interventions should be incorporated into treatment programs. In this regard, teachers can play a pivotal role by cultivating positive relationships with parents. Positive parent-teacher relationships promote parental feedback to practitioners, enhance treatment outcomes, and extend positive effects of school programming into the home (Heward, Dardig, & Rossett, 1979).

In addition, parents can become trainers of their children by structuring activities and managing behavioral con-

TABLE 8
Treatment Studies with Depressed Children and Adolescents

Treatment	*Study*	*Sample*	*Findings*
Social Skills Training	Calpin & Cincirpini (1978)	Two depressed inpatients (10-year-old girl, 11-year-old boy)	Improvement for both children on specific social skills (e.g., eye contact)
	Calpin & Kornblith (1977)	Four inpatient boys with aggressive behavior	Improvement of all boys on specific social skills (e.g., requests for new behaviors)
	Fine, Forth, Gilbert, & Haley (1991)	Five groups of 30 adolescent outpatients	Improvement to "nonclinical" levels on depression scales, but to a lesser degree than subjects receiving group therapy
	Frame, Matson, Sonis, Fialkov, & Kazdin (1982)	Borderline mentally retarded 10-year-old depressed male inpatient	Improvement on all target behaviors (e.g., inappropriate body position, lack of eye contact, poor speech quality)
	Petti, Bornstein, Delamater, & Conners (1980)	Chronically depressed 10 1/2-year-old inpatient girl	Improvement on all target behaviors (e.g., eye contact, smiles, duration of speech)
	Matson et al. (1980)	Four depressed emotionally disturbed boys	Increased positive social responses on role-play scenarios for target behaviors (e.g., giving compliments)
	Schloss, Schloss, & Harris (1984)	Three depressed inpatient males	Improvement on five target behaviors (e.g., greets adult, maintains conversation, says goodbye)
Cognitive-Behavioral Interventions	Butler, Miezitis, Friedman, & Cole (1980)	56 fifth- and sixth-grade students	Decreases in depression for role-play and cognitive restructuring conditions; most improvement for role-play
	Maag (1988b)	56 adolescent inpatients	Decreases in depression and negative self-statement for subjects receiving stress inoculation training
	Reynolds & Coats (1986)	30 moderately depressed high school students	Decreases in depression and anxiety for subjects receiving either cognitive restructuring or relaxation training
	Stark, Kaslow, & Reynolds (1987)	29 fourth-, fifth-, and sixth-grade students	Decreases in depression for subjects receiving either self-control or problem-solving training

TABLE 9
Common Psychopharmacologic Medication Used with Depressed Children or Adolescents

Type (Trade name)	*Indication*	*Dosage**	*Therapeutic Effects*	*Side Effects*	*Other Considerations*
Tricyclics:					
Imipramine (Tofranil)	Unipolar in children	10-175 mg	Improvement in vegetative symptoms at first, followed by improvement in mood some 3 or 4 weeks later	Dry mouth, drowsiness (especially Elavil), blurred vision, constipation, cardiac arrythmias (EKG monitoring is essential and over-dose in suicidal patients becomes a concern)	After offset of 1 month, discontinue gradually over 3 or more months (with-drawal symptoms mimic depression). Has been used to treat separation anxiety, hyperactivity, enuresis.
	Unipolar in adolescents	75-225 mg			
Amytriptyline (Elavil)	Unipolar in adolescents (little research with children)	45-110 mg			
Lithium Carbonate (Lithonate)	Bipolar in adolescents and occasion-ally in multiple episodes of unipolar	450-1800 mg	Improvement in symptoms in 4-10 days, with most of effect within first 2 weeks; "smooths" rather than elimi-nates symptoms, but early treatment may suppress recurrences	Nausea, drowsiness, thirst, frequent urination, hand tremor, possible cardiac or kidney problems	Small dose added to tricyclic medication during withdrawal as long-term prophylaxis against recurrence. Has been used to treat aggression.
Monoamine Oxidase Inhibitors (Nardil)	Atypical depression in adolescents	30-60 mg	Gradual improvement over 1- to 3-week period	Nausea, dizziness, fainting, sleep disturbance and possible fatal reactions upon ingestion of certain cheese or yeast products	Used primarily in intractable conditions refractory to other drugs.
Carbamazepine (Tegretol)	Bipolar in adolescents, especially rapid-cycling	30-60 mg	Relatively more rapid onset of improvement	Nausea, drowsiness, weight loss, ataxia in instances, and possible toxic reac-tions with lithium	Primarily a seizure medication but has been used in lithium-resistant depression.
Fluoxetine Hydrochloride (Prozac)	Unipolar depression in adolescents	20-80 mg	Gradual improvement over 5-6 weeks (long-term effects have not been systematically studied)	Anxiety, nervousness, insomnia, weight loss, hypomania or mania, and seizures	Prozac has not been systematically studied for its potential for abuse, tolerance, or physical dependence

*These are doses in what have generally been considered as optimum levels and, in most cases, are determined on a mg/kg ratio based on body weight. Dosage levels vary widely, so these ranges should be considered with caution.

tingencies that promote participation in activities and social interaction (Kazdin, 1990). Parents have effectively implemented reinforcement and punishment techniques and taught prosocial behaviors to their children with externalizing behaviors (e.g., Kazdin, 1985; Patterson, 1982). Parent programs have resulted in decreases in maternal depression and increases in family cohesion (e.g., Eyberg & Robinson, 1982; Forehand, Wells, & Griest, 1980; Karoly & Rosenthal, 1977; Patterson & Fleischman, 1979).

School-based intervention adds several other dimensions as well. Many special educators already conduct social skills training and utilize other cognitive-behavioral techniques for working with aggressive and socially incompetent youngsters (Maag, 1990). Treating depression represents a natural extension of these responsibilities. Furthermore, peers can be recruited for the intervention process as they represent a resource for promoting entrapment (McConnell, 1987) of behaviors that may combat depression. Special educators, therefore, can play a vital role in the early identification, assessment, and treatment of depression.

SUMMARY AND CONCLUSION

Depression represents one of the most significant mental health problems facing children and adolescents. An emerging body of research addresses the nature and characteristics of this disorder in school-aged populations, but educators just recently have begun to address this problem. Part of the difficulty has been educators' lack of knowledge of this disorder and its impact on youngsters' functioning.

Early identification is considered essential, and schools should play an important role in this process. Assessment should focus not only on depressive symptomatology but also on related characteristics, such as social skills. Perhaps most important in treating depression from a school standpoint is that many special educators currently employ many of the intervention strategies that are effective for ameliorating depression for a variety of other conditions such as conduct and attentional disorders. Treatment can be enhanced by sequencing intervention techniques systematically and employing a structured training format.

No one intervention approach will be optimally effective with each youngster. Youngsters who have similar depressive symptomatology may vary greatly with respect to etiological factors, related characteristics, and environmental circumstances. For this reason, depression must be viewed from a holistic framework. This model should guide the development and implementation of treatment decisions. In sum, decisions regarding depression should be made on the basis of empirically based knowledge and the youngster's specific characteristics.

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