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The Disease of Our Time "Depression": The Causes, Treatments and Influences on Children and Adolescents[a]

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Abstract

As a common research agenda, depression is a mental disorder that affects all age groups and has serious negative impacts on the individual's life. Depressed children tend to seem compliant, quiet, and calm, so childhood depression can only be recognized and treated when they show certain behaviors such as school absenteeism or tantrum. Depressed children and adolescents cannot think clearly, so they cannot make healthy decisions in their family and school life and peer relationships, negatively affecting their academic and social life. In this respect, it is critical for children and adolescents prone to depression and less coping skills to seek help for their mental health and social well-being. This research aimed to raise awareness on this issue and to provide a resource to field experts and families by breaking down the prejudices that depression is only seen in adults. Therefore, this research would contribute to the relevant literature.

Keywords

Depression
Depression in Children
Depression in Adolescent
Intervention

About Article

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Zamanımızın Rahatsızlığı "Depresyon": Nedenleri, Tedavi Yöntemleri, Çocuklara ve Ergenler Üzerindeki Etkileri

Özet

Depresyon, bireyin yaşamı üzerinde ciddi olumsuz etkileri olan, her yaş grubunu etkileyen araştırma konusu olmuş ruhsal bir bozukluktur. Çocuklar depresyon yaşarken aslında uyumlu, sessiz ve sakin göründükleri için ancak okuldan kaçma, öfke krizi geçirme v.s. durumlarında fark edilebilmekte ve bunun sonucu yardım alabilmektedirler. Genetik yatkınlığın yanı sıra yaşanan stresli olaylar depresyonun en önemli belirleyicilerindendir. Depresyon yaşayan çocuk ve ergenler sağlıklı düşünememekte dolayısı ile aile, arkadaş ve okul yaşamında sağlıklı kararlar verememektedir. Bu durum onların hem akademik hem sosyal hayatını oldukça olumsuz etkilemektedir. Bu açılardan depresyona girmeye meyilli, olumsuz yaşam olaylarıyla baş edebilme becerisi düşük olan çocuk ve ergenlerin yardım alması kendilerinin ve toplumun mental sağlığı ve refahı açısında oldukça kritiktir. Bu çalışma ile depresyonun sadece yetişkinlikte oluşabileceği yargısını kırarak bu konuda farkındalık oluşturup, alan uzmanları ve ailelere bir kaynak sunmak amaçlanmıştır. Bu amaçla bu çalışmanın alandaki bu boşluğu doldurması düşünülmüştür.

Anahtar Kelimeler

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Introduction

Depression

Depression is a mental health problem that can be observed from infancy onwards. It shows different symptoms in different age groups. Although there are many similar features between adult and child depression, depressive symptoms in children vary by age (Weissman et al., 1980). Some symptoms of adult depression differ from those in children. For example, while slow speech, lack of eye contact, and thought disorders are common in adults, school refusal is a prominent symptom of child depression (Kashani et al., 1981). Teri (1982) underlined three leading differences between adolescent depression and adult depression. Accordingly, (a) Body image (low body satisfaction, feeling ugly and unconfident, dissatisfaction with the past, and bodily changes) plays a more critical role in adolescent depression than adult depression. (b) While there is a positive correlation between adolescent depression and assertiveness, a negative correlation is observed in adults. (c) While family and peer relationships are of great importance for adult depression, they do not play a central role in adolescent depression. In brief, although depression may show similar symptoms in infants, adolescents and adults, there are still differences.

Depression adversely impacts adolescents' emotional development and especially academic achievement. Children and adolescents suffer from depression just like adults (Schacter ve Romano, 1993). Children generally do not show depressed moods; instead, they are likely to express their depression through various behavioral outcomes such as arguing with peers and adults, low academic achievement, aggression, and truancy (Albrecht & Herrick, 2006).

Adolescence is characterized by *change*. During adolescence, adolescents undergo various exciting and positive changes, while some can be pretty negative and lead to undesirable results (Shapiro,1994). Negative changes also play a very critical role in the onset of depression. It is estimated that the prevalence of children depression in early adolescence (about 12-year-olds) is relatively low, ranging from 1% to 3% (Kessler et al., 2001). In late adolescence (especially around 18-year-olds), the prevalence rate is very high, around 20% (Ingram, 2009). Most research on childhood depression has focused on the school-age population, in which children who can express themselves verbally may exhibit depressive behaviors similar to adult depression (Schachter & Romano, 1993). The most noticeable symptom in those children is the decline in school achievement. It is also characterized by specific behaviors such as truancy, aggressiveness, and lying (Kayaalp, 1999). Although decreased school performance and the lack of interest and pleasure in daily activities are typical in children depression, aggression is more common in children depression than adult depression (Denko & Friedman, 2014).

The symptoms of adolescent depression are pretty similar to those in adulthood (Schachter & Romano, 1993). It is necessary to be cautious and attentive about the depression symptoms in adolescence so as not to confuse them with adolescent characteristics. Shapiro (1994) suggested providing treatment for those who experience particular symptoms for at least two weeks, such as a decline in academic performance, attention problems, frustration, depressed and unhappy mood, lack of interest in daily activities, fatigue, and thoughts of death. Shapiro (1994) also stated that adolescents do not tend to share their feelings with their families, that peers and friends are very important in this period, and emphasized that adolescence may trigger depression as well.

Adolescence depression is highly likely to recur. After recovery, a different major depressive disorder (MDD) can be seen in 40% of adolescents within 2-5 years. Despite a high remission rate (a decline or halt in symptoms), there is still a risk of recurrence, and 40% of adolescents have another MDD within 2-5 years after recovery (Rao et al., 1999).

Table 1. Comparison of the Depression Symptoms in Childhood, Adolescent and Adulthood

Childhood	Adolescent	Adulthood
- Constant unhappiness and complaints - Breaking the rules - Frequent disappointment crying spells, insecurity, and hypersensitivity - Distraction, inability to remember, indecision and racing thoughts - Eating and sleeping problems - Bedwetting, constipation, diarrhea - Chronic sadness and fear - Excessive self-focus - Slowness in speech and movements - Pain in various parts of the body, nail-biting - Suicidal ideation and attempts	- Somatic pains, muscle tension, digestive disorders - Sadness, uneasiness, and anxiety - Unrestrained anger - Lack of self-confidence, excessive self-criticism, and guilt	- Concentration and thought disorder, indecision and memory failures - Slow, restless speech and movements - Anhedonia - Fatigue, exhaustion, and irritability - Change in eating habits, excessive weight loss or excessive weight gain - Excessive concern with weapons and death themes in literature, music, and paintings, the excessive mention of death - Suicidal ideation and attempts

Note. From *depression in children* (p. 31) by J. A. Miller, 1998, Özgür Publications.

Approximately 20% of young adults have depression until they are 18. Kessler et al. (2001) reported that the prevalence rate of depression increases significantly (4.7%) in adolescence than in the preschool period. According to a comprehensive study, depression symptoms that begin at about 13 increase markedly during adolescence (Hankin et al., 1998). Research also suggests an abrupt increase in female depression during adolescence stems from increased estrogen levels (Hulvershorn & Leibenluft, 2015). A recent extensive study has shown that delays in developmental milestones are significantly correlated with developing depression and anxiety symptoms in adolescence (North et al., 2013). Accordingly, it can be understood that early diagnosis and intervention for adolescent depression are vital for both a healthy transition to adulthood and a low depression recurrence rate in adulthood.

Causes of Depression

The main problem in mood disorders is related to affectivity. However, many factors cause depression. According to Efilti (2016), abrupt emotional changes and biological factors are the primary causes. Similarly, Tan (2008) divided the causes of depression into two: biological and psychological causes. Cowan (2013) listed genetic factors, biochemical factors, aging, sex, stress, and personality traits as the causes of depression. In this context, the causes of depression can be listed as follows:

Biological Causes

Changes in brain chemistry. The lack of serotonin, known as the happiness hormone, and dopamine and adrenaline, known as energy, motivation, and attention hormones, can lead to depression (Efilti, 2016). Like many other researchers, Blackburn (2005) underlined the biological factors as one of the causes of depression and emphasized the roles of genetics, the changes in brain chemistry, and hormones. Avşaroğlu (2016) similarly listed the biological causes: biological amines, neuroendocrine systems, genetics, structural disorders in the brain, and sleep disorders. Albrecht and Herrick (2006) reported that depression is correlated with chemical imbalances in the brain - the changes in the levels and activity of various neurotransmitters and that depression is often a genetic or hereditary disorder. Ingram (2009) similarly stressed the critical role of the changes in the brain in understanding depression, especially in adolescents, although such changes cannot be observed as easily as physical changes. According to Kandel's model (1998) which shows mind-brain interaction, the possible causes of depression originate in the brain; daily life habits and experiences affect gene expression; psychosocial factors impact the brain; altered gene expression leads to a specific behavior that triggers the abnormality, and psychotherapy provides long-term behavioral change by changing gene expression. Therefore, genetic and environmental factors are very influential in determining the cause and treatment of depression.

Genetics and family history. It has been revealed that if one of the identical twins gets depressed, the risk of the other twin getting depressed is high, with an average of about 65% (Blackburn, 2005). A relative of a person with unipolar depression has a much higher risk of becoming depressed Parental depression, especially chronic one, may affect a child's mood disorder through genetic mechanisms, cognitive distortions, or conflicts in parent-child interaction. Researchers prove the relationships between problematic mother and child relationship, child behavioral symptoms, cognitive distortions, and depression (Gotlib & Joormann, 2010; Olino et al., 2016). The treatment of maternal depression is essential as it would prevent the onset of depression and reduce the risk of depression in children (Cuijpers et al., 2015). A study in the USA revealed that parent-child interactions characterized by maltreatment or conflicts increase the risk of depression (Lewis et al., 2016). Child neglect and abuse enhance not only the risk of depression but also the possibility of comorbidity (e.g., substance abuse), chronic depression, and unresponsiveness to treatment (Infurna et al., 2016; Nanni et al., 2012). Negative attitudes also affect the risk of depression and suicidal ideation (Gonzalez et al., 2012; Moretti & Craig, 2013).

Physical diseases and drugs. In addition to alcohol and drugs that give temporary pleasure, the diseases such as epilepsy, Parkinson's, and cancer dramatically influence the quality of life, and certain drugs used in these cases play an essential role in developing depression (Tan, 2008). Diseases and the drugs used to treat them can also cause depression symptoms (Albrecht & Herrick, 2006; Hood et al., 2012). In addition to diseases related to the central nervous system, such as epilepsy, migraine, or asthma, treatments of some chronic diseases increase the risk of depression (Goodwin et al., 2014; Szigethy et al., 2011). Pediatric depression in youth is proven to be correlated with epilepsy (Kanner et al., 2012). Bilgiç et al. (2006) investigated depression and anxiety levels in children with epilepsy and supported the argument that psychiatric disorder symptoms are more common in children with epilepsy.

Psychological Causes

Learned helplessness. People who have lost hope due to adverse life events and believe they will reencounter misfortune are highly likely to develop depression. Seligman (1975) stated that a depressed person's incapability to intervene in negative life events drives them into despair, and what leads a person into depression is the belief that everything is out of control (Shapiro, 1994). Seligman (1975) emphasized the important role of learning on depression. In his studies on animals, he found that animals exposed to unavoidable shocks quit and passively experienced pain over and over again. It is observed that depressed people are also helpless and give up on finding a solution to the problem.. The sense of helplessness and hopelessness can drive them to depression. In this model, whether a person labels life events as fortune or misfortune affects their mood. If a child develops a mindset of generalizing, cruel, and accusatory, they tend to develop depression due to the failure to find solutions to problems (Miller, 1998).

Stressful and unfavorable life events. Stressful life events such as losing a loved one, separation, and failing an exam are critical determinants of depression (Blackburn, 2005). Ingram (2009) indicated that stress and adverse life events play an important role in developing depression. Kennedy et al. (1998) proved that losing a loved one and unfavorable life events are serious factors that lead to depression. Especially the loss of a parent at an early age enhances the risk of depression (Blackburn, 2005). Albrecht and Herrick (2006) similarly reported that although depression has biological origins, stressful life events trigger the onset of depression. Certain life events are considered more stressful than others. For example, divorce and the death of a spouse or an offspring are primary stressors, while marriage problems, beginning a new job, a serious disease, going to college, moving, getting married, or the birth of a child also impose stress. The accumulation of mild stressors can lead to depression as well. Losing a sibling, parent, or close friend increases the risk of depression (Brent et al., 2009; Brent et al., 1996). The risk of depression is high in the case of parental death, especially mother loss (Brent et al., 2009). In a follow-up study on more than 5000 children followed from childhood to adolescence, father loss in early childhood increased the prevalence of depressive symptoms in 14 years, there was a significant correlation between them, and it was stronger in girls than boys (Culpin et al., 2013). Similarly, depressed people have a pessimistic sense of the self, the future, and the world, and such prejudices cause the onset of depression symptoms, especially in the face of stressful life events (Carter & Garber, 2011; Gotlib & Joormann, 2010; Hankin, 2012). Moretti and Craig (2013) indicated that suicidal ideation in sexually abused individuals in early childhood increased by 146% compared to adolescents.

Consequences of Depression

The negative effects of depression, which negatively affects all areas of life, can be listed as follows:

Emotion Regulation Disorders

Depression is characterized by sadness, sorrow, and bitter feelings. Physical appearance and voice manifest themselves, and people can easily recognize the sadness and restlessness of a depressed patient. Poor life satisfaction/anhedonia and decreased interest in activities are common symptoms (Parker, 2004). In addition to suffering from chronic sadness, depressed individuals are primarily unwilling to engage in daily activities due to exhaustion. They

generally have sad facial expressions. A depressed child may seem unwilling to do things they used to enjoy or may even think they do not deserve to have fun (Miller, 1998). Blackburn (2005) stated that depressed person sometimes becomes less pessimistic during the day due to others' pressure, although sometimes they cannot leave pessimism or negativity. For instance, a friend who comes over or a pleasant event can relieve pessimism; however, it is likely to return after a while. Emotions such as frustration and anxiety are also common in depressed people.

Behavioral Disorders

The slowness of movement is a prevalent symptom of depression. Problems in self-expression can be seen with delays in motor skills and fatigue (Tan, 2008). Although depressed people often feel restless, they may lack motivation. Chronic discomfort and passive behaviors called psychomotor agitation are observed in depression as well (Miller, 1998). Depression symptoms are interrelated, and any change affects another. For example, a sad, unhappy, and restless person may behave exhaustively, sluggishly, and be indifferent to activities. It can be inferred that mood affects behavior.

Thought Disorders

Negative thoughts (e.g., pessimism, worthlessness, helplessness, the feeling of inadequacy, and the thought of death) occupy the mind. The thought patterns seen again are regret, clinging to the past, and thinking it is wrong (Efilti, 2016). Depressed people may suffer from distortion in perception. For example, a student who gets an A on the mathematics exam may think they have failed it even if they make only one mistake. Depressed individuals tend to criticize themselves. Concentration disorders, thoughts of death, and suicide can also be seen (Miller, 1998). Blackburn (2005) suggested that people with depression experience problems such as low self-esteem, guilt, worthlessness, hopelessness, and indecision. For those, reading or even talking may be a burdensome task, and they may even think to have a mental problem.

Physiological Disorders

In addition to environmental factors, biological factors are influential in physiological dysfunctions (Miller, 1998). Weight loss or gain and sleep problems (e.g., insufficient or excessive sleep) are among the most prominent depression symptoms (Blackburn, 2005; Efilti, 2016; Miller, 1998). Additionally, depressed individuals may suffer from extreme fatigue, exhaustion, bodily pain, and concentration problems. In depression, it is observed that those individuals cannot find the strength to do even the critical tasks, do not want to get out of bed, and have such extreme fatigue and exhaustion that they cannot even spare time for their loved ones (Blackburn, 2005).

Suicide

One of the consequences of depression is a suicide attempt. It is very prevalent in depressed people, and the main reason for suicide is one’s negative thoughts. It has been reported that 16 out of 100,000 people commit suicide each year in the UK, and at least 50 people attempt suicide (Blackburn, 2005). Depressed people may have unrealistic thoughts, such as being a burden to the world or having unsolvable problems, and they may want to end their lives. The emotional disorder is the most significant risk factor for suicide adult depression (Asarnow et al., 2011; Barlow, 2002; Conwell et al., 2002; Ingram, 2009) indicated that almost a quarter (24%)

of chronically depressed adolescents had a history of suicide attempts. The primary motive that drives a depressed person to commit suicide is that life is not worth living (Rihmer, 2007).

Suicide is a very high risk for depressed youth. The Centers for Disease Control and Prevention reported that 20% of high school students had seriously considered suicide, and 1 in 12 had attempted suicide in the previous year. It was also found that while boys were more likely to kill themselves than girls, girls attempted suicide more than boys. Other studies have shown that more than 90% of those who killed themselves had at least one psychiatric disorder. Mood disorders are particularly associated with an increased risk of suicide during a depressive episode. People with depression are more likely to commit suicide if they have panic attacks, insomnia, or alcohol or drug use. Those recovering from depression may also be at increased risk of suicide. It is estimated that approximately 15% of patients who need to be hospitalized for a major depressive episode are at a lifetime risk for suicide (Rothberg & Feinstein, 2014).

Academic Problems

The school environment is one of the areas that impact depressed children or adolescents. A depressed child is faced with problems such as insomnia, concentration problems, lack of motivation, anhedonia, and worthlessness. Those problems negatively affect academic performance (Efilti, 2016). Miller (1998) listed the school problems experienced by depressed children as follows: being late for school, truancy, school absenteeism, low academic expectancy, daydreaming, attention problems, and social shyness. Since children express themselves most in a school environment, problems that are not observed at home can be observed at school. Teachers must notice many of the symptoms mentioned above to inform the school administration and parents, which would considerably contribute to the diagnosis and treatment process. In this regard, teachers have critical positions. They should attempt to explore the reasons and improve the decreased academic performance with the help of school-family cooperation.

Substance Abuse

Overwhelmed and depressed children may use substances to distract their minds from problems, which may become a habit and an addiction in time. Early intervention is very important, especially in children diagnosed with depression at an early age, among whom the possibility of developing alcohol and substance use is much higher (Miller, 1998). According to the National Epidemiological Survey on Alcohol and Related Conditions, 41% of people with alcohol use disorder met the criteria for primary depression, 17% for co-depression, and 42% for secondary depression. It is reported that only 36.8 % of those who already had a mood disorder sought a non-specific treatment for a mood disorder. Interestingly, people with manic symptoms were less likely to seek help than those with major depressive episodes. It is also found that the increasing rate of health service use is correlated to severe depression and accompanying psychiatric and medical disorders (Hasin & Grant, 2015).

Social Influences

Although the cost of depression seems to only belong to the depressed person or their family, it is also a costly burden for society. Decreased workplace productivity due to inadequate personnel and frequent use of primary health care services lead to a considerable cost burden for society (Albrecht & Herrick, 2006). In research on direct and indirect depression treatment costs associated with the morbidity (prevalence rate) and mortality (death rate), the data pointed to the epidemiological estimates of the prevalence of major depression and the

number of suicides associated with secondary depression (Stoudemire et al., 1986). The research examined the number of hospitalizations, physician and mental health care providers' wages, home/nursing home costs, and medication costs. Direct and indirect costs were approximately US $26.3 billion per year. 23% of depressed patients had to stay bedridden. Patients with major depressive disorder more frequently use healthcare services than other types of patients. Depression has been more associated with impairment in occupational functioning, interpersonal relationships, and many other medical illnesses. The cost of depression, especially a lost workday, is higher than other medical illnesses (Reddy, 2010). According to Briley & Moret (2010), social dysfunctions, decreased income due to absenteeism, poor performance or unemployment, decreased productivity (Broadhead et al., 1990), and many other unfavorable outcomes for depressed people and their families accompany depression. Depression is also an important reason for separation or divorce, although it is a period when a depressed person needs social support and care.

Childhood Depression

Psychiatric disorders may play a role in preventing young adults from developing typically and fulfilling their potential. Therefore, early diagnosis and treatment are essential to eliminate the possible influences in subsequent years (Ford et al., 2003). Childhood depression was recognized as a mental disorder in the 1970s. The psychiatrists Dr. Leon Cytryn and Dr. Donald Mcknew from the National Institute of Mental Health categorized childhood depression into three: acute, chronic, and masked depression. In 1980, it was included in DSM-III (Shapiro, 1994). Although there are many discussions about infant depression in the literature, pediatricians should be cautious about depression symptoms in infants (Schachter & Romano, 1993). Children depression is much more prevalent than previously assumed (Frommer, 1967). Depression, once thought to occur in adulthood, can be seen in childhood today. Bowlby (1980) stated that infants' responses to maternal deprivation or separation are similar to adulthood depression symptoms. Many studies have proved that the loss of one parent is a leading risk for childhood depression.

Depressive disorders are seen in children of all ages, but the prevalence increases with age. Although it is difficult to diagnose a depressive disorder as "depression in older children and adults, it is well-known that even infant depression leads to negative emotional changes at an early age (Schachter & Romano, 1993). The preschool period is also characterized by various and multidimensional learning. Ossofsky (1974) observed depressed preschoolers and found that mood disorders (e.g., aggression, sadness, and excessive crying), vegetative disorders (e.g., insomnia, decreased appetite), and behavioral disorders (e.g., hyperactivity, tantrums, and indifference to games) are among depression symptoms. Depressive disorders often involve aggression, separation from family and peers, and poor academic achievement, resulting in social isolation in children and adolescents (Sadock & Sadock, 2009). Untreated depression in children may lead to negative consequences, including developmental outcomes (Shapiro, 1994). In clinical trials on children and adolescents, approximately 25% had depression (Carr, 2004), which proves the high prevalence of children depression.

Depressed children cognitively tend to have a negative perspective of themselves, others, and the world (e.g., family, friends, school) and have hostile attitudes. They also have little hope for the future (Carr, 2004). Depression affects a child's tasks, concentration, memory, effort, and patience (Huberty, 2012). It leads to indifference to lessons and a lack of motivation and concentration, which influences academic success. School is the primary setting in which the

symptoms of psychological disorders can be observed. There are some depressive symptoms that teachers can observe at school (Bauer, 1987):

Academic indicators: decreased school performance, indifference to activities, less academic effort, incapability

Emotional indicators: low self-esteem, irritability, worthlessness, guilt, separation from friends, sadness, unhappiness, undesired habits, poor socialization

Social-behavioral indicators: hyperactivity, inability to study, playing alone, over activity students, drowsiness, frustration, lying, stealing, aggressive behaviors, physical complaints, restlessness among older students, phobias, avoidance from older students

Physical symptoms: fatigue, enuresis, and encopresis in younger children, hyper excitability, retardation, sleep problems, weight loss or gain, exhaustion, and inconsistent appetite.

The long-term effects of childhood depression symptoms and their interaction with mood disorders in adolescents and adults are still controversial issues (Garber et al., 2009). As children mature cognitively, socially, and physiologically in adolescence, depressive symptoms become typical of adulthood depression symptoms. However, a critical point is how to distinguish between "normal" adolescent turmoil and psychopathology. Therefore, additional attention is given to the time, severity, and symptoms in diagnosing depression in this age group (Schachter & Romano, 1993). DSM criteria are used to diagnose depressive disorders regardless of age, from preschoolers to adolescents. Two minor developmental variations include irritability in children and adolescents, dysphoric mood symptom, and dysthymia, which last one year rather than two years. Therefore, according to DSM-IV, distinctive developmental differences in depressive disorder symptoms are few (Garber et al., 2009).

Treatment Approaches for Depression

Cognitive Behavioral Therapy (CBT)

Cognitive-behavioral therapy (CBT) is a widely recognized and effective intervention in treating mental health problems (Beck, 1995). A recent review of controlled cognitive-behavioral studies on children and adolescents found that, as in adults, CBT resulted in consistent improvement both in children and adolescents. The findings from a comprehensive controlled study comparing cognitive-behavioral interventions with nondirective supportive psychotherapy and systemic behavioral family therapy suggested that 70% of adolescents had some improvement in each intervention (Sadock & Sadock, 2009). In one of the pioneer studies on CBT effectiveness, (Brent et al., 1997) reported faster improvement in depression symptoms and higher rates of remission (elimination or reduction of symptoms) in adolescents who received CBT compared to those who received family therapy or nondirective supportive therapy. In addition to individual CBT, researchers examined the effectiveness of CBT group therapy. Regardless of parental intervention, adolescents participating in the Coping with Depression-Adolescent (CWD-A) program showed more significant improvement and higher remission rates than those in the control group (Clarke et al., 1999; Lewinsohn et al., 1990).

Psychodynamic Therapy

This theory assumes that children do not experience depression (Root, 2000). Instead, it is considered the function of self-aggression and the sense of guilt. The psychoanalytic approach underlines the sense of guilt as a central component of depression, regulated by the superego. Accordingly, young children do not have a completely developed superego; they cannot experience guilt, so they cannot develop depression. Consequently, from a psychoanalytic perspective, depression can only occur in adolescence when the presence of a reasonably well-developed and heightened sense of self-awareness is possible (Huberty, 2012).

Depression occurs when people simultaneously have opposite feelings (both love and hatred) and directs their frustration or anger toward themselves instead of reflecting it on others. Freud argues that those opposite feelings are related to childhood disappointments and frustrations (Blackburn, 2005). In an experimental study on 58 children diagnosed with anxiety disorder and depression, Muratori et al. (2002) applied dynamic psychotherapy based on the family-child model to children and families separately. During a 2-year follow-up period, a significant number of students in the experimental group showed clinical improvement compared to those in the control group, which proved the effectiveness of psychodynamic therapy in addition to other studies in the literature. It was also observed in preliminary research on adolescents (11-17 years old) with moderate and severe depression that brief psychoanalytic therapy could be effective in treating child and adolescent depression. This therapy can be very effective in treating chronic problems and comorbidities in youths as it primarily addresses the development process rather than focusing on symptom reduction (Midgley et al., 2013).

Interpersonal Therapy (IPT)

Interpersonal therapy (IPT) assumes that depression occurs in an interpersonal context and affects social relationships and, in turn, mood. Thus, IPT focuses on depressive symptoms in interpersonal interactions and relationships. There is a variety of cultural and research evidence that depressive symptoms worsen when depressed adults, adolescents, and children lose the emotional and social support of others (Huberty, 2012).

The effectiveness of interpersonal therapy (IPT-A) in relieving depressive symptoms in adolescents was explored in randomized controlled clinical trials (Mufson et al., 1999; O'Shea et al., 2015). Depressed adolescents treated with IPT-A showed fewer depressive symptoms and better social functioning than adolescents in the control group (Rosselló et al., 2008). Among the findings, IPT-A was an effective treatment in both low-income and middle-class populations. It was also observed that IPT-A was particularly effective in solving parent-adolescent conflicts (Gunlicks-Stoessel et al., 2010; Mufson et al., 2004). IPT-A underlines interpersonal competencies and skill training. It rehabilitates the person by addressing challenges and building on personal strengths to increase independence. Thus, IPT-A is particularly effective for adolescents, as individuation and autonomy are very important to them (Mufson & Young, 2018). IPT is an effective treatment for various psychological disorders in adolescent and adult populations. Meta-analyses have found that IPT has moderate-to-large efficacy in treating depression, at least equivalent to CBT (Cuijpers et al., 2011; Cuijpers et al., 2008). IPT-A helps teens develop interpersonal relationships and teaches clients how interpersonal relationships affect their well-being by raising their emotional awareness and improving communication and problem-solving skills (Mufson et al., 1999).

Group Therapy

Treatment groups for children and adolescents vary by disorder, age, group structure, and therapeutic approach. Group therapies with developmentally appropriate formats can be used with children of all ages. Groups can focus on behavioral, academic, and social skills and psychodynamic issues (Sadock et al., 2015). Group therapy is a very effective treatment for depression. In group therapy, it is very important for a person to realize that others also have experienced the same problem, which facilitates self-disclosure. Since friendship and peer relations are particularly important for adolescents, the approach can be effective in this age group which is open to suggestions (Shapiro, 1994). Lewinsohn et al. (1970) reported to have used a behavior-oriented approach to group treatment of depressed people. In this sense, group meetings served to provide alternative social behavior and outcomes for patients. Group members were given feedback during individual therapy sessions between group sessions. The session was structured as a "self-study" group where members could learn about their behaviors' effects on others. Other theories revised this approach by applying different techniques.

Family Therapy

Given the strong bond between family and couple relationships and mental disorders, family-based therapies have been developed to target both childhood, adolescence, and adult mental health. Family-based interventions for disorders such as depression and anxiety have recently gained popularity (Kaslow et al., 2012). Family therapy helps both patients and their family members cope with the symptoms (Sadock et al., 2015). It aims to address family issues together with the patient and family members to resolve interpersonal conflicts that cause depression. It is necessary to reorganize the family system and relationship patterns. All family members are involved in reducing depressive symptoms (Wasserman, 2011). Considering the restlessness and communication problems in a family with a depressed child, it is a fundamental approach to include the whole family in therapy to regulate these relationships. Including the whole family in therapy, especially under the following conditions was emphasized (Shapiro, 1994):

a. If there is a conflict between the child or teen and the family;
b. If the child or teen is worried about certain situations in a family;
c. If the child or teen has behavioral problems in addition to depression;
d. If the child or teen has suicidal ideation;

In light of the findings, individual therapies are often more effective than family therapies. Research on the treatment of childhood depression has also revealed that family involvement does not always yield better outcomes in treatment (Priest et al., 2015). For example, Birmaher et al. (2000) found that children receiving individual therapy had fewer depression symptoms than children receiving family therapy.

Conclusion

Depressed individuals may have disturbances in thoughts, feelings, and acts. A child may encounter adaptation problems in the transition from family to school life. Unless resolved, such problems lead to significant problems, including psychological well-being. Depression and anxiety disorders are among the most common mental disorders in children, and they dramatically affect a depressed child's psychological and social life. They become the agents of unhappy and confused generations if they are not treated. Indeed, the recurrence rate in

adulthood is relatively high. Depressed children show inconsistency in their feelings, thoughts and behaviours. While attention problems, worthlessness, self-blame tendency are dominant in thought; anxiety, uneasiness, decreased interest in emotion; it is possible to see symptoms such as sleep problems and weakness in behaviour. In order to minimise these problems, studies in this field are considered very important. Schools are the primary settings where the symptoms of psychological disorders can be observed. Depression dramatically impacts a child's motivation, concentration, memory, effort, and patience. In this respect, it is suggested to consider the well-being of both depressed individuals and society and to carry out individual and group studies on improving children's coping skills, life satisfaction, and psychological resilience. Especially in the light of the studies that CBT-based individual and group therapies are effective in reducing depression, it is thought that group studies using CBT techniques will be very effective.

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