



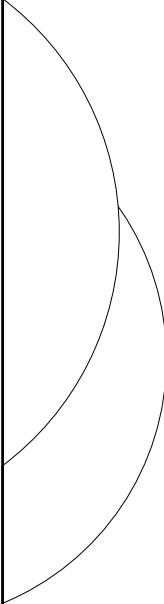
United Behavioral Health

presents

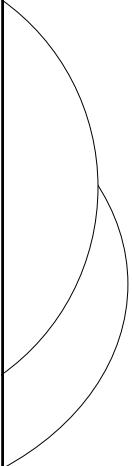
Strategic Treatment of Depression

Faculty: Michael D. Yapko, Ph.D.

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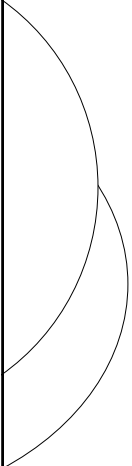


I will be touching on the key points to consider in treatment, but I have provided many more slides than I can possibly cover in an hour in order to let you know about some of the key concepts and important studies to inform your practice



A World Health Organization (WHO) Prediction

- Depression is currently the **FOURTH** most significant cause of suffering and disability worldwide (behind heart disease, cancer and traffic accidents) and, sadly,
- It will be the **SECOND** most debilitating human condition by the year 2020



New Recommendations for Depression Screening

- The U.S. Preventive Services Task Force (USPSTF) finds “good evidence that screening for depression in primary care practices can improve clinical outcomes in adult patients.”
- The method of depression screening can range from structured written questionnaires to simply asking two questions: one about mood and one about anhedonia.

*USPSTF, Annals of Internal Medicine, May 21, 2002, 136: 760-764
Or visit: www.ahrq.gov/clinic/3rduspstf/depression*



Assessment Tools

- ***Client-rated:*** Beck Depression Inventory (BDI), Zung Depression Scale, Center for Epidemiological Studies Depression Scale (CES-D), Cognitions-Checklist-Depression (CCL-D)
- ***Clinician-Rated:*** Hamilton Rating Scale for Depression (HRSD)



Forms Of Depression

- Major depressive disorder (MDD); unipolar
- Dysthymia
- Manic-depression, depressed phase; bipolar
- Seasonal Affective Disorder (SAD)

The focus of this workshop is Major Depression, by far the most common mood disorder in the U.S. - and the rest of the world.



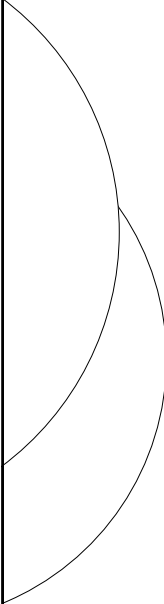
Is Depression Caused By:

- ❖ Genetics?
- ❖ A biochemical imbalance?
- ❖ Psychosocial stressors?
- ❖ Cognitive distortions ?
- ❖ A lack of environmental and social rewards?
- ❖ Social inequities?
- ❖ Cultural/familial influences?
- ❖ Mishandling key vulnerable situations?



The Biopsychosocial Model Of Depression

- Depression has a **biological** component (genes and biochemistry, diseases, drugs)
- Depression has a **psychological** component (cognitive distortions, history)
- Depression exists in a **social** context (social disturbances, distress, cultural influences)

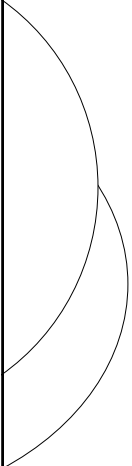


My focus here is on the *non-biological* treatment of depression in order to acknowledge a large and still growing problem that is about much, much more than just “bad chemistry”



Reasonable Conclusions About Genes and Depression

- Complex experiences like depression are almost invariably a product of genes **and** environment, and not either factor alone.
- Genetic influences can account for anywhere from as little as 11% to as much as 50% of the variance in depression; significant, but not overwhelming
- The genetic evidence has been **at least** as powerful in pointing to environmental influences on depression as it has genetic influences



Reasonable Conclusions About Genes and Depression (continued)

- It is as inaccurate to state that depression is *not* heritable as to say that it is.
- Any genetic influences will operate through specific personality, psychological and cognitive features, not a global entity called depression
- A gene-environment correlation means variations in genetic expressions are systematically associated with varying environmental circumstances



Suicide Risk Factor Assessment

- Top predictors: Hopelessness, impulsivity
- Age/gender (e.g., males over 50)
- Symptoms (mild or severe)
- Life stressors (work, home)
- Acute vs. chronic (sudden onset is worse)
- Suicidal plan (clarity, lethality)
- Co-morbid mental conditions



Strongest Predictors of Suicidal Behavior in One Recent Study

- History of a previous suicide attempt
- Higher subjective rating of depressive symptoms (Hamilton, Beck scales)
- History of cigarette smoking
- Pessimism
- Fewer perceived reasons for living
- Aggressive and impulsive acts (measured by *Brown-Goodwin Aggression Scale* and *Barratt Impulsivity Scale*)

Oquendo, Galfavly & Russo, *American J of Psychiatry*,
2004(August); 161(8): 1433-1441



Talking About Suicide

- Ask directly about suicidal thoughts; asking does not promote the idea
- Speak matter-of-factly about suicide; No need to be apologetic for asking



Managing Suicide Risk

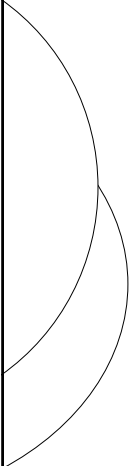
Therapists have an ethical obligation to plan specific interventions to prevent clients from committing suicide, including:

- ❖ Assess acuteness of risk
- ❖ Discuss a waiver of confidentiality for suicide risk
- ❖ Develop an emergency plan
- ❖ Establish procedures for hospitalization
- ❖ Utilize other interventions (e.g., contract)
- ❖ Remove potential instruments of suicide
- ❖ Make use of antidepressants if needed



Depression is Often Co-Morbid With:

- Anxiety Disorders
- Substance-Related Disorders (especially alcoholism)
- Anorexia and Bulimia
- Personality Disorders
- Medical Conditions



Anxiety as a Risk Factor for Depression

Depending on the type of primary anxiety disorder, the risk for onset of secondary depression is increased 2-4x above the risk expected for subjects with no previous history of anxiety disorders. The ***number of anxiety disorders present***, the persistence of ***anxious avoidance behavior***, and the ***degree of psychosocial impairment*** are strongest factors associated with depression onset.

Wittchen et. Al, *Acta Psychiatrica Scandinavica*, 102(406), 2000



The Cognitive Cornerstones of Depression and Anxiety Co-Morbidity

Negative thoughts involving an:

Overestimation of danger, threat and fear and an

Underestimation of one's abilities to cope with threats

This is true both for adults and children

Bogels & Zigterman, *J of Abnormal Child Psychology*, 28(2), 2000

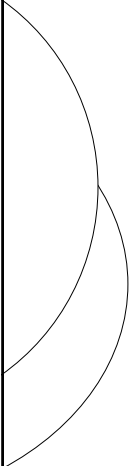


Differences in Somatic Symptomatology

Depressed patients have more conspicuous vegetative symptoms, such as anorexia, weight loss and diminished libido

Anxious patients have symptoms more closely associated with sympathetic nervous over-activity, such as tachycardia, sweating, and symptoms induced by hyperventilation.

Maser et al., in *Handbook of Depression*, 1995



Somatic Complaints and Depressive Comorbidity

- Somatic symptoms are the predominant reason why depressed patients typically initially present in primary care
- Unexplained or multiple somatic symptoms are strongly associated with coexisting depression
- Other predictors include: recent stress, lower self-rated health and higher somatic symptom severity, high healthcare utilization, difficult patient encounters (physician rated), and chronic medical disorders

Kroenke, K. (2003). *International Journal of Methods of Psychiatric Research*; 12(1): 34-43.

Overview: Depression and Medical Comorbidity Issues

- Patients with chronic medical illness have a high prevalence of MDD
- MDD may decrease the ability to habituate to the aversive symptoms of medical illness, such as pain
- MDD is associated with an approximately 50% increase in medical costs of chronic medical illness, even after controlling for severity of physical illness

Katon, W. (2003). *Biological Psychiatry*; 54(3):216-226.

Overview: Depression and Medical Comorbidity Issues

- Depressive symptoms and MDD are associated with increased morbidity and mortality from such illnesses as diabetes and heart disease
- The adverse effect of MDD on health habits, such as smoking, poor diet, over-eating, sedentary lifestyle, and poor adherence to medical regimens, as well as direct adverse physiologic effects, may explain the increased rate of morbidity and mortality

Katon,W. (2003). *Biological Psychiatry*; 54(3):216-226



Four Primary Factors to Consider in Determining a Primary Diagnosis

- Predominant mood
- Sleep pattern
- Psychomotor change
- Response to exercise

Clayton, *J of Clinical Psychiatry*, (Suppl.11),1990



Overlap Symptoms of Depression or Anxiety

- Dysphoria
- Sleep disturbance
- Appetite disturbance
- Impaired concentration
- Fatigue
- Irritability
- Non-specific somatic complaints

Clayton, *J of Clinical Psychiatry*, (Suppl.11),1990



When the Anxiety Disorder is Primary

- Anxious mood
- Initial insomnia
- No psychomotor change
- No significant therapeutic response to exercise

Clayton, *J of Clinical Psychiatry*, (Suppl.11),1990



When the Depression is Primary

- Depressed mood
- Terminal insomnia
- Psychomotor agitation or retardation
- Positive response to exercise

Clayton, *J of Clinical Psychiatry*, (Suppl.11), 1990



Sleep Disturbances

- More than 90% of patients in major depressive episodes report sleep difficulties, making it the single most frequent complaint of depressed patients.
- Depressive sleep is shortened, shallow, fragmented, and REM sleep is altered, based on subjective reports and empirically confirmed with polysomnographic (PSG) studies.

Szuba et al., *Depression and Anxiety*, December, 2000



Pre-Sleep Cognitive Activity and Insomnia

Cognitive arousal, dysfunctional cognition, and fear of insufficient sleep are sleep-inhibiting factors. In self-report, insomniacs were 10 times more likely to cite cognitive arousal as central to their sleep difficulties, compared with somatic arousal. The need to aim for minimal cognitive processing, drive, effort and affective load are treatment goals.

Harvey, *British J of Clinical Psychology*, 39, 2000



Sleep Disturbances Have Serious Clinical Implications

Sleep disturbances can:

- disrupt the timing of neurotransmitter and neuroendocrine release
- exacerbate a negative mood
- bring about a poor performance
- disrupt social schedules that regulate biological rhythms

Thase, *J of Clinical Psychiatry*, (Suppl.11), 2000



Sleep Disturbance Increases Risk for Alcohol-Related Problems

Using prospective data from the ECA program, researchers assessed the risk of alcohol-related problems among individuals with self-reported sleep disturbances because of worry. Survey respondents who reported sleep disturbances, more than 12 years later, had twice as high a rate of alcohol-related problems.

Crum et al., *Am J of Psychiatry*, July, 2004, 161(7):1197-1203

CBT vs. Ambien

- 63 young and middle-aged adults with chronic sleep-onset insomnia (one hour or more) received CBT, Ambien, combination therapy, or placebo. Primary outcome measure was sleep-onset latency based on sleep diaries and secondary measure was sleep efficiency (amount of time spent asleep divided by the total time allotted for sleep).
- CBT resulted in the greatest number of normal sleepers after treatment as measured by subjective and objective sleep-onset latency of 30 minutes or less. CBT maintained therapeutic gains at long-term (one year) follow-up.
- Combined treatment offered no advantage over CBT alone.



CBT vs. Ambien for Sleep: CBT Should Be First- Line Approach

“Our results suggest Cognitive-behavior therapy (CBT) should now be considered the first line of treatment for (sleep onset) insomnia...Sleeping pills are the most frequent treatment for insomnia, yet CBT techniques clearly were more successful in helping the majority of study participants become normal sleepers”

Study lead author Gregg Jacobs, Ph.D.
Beth Israel Deaconess Medical Center,
Boston, MA



Therapeutic Technique ***Does*** Matter

"...recent data indicate that psychological treatments require considerable clinical expertise and a strong therapeutic relationship to maximize efficacy...specific strategies that experienced therapists choose to undertake when confronted with a variety of different patient styles contribute to the determination of outcome."

Barlow, D. *American Psychologist*, December, 2004, p.874



Therapeutic Technique ***Does*** Matter

“... expert therapists confronted with patients with low motivation who then became more nondirective were associated with better results than therapists who remained directive, a finding that echoes previous results on patient-treatment matching.”

Barlow, D. *American Psychologist*, December, 2004, p.874



Distinguishing Content From Process

The client presents a story, including a description of symptoms. This represents ***what*** has happened or is happening—the *content* (issues). The therapist's task is to identify ***how*** the client generates symptomatic experience—the *process* (patterns). Treating only the content of a problem is a reliable path to relapse.



Issues vs. Patterns

- Breakdown of family
- Technology
- Nuclear destruction
- Self-fulfillment
- Geo mobility
- Television
- Helplessness
- Low frustration tol.
- Hopelessness
- Personalization
- Less social skill
- Global thinking



Key Patterns On Which To Focus

- Cognitive Style
- Attributional Style
- Relational Style
- Coping Style
- Problem-Solving Capabilities
- Temporal Orientation
- Discrimination Skills



Learning to Think Strategically

- What are the goals in concrete terms? What is the order of priority?
- What specific resources (abilities) will the client need in order to accomplish the goals? Can you identify them and create a learnable linear sequence for applying them?
- Does the client already have these resources and they are in some way dissociated? Or, does the client need to be trained to develop the requisite resources?
- How will contextualization be accomplished? Through hypnosis? Task assignments?



Goals of Therapy

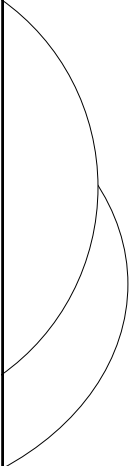
- ✓ Establish a collaborative relationship
- ✓ Pattern interruption, pattern building
- ✓ Symptom reduction, symptom elimination
- ✓ Deficit reduction, deficit elimination
- ✓ Risk factor reduction, elimination
- ✓ Generative change



Global Thinking *in the Symptom*
Context Virtually Precludes the Ability

to:

- Compartmentalize (contain anxiety)
- Think linearly, sequentially
- Maintain good boundaries
- Make key discriminations



Ambiguity is a Risk Factor

- People strive to understand and make “meaning”
- Ambiguity raises, while certainty lowers, anxiety; projection as a coping device
- Cognitive distortions represent efforts to reduce, eliminate ambiguity
- A therapeutic goal is to learn to both RECOGNIZE and TOLERATE ambiguity



Attributional Style Affects Your:

- Mood
- Health
- Productivity
- Sociability/Likeability

The consequences for adopting the arbitrary life perspective one holds are ***not*** equivalent in people



Attributional Style

- Purpose: To identify the client's characteristic patterns for self-explaining the events of life
- Describe the event in objective terms ("Here's what happened.")
- State perceptions of the major cause of the event ("I think it happened this way because...")



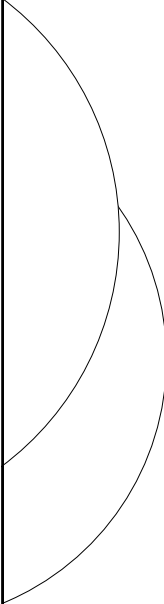
Attributional Style Patterns to Identify

- ❖ Internal or external ("It's me/ It's them.")
- ❖ Stable or unstable ("It will always be this way/ It will change.")
- ❖ Global or specific ("It affects everything/ It affects only this.")



Stable Style Predicts Whether the Client Will be Prone to :

- ❖ seek treatment
- ❖ progress quickly or slowly
- ❖ actively participate in treatment
- ❖ experience a partial or complete recovery
- ❖ relapse



The first task in treatment is to shift the person from a stable to unstable attributional style

Co-create Vision of What is Possible:
Realistic Hopefulness is Crucial!



Expectancy and Treatment Effects

“Patients pretreatment expectations of therapeutic effectiveness predicted their active engagement in therapy, which then led to greater involvement across cognitive therapy, IPT and ADM... patients’ expectancies after some experience of therapy may be an even stronger predictor of outcome.”

Scott & Watkins, Current Opinions in Psychiatry, 17(1): 3-7, 2004
www.medscape.com/viewarticle/466373



EEG Predictions of ADM Treatment Response

- Just this past August (2006), a study published reported findings from the UCLA Neuropsychiatric Institute regarding the relationship between EEG changes and clinical outcome on patients taking Effexor and Prozac
- Findings: Changes in prefrontal EEG patterns *during a placebo lead-in phase*, often conducted before randomization to drug treatment in clinical trials, predict response to ADM treatment in MDD patients

Hunter et al., *American Journal of Psychiatry*,
August, 2006; 163(8): 1426-1432



EEG Predictions of ADM Treatment Response

- Decreases in prefrontal cordance were associated with lower final depression scores, and medication responders differed significantly from medication non-responders
- The authors stated: "Brain changes during the placebo lead-in phase may confound apparent medication effects associated with clinical outcomes in medication-treated subjects."

Hunter et al., *American Journal of Psychiatry*,
August, 2006; 163(8): 1426-1432



Key Point: Expectancy Influences Treatment and EEG Response

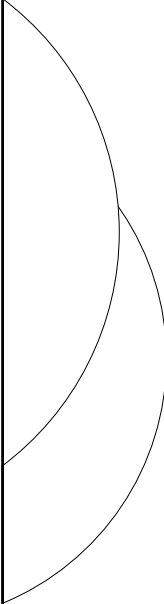
- The authors state: “**Some neurophysiological changes that are associated with endpoint antidepressant outcome reflect non-pharmacodynamic factors**”
- “Future studies should examine how brain changes during the lead-in period may be associated with **patient expectations**, the therapeutic relationship, and treatment history.”

Hunter et al., *American Journal of Psychiatry*,
August, 2006; 163(8): 1426-1432



What Specifically Do ***You*** Do To Build
Positive Expectancy?

How do you congruently communicate the
idea that things can change?



**It is the future, not the past, that
determines the present; the
prophecy of the event leads to the
event of the prophecy**

Paul Watzlawick



Is Antidepressant Efficacy Overblown?

“Published medical evidence fails to support a clinically meaningful benefit of antidepressant therapy...selective presentation of data from drug trials explain the benefits that are claimed.”

Moncrieff & Kirsch, July 16 (2005), *British Medical Journal*, 331, 155-157.



No Amount of Medication Can Change Your:

- Coping style
- Explanatory style
- Relationship style
- Cognitive style
- Problem-solving skills
- Support network
- History



Exercise as an Antidepressant

- Physical exercise has been shown to be nearly as effective as therapy; results show after only 5 weeks of 3x/week aerobic exercise, 20-60 minutes
- Empowerment (self-efficacy)
- Action orientation; non-ruminative,
- Goal orientation, positively reinforcing

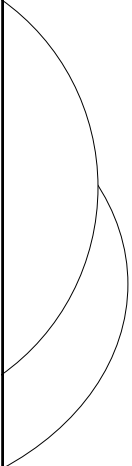
Tkachuk&Martin,6/99,Prof.Psych:R&P



Exercise and Depression

"...significant improvements can be achieved with clinically depressed individuals, with as little as 5 weeks of thrice weekly supervised sessions of aerobic (walk or run) or non-aerobic exercise activity of low to moderate intensity (50% of maximum heart rate) lasting from 20-60 minutes in duration..."

Tkachuk & Martin, *Prof Psych: Res & Practice*, June '99



Cognitive Therapy vs. Other Therapies for Depression

A recent (2002) meta-analysis suggests CT is no more effective than other brief therapies. It seems the most important factors in day to day practice are not the specific model of brief therapy, but the competent delivery of the treatment and general aspects of the therapy process (e.g., alliance)

Wampold et.al, *J of Affective Disorders*, 68: 159-165

Family Environment and Perceptions of Control

“A family environment characterized by limited opportunity for personal control is associated with the development of anxiety and depression. Environment fosters a cognitive template, with early experience contributing to the formation of a vulnerability.”

Barlow, *American Psychologist*, Nov., 2000



Extreme Perceptions Regarding Controllability

- ***Learned Helplessness:*** Learned expectations that one's efforts will have *no* effect on the outcome
- ***Illusion of control:*** Learned expectations that one's efforts are the *sole* determinant of the outcome



Depressed Individuals Tend to
Underestimate Their Personal Power...

Thus, passivity seems like a reasonable
response



Coping Styles

- Approach (direct) problem-solving
- Avoidant coping
- Ruminative coping

Avoidance and rumination are highly correlated with depression



Does Rumination Predict Depression?

Ruminative responses to depressive symptoms predict:

- ❖ higher levels of depressive symptoms over time (after accounting for baseline levels)
- ❖ depressive disorders, including new onsets
- ❖ chronicity of depressive disorders
- ❖ anxiety symptoms

Nolen-Hoeksema, *J of Abnormal Psychology*, March, 2000



Rumination Effects

Rumination leads to:

- More negative, biased interpretations of events
- Greater recall of negative autobiographical memories and events
- Impaired problem-solving
- Reduced willingness to participate in pleasant activities

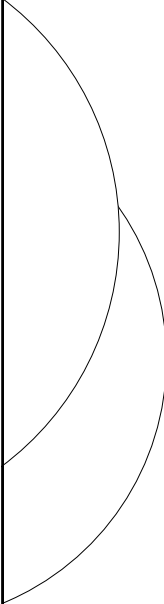
Spasojevic & Alloy, *Emotion*, March, 2001, p.33



Rumination Impairs Problem Solving

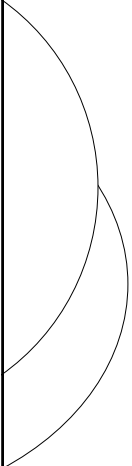
“Even when a person prone to rumination comes up with a potential solution to a significant problem, the rumination itself may induce a level of uncertainty and immobilization that makes it hard for them to move forward.”

Nolen-Hoeksema, *Monitor on Psychology*, Nov., 2005, 36(10), p.38



Socrates said, "The unexamined life isn't worth living."

Given the detriments of rumination, neither is the **over**-examined life.



Action Oriented vs. Ruminative Coping Styles

It is no coincidence that the therapies with the greatest empirical support all emphasize **ACTION** in treatment; clients may *feel* better in merely supportive therapy, but they will *do* better in treatment with direction.



Assigning Homework (HW)

Premise: HW has positive causal effects on changes in MD.

HW provides opportunities to practice skills learned in session and can lead to generalization of skills outside of sessions.



Assigning Homework (HW)

Affirmed: Patients who did the most HW improved much more than patients who did little or no HW.

Depression severity did not appear to influence HW compliance.

Burns & Spangler, *J Consulting & Clin. Psych*, Jan., 2000



Depression and Stressful Life Events as Reciprocal

- Negative life events precipitate the onset of major depressive episodes (see Mazure, Clinical Psychology: Science and Practice, 1998)
- A growing body of evidence shows the reverse causal relationship: Depression generates stressful life events.
- Individuals with co-morbid anxiety and dysthymia experience higher rates of events that were at least partly dependent on their own behavior.



Stress Generation Patterns

- The presence of depression and/or anxiety seriously compromises these individuals' stress coping resources. Minor aggravations become major problems.
- Poor problem solving skills lead to poor choices, which aggravate negative circumstances.

Hammen, Journal of Abnormal Psychology, 1991
Harkness & Luther, Journal of Abnormal Psychology, 2001



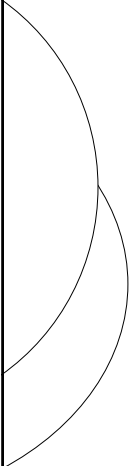
Depression and Undermining the Self

Depressed people persistently behave and think in ways that undermine their well-being: Inappropriate social behavior invites rejection, and positive feedback is rejected or “twisted ” to fit one’s negative self-image



Focal Points in Treatment

- ❖ Direction vs. Support
- ❖ Ability vs. Motivation
- ❖ Process vs. Content
- ❖ Future vs. Past/Present oriented
- ❖ Individualized vs. Standardized
- ❖ Amplifying strengths vs. Diminishing weaknesses



Symptom Characteristics *Is the problem:*

- internal or external?
- intrapersonal or interpersonal?
- past, present or future oriented?
- over or under compartmentalized?
- associative or dissociative?
- temporary or permanent?
- context-specific or generalized?

Intervention Characteristics

- Outcome Oriented
- Active interventions
- Future-oriented
- Change-oriented
- Specific targets
- Experiential
- Individualized approaches



A Key Report on Women's' Depression

*Summit on Women and Depression:
Proceedings and Recommendations*

Published in 2002 by the American Psychological Assn., it reflects the research of 35 internationally renowned experts from a variety of disciplines.

Copies are available online. Go to:
www.apa.org/pi/wpo/women&depression.pdf

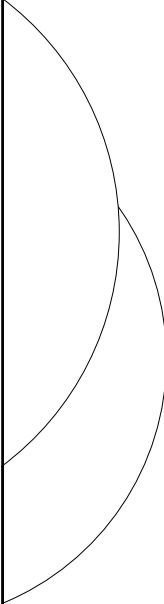


NIMH Strives to Raise Awareness of Men's Depression

The goal is to reduce the stigma of men seeking help for depression. The website encourages men to seek help, explains treatment options, and encourages families and friends to provide support.

<http://menanddepression.nimh.nih.gov>

Or toll free (866) 227-6464



The quality of your relationships is a significant predictor of your risk for depression

What about social skills training as a preventive opportunity?

Depression's Social Effects...Depressives Have:

- ❖ fewer social skills
- ❖ fewer close relationships
- ❖ less elaborate social networks
- ❖ less rewarding relationships
- ❖ fewer social contacts
- ❖ less social support
- ❖ more marital problems
- ❖ more family arguments
- ❖ more pessimism about the future of their relationships

Keltner & Kring, Review of General Psychology, 9/98

Shyness, Loneliness and Depression are Related

- Shyness/Depression .30
- Loneliness/Depression .42
- All are associated with higher levels of anxiety, poor social networks, high attendance to negative feedback and high self-focus

SHYNESS AND LONELINESS HAVE PREDICTIVE VALUE FOR DEPRESSION

(Dill & Anderson, *The Interactional Nature of Depression*, 1999)



Interpersonal Patterns That Maintain Depression

- **Negative feedback seeking** (seeking out information that confirms their already low self-concepts)
- **Excessive reassurance seeking** (desiring and repeatedly asking for reassurances as to their worth while rejecting positive input)
- **Interpersonal conflict avoidance**



Maladaptive Mate Selection

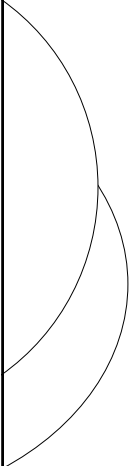
- ❖ The choice of a mate is a strong determinant of stress level and overall family adjustment
- ❖ Poor self-concept and perceived limited choices
- ❖ Similarity and familiarity with “damaged” partners
- ❖ Family “re-enactment”
- ❖ Complementarily in seeking “excitement”

(Hammen, *The Interactional Nature of Depression*, 1999)

Marriage and Depression

- Are marital discord and depression clinically linked?
- Do poor marriages predict increased vulnerability?
- Does marital discord predict later depression?
- Does marital discord “cause” depression and vice-versa?
- Can marital therapy relieve depression?

THE ANSWER IS “YES” TO ALL!



Depression as a Family Issue

“When an adult is depressed, it is likely to signal that the spouse and children are involved, either as contributors to the current distress or as unwitting targets of the consequences of the mood disorder and its underlying causes. Thus, to break the cycle of intergenerational transmission of depression, it is often necessary to treat the entire family, or at least to evaluate the children’s own mental health and functioning, and to educate the affected parents about the potential effects of their disorders on their children.”

Hammen, Children of Depressed Parents, 2002 p. 193



Goals in Family Therapy for Depression

- Provide legitimate avenues of depersonalization (enhanced individual boundaries)
- Create a context conducive for recovery (empathetic, supportive, goal-oriented)
- Identify coping, communication, problem-solving skills to develop
- Provide perspective, information
- Diversify the support system



Depression Intensifies From One Generation to the Next

The first such study following *3 generations of high-risk families* and has taken more than 2 decades to complete showed most of the prepubescent grandchildren with a 2 generation history of depression developed anxiety disorders that developed into depression as they aged into adolescence.

Weissman et al., *Archives of General Psychiatry*, January, 2005



Length of Post-partum Depression and Infant Recovery

"...mothers who were depressed during the first few months of their infants' life but were no longer depressed by 6 months had infants whose development was normal at 1 year. In contrast, mothers who remained depressed over the infants first 6 months of life had infants who developed a depressed style of interacting and later at 1 year showed inferior mental and motor development performance and were at lower growth percentiles..."

Field, in Children of Depressed Parents, 2002 pp 75-6



Parents' Mood vs. Parents' Skill

"...depressed mothers receiving treatment often reported improved mood even though their interactions with their infants remained significantly less positive than those of non-depressed controls. Therefore, intervention strategies should include both symptom relief, through medication or psychotherapy, and specific help with the stresses and problems of parenting."

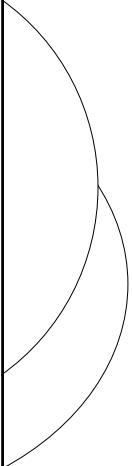
Lyon-Ruth et.al. Children of Depressed Parents, 20002 p.112



Essential Skills for Children of Depressed Parents

- Teach children they are not responsible for and cannot control the stressors associated with their parents' depression
- Teach children to understand and accept their parents' depression
- Teach them to cognitively reframe these problems
- Teach how to maintain a positive mental attitude
- Teach them how to distract themselves through pleasant activities

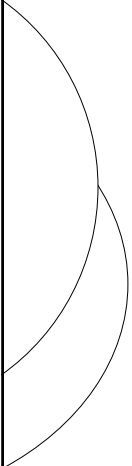
Compas et.al., Children of Depressed Parents,
2002 p. 244



The Risks to Children of Depressed Parents

- The risks seem to be greatest when parental depression is accompanied by personality disorder
- The risks are at least as high when the parent has a unipolar depressive disorder as when he or she has a bipolar affective disorder
- The risk for conduct disorders, anxiety disorders and substance abuse disorders, not just depression, increases at the same rate as depressive disorder when a parent is depressed.

Silbert & Rutter, in Children of Depressed Parents, 2002



Concerns About the Functioning of Children of Depressed Parents

- Depression is heritable
- Infants of mothers depressed during pregnancy exposed to neuroendocrine abnormalities, reduced blood flow to the fetus, poor health behaviors
- Symptoms of depression are inconsistent with or even preclude good parenting
- Lives of children with depressed parents may be more stressful

Gotlib & Goodman, in Children of Depressed Parents, 2002



Mother-Infant Interactions and Neurological Risks

“Severe neglect, neglectful and/or emotionless parenting appears to have specific and long lasting biochemical and behavioral consequences...Early exposure to stressful stimuli in the environment can impact the monoaminergic neurotransmitter systems, the structural development of the brain, and alter gene expression.”

Konyecsni & Rogeness, Sem in Clin Neuropsychiatry, Oct., '98



Instruments for Assessing Depression in Children

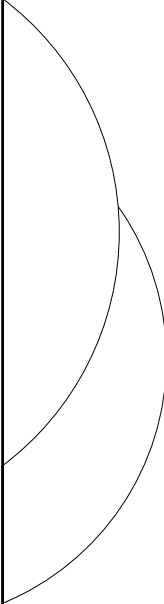
- Child Assessment Schedule Ages 7-18
- Child Behavior Checklist Ages 4-18
- Children's Depression Inventory Ages 8-17
- Children's Depression Scale Ages 9-16
- Children's Depression Adjective Checklist Ages 8-12
- Children's Depression Rating Scale – Revised Ages 6-12



7 General Strategies for Empowering Children

TEACH:

- Positive self-soothing skills
- Self-hypnosis (e.g., guided imagery, visualization, calming)
- Linear (cause-effect) thinking (for extrapolation)
- How to create multiple perspectives/interpretations
- "Reality-testing"
- Critical thinking skills (making distinctions)
- Empathy



So much of human misery could be
prevented if people would just take a
moment to think ahead

But, who is teaching them to do that?



The Foundation of Prevention is the
Ability to ***Think Ahead***

Emphasize the Skill of Foresight



Seligman's Prevention Program

Two distinct parts:

1. Cognitive therapy and
2. Social problem solving using
 - Comic strips
 - Role playing
 - Games
 - Discussions
 - Videos

The Optimistic Child



Prevention: Gottman's "Emotion Coaching"

1. Become aware of the child's emotion
2. Recognize the emotion as an opportunity for intimacy and teaching
3. Listen empathetically, validating the child's feelings
4. Help the child find words to label the emotion he is having
5. Set limits while exploring strategies to solve the problem at hand

John Gottman *Raising an Emotionally Intelligent Child*



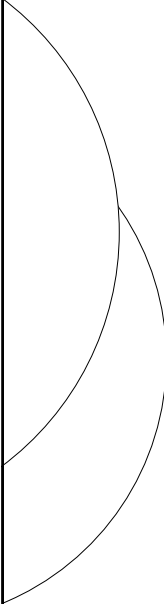
Ideal Intervention Characteristics for Addressing Depression

- Outcome Oriented
- Active interventions
- Future-oriented
- Change-oriented
- Specific targets
- Experiential
- Individualized approaches



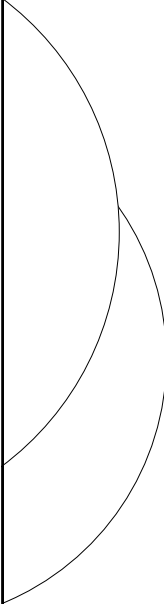
HIGHLY RECOMMENDED SELF-HELP RESOURCES

- Breaking the Patterns of Depression(Yapko)
- Hand-Me-Down Blues (Yapko)
- Focusing on Feeling Good CD Program (Yapko)
- Learned Optimism (Seligman)
- Emotional Intelligence (Goleman)
- The Optimistic Child (Seligman)
- Feeling Good (Burns)
- Mind Over Mood (Greenberger/Padesky)



The means by which we live have outdistanced the ends for which we live. Our scientific power has outrun our spiritual power. We have guided missiles and misguided men.

Martin Luther King, Jr.



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