Antidepressants and Alternative Approaches to Helping Children

And Adolescents Struggling with Depression

Thomas B. Johnson

INTRODUCTION

During the last 20 to 30 years, there has been a significant increase in the number of individuals being diagnosed with depression. In 1980, The US National Institute of Mental Health completed a study of approximately 20,000 Americans and found that 3.7% of the adults in the preceding year had experienced a major depressive episode. Over 6% reported that they had experienced a major depressive episode at some point in their lives. Those statistics almost tripled 10 years later with over 10% of the respondents reporting a major depressive episode in the preceding year and over 17% indicated that they had experienced major depression at some point in their lives (Johnson, 2004, Thayer, 2001). The May 13, 2008 issue of the National Survey on Drug Use and Health NSDUH includes a study entitled *Major Depressive Episode Among Youths age 12 to 17 in the United States: 2004-2006.* This report includes an analysis of the increase in the rates of major depressive episodes among youths age 12 to 17. They report that among youths in this age group, nearly half reported, "severe impairment in at least one of four role domains (i.e., home, school/work, family relationships, or social life), and nearly one-quarter reported very severe impairment in at least one of the domains," (2008, p. 1).

The National Institute of Mental Health website points out that diagnosing depression in children and adolescents can be quite challenging and in some ways more difficult than diagnosing depression in adults (www.nimh.nih.gov). They note that: "Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child is just going through a temporary 'phase' or suffering from depression." It has only been in the last

two decades or so that the depression in children has been taken very seriously. "The depressed child may pretend to be sick, refuse to go to school, cling to a parent, or worry that one or both parents may die. Older children or adolescents may sulk, get into trouble at school, be negative, agitated, grouchy, and/or feel misunderstood."

In his classic work, *Real Boys: Rescuing our Sons from the Myths of Boyhood* (1998), William Pollack discusses how depression in boys (and men) can look quite different from depression in girls and women. Boys tend to act out depression through a myriad of behaviors. He suggests a new diagnostic tool, which diagnoses depression by watching carefully for a variety of symptoms. Some of the symptoms that he thinks are particularly important for determining depression in boys include: Depleted or impulsive mood, increase in intensity or frequency of angry outbursts, denial of pain, increasingly rigid demands for autonomy or acting out, various physical symptoms (such as sleep disturbance, eating or weight disorders), inability to cry, increased aggressiveness, and etc.

While it can be very challenging to determine whether or not a child or adolescent is depressed, various scientists have offered estimates about the incidence of childhood depression. For example, James Garborino, in his book, *Lost Boys*, (1999), reviews the research of Harvard Professor, Ronald Kessler and others. Garborino references the fact that Kessler estimated that the rate of serious depression among American youth had increased from approximately 2% in the 1960's to almost 25% in the 1990's. These high rates of depression are being found equally among affluent and poor youth. The former chairman of the White House Commission on Complementary and Alternative Medicine Policy, Dr. James Gordon, cites studies indicating, "one-fifth to one fourth of all U.S. adolescents will experience an episode of major depression by the time they are twenty" (2008, p.6).

With the increase in the number of individuals being diagnosed with depression has come a significant increase in the use of antidepressants both with adults and children. The use of antidepressants has become increasingly controversial since the "black box warnings" issued by the US Food and Drug Administration and the "banning" of most antidepressants in the United Kingdom. In an article entitled *Drugs for Depressed Children Banned,* the health editor of the Guardian, Sarah Boseley, reported that: "The Medicines and Healthcare Products Regulatory Agency (MHRA) told doctors last night not to prescribe all but one of the antidepressants known as selective serotonin reuptake inhibitors (SSRIs). The exception is Prozac, which is licensed for use in depressed children in the US. The MHRA warned that, at best, it helps only 1 child in 10. The agency-which is the government's watchdog body on drug safety-has reached this point only after intense pressure from patients and campaigners. They were concerned about patients-at first mainly adults-who appeared to have become suicidal on the drugs and others who had gotten hooked and suffered distressing symptoms when they tried to stop taking them," (Boseley, 2003, p.1). Ironically, shortly after this action by the MHRA, Eli Lilly, the manufacturer of Prozac, sent a letter/fact sheet to all UK physicians indicating that Prozac was "not indicated for children" for any condition. (A copy of this letter can be viewed at the www.ahrp.org website under the title *Eli Lilly Prozac UK Fact Sheet: 'Not Recommended' for Children – PMDD Withdrawn in UK, December 19, 2003).*

Along with this controversy has come an increased interest in looking at alternative ways of understanding and supporting individuals struggling with depression. This interest was highlighted when the UK's National Institute for Health and Clinical Excellence (NICE) and the National Collaborating Center for Mental Health issued new standards for treating depression in children, adolescents and young adults on 9/28/2005 (see www.nice.org.uk).

This article will look at various perspectives on depression and especially childhood depression, as well as the various approaches that have been developed by researchers and healthcare professionals who provide treatment to individuals and families struggling with depression. The article will also look at what healthcare professionals, educators, and parents can do to prevent and treat significant symptoms of depression in children and adolescents. The article includes addendums, which should be of value to educators, and practitioners who would like to offer handouts to parents and/or teachers regarding follow up activities. Also, there is a case study presented which could be used for educational discussions of the topic.

DEFINITIONAL ISSUES AND CONTROVERSIES

Depression – The National Institute of Mental Health refers to depression as **"**a serious medical illness." They list the following as being symptoms of this medical illness or "mental illness:"

- Persistent sad, anxious or "empty" feelings
- Feelings of hopelessness and/or pessimism
- Feelings of guilt, worthlessness and/or helplessness
- Irritability, restlessness
- Loss of interest in activities or hobbies once pleasurable, including sex
- Fatigue and decreased energy
- Difficulty concentrating, remembering details and making decisions
- Insomnia, early-morning wakefulness, or excessive sleeping
- Overeating, or appetite loss
- Thoughts of suicide, suicide attempts
- Persistent aches or a pain, headaches, cramps or digestive problems that do not ease even with treatment.

While the NIMH definition makes it clear that depression should be considered a "serious medical illness," there are scientists and mental health professionals in this country, as well as other countries, who offer alternative perspectives to the mainstream medical model of depression. Georgetown University School of Medicine Professor, James Gordon, points out that "a fifty-year research effort has turned up no convincing biochemical abnormalities in the brains, spinal fluid, or blood in depressed people" (2008, p. 10). He goes on to convincingly argue that depression is not a disease. Also, in their book *Depression: An Emotion not a Disease* (2005), Irish MD's, Michael Corry and Aine Tubridy, define depression as "an emotional response at the core of which are the feelings of helplessness, hopelessness and loss of control. Any life difficulty which we find to be insurmountable can cause depression," (Corry & Tubridy, p. 16).

In the United States, a group of scientists and practitioners affiliated with Florida International University have organized a website and curriculum located at www.CriticalThinkRx.org (2010). This website and curriculum funded at FIU is supported by a grant funded by the State Attorney General Consumer and Prescriber Grant Program. This program is administered by the Center for Evidence-based Policy at Oregon Health Sciences University. These scientists point out that mainstream mental health practice subscribes to a "medical" model of depression and supports medication of children with psychotropic drugs as a first resort without well-established evidence of safety of efficacy. They point out that conflicts of interest in the psychiatric drug treatment and research enterprise "blur boundaries between marketing and science, adding to the complexity of nonmedical professionals involvement with clients on medication." They go on to say "CriticalThinkRx offers an alternative perspective based on empirical evidence to stimulate critical thinking and a more balanced evaluation of the prescription situation based on ethical codes of practice of medical and nonmedical helping

professionals."

Mainstream perspectives are probably best reflected in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (2000) and the National Institute of Mental Health. These sources are considered to be two of the most authoritative references for a significant number of American mental health professionals. The NIMH website (2010) lists the following forms of depressive disorders. The most common of these are major depressive disorder and dysthymic disorder.

- **Major depressive disorder**, also called major depression, is characterized by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. An episode of major depression may occur only once in a person's lifetime, but more often, it recurs throughout a person's life.
- **Dysthymic disorder**, also called dysthymia, is characterized by long-term (two years or longer) but less severe symptoms that may not disable a person but can prevent one from functioning normally or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes.

  Some forms of depressive disorder exhibit slightly different characteristics than those described above, or they may develop under unique circumstances. However, not all scientists agree on how to characterize and define these forms of depression. They include:

- **Psychotic depression**, which occurs when a severe depressive illness is accompanied by some form of psychosis, such as a break with reality, hallucinations, and delusions.
- **Postpartum depression**, which is diagnosed if a new mother, develops a major

depressive episode within one month after delivery. It is estimated that 10 to 15 percent of women experience postpartum depression after giving birth.

- **Seasonal affective disorder (SAD)**, which is characterized by the onset of a depressive illness during the winter months, when there is less natural sunlight. The depression generally lifts during the spring and summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not respond to light therapy alone. Antidepressant medication and psychotherapy can reduce SAD symptoms, either alone or in combination with light therapy.
- **Bipolar disorder**, also called manic-depressive illness, is not as common as major depression or dysthymia. Bipolar disorder is characterized by cycling mood changes- from extreme highs (e.g., mania) to extreme lows (e.g., depression). Visit the NIMH website for more information about bipolar disorder.

INCIDENCE AND CAUSES OF DEPRESSION

As indicated earlier in this article, there have been reports of dramatic increases in the rates of depression in the general population with adults and children. The authors of *The Mindful Way Through Depression: Freeing Yourself from Chronic Unhappiness,* (Mark Williams, et al, 2007) report that approximately 12% of men and 20% of women will suffer major depression at some time in their lives. They go on to state that the first episode of depression increases the chance that the person will experience another episode of depression by 16%. They estimate that some 10 million people in the United States are taking antidepressant medications.

Corry and Tubridy (2005) argue that depression should be seen as an emotional response, at the core of which is feelings of helplessness, hopelessness, and loss of control. Any life stressor, which a person finds to be insurmountable, can cause depression. Bullying, abuse, betrayal and

ridicule, accidents and life threatening situations, financial burdens, substance abuse, chronic pain, illness, family distress, etc., contribute to these types of feelings. They discuss the molecules of depression and point out that there are hundreds of different kinds of neurotransmitter substances and hormones, which affect the nervous system and can play a part in making a person depressed. There may be too little or too much of these substances. Some of the major chemicals appear to be adrenaline, noradrenalin, dopamine, GABA, serotonin, acetylcholine, and melatonin. Additionally, sleep deprivation, lack of exercise, certain medications and/or nutritional factors can cause or contribute to feelings of depression.

Comprehensive psychological, medical and nutritional assessments are important to consider when trying to understand what might be contributing to any individual's experience of prolonged or frequently occurring feelings of depression. It is the position of this article that those experiences and factors, which provoke disabling feelings of depression, need to be properly evaluated in order to develop effective prevention and/or treatment programs for individuals struggling with depression. It is also important to recognize that feelings of depression occur among many people without becoming disabling or requiring formal assessments and/or treatments.

INTERVENTIONS

Antidepressants

There has been a dramatic increase in the number of prescriptions of antidepressants for both children and adults in the United States, Canada, Great Britain, and other countries. For many years, the treatment of depression with Selective Serotonin Reuptake Inhibitors (SSRI) such as Prozac, Zoloft, and Luvox has been common practice. Joseph Glenmullen reported at the turn of this century (2000) that approximately 28 million Americans or 1 in every 10 had taken one of

the SSRI antidepressants, (Glenmullen, 2000). Several years ago, Canadian Child Psychiatrist, Jane Garland, (2004) reported that more than 11 million children in the US have been prescribed SSRI and/or SNRI antidepressants. Antidepressants are now the most widely prescribed medication in the United States, surpassing drugs that lower cholesterol, blood pressure and pain according to the National Market Research Firm IMS Health (Gottschlich, 2008).

The theoretical rationale justifying this type of intervention has been that depression is a reflection of an inadequate amount of serotonin. However, no tests to date have been devised to evaluate whether or not this is a valid assumption. Those who argue for the use of SSRIs will often compare this intervention with thyroid dysfunction, pointing out that hypothyroidism is due to an inadequate supply of thyroxin. When that is the case then medical doctors will prescribe Synthroid or some other medication to make up for the deficiency. However, with hypothyroidism, there are medical tests to measure the levels of thyroxin, pre-intervention and post-intervention. Of course, hypothyroidism, in itself, can be a cause of depression. However, with no tests available to measure serotonin, we are left with a theoretical position that has yet to be proven.

The NIMH website states: "Our knowledge of antidepressant treatments in youth, though growing substantially, is limited compared to what we know about treating depression in adults." Some researchers have found that antidepressant medications in themselves may induce suicidal behavior in youth. Following a comprehensive review of the available published and unpublished clinical trials of antidepressants in children, the FDA, in 2005 adopted "a 'black box' warning label on all antidepressant medications to alert the public about the potential increased risk of suicidal thinking or attempts in children and adolescents taking antidepressants.

In 2007, the FDA proposed that makers of all antidepressant medications extend the warning to include young adults up through the age of 24." (www.nimh.nih.gov), (07/1/10).

Dr. Jane Garland is a Clinical Associate Professor of Psychiatry at the University of British Columbia in Canada and Director of the Mood and Anxiety Disorders Clinic at British Columbia Children's Hospital. In an article published in the *Canadian Medical Journal Association* (2004) she concluded "that the disappointing reality is that antidepressant medications have minimal to no effectiveness in childhood depression beyond a placebo effect…the physician treating a child or adolescent with recent onset of depression is advised to begin with education regarding sleep hygiene, exercise, practical coping skills and family intervention, and to provide the frequent, supportive contact typical of clinical trials" (p. 490).

More recently, a group of American, British, and Canadian scientists conducted a meta-analysis of antidepressant medications in both published and unpublished studies. They concluded that antidepressant medications are virtually no better than placebos at treating depression. The study provided striking evidence that antidepressants do not appear to benefit mildly or moderately depressed patients and may benefit only those who are so severely depressed that they are essentially biologically shut down. Kirsch and his co-authors (2008) used published studies and unpublished drug company data that they obtained under the Freedom of Information Act and found virtually no difference among four of the most widely prescribed antidepressants including - Prozac and generics, Paxil and generics, Effexor and generics, and nefazodone - and placebo in patients with moderate depression and only a small difference among the severely depressed.

The January 2008 issue of the *New England Journal of Medicine* includes the article, *Selective Publication of Antidepressant Trials and its Influence on Apparent Efficacy* by Dr.

Eric Turner, et al. Dr. Turner is a professor at the Oregon Health & Science University. He and his co-authors report that 10% of Americans including children, teenagers and adults take antidepressants. Antidepressants are now the most widely prescribed family of drugs in America with an 11.9 billion dollar market in the US alone in 2007. These authors found that antidepressants are not as effective as consumers have been led to believe. Pharmaceutical companies have exaggerated the performance of their drugs and the authors refer to this as "the dirty little secret" of the psychiatric world.

Not only are antidepressants of questionable value for mildly to moderately depressed individuals; they actually increase suicidality in a subset of children and adults. Some psychiatrists have also reported on the potential for dependence or addiction in these drugs. For example, Dr. David Healy is an internationally recognized psychophamacologist who is Professor of Psychological Medicine at Cardiff University in the United Kingdom. He is the author of numerous books and peer-reviewed articles on depression and antidepressants. In his book, *Let Them Eat Prozac,* he documents the SSRI and suicidality connection along with research connecting SSRIs with addiction. In this book, he reviews various studies linking SSRIs with what he refers to as "emotional blunting," a well as suicidality and addiction. He believes that SSRI dependency or addiction may actually be more common and serious than benzodiazepine (e.g. Valium, Klonopin and Librium) dependence. Unlike insulin or thyroid hormone, which are replacements for deficiencies, the SSRIs are alien chemicals and act as brain suppressors. Many psychiatrists assume that serotonin levels decrease when we feel depressed and SSRIs then make up for decreases or deficiencies. However, Healy concludes from his review of the research that there is no evidence for this and no abnormality of serotonin metabolism has ever been documented (2003).

Alternative Treatments

Because of these concerns about the lack of effectiveness of antidepressants especially with children and young adults struggling with depression and the linkage of antidepressants with suicidality and possibly addiction; the United Kingdom's National Institute for Health and Clinical Excellence issued new standards for treating depression in children and young people. This guidance was offered in conjunction with the UK's National Collaborating Center for Mental Health. The guidelines were issued on September 28, 2005 (www.nice.org.uk.). The guidelines recommend that:

- Children and young people with moderate to severe depression should be offered, as a first-line treatment, a specific psychological therapy (such as cognitive behavioral therapy, interpersonal therapy or family therapy of at least three months' duration).
- Antidepressant medication should not be offered to children or young people with moderate to severe depression except in combination with a concurrent psychological therapy and should not be offered at all to children with mild depression.
- Healthcare professionals and primary care, schools and other relevant community settings should be trained to detect symptoms of depression and to assess children and young people who may be at risk of depression.
- Attention should be paid to the possible need for parents' own psychiatric problems (particularly depression) to be treated in the parallel if the child or young person's mental health is to improve.

The chief executive of NICE and executive lead investigator for the guidelines, Andrew Dillon, indicated that: "This guideline makes it clear that psychological treatments are the most effective way to treat depression in children and young people. It is important

> to children and young people taking anti-depressants do not stop taking them abruptly, but we would advise people to talk to their GP at their next regular review about whether a psychological treatment may be a more effective treatment option."

As suggested earlier in this paper, CriticalThinkRx.org offers guidelines that are very similar to the NICE guidelines. They point out that there is ample evidence to support the use of psychosocial interventions before initiating medication. Also, they document the lack of efficacy and safety of various psychotropic medications.

The mainstream practice of using antidepressants with individuals struggling with depression has been significantly challenged by those scientists evaluating all of the research-including the unpublished studies which have only recently become available. The NICE guidelines, the CriticalThinkRx guidelines and the advice offered by Dr. Jane Garland, Dr. Peter Breggin (2008) and others emphasize the importance of psychological therapies, stress management and lifestyle changes based on accurate assessments of what might be causing or exacerbating disabling feelings of depression.

Dr. Herbert Benson and other medical scientists contributing to the Harvard Medical School's *Stress Management: Techniques for Preventing and Easing Stress* model point out there are a wide variety of stressors, which can cause depression. As part of the assessment process, not only is it important to look at life stressors such as what Corry and Tubridy mention referenced earlier in this chapter, it is important to look at the role of sleep, nutritional factors and other possible causes of depression. Knowing the causes or the triggers can help in the development of effective prevention and intervention for individuals, his or her family, helping professionals and educators involved in supporting the child or adolescent.

This is the position advanced by Dr. Mark Hyman in his recent article, *Why Antidepressants Don't Work for Treating Depression,* (2008). Dr. Hyman is the Editor-in-Chief of Alternative Therapies in Health and Medicine, the premier peer-reviewed professional journal in the fields of integrative medicine and alternative medicine. He is on the Board of Advisors and Faculty of Georgetown University School of Medicine's Food as Medicine Training Program. He advances the same position advanced here that we need to move away from simply treating symptoms with drugs that are no better than placebos to conducting the appropriate assessments that identify what is behind the symptoms of depression. He points out that there are multiple causes of depression and each one needs a different approach to treatment. For example, in his practice, he has found that some people suffer from depression due to excess levels of mercury, as a result of hypothyroidism, vitamin D deficiency, omega-3 deficiencies, etc. (Hyman, 2008).

Sleep Disturbance

Researchers from the Harvard Medical School and The University of California at Berkeley have recently identified sleep disturbance as a possible cause or contributor to depression. As scientists at the National Sleep Foundation (2010) point out, sleep disturbance is often identified as a symptom of depression but researchers also indicate that it can be a contributing factor in the onset of depression. In an article entitled *The Human Emotional Brain without Sleep – A Prefrontal Amygdala Disconnect*, Seung-Schiku Yoo, and four other scientists conducted one of the first neurological investigations into what happens to the emotional brain in a sleep deprived state (2007).

The amygdala, the region of the brain that alerts the body to protect itself in times of stress, apparently goes into overdrive on limited or no sleep. This consequently shuts down the prefrontal cortex, which directs logical reasoning, and prevents the release of chemicals needed

to calm down the stress response or what is commonly referred to as the fight or fight reflex. These researchers have laid the groundwork for further investigation into the relationships between sleep and depression, as well as other psychiatric conditions. This research and other clinical research have demonstrated that some form of sleep disruption is often present in depression and other psychiatric disorders.

Knowing this research connecting sleep disturbance and depression can help parents and healthcare providers ask questions about their child or patient's experience of depression. Naturally, if sleep disturbance is causing or exacerbating depression then improving sleep should be a focus of the intervention. This same logic applies to the following factors, which are discussed below.

Nutritional Factors

Scientists studying the relationship between depression and nutrition have found low blood concentrations of folate and vitamin B12 among depressed patients. www.NutritionMD.org reviews this research and points out that the association between folate and elevated homocysteine levels, which are also frequently found in depressed patients, may mediate depression. If the causes of depression were due to the low concentrations of these vitamins, it would logically follow that including appropriate intake of these vitamins would be key to both prevention and treatment.

Another significant line of research looking at inadequate nutrition and depression is found in the research on the role of omega-3 fatty acids in depression. Again, www.NutritionMD.org states that depression can be associated with low levels of long-chain omega-3 fatty acids (i.e. eicosapentaenoic and docosahexaenoic acids) in red blood cell membranes. Some studies have found that in countries where intakes of these fatty acids are higher, depression is less prevalent.

The July 2007 issue of the University of California, Berkeley Wellness Letter points out that researchers reviewing studies for the American Psychiatric Association were so impressed with the association between low levels of omega-3 fatty acids and depression that they are now recommending that anyone with mood or depressive disorders should consume at least one gram of omega-3 a day from fatty fish or supplements. Of course, this should be done in consultation with a knowledgeable and properly licensed healthcare professional. There are now laboratories such as Genova Diagnostics (www.GDX.net), which can aid the diagnostician in determining whether or not there are nutritional or toxic factors that may be contributing to depression. In addition to nutritional factors, overexposure to heavy metals like lead and mercury has been shown to induce depression.

Exercise

Earlier in this chapter, I referenced the Harvard Medical School's *Stress Management: Techniques for Preventing and Easing Stress* model. In this model, the Harvard Healthy Eating Pyramid is cited as an important starting point for dealing with any kind of distress, not only that associated with depression. The foundation of the Harvard Healthy Eating Pyramid is daily exercise and weight control. The authors state that: "Nearly every form of exercise offers a host of health enhancing benefits if performed regularly at moderate intensity. Exercise improves cholesterol levels, lowers blood pressure, keeps bones strong and healthy, and enhances the immune system. It also boosts metabolism and **mood**…(2006, p. 19)."

In an article published by the International Center for the Study of Psychiatry and Psychology in the summer of 2004, this author, (Johnson, 2004) reviewed some of the research linking depression with the lack of exercise. The article states: "Psychiatric researchers in the Department of Psychiatry and Behavioral Sciences at Duke University compared the use of

exercise verses Zoloft in order to determine the relative effectiveness or ineffectiveness of each approach plus a combined approach in patients diagnosed with major depression. In the initial Duke study, which lasted for just four months, one-hundred and fifty-six patients diagnosed with major depression were randomly assigned to one of three interventions: exercise, the antidepressant Zoloft or both. After four months, patients in all groups showed improvement. However, six months later, those in the exercise group had significantly lower relapse rate (p. equals .01) than those in the medication group and those in the exercise plus medication group. Depressive symptoms had returned in only 8% of the exercise-only patients whose symptoms had initially disappeared. This compares with 38% in the drug group and 31% in the exercise-plus-drug group. This finding was surprising to the Duke researchers and they commented, "This was an unexpected finding because it was assumed that combining exercise with medication would have, if anything, an additive effect," (Babyak et. Al., 2000, p. 636).

In addition to the Duke studies, the American Psychological Association website references additional studies showing therapeutic benefit of regular exercise in an article entitles *Exercise Helps Keep Your Psyche Fit* (www.apa.org/releases/exercise.html). The APA authors point out that recent reviews of psychological research show that exercise is an effective but underused treatment for mild to moderate depression.

Meditation/Relaxation Training

Dr. Herbert Benson and others associated with the Harvard Medical School have documented the benefits of meditation/relaxation training in the treatment of depression. Also, a very practical and evidence-based approach to depression using cognitive restructuring exercises and meditation has been advanced by the authors of *The Mindful Way Through Depression* (2007). The senior author, Mark Williams, and his associates state: "Recent scientific

discoveries have given us a radically new understanding of what feeds depression or chronic unhappiness: At the very earliest stages in which mood starts to spiral downward, it is not the mood that does the damage, but how we react to it; and our habitual efforts to extricate ourselves, far from freeing us, actually keeps us locked in the pain we are trying to escape," (p.2). Their program can cut the risk of relapse by approximately half in those who have had three or more episodes of depression. While antidepressant medication only treats symptoms and may offer a temporary lift to depression, the drug only works as long as patients are taking them. Typically, when the medication stops, the depression comes back. Depression is almost as likely to lift with a placebo (sugar pill) as with an antidepressant drug. These authors develop the insight that unhappiness or depression in and of itself is not necessarily the problem as feelings of unhappiness and depression are "an inherent and unavoidable part of being alive." The major problem or aspect of the problem that these authors focus on has to do with the "harshly negative views of ourselves that can be switched on by unhappy moods that untangle us, (p. 24).

Researchers at Monash University in Melbourne, Australia, compared relaxation training and other cognitive strategies with antidepressant medication in treating depressed adolescents. These researchers studied the reactions of depressed adolescents between the ages of twelve and eighteen and offered different depression treatments. The teenagers were divided into three groups and were treated with antidepressant medication, cognitive behavior therapy and a combination of both. Those in the cognitive behavior therapy group were taught relaxation strategies, social skills and helpful ways of thinking and reacting to situations. The depressed teenagers in that group did much better than those taking the antidepressant and even did better than those taking the antidepressants and participating in the cognitive therapy. The lead

researcher reported that: "We expected the combined treatment would be superior but found the cognitive behavioral therapy alone leads to a more rapid treatment response." (www.theage.com.au/articles/2003/06/03/1054406176511.html)

Summary and Conclusions

This article develops the thesis that feelings of unhappiness and depression are an inherent and an unavoidable part of being alive. Depression should not necessarily be seen as a medical illness or as a type of mental illness. Of course, frequently occurring feelings of depression that create distress and dysfunction should be properly evaluated before developing potentially effective interventions.

Mainstream perspectives offered by the National Institute of Mental Health and alternative perspectives on both the nature of depression and ways of supporting individuals struggling with depression have been offered in this article. Antidepressants are now the most widely prescribed drugs in the United States. Critical reviews of the value of antidepressants have found them lacking, both in terms of efficacy and safety. Effective and safe interventions should be based on accurate assessments of what is contributing to disabling and recurrent feelings of depression. Appropriate evaluation of sleep patterns, exercise, nutrition, stress factors, cognitive factors, medical illnesses, etc. need to be conducted as a foundation for developing appropriate interventions. Any effective intervention needs to be based upon the well-established medical dictum, "First, do no harm."

REFERENCES

American Psychiatric Association (2000). Diagnostic and statistical manual of mental disorders (4th ed.). (DSM-IV). Washington D.C.: American Psychiatric Association.

American Psychological Association (1999). Exercise helps keep your psyche fit. Retrieved June 25, 2008 from http://www.apa.org/release/exercise

Babyak, M. et al, (2000). Exercise treatment for major depression, maintenance of therapeutic benefits at ten months. *Psychosomatic Medicine,* 62: 633-638.

Benson, Herbert & Harvard Medical School (2006). Stress management: Techniques for preventing and easing stress. Cambridge, MA: *Harvard Health Publications*.

Boseley, S. (December 10, 2003). Drugs for depressed children banned. www.guardian.co.uk

Breggin, P. (2008). *Brain-disabling treatments in psychiatry* (2nd ed.). New York: Springer Publishing Company.

Corry, M. & Tubridy, AINE (2005). *Depression: An emotion not a disease*. Dublin: Mercier Press.

CriticalThinkRx.org, website (2010).

Dawdy, P. (2008). Willamette Week Online. Retrieved April 4, 2008 from http://www.wweek.com, Bitterpill.

Garbarino, J. (1999). *Lost boys*. New York: The Free Press.

Garland, J. (Feb. 17, 2004). Facing the evidence: Antidepressant treatment in children and adolescents. *Canadian Medical Association Journal.* 170 (4).

Genova Diagnostics. www.GDX.net

Glenmullen, J. (2000). *Prozac backlash: Overcoming the dangers of Prozac, Zoloft, Paxil and other antidepressants with safe, effective alternatives*. New York: Simon & Schuster.

Gordon, J. (2008). Unstuck: Your Guide to the seven-stage journey out of depression. New York: Penquin Press HC.

Gottschlich, A. (May 18, 2008). Antidepressants number one prescribed medication in US. www.BaytonDailyNews.com/n/content/oh/story/news/local/2008/05/18/ddn05

Healy, D. (2003). *Let them eat Prozac*. Toronto: James Lorimer & Ltd.

Hyman, M. (2008). *Why antidepressants don't work for treating depression.* www.ultrawellness.com

Johnson, T. (2003). A look at depression and current trends in treatment. *Communiqué*, 32 (2).

Johnson, T. (2004). Most SSRI antidepressant drugs for children banned in the UK. *Communiqué*, 32 (5).

Johnson, T. (2004). Alternative ways of supporting individuals struggling with depression. *International Center for the Study of Psychiatry & Psychology Newsletter.*

Kirsch, I. et. al. Initial severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. *PloSMedicine*. 2008: 5(2): E45.

National Institute of Mental Health, www.NIMH.nih.org, website (2008).

NICE.org.UK, website.

NutritionMD.org, website (2010).

Office of Applied Studies. (May 13, 2008). Substance abuse and mental health services Administration of the Department of Health and Human Services, National Survey on Drug Use and Health. Major Depressive Episode Among Youths Age 12 to 17 in the United States: 2004-2006.

Pollack, W. (1998). *Real boys: Rescuing our sons from the myths of boyhood*. New York: Henry Holt & Company.

Sharav, V. (Sept. 21, 2003). UK issues ban on second SSRI antidepressant for children, www.ahrp.org, website.

Thayer, R. (2001). *Calm energy: How people regulate mood with food and exercise*. New York: Oxford University Press.

Turner, E., Matthews, A., Linardatos, B., Tell, R. & Rosenthal, R. (January 17, 2008). Selective publication of antidepressant trials and its influence on apparent efficacy. *New England Journal of Medicine*. 358; 3 www.NEJM.org, website.

University of California at Berkeley School of Public Health (July 2007). University of California, Berkeley Wellness Letter.

Walker, M. (October 22, 2007) The human emotional brain without sleep – A prefrontal amygdala disconnect. *Current Biology.*

Williams, M., Teasdale, J., Segal, Z. & Cabot-Zinn, J. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. New York: The Guilford Press.

PARENT HANDOUT – ALTERNATIVE WAYS OF UNDERSTANDING AND SUPPORTING CHILDREN AND ADOLESCENTS STRUGGLING WITH DEPRESSION

The challenge for parents trying to understand their children's feelings of depression can be very daunting. In fact, even recognizing that certain behaviors are potentially symptomatic of depression can be difficult and confusing. Children, especially boys, may "act out" their feelings of depression in ways that come across as oppositional and disruptive. Younger children, in particular, may be unable to recognize that their distress represents depression and they often lack the verbal skills and/or insights to tell a family member or teacher that they are depressed. As this chapter points out, a certain amount of unhappiness and depression in life is normal. It is only when those feelings create prolonged or recurring unhappiness that parents may need help both in assessing and treating their child's problems. Establishing healthy lifestyle practices can actually prevent disabling depression. The most important healthy practices include making sure that your child gets a reasonable amount of sleep each night. For example, the National Sleep Foundation recommends that adolescents should generally average approximately nine hours of sleep in a 24-hour period. Inadequate sleep can cause or exacerbate depression so it logically follows that establishing healthy sleep hygiene practices may actually prevent depression. Of course, there are times when a child is sleeping excessively and that in itself may be a symptom of dysfunctional depression.

Eating well-balanced, plant-based diets may prevent and/or reverse disabling levels of depression. The Harvard Healthy Eating Pyramid is offered as a starting point for parents and as a superior alternative to the old USDA Pyramid, which has been discredited due to the inordinate influence of the meat, dairy and egg industries. NutritionMD.org was developed by the

Physicians Committee for Responsible Medicine as an evidence-based source of information for consumers and healthcare professionals alike. The reader is strongly encouraged to go to this website for accurate guidance on preventing depression, as well as other mental health and medical conditions. Parents can be easily confused by the marketing efforts of pharmaceutical companies, which bring the weight of billions of dollars of resources to bear on their advertising programs. The United States is only one of two countries that permit direct-to-consumer pharmaceutical advertising. It is common practice these days for parents to get their information from drug ads and then they go to their medical doctors and get prescriptions for themselves and/or their children for treating depression without going through the more thorough and accurate steps of getting accurate assessments.

Resources

American Psychological Association, website (APA.org).

Benson, Herbert & Harvard Medical School (2006). Stress Management: Techniques for preventing and easing stress. Cambridge, MA: *Harvard Health Publications*.

CriticalThinkRx.org, website.

Garbarino, J. (1999). *Lost boys*. New York: The Free Press.

National Association of School Psychologists (NASPonline.org).

National Sleep Foundation (SleepFoundation.org).

NutritionMD.org, website.

Pollack, W. (1998). *Real boys: Rescuing our sons from the myths of boyhood*. New York: Henry Holt & Company.

Ultrawellness.com, website.

Williams, M., Teasdale, J., Segal, Z. & Cabot-Zinn, J. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. New York: The Guilford Press.

TEACHER HANDOUT – ALTERNATIVE WAYS OF UNDERSTANDING AND SUPPORTING CHILDREN AND ADOLESCENTS STRUGGLING WITH DEPRESSION

Teachers and other educators are often the first adults to recognize children's distress that may take the form of depression. Depression may first be suspected with children who are underachieving, not paying attention in class, falling asleep in class, using mind-altering drugs such as alcohol or marijuana, bullying, etc. It is certainly important for teachers who suspect that one of their students is struggling with depression to confer with colleagues who have expertise in both the assessment and treatment of depression. Often, guidance counselors, social workers, and/or school psychologists have the kind of expertise that can be useful to teachers, as well as parents.

As William Pollack points out in his classic work *Real Boys*, boys often express their feelings of depression differently than girls. Studies at Stanford University and Harvard reveal that some of the most important symptoms of depression in pre-pubescent boys include behavioral disturbances such as being irritable or misbehaving and anhedonia which is a lack of pleasure, especially in relationship to friends and friendships. Boys may be reluctant to acknowledge feelings of sadness or vulnerability. Boys are often pressured to mask their emotional pain and fail to admit or even know that they are experiencing depression. Girls tend to find it easier to acknowledge feelings of sadness or depression than boys. Boys often feel pressured to minimize their emotional pain.

Stanford University scientists have found that girls tend to "ruminate" on their sadness, symptoms and possible causes. Girls are also more likely to cry and admit feelings of unhappiness, hopelessness or helplessness and seek out support from friends and family.

Diagnosing depression in boys can be difficult for a number of reasons, according to Pollack. It is often hard to make a distinction between the normal strategies that a boy uses to deal with day-to-day hurts and disappointments from the symptoms of actual depression. Depression is also often hard to diagnose in boys because boys often mask the behaviors associated with depression such as sulking, crying and/or withdrawing. Classic symptoms of depression in girls and women include becoming weepy, openly expressing hopelessness, helplessness, and despair. These symptoms are reportedly much less common in boys.

Dr. Pollack's book *Real Boys* is strongly recommended to educators who are interested in understanding some of the ways in which depression can be manifest in boys and men. Additional resources are the same ones listed in the parent handout.

CASE STUDY

Todd is a 13-year-old, eighth grade student at a New England middle school. He was referred by his parents for assessment and possible treatment for a variety of problems including feelings of depression, inattention, distractibility, and academic underachievement. Two different psychologists and a psychiatrist had previously evaluated him within the previous two years. The primary intervention offered was psychotropic medication. There was limited counseling offered but it was mostly provided in the context of looking at whether or not the medication was helpful. The interventions were not effective and Todd's parents were discouraged about the kind of support and treatment offered. They were interested in alternatives to the use of psychotropic medication and were willing to engage in a combination of individual and family therapy.

A previous psychological assessment revealed that Todd's overall IQ was approximately at the 90th percentile with intellectual strengths in all areas measured. There was no evidence of any cognitive deficiency from the psychological testing. A review of previous records revealed that Todd has been struggling with feelings of anxiety, depression, inattention and low self-esteem. He and his parents were unhappy with the use of mind-altering drugs and did not see any positive benefits from the interventions that were offered. In fact, at the time of referral, his achievement and conduct appeared to be deteriorating at school. One of the psychologists had evaluated him at the request of the special education department of his school to determine if he was eligible for special education services. Even though he was diagnosed with depression, had poor attendance and was failing most of his classes, the special education team determined that he did not meet the criteria for any of the handicapping conditions.

During part of the assessment for the development of a treatment plan with the family psychologist, Todd described himself as always feeling tired and as having difficulty sleeping through the night. He generally did not feel like getting up in the morning to go to school. In addition to acknowledging the sleep disturbance, poor eating habits, and frequent feelings of tiredness, he also reported feelings of depression, anxiety, irritability, and difficulty concentrating. His parents essentially concurred with his self-assessment. Even though his parents were divorced, they agreed to support their son by participating in family therapy.

The interventions offered were consistent with the NICE guidelines, Jane Garland's recommendations and the Harvard Stress Control model. Todd was seen both individually and in relationship/communication oriented family psychotherapy. The treatment focused on helping each of the family members to improve their communication and to facilitate collaborative problem solving. Through the family counseling, we discussed the possible connections between Todd's sleep disturbance, poor eating and exercise habits, family communication problems and the lack of effective stress control strategies with his recurring feelings of depression and other problems.

Todd and his family were introduced to the Harvard Stress Control model. Handouts were provided to them and guidance was offered on how to shift from a meat-based and junk food diet to a well balanced plant-based diet that would be consistent with the recommendations of the Physicians Committee for Responsible Medicine and the foundations of the Harvard Healthy Eating Pyramid. Todd and his father agreed to working out together with weights. Additionally, Todd was introduced to meditation. The meditation was offered as a way of lowering his stress level and also helping him in the transition to getting ready for sleep. It was determined that Todd had the bad habit of listening to very stimulating rock music prior to bedtime. It was

pointed out that this could be contributing to his sleep disturbance. Also, we looked closely at his eating habits and his therapist explained how his intake of certain types of foods might be contributing to his sleep disturbance. He learned meditation skills in consultation with the family psychologist and did follow-up meditating at home.

In addition to the individual and family oriented interventions listed above, the family psychologist provided consultations to key members of his school community, including his academic advisor, the school social worker and his guidance counselor. His sleeping and eating patterns improved. He began taking a vegetarian omega-3 supplement. His school attendance improved dramatically and his grades improved, as well. He had been in danger of failing his eighth grade year, but through his efforts and the supports provided, he was successful in moving onto the ninth grade. Perhaps, most importantly, the family learned new and more effective skills of communication and collaborative problem solving.

DISCUSSION QUESTIONS

1) How does the National Institute of Mental Health look at depression? What are the different forms of depression, according to the NIMH?

2) What is the dominant approach to treating depression discussed in this article? What is the evidence regarding this approach? If the evidence is not supportive, what might be some of the reasons why this intervention continues to be promoted?

3) Are there any biochemical assessments that can distinguish between a person who is depressed and a person who is not depressed? Are there any biochemical or laboratory assessments that might help a clinician in determining if there are deficiencies or toxicities that could be contributing to feelings of depression? Identify some of the interventions that appear to have helped Todd and his family deals with his feelings of depression and his underachievement.

BIOGRAPHICAL NOTES

DR. THOMAS B. JOHNSON completed his graduate studies at Brown, Harvard, UC-Berkeley and Duke. He is a licensed psychologist in private practice in Auburn, Maine specializing in health, family and school psychology. He is the founder and first president of the Maine Division of the American Association for Marriage and Family Therapy. He served as Contributing Editor for the National Association of School Psychologists' *Communiqué* from 1996 to 2006.