DEPRESSION IN ADULTS, CHILDREN AND ADOLESCENTS

Much of this guideline is based on existing guidelines for clinical practice developed by the Agency for Health Care Policy and Research (AHCPR) Depression Guideline Panel (Rush et al., 1993a; 1993b); The American Psychiatric Association Depression Guideline Panel (APA, 1993); and the American Academy of Child and Adolescent Psychiatry's (AACAP) Practice Parameters for the Assessment and Treatment of Children and Adolescents with Depressive Disorders (AACAP, 1998).

1. INTRODUCTION – EMOTIONAL AND PHYSIOLOGIC MANIFESTATIONS OF DEPRESSIVE DISORDERS

Depression is a symptom of several disorders that range from mild to severe, and from transitory to chronic. The onset of depression can occur at any age and may be triggered by a single event or a series of events. These events may be experienced as traumatic or insignificant at the time and usually require careful clinical assessment to be fully understood. Anyone who has been the victim of a crime is likely to experience the event as upsetting or traumatic and, therefore, may experience some depressive symptoms. Depressed mood alone does not constitute a depressive disorder. Depression as a mood disorder in adults can include a variety of emotional and physiological symptoms. These are summarized below and the DSM-IV (1994) diagnostic criteria for depression are presented in Table 1.

In the **emotional arena,** symptoms can be expressed verbally or non-verbally, and can include: sadness, tearfulness, low self-esteem, obsessive self-critical thoughts, inability to experience pleasure, loss of ambition, loss of interest, indecisiveness, inability to concentrate, irritability, anxiety, anger, pessimism, guilt, helplessness, hopelessness, and suicidal fantasies. Any one or more of the emotional states listed above may be the primary emotional state of a person suffering from depression, not just sadness.

In the physiologic arena, **symptoms can include: fatigue, insomnia, increased need for sleep, increase or decrease in appetite, anorexia, digestive problems, constipation, social withdrawal, sexual dysfunction, and hypochondriasis.**

For children and adolescents, the clinical manifestation of depression varies across developmental stages and diverse ethnic groups, but is generally analogous to adult symptoms (see Table 1). When compared to adults, children and adolescents generally present with more symptoms of anxiety (i.e. phobias and separation anxiety), somatic complaints, auditory hallucinations and increased irritability. Instead of verbalizing feelings, children may express increased irritability and frustration through temper tantrums and behavioral difficulties. Children have fewer delusions and fewer serious suicide attempts than adults; this is attributed to the lack of cognitive maturation in children. In middle to late childhood, children report more cognitive components of their depressed mood, as well as low self-esteem, guilt, and hopelessness. Adolescents tend to experience more sleep and appetite disturbances, delusions, suicidal ideation and

attempts, and impairment of functioning than younger children, and more externalizing behavioral problems than adults.

TABLE 1: DEPRESSIVE DISORDERS DSM-IV DIAGNOSTIC CRITERIA

Major Depressive Disorder (MDD), *Single Episode Criteria* 296.2x

A. Presence of a single Major Depressive Episode:

(1) At least 5 of the following **symptoms** must be present every day or nearly every day during the same **2-week period** and represent a change from previous functioning.
(2) At least one of the following symptoms is either:
* Depressed mood, or
* Loss of interest or pleasure.

Symptoms: ≥5

(1) Depressed mood most of the day, as indicated by either subjective account or observation by others. **In children and adolescents** – mood can be irritable.
(2) Markedly diminished interest or pleasure in all, or almost all, activities.
(3) Significant weight loss when not dieting or weight gain, or decrease or increase in appetite. **In children** – consider failure to make expected weight gains.
(4) Insomnia or hypersomnia.
(5) Psychomotor agitation or retardation (observable by others).
(6) Loss of energy or fatigue.
(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional).
(8) Diminished ability to think or concentrate, or indecisiveness.
(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation w/o a specific plan, or a suicide attempt or a specific plan for a suicide attempt.

B. The Major Depressive Episodes are *not* better accounted for by Schizoaffective DO and are not superimposed on Schizophrenia, Schizophreniform DO, Delusional DO, or Psychotic DO NOS.

C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

Key: DO = Disorder, NOS = Not Otherwise Specified.

TYPES OF DEPRESSIVE DISORDERS

Depression may signal both a single primary disorder or a combination of disorders (e.g., dysthymia and major depressive episode). The conditions which may underlie depression must be carefully evaluated to determine what the depression means in a given person. Since there is no comprehensive guide to the types of depression most prevalent in crime victims, all possible diagnostic meanings of the depression must be considered. A crime is a stressful event that can trigger a depressive disorder. Other factors that may increase the likelihood of a depressive disorder as the result of a crime include: family history of depressive disorder(s), individual history of depressive disorder(s), suicidal thoughts or attempts, lack of a social support network, and current or past drug abuse. Women are twice as vulnerable to depression as men are.

The major categories of depressive disorders, briefly defined below, include:

1) **Adjustment disorder with Depressed Mood (or Mixed Anxiety and Depression)**
2) **Dysthymic Disorder**
3) **Bipolar Disorder**
4) **Cyclothymic Disorder**
5) **Major Depressive Disorder (MDD)**

Depressive disorders can also be described differently in diverse cultures, such as "nerves" or "headaches" in Latino cultures, "imbalance" in Asian cultures, and "heartbroken" in some Native American cultures.

1. Adjustment Disorder with Depressed Mood (or Mixed Anxiety and Depression):

Depressive symptoms or depressive symptoms mixed with anxiety that develop within 3 months in response to an identifiable stressor or stressors. Prevalence of this disorder, as the primary diagnosis, is approximately 5%-20% in men and women (DSM-IV, 1994). This condition is by definition acute and generally treatable within six months of onset. Continuing stressors may lengthen the persistence of the Adjustment Disorder. Depressive symptoms in Adjustment Disorder are higher than the precipitating event would logically engender and there is impairment in social or work functioning to some degree. Treatment generally consists of psychotherapy with occasional short-term use of psychotropic medication. The diagnosis of Adjustment Disorder does not apply when the symptoms represent bereavement. Children with this disorder tend to experience mood fluctuations and impairment of functioning within the three months following the identifiable stressor; however, they do NOT meet diagnostic criteria for MDD. Overall, this disorder is associated with less severe mood disturbance, fewer symptoms and no relapse.

2. Dysthymic Disorder (DD):

Chronically depressed mood that is present most of the time for at least two years for adults and one year in children. This disorder affects approximately 6% of the population, more specifically 4% of women and 2% of men (APA, 1994; Rush et al., 1993a). Depressed mood is not substantially affected by outside stressors. Eating and sleeping disturbances are common. Identity is linked to depressed mood, and depressed feeling is experienced as normal. Course of treatment varies, depending on presence of acute episodes of major depression and degree to which productivity and functioning are impaired. Dysthymic Disorder often occurs in combination with Major Depressive Disorder or Personality Disorder. Children with DD may manifest irritable mood instead of depression. Other symptoms such as feelings of being unloved, anger, self-deprecation, somatic complaints, anxiety and disobedience have been noted in children. Fewer children than adolescents suffer from this disorder.

3. Bipolar Disorder:

This disorder is marked by one or more episodes of manic mood which may include: elation; grandiosity; illogical and/or psychotic thought processes; pressured speech; decreased need for sleep; increased sociability; distractibility; flight of ideas; impairment in functioning (especially in structured situations like work); lowered frustration tolerance; promiscuity; assaultive and/or criminal behavior; and significant deficits in judgment. Behavior is impacted more seriously than in hypomanic moods which have many of the same symptoms. These episodic moods may alternate with mild to severe depressed moods. The classic type of Bipolar Disorder is a mixture of mania and Major Depressive episodes. Lifetime prevalence of this disorder is 0.4% - 1.6% for both men and women. Bipolar Disorder usually begins before age 30. Not all types of Bipolar Disorder include psychotic process. Manic episodes can vary in duration and interval between episodes but generally occur one to four times a year and without treatment lasts less than a week. Course of treatment for acute manic episodes is generally less than three months and includes medication, and when appropriate, psychotherapy.

The nature and course of Bipolar Disorder in children is not yet fully understood and is currently the subject of some controversy. The primary issues concern whether rapid or ultra rapid mood cycling and significant difficulties in affective dysregulation constitute the same disorder that is seen in adults, or leads to Bipolar Disorder as manifested by adults. It is also especially important that developmentally normal variations in mood fluctuations and impulsivity not be characterized as evidence of the disorder.

4. Cyclothymic Disorder:

This disorder is a mild form of Bipolar Disorder and includes hypomanic, as opposed to manic, episodes; depressed mood, as opposed to major depressive episodes; and does not include psychotic process. Cyclothymic Disorder may become a Bipolar Disorder. A two-year period of less extreme fluctuating moods without clear internal or external

triggers is necessary to make this diagnosis. Prevalence of this disorder is 0.4% for men and women. Treatment may include psychotherapy and psychotropic medication.

5. Major Depressive Disorder (MDD):

This disorder is characterized by the following: severe ongoing depressed mood; loss of pleasure in activities; changes in appetite and sleep; decreased energy; lowered self-esteem; self-critical thoughts; inability to feel happy, sad or to have feelings in general; feelings of guilt; irritability; psychotic thoughts; indecisiveness; sexual dysfunction; feelings of sadness or despair; thoughts of death; suicidal thoughts; and impaired functioning in relationships or at work. A Major Depressive Episode cannot be diagnosed during the first two months after the death of a loved one. The symptoms of MDD can vary significantly but must include loss of pleasure and, usually, decreased appetite and insomnia. This disorder affects 10-25% of all women and 5-9% of all men during the life cycle. Treatment of an acute episode of MDD includes medication, psychotherapy and, at times, help with daily life tasks.

MDD affects approximately 2% of children and 4-8% of adolescents. The male-female ratio is 1:1 in early childhood but 1:2 by adolescence (Birmaher et al., 1996a). It is not clear why girls are twice as likely to suffer from depressive disorders as boys in adolescence, but it has been hypothesized that girls carry more risk factors for depression than boys. For example, girls tend to use more ruminative and self-focused problem solving styles than boys, worry more about their body image and deal earlier with the psychosocial and biological consequences that accompany puberty.

CO-MORBIDITY IN ADULTS

Although there is no epidemiological study of depression in the wide spectrum of crime victims, some well-established findings gathered from trauma survivors with Post-Traumatic Stress Disorder (PTSD) would presumably apply, for example, survivors of war, massive traumas, and natural disaster. Studies have consistently shown that depression, along with generalized anxiety, is one of the most common co-occurring diagnoses with PTSD; in fact, almost half of adults suffering from PTSD also suffer from depression (Kessler et al., 1995). Co-morbidity with PTSD would be expected for depression due to the overlap in symptom criteria; for example, DSM-IV criteria C and D PTSD symptoms (e.g. diminished interest, restricted range of affect, sleep disturbances, difficulty concentrating) overlap with several of the hallmark symptoms of depression. Substance abuse, as well as eating disorders and obsessive-compulsive disorders, are not uncommon among individuals suffering from depression. Separate studies of spousal death or individuals who have experienced physical or sexual assault suggest a significant number (30%) will meet criteria for depression during the first year of recovery (Jones, 1993). If these depressions begin immediately after the death or assault they are at a greater risk of persisting and creating dysfunction.

CO-MORBIDITY IN CHILDREN

The majority of children with depressive disorders suffer from other psychiatric disorders; in fact, 40-90% of youth with MDD have other psychiatric disorders with 20-50% having two or more co-morbid diagnoses (AACAP, 1998; Birmaher et al., 1996a). Studies with traumatized children (e.g., sexually abused, natural disaster survivors) have revealed that depression often accompanies PTSD symptoms. For example, in a recent study, McLeer et al. (1998) found that of 80 sexually abused children, 36.3% were diagnosed with PTSD, and of that group, 13.8% were diagnosed with co-morbid major depression and 10.3% with dysthymia. The other most frequent co-morbid diagnoses include anxiety disorders, disruptive disorders, and substance use disorders. Younger children more commonly manifest Separation Anxiety Disorder, while co-morbid substance abuse, conduct disorder, social phobia, and general anxiety disorder are more common in adolescents. Substance abuse and conduct disturbances tend to appear after the onset of child MDD and may persist after depression remits. Studies have revealed that depressed melancholic symptoms, fewer recurrences of depression, yet a higher incidence of adult criminality, more suicide attempts, higher levels of family criticism and response to placebo.

Overall, co-morbid disorders in depressed children raise concern because they appear to influence risk for recurrent depression, duration of the depressive episode, suicide attempts or behaviors, and responses to treatment and mental health service utilization. There is also particular concern for children suffering from double depressions (MDD and DD) and co-morbid anxiety and depression; these children often present with more severe, longer lasting depressive symptomatology, increased risk for substance abuse, increased suicidality, poor response to treatment, and more psychosocial problems.

CONCEPTUAL MODELS OF DEPRESSION: DYNAMIC VS. ADYNAMIC

While depression is an ubiquitous clinical problem, there is no objective way to diagnose it beyond the self-report of sometimes non-specific signs and symptoms. With the introduction of the DSM classification of psychiatric disorders in the 1980's, an **adynamic** system, which defines depression as an aggregation of clinical signs and symptoms, was adopted. By themselves, these signs and symptoms are non-specific, but their combination over a long enough period of time suggests a threshold or "criteria" for the diagnosis of depressive disorders (see Table 1 and the section on diagnosis). There is a longer standing **dynamic** concept of depression—that depressive signs and symptoms comprise a maladaptive response to a significant loss or to a fixed image of self as inadequate, helpless and blameworthy. It is appropriate to begin with a presumption that anyone who has experienced a serious criminal assault, rape or the homicide of a family member is presenting with a **dynamic** traumatic event. Signs or symptoms of depression should be viewed in the context of the occurrence of a traumatic event. Sadness, hopelessness, insomnia, self-deprecatory ideation, etc. will thus bear some connection to the persistent memory of the crime. This should not exclude the possibility that depression as an **adynamic** disorder may also intervene. These two conceptual models of depression need not be mutually exclusive. This document will present guidelines for

assessment and management of depression that will include both conceptual models that will combine psychologic and psychopharmacologic therapies.

2. ASSESSMENT AND MANAGEMENT OF DEPRESSIVE DISORDERS IN ADULTS

Detection, Diagnosis, and Assessment

The recognition and diagnosis of depression depends upon a clinician's awareness of risk factors for depression, as well as presence of key signs, symptoms and history of illness. Because effective treatments rests on accurate diagnosis, a systematic approach to the identification of depressive disorders is recommended. Self-report questionnaires can be extremely useful in screening individuals with significant depressive symptoms that should be further explored and evaluated through clinical interview. The clinical interview has been found to be the most effective method for detecting depression because it allows the clinician to assess the criterion symptoms for depressive disorders and determine whether the symptoms are of sufficient intensity, number, and duration to meet the DSM-IV criteria. Once a clinician suspects or diagnoses a depressive disorder, it is recommended to conduct and record the results of a mental health status examination assessing suicidal risk and other domains of social, psychological and physical functioning. However, **before** conducting extensive biological, neuropsychological, or psychological testing, a clinician should spend considerable time carefully interviewing the client and, when appropriate, other informants/caretakers. In other words, the use of psychological and neuropsychological tests are **not** recommended for routine use in screening for depressive disorders. In certain cases, however, these tests may be extremely useful in differential diagnosis of depression.

6. Diagnostic Instruments

There are a variety of easy to administer, cost effective client self-report measures and clinician-completed scales readily available to practitioners. Meichenbaum (1994) and Smith, Mosley, and Booth (1996) profiled some of the most widely accepted self-report and diagnostic instruments used by clinicians to screen individuals for depression in primary care setting; some of these are listed in Table 2.

TABLE 2: DIAGNOSTIC INSTRUMENTS	
Self-Report Instruments (For screening individuals for depression in primary care settings):	**Diagnostic Tools** (These scales require a trained interviewer to administer):
1. General Health Questionnaire (GHQ) (Goldberg, 1972) 2. Beck Depression Inventory (BDI) (Beck, et al., 1961; Beck, 1972) 3. Zung Self-Rating Depression Scale (ZSRDS) (Zung, 1975) 4. Center for Epidemiological Studies Depression Scale (CES-D)(Radloff, 1977)	1. Diagnostic Interview Schedule (DIS)(Robins et al. 1981) 2. Hamilton Rating Scale for Depression (HRSD)(Hamilton, 1986) 3. Inventory of Depressive Symptomatology – Clinician Rated (IDS-C)(Rush et al., 1986; Rush et al., 1996)
Client Self-Report Measures	
1. Inventory to Diagnose Depression (IDD)(Zimmerman, Coryell, Stangle et al., 1986; Rush et al., 1996) 2. The Depression Outcomes Module's (DOM) Depression-Arkansas Scale (D-ARK)(Smith et al., 1994) 3. Inventory of Depressive Symptomatology – Self-Report (IDS-SR)(Rush et al., 1986; Rush et al., 1996)	

GENERAL TREATMENT OVERVIEW

The five formal treatments for adults with depressive disorders include pharmacotherapy, psychotherapy, a combination of both, electroconvulsive therapy (ECT) and light therapy. Medications have been shown to be effective in all forms of depression, yet no one antidepressant medication is clearly more effective than another is and no single medication results in remission for all patients.

Some patients cannot tolerate medications due to physical conditions, some simply do not wish to take medications or do not respond to medication, and others may request psychotherapy as the first-line treatment. Psychotherapy alone may reduce the symptoms if the depression is mild to moderate, non-psychotic, not chronic and not highly recurrent.

The combination of medication and psychotherapy may prove beneficial to individuals with a history of chronic psychosocial problems who have responded **partially** to either medications or psychotherapy alone, and/or with a history of treatment adherence difficulties. Medication is indicated for severe and psychotic depression. ECT is indicated for patients suffering from severe or psychotic forms of depression with intense, prolonged symptoms associated with neurovegetative symptoms; for patients who are significantly functionally impaired who have not responded to adequate trials of medications or other therapies, or cannot tolerate medications; and, those who are at an imminent risk for suicide. Light therapy is considered for mild to moderately severe forms of seasonal, non-psychotic, depressive winter episodes.

CRIME-SPECIFIC TREATMENT FOR DEPRESSION

Currently, there is no literature on the treatment of depression specific to crime victims. However, many studies have shown that trauma-specific treatment approaches (e.g., focusing on posttraumatic stress symptoms like avoidance and re-experiencing while addressing cognitive distortions) used with individuals suffering from posttraumatic stress symptoms are effective in reducing concurrent depressive symptoms. It is recommended that a trauma-specific approach be initially used for individuals displaying depressive symptoms.

If the individual does not experience relief of depressive symptoms, then a more specific psychotherapeutic approach, e.g. Cognitive Behavioral Therapy (CBT) or Interpersonal Therapy (IPT) is indicated. The rationale for the use of CBT to treat depression is based on the idea that depressed patients have a distorted view of themselves, the world, and the future. CBT techniques aim to identify and counteract these cognitive distortions and mis-attributions. The IPT approach aims at clarification and resolution of grief-related problems, interpersonal roles, role disputes and transitions, and interpersonal difficulties. Presumably the mild depressive syndromes associated with grief and trauma distress will be focused on the memory of the crime. Symptoms will be less pervasive and will be addressed by the individual or group therapy that focuses on the grief related (dynamic) symptoms in these depressed, grief stricken subjects (Pasternak et al., 1991). This study highlights the intuitive clinical wisdom of remaining flexible and inclusive with clinical interventions.

3. ASSESSMENT AND MANAGEMENT OF DEPRESSIVE DISORDERS IN ADOLESCENTS AND CHILDREN

Very little evidence-based research has been conducted on child and adolescent depressive disorders. Most of the studies regarding treatment and efficacy data have been based on clinical experience or have involved adults. None of the research has specifically involved child or adolescent victims of crime. Therefore, caution should be used when applying adult research to children.

DETECTION, DIAGNOSIS AND ASSESSMENT

Depressive disorders in youth are often recurrent and accompanied by co-morbid conditions, poor psychosocial outcome and high risk of suicide and substance abuse, therefore the early detection, diagnosis and aggressive treatment of these disorders is critical. It is important to assess for symptom clusters that define subtypes of depression like seasonality, atypical symptoms, and psychosis in order to develop an appropriate treatment plan. The most useful diagnostic tool for clinicians is the comprehensive diagnostic evaluation, including interviews with child, caregivers, and other collateral sources. The psychiatric assessment of depressed children and adolescents should be conducted by a trained clinician that is aware of the developmental and cultural factors

that may significantly impact a child's presentation. Lifetime mood charts and mood diaries can be used to document the longitudinal course of depression.

GENERAL TREATMENT OVERVIEW

Psychotherapy is considered appropriate for all children and adolescents diagnosed with depressive disorders. Antidepressant medications are helpful in some cases, especially when patients are not responding to an adequate trial of psychotherapy and/or display severe depression. Opinions among clinicians vary regarding treatment planning and treatment duration, however. It is agreed that all interventions should be adapted to the developmental stage of the child or adolescent and be provided in the least restrictive setting for the child.

It is important for a treatment plan to match the intent of treatment to the severity of symptoms. Multiple sessions per week may be warranted during the acute treatment phase. The inclusion of caregivers in treatment is strongly recommended to facilitate the resolution of depressive symptoms. It is critical to foster an effective therapeutic rapport and alliance early in treatment so as to maintain and increase family involvement over the treatment course.

A clinician should provide education to the child and all family members regarding the disorder and treatment to decrease mis-attributions made by children and caregivers (i.e. self-blame: "It's all my fault. I'm a bad parent." Or blaming the child: "It's my kid's fault, he's just lazy or manipulative."). Psycho-education enhances the team approach and overall compliance with treatment. Furthermore, parental mental health issues should be addressed.

If warranted parents should be offered the appropriate treatment.

TREATMENT LITERATURE AND RECOMMENDATIONS

There is controversy regarding whether psychotherapy, pharmacotherapy or a combination should be offered as first-line treatment for children and adolescents suffering from MDD. In fact, there is a debate regarding which psychotherapies or which parts of the psychotherapies are most efficacious. Several factors should be considered when choosing the initial acute therapy: (1) severity, (2) number of prior episodes, (3) chronicity, (4) subtype, (5) age of the patient, (6) contextual issues (family conflict, academic problems, exposure to negative life events), (7) compliance with treatment, (8) previous response to treatment and (9) the patient's and family's motivation for treatment (AACAP, 1998 p. 72). Other factors that also influence the selection and outcome of treatment are clinician availability, motivation, and expertise with a specific therapy.

Drawing from clinical experience and the few randomized treatment studies done with children and adolescents, psychotherapy has shown to be a helpful initial acute treatment for mild to moderate treatment modalities like psychodynamic psychotherapy, Interpersonal therapy (IPT) and family therapy have been proven effective and are often

used clinically. The rationale for the use of CBT for depression is based on the idea that depressed patients have a distorted view of themselves, the world, and the future. CBT approaches teach children how to identify and counteract these inaccurate belief systems and mis-attributions. Continuation therapy is recommended when using CBT with children because clinical studies have shown a high rate of relapse upon follow-up.

The IPT approach, which focuses on interpersonal roles, role disputes and transitions and interpersonal difficulties, has been shown to be useful in the acute treatment phase with a low relapse rate. Psychodynamic therapy can help children better understand themselves, identify feelings, challenge maladaptive behavior patterns, improve communications with others, and gain coping skills. More research comparing these therapies is needed to better understand their effects. See reviews by Bemporad, (1994) and Birmaher et al., (1996b) for further discussion on psychotherapeutic techniques used with depressed children.

Antidepressant medication may be indicated for children and adolescents with depression of enough severity to interfere with academic and social functioning and the prevention of effective psychotherapy, and depression that fails to respond to an adequate trial of psychotherapy. Tricyclic Antidepressants (TCAs) and Selective Serotonin Reuptake Inhibitors (SSRIs) are the most commonly used medications with depressed children and have yielded conflicting results. The few studies that have been conducted on the use of these medications are open or methodologically flawed. Double-blind trials have shown no significant differences between TCAs and placebos. Overall, children and adolescents respond at a high rate to placebos.

Due to the positive results of SSRIs with adults with MDD, these medications are now commonly used to treat depressed children. To date, SSRIs are considered the "antidepressants of choice" for children needing medication because they are relatively safe due to their very low lethality after overdose, have a good side effects profile, are easy to administer (once a day), and can be maintained on a long-term basis. Pharmacotherapy alone is never considered a sufficient treatment. Pharmacotherapy combined with psychotherapy is recommended. A combined treatment approach not only stabilizes the patient's mood, but enhances the likelihood of alleviating depressive symptoms, improving self-esteem, enhancing coping skills and adaptive strategies, and improving relationships with family and peers (AACAP, 1998). The high degree of co-morbidity and psychosocial and academic problems caused by depression support the use of multimodal treatment approach.

Continuation therapy lasting for at least six months is recommended for all children and adolescents being treated for MDD. Continued treatment is supported by the high rate of relapse and recurrence of depression. After child patients have been asymptomatic for 6-12 months, the clinician must determine whether or not to continue therapy on a maintenance basis in order to prevent recurrence. Maintenance therapy is supported for patients with multiple or severe depressive episodes and those at high risk for recurrence. For example, patients who have a family history of Bipolar Disorder or recurrent

depression, co-morbid psychiatric disorders, or are currently in a stressful and non-supportive living environment are potential candidates for maintenance therapy.

CRIME-SPECIFIC TREATMENT FOR DEPRESSION

As with adult crime victims, trauma-focused treatment (e.g., addressing PTSD symptoms and cognitions) produces improvement in childhood depressive symptoms. It is recommended that this be the first-line treatment. When symptoms do not abate or the child deteriorates or becomes suicidal, a shift to standard psychotherapeutic approaches is indicated.

REFERENCES

American Academy of Child and Adolescent Psychiatry. (1998). Practice parameters for the assessment and treatment of children and adolescents with post-traumatic stress disorder. Journal of the American Academy of Child & Adolescent Psychiatry, 37 (Suppl. 10), 4s – 26s.

American Psychiatric Association. (1993). Practice guideline for major depressive disorder in adults. American Journal of Psychiatry, 150 (Suppl. 4), 1-26.

American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Disorders (4th ed.). Washington, DC: American Psychiatric Association.

Beck, A.T. (1972). Measurement of Depression: The Depression Inventory. In A.T. Beck (Ed), Depression: Causes and Treatment. Philadelphia: University of Pennsylvania Press.

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. Archives of General Psychiatry, 4, 561-571

. Bemporad, J.R. (1994). Dynamic and Interpersonal theories of Depression. In W.M. Reynolds and H.F. Johnson (Eds.), Handbook of Depression in Children and Adolescents (pp. 81-95). New York: Plenum.

Birmaher, B., Ryan, N.D., Williamson, D.E., Brent, D.A., Kaufman, J., Dahl, R.E., Perel, J., and Nelson, B. (1996a). Childhood and adolescent depression: a Review of the past 10 years. Part I. Journal of American Academy of Child and Adolescent Psychiatry, 35. 1427-1439.

Birmaher, , B., Ryan, N.D., Williamson, D.E., Brent, D.A., Kaufman, J., Dahl, R.E., Perel, J., and Nelson, B. (1996b). Childhood and adolescent depression: a Review of the past 10 years. Part II. Journal of American Academy of Child and Adolescent Psychiatry, 35. 1575-1583.

Crime Victims Compensation Program. (1999). Mental Health Treatment Guidelines. Olympia, WA: The Department of Labor and Industries.

Goldberg, D.P. (1972). The Detection of Psychiatric Illness by Questionnaire. London: Oxford University Press.

Hamilton, M. (1986). The Hamilton Rating Scale for Depression. In N. Sartorius and T. Bant (Eds.), Assessment of Depression (pp. 143-152). New York: Springer-Verlag NY Inc.

Jones, S. (1993). Pathologic Grief: Maladaption to loss. American Psychiatric Press Inc.

Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., and Nelson, C.B. (1995). Post-traumatic stress disorder in the national co-morbidity study. Archives of General Psychiatry, 52, 1048-1060.

McLeer, S.V., Dixon, J.F., Henry, D., Ruggiero, K., Escovitz, K., Niedda, T., and Scholle, R. (1998). Psychopathology in non-clinically referred sexually abused children. Journal of American Academy of Child and Adolescent Psychiatry, 37. 1326-1333.

Meichenbaum, D. (1994). A Clinical Handbook/Practical Therapist Manual for Assessing and Treating Adults with Post-Traumatic Stress Disorder (PTSD). Waterloo, Ontario, Canada: Institute Press.

Pasternak, R.E., Reynolds, C.F., Schlernitzauer, M., Hoch, C.D., Buysse, D.J., Houck, P.R., and Perel, J.M. (1991). Acute open-trial nortriptyline therapy of bereavement-related depression in late life. Journal of Clinical Psychiatry, 52, 307-310.

Radloff, L.S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. Applied Psychological Measures, 1, 385-401.

Robins, L.N., Helzer, J.E., Croughan, J. & Ratcliff, K.S. (1981). National Institute of Mental Health Diagnostic Interview Schedule: History, Characteristics, and Validity. Archives of General Psychiatry, 38, 381-389.

Rush, A.J., Giles, D.E., Schlesser, M.A., Fulton, D.L., Weissenburger, J., and Burns, C. (1986). The Inventory for Depressive Symptomatology (IDS): Preliminary Findings. Psychiatry Research, 18 (1), 65-87.

Rush, A.J., Golden, W.E., Hall, G.W., et al (1993a). Depression in Primary Care: Vol. 1. Detection and Diagnosis (Clinical Practice Guideline No. 5, AHCPR Publication no. 93-0550). Rockville, MD: Agency for Health Care Policy and Research. Available: http://www.ahcpr.gov

Rush, A.J., Golden, W.E., Hall, G.W., et al (1993b. Depression in Primary Care: Vol. 2 Detection and Diagnosis (Clinical Practice Guideline No. 5, AHCPR Publication no. 93-0551. Rockville, MD: Agency for Health Care Policy and Research. Available: http://www.ahcpr.gov

Rush, A.J., Guillion, C.M., Basco, M.R., Jarrett, R.B. and Ribedie, M.H. (1996). The Inventory of Depressive Symptomatology (IDS): Psychometric Properties. Psychological Medicine.

Smith, G.R., Burnam, M.A., Burns, B.J., Cleary, P.D., and Rost, K. (1994) Outcomes Module for Major Depression (Little Rock: University of Arkansas).

Smith, G.R., Mosley, C.L., and Booth, B.M (1996, August). Measuring Health Care Quality: Major Depressive Disorder (AHCPR Publication No. 96-N023). Rockville, MD: Agency for Health Care Policy and Research.

Zimmerman, M., Coryell, W., Stangl, D., and Pfohl, B. (1987). Validity of an operation definition for neurotic unipolar major depression. Journal of Affect Disorders, 12, 29-40.

Zung, W.W. (1975). A rating instrument for anxiety disorders. Psychometrics, 12, 371-379.

RELATED READING

Anderson, J.C., and McGee, R. (1994). Co-morbidity of Depression in Children and Adolescents. In W. M. Reynolds and H.F. Johnson (Eds.), Handbook of Depression in Children and Adolescents (pp. 581-601). New York: Plenum.

Fleming, J.E., and Offord, D.R. (1990), Epidemiology of Childhood Depressive Disorders: A Critical Review. Journal of American Academy of Child and Adolescent Psychiatry, 29, 571-580.

Jacobson, N.S., and Hollon, S.D. (1996). Cognitive-Behavior Therapy Versus Pharmacotherapy: Now That the Jury's Returned Its Verdict, It's Time to Present the Rest of the Evidence. Journal of Consulting and Clinical Psychology, 64, 74-80.

Kashani, J.H., Beck, N.C., Hoeper, E.W., and Fallahi, C. et al (1987). Psychiatric Disorders in a Community Sample of Adolescents. American Journal of Psychiatry, 144, 584-589.

Kashani, J.H., Carlson, G.A., Beck, N.C., and Hoeper, E.W., et al (1987). Depression Depressive Symptoms, and Depressed Mood Among a Community Sample of Adolescents. American Journal of Psychiatry, 144, 931-934.

Lewinsohn, P.M., Clarke, G.N., Seeley, J.R., & Rohde, P. (1994). Major Depression in Community Adolescents: Age at Onset, Episode Duration, and Time to Recurrence. Journal of American Academy of Child and Adolescent Psychiatry, 33, 809-818.

Lewinsohn, P.M., Duncan, E.M., Stanton, A.K., and Hautziner, M. (1986). Age at Onset for First Unipolar Depression. Journal of Abnormal Psychology, 95, 378-383.

Lewinsohn, P.M., Hops, H., Roberts, R.E., Seeley, J.R., and Andrews, J.A. (1993). Adolescent Psychopathology: I. Prevalence and Incidence of Depression and Other DSM-III-R Disorders in High School Students. Journal of Abnormal Psychology, 102, 133-144.

Rynearson, E. (1972). Identifying the Depressed Patient. Bulletin of the Mason Clinic, 26, 125-130.

Shulberg, H.C., Block, M.R., Madonia, M.J., Scott, C.P., Lave, J.R., Rodriquez, E., and Coulehan, J.L. (1997). The "Usual Care" of Major Depression in Primary Care Practice. Archives of Family Medicine, 6, 334-339.

Thase, M.E., and Kupfer, D.J. (1996). Recent Developments in the Pharmacotherapy of Mood Disorders. Journal of Consulting and Clinical Psychology, 64, 646-659.