



Depression: A Brief Overview

During the teen years, feelings of sadness or hopelessness may seem common. Youth may suddenly become moody or irritable. These experiences are also hallmarks of depression. Indeed, one of the more common diagnoses during these years is depression (Merikangas et al., 2010). This diagnosis requires specific symptoms or features that exist over a period of time and cause major challenges (American Psychiatric Association [APA], 2022b). This means that the feelings the individual is having do not easily go away. These experiences result in considerable struggles in important life areas, like work, school, or with family and friends.

It is estimated that over 2.5 million youth have severe depression (Mental Health America [MHA], 2020). In a classroom of 30 students, it is likely that two or three students will have this experience (9.7% of youth). Depression tends to first show up when youth are between 11 and 14 years old. These kinds of mood disorders (like depression) are the most likely to be present at the same time as other disorders (like anxiety or attention deficit hyperactivity disorder; Merikangas et al., 2010). There are some groups of youth who are more vulnerable than others; those who identify as ethnic minority, females, and sexual minority youth have all been shown to be at higher risk for developing depression (Merikangas et al., 2010; MHA, 2020). There are complex reasons why these groups might be more at risk. For example, in a recent summary, Lai and colleagues (2017) showed that certain cultural beliefs may lead to shame about mental health challenges, which can increase suicidal thoughts and behaviors. Challenges around recent events, such as COVID-19, are highlighting increasing rates and needs (MHA, 2020; Schafer et al., 2021).

DIAGNOSIS

A diagnosis of depression is made by a mental health care provider, often one outside of the educational setting (e.g., a marriage and family therapist [MFT]). The *Diagnostic and Statistical Manual of Mental Disorders* (fifth edition—text revision [DSM-5-TR]; APA, 2022b) provides the guidelines these professionals use to make that diagnosis.

Depression is a term that covers several different but related types of disorders (see Table 1). Additionally, there are several diagnoses that include major depressive episodes (or symptoms) along with other experiences, such as manic phases (e.g., having feelings of increased energy). While it might not be important to know the differences between these diagnoses, understanding that they exist can help to prevent confusion.

Table 1. Depressive and Related Disorders

• Disruptive mood dysregulation disorder • Major depressive disorder • Persistent depressive disorder (dysthymia) • Premenstrual dysphoric disorder • Depressive disorder due to another medical condition • Other specified depressive disorder • Unspecified depressive disorder • Prolonged grief disorder	• Bipolar I disorder • Bipolar II disorder • Cyclothymic disorder • Substance/medication-induced bipolar and related disorder • Bipolar and related disorder due to another medical condition • Other specified bipolar and related disorder • Unspecified bipolar and related disorder
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Episodes of depression have in common sad, empty, or irritable mood experiences. They usually include some type of body (i.e., somatic) or thought (i.e., cognitive) changes that make it hard for the person to function (APA, 2022b). Table 2 outlines the symptoms of depression. For each of the diagnoses outlined in Table 1, the number of symptoms, the time frame (e.g., for 2 weeks), and the level of impairment required may vary. For example, for major depressive

disorder, one of the symptoms must include either depressed mood or loss of interest or pleasure (i.e., one of the first two symptoms listed in Table 2). In the school setting, adults or friends may notice that a student has had changes in mood or has lost interest in doing things they used to, like being around their friends. They may notice a friend has become much more irritable and agitated, lashing out at others or saying things that might hurt others' feelings. Their friend may say that they are feeling groggy and sluggish or don't feel like doing anything. They might notice that the student is struggling to complete work and focus on tasks. They may also directly see or hear signs that the student is thinking about suicide.

Table 2. Symptoms of Depression

Depressed mood (e.g., feeling sad, empty, hopeless, or irritable)
Lack of interest or pleasure in all or almost all activities
Changes in weight (e.g., weight loss or gain)
Changes in sleep (e.g., insomnia or hypersomnia)
Changes in motor activity (e.g., hyperactivity or motor retardation)
Changes in energy (i.e., fatigue or loss of energy)
Feelings of worthlessness or of inappropriate or excessive guilt
Cognitive impairments (e.g., difficulty concentrating)
Recurrent thoughts of death or suicidal thoughts or behaviors

As mentioned earlier, depression tends to first show up between the ages of 11 and 14 (Merikangas et al., 2010). How depression exists for an individual may vary. Some youth may have an almost constant experience of symptoms, but others may have distinct periods with and without symptoms. Some youth may have periods with minor impact on their daily functioning, while others may have periods of time when they are unable to take care of some basic needs. One of the most concerning symptoms may be thoughts or behaviors around suicide. While suicidal ideation or behaviors can exist outside of depression, increases in these experiences for youth are of additional concern for parents and educators (Ivey-Stephenson et al., 2020).

If they have immediate concern about suicide or safety, parents or educators should call the national suicide crisis line (9-8-8). If they suspect thoughts and behaviors, connecting with the student's school psychologist is an important first step. A helpful resource for identifying these thoughts and behaviors and talking with the youth about them is the American Foundation Suicide Prevention (AFSP) resource listed at the end of this document. Working with mental health professionals to support the student's mental health is key.

DEPRESSION IN SCHOOLS

Many youth who experience depression will find it difficult to engage in the daily demands of school. This may look like a student who has no energy and is not able to focus, and therefore is not attending classes or completing work. This may also look like a student who is irritable and hopeless, who is being disrespectful to staff and fighting with peers. Outside of formalized supports like special education or a 504 accommodation plan, there are things parents and educators can do to address depression in the schools (Hart, 2019). Providing an environment where youth can talk about their feelings (especially their more negative feelings) and feel okay asking for help is critical. Creating an environment where families destress together, perhaps including mindfulness strategies, and build a healthy lifestyle together can not only address depression but also encourage development of a positive relationship. Educating the students about mental health and ensuring they know where to go for help is vital. Additionally, setting up a collaborative relationship with any mental health professionals—whether on the school campus or off—will set a student up for success in their treatment.

Interventions/Treatments

There are several specific treatment types that have been shown to be helpful for youth with depression (APA, 2022a; Li et al., 2021). Two forms of therapies have been shown to be particularly effective and have been investigated in

different races and cultures (i.e., cognitive–behavior therapy and interpersonal psychotherapy; Li et al., 2021). Additionally, there are several programs that address depression at different levels of intensity in the school system; these programs might exist in something called a multitiered system of supports or MTSS.

Cognitive–behavior therapy (CBT) forms the foundation for many therapeutic approaches. It is based on the idea that thoughts, feelings, and behaviors are all connected. Changes in one area can direct changes in another. This treatment may include aspects of education, exploration, and practice. Mental health professionals may have students work together in small groups, parents may be asked to participate, and youth may be asked to do homework outside of their session. The program may consist of a specific number of sessions with a mental health professional, or it may be less strictly identified.

Interpersonal psychotherapy for adolescents (IPT-A) is another form of therapy that focuses specifically on the important relationships in the youth’s life. IPT-A looks to help youth develop more effective communication strategies and to address challenges in relationships. It focuses on four primary problem areas: grief, interpersonal role disputes, role transitions, and interpersonal deficits. Like CBT, IPT-A may include various activities that help assess, educate, and explore depression and practice new strategies around building competence for the youth. It typically takes place during a set number of weekly sessions (i.e., 12 to 16).

Three programs that have been developed to address depression for students with various levels of needs are the Adolescent Depression Awareness Program (ADAP), the Coping with Stress Program (CWS), and the Adolescent Coping with Depression Program (CWD-A; Hart, 2018). ADAP was developed to provide education for all students and staff on campus about the signs and symptoms of mental health disorders (Swartz et al., 2010). The primary message is that mental illness is treatable. CWS provides a more targeted intervention for youth who may be at risk for depression, but who aren’t currently depressed. It focuses on building coping skills so that depression can be avoided (TEAMS/PODS Intervention Team, 2003). CWD-A was developed for youth who are currently experiencing depression (Clarke et al., 1990). CWD-A also looks to destigmatize mental illness and build coping skills, but it takes place at a more intense level than either ADAP or CWS.

Incorporating mindfulness strategies into the education system can also be useful for students. These types of activities have been shown to impact students broadly (Porter et al., 2022; Zoogman et al., 2015). Mindfulness encourages a person to bring their awareness to the present moment without judgment. Porter and colleagues (2022) describe two aspects of mindfulness-based interventions: (a) self-regulation of attention and (b) approaching experiences with curiosity, openness, and acceptance. Bringing these strategies into the classroom has been shown to improve mood symptoms for various minoritized youth (Porter et al., 2022).

An important component of a student’s treatment for depression may include medications. There are many different types of medications available to treat depression. Often, several different medications may be tried before finding one that seems to work. This course of treatment may require parents to work with a mental health professional who is not providing other types of treatment for the youth—for example, a school psychologist may be providing CWD-A through small groups on campus, while medications are monitored by a psychiatrist or other healthcare provider. The school nurse can be a crucial partner for parents who are navigating the question of whether to add medications to their child’s treatment plan. It may be necessary for parents to try to navigate among several different organizations or providers, which can be challenging. Sometimes there may be one provider who is designated as a “case manager” to coordinate the treatments.

Formalized Supports: Special Education and 504 Accommodation Plans

It may be the case that a student is strongly affected by their depression, and interventions, such as short-term counseling, have not increased the student’s ability to function in the school setting. In these situations, school psychologists, teachers, administrators, and parents may look to formalized supports like special education or a 504 accommodation plan to help support the student. A diagnosis of depression is not necessary for a student to qualify for special education or a 504 accommodation plan. There is no specific special educational disability category for depression, but the most likely category a student may be evaluated for would be Emotional Disturbance.

A student who qualifies for special education under Emotional Disturbance also must have symptoms that occur over a period of time and that significantly impact the student—particularly their performance in the educational setting. This category tends to focus on challenges with relationships, mood or depression, and physical symptoms or fears. It is important to note that most students experiencing depression do not require special education support. Table 3 highlights the characteristics outlined by the federal law that governs special education, called the Individuals with Disabilities Education Improvement Act (IDEA, 2004). Each state will have its own specific criteria that is directed by IDEA and may include different aspects as well.

Table 3. Emotional Disturbance Eligibility Criteria

• Challenges with learning that cannot be explained by other factors (e.g., health) • Challenges building and maintaining satisfactory relationships with peers and teachers • Feelings or behaviors that are inappropriate within context • General and pervasive feeling of unhappiness or depression • Development of physical symptoms or fears associated with personal or school problems

When a student qualifies for special education, the Individualized Education Program (IEP) team will develop a plan for how to best support the student's unique needs around their depression. This may consist of small-group or one-on-one work with a school psychologist (when staffing levels and district policies allow). It may include changes in instructional delivery. It may result in alternate ways for a student to demonstrate learning (e.g., changes in assignments). It may include changes to the setting in which the student receives their instruction (e.g., a different classroom). It may result in changes to the amount of time a student spends in school (e.g., reducing the school day to a half-day).

RESOURCES

- American Foundation for Suicide Prevention (AFSP): This website has a lot of great information for parents and educators about suicide; this page includes text and videos about identifying suicidal thoughts and behaviors in a teen and what to do if you suspect suicidal thoughts and behaviors.
 - <https://afsp.org/teens-and-suicide-what-parents-should-know>
- Depression in children and youth: Providing support in the home: This handout provides information and suggestions for parents to understand and work with their child who is experiencing depression.
 - Hart, S. R. (2019). Depression in children and youth: Providing support in the home. In G. Bear & K. Minke (Eds.), *Helping Children Handouts: Prevention and Intervention Strategies at School and Home*. National Association of School Psychologists.
- Erika's Lighthouse: A website for educators, parents, teens, and supporters with information about depression, treatments, and other strategies.
 - https://www.erikaslighthouse.org/the-toolbox/learn-about-depression/?gclid=CjwKCAjw-L-ZBhB4EiwA76YzOfZo-9dwh9S9G-0NKU3sN9cf31qPMphFEpzA325_f7d80JKpC1WckhoCkvwQAvD_BwE

REFERENCES

- American Psychiatric Association. (2022a). *Depression treatments for children and adolescents*. <https://www.apa.org/depression-guideline/children-and-adolescents/>
- American Psychiatric Association. (2022b). *Diagnostic and statistical manual of mental disorders* (Fifth edition—Text revision).
- Clarke, G., Lewinsohn, P., & Hops, H. (1990). *Leader's manual for adolescent groups: Adolescent coping with depression course*. <https://www.saaus.com/adolescent-coping-with-depression-course>
- Hart, S. R. (2018). Adolescent depression in the schools: Evidence-based prevention and intervention programs. SAMHSA Now is the Time—Technical Assistance Center (NITT-TA) Issue Brief.
- Hart, S. R. (2019). Depression in children and youth: Providing support in the home. In G. Bear & K. Minke (Eds.), *Helping Handouts: Supporting Students at School and Home*. National Association of School Psychologists.

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- Individuals with Disabilities Education Improvement Act (2004). www.ed.gov/about/offices/list/osep/index.html.
- Ivey-Stephenson, A. Z., Demissie, Z., Crosby, A. E., Stone, D. M., Gaylor, E., Wilkins, N., Lowry, R., & Brown, M. (2020). Suicidal ideation and behaviors among high school students—Youth risk behavior survey, United States, 2019. *Morbidity and Mortality Weekly Report*, 69(1), 47–55. <https://doi.org/10.15585/mmwr.su6901ab>
- Lai, D. W. L., Li, L., & Daoust, G. D. (2017). Factors influencing suicide behaviours in immigrant and ethno-cultural minority groups: A systematic review. *Journal of Immigrant Minority Health*, 19, 755–768. <https://doi.org/10.1007/s10903-016-0490-3>
- Li, J., Liang, J.-H., Li, J.-Y., Qian, S., Jia, R.-X., Wang, Y.-Q., & Xu, Y. (2021). Optimal approaches for preventing depressive symptoms in children and adolescents based on the psychosocial interventions: A Bayesian network meta-analysis. *Journal of Affective Disorders*, 280(Part A), 364–372. <https://www.doi.org/10.1016/j.jad.2020.11.023>
- Mental Health America. (2020). 2021: *The state of mental health in America*. <https://mhanational.org/issues/state-mental-health-america>
- Merikangas, K. R., He, J.-P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry*, 49(10), 980–989. <https://doi.org/10.1016/j.jaac.2010.05.017>
- Porter, B., Oyanadel C., Sáez-Delgado, F., Andaur, A., & Peñate, W. (2022). Systematic review of mindfulness-based interventions in child-adolescent population: A developmental perspective. *European Journal of Investigation in Health, Psychology, and Education*, 12(8), 1220–1243. <https://doi.org/10.3390/ejihpe12080085>
- Schafer, K. M., Lieberman, A., Sever, A. C., & Joiner, T. (2021). Prevalence rates of anxiety, depressive, and eating pathology symptoms between the pre- and peri-COVID-19 eras: A meta-analysis. *Journal of Affective Disorders*, 298(Part A). <https://doi.org/10.1016/j.jad.2021.10.115>
- Swartz, K. L., Kastelic, E. A., Hess, S. G., Cox, T. S., Gonzales, L. C., Mink, S. P., & DePaulo, J. R. (2010). The effectiveness of a school-based adolescent depression education program. *Health Education & Behavior*, 37(1), 11–22. <https://doi.org/10.1177/1090198107303313>
- TEAMS/PODS Intervention Team. (2003). The adolescent coping with stress course: Leader manual—An eight-session curriculum developed for the prevention of unipolar depression adolescents with an increased future risk. <https://research.kpchr.org/Research/Research-Areas/Mental-Health/Youth-Depression-Programs#Downloads>
- Zoogman, S., Goldberg, S. B., Hoyt, W. T., & Miller, L. (2015). Mindfulness interventions with youth: A meta-analysis. *Mindfulness*, 6, 290–302. <https://doi.org/10.1007/s12671-013-0260-4>

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