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Identifying Depression in Students with Mental Retardation

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The belief that people with mental retardation are always happy, carefree, and content is a misconception. In reality, students with mental retardation are at risk for the same types of psychological disorders as are students without cognitive deficits (Crews, Bonaventura, & Rowe, 1994; Johnson, Handen, Lubetsky, & Sacco, 1995; Sovner & Hurley, 1983).

Many researchers have actually found a *higher* rate of depressive disorders in people with mental retardation (e.g., Borthwick-Duffy & Eyman, 1990; Menolascino, 1990; Reiss, 1990). Teachers should be aware of this increased risk for depression so that they can appropriately refer their students for diagnosis and treatment. In this article, we present suggestions for detecting and treating childhood depression.

Prevalence and Symptoms of Depression

Although little research has investigated the precise prevalence of depression in children with mental retardation, special education teachers will likely encounter students with depression. Several studies have suggested that these children exhibit symptoms of sadness, loneliness, and worry at a much higher rate than do their peers without disabilities (e.g., Matson & Frame, 1986; Reiss, 1985). These studies estimated that as many as 10% of children with mental retardation suffer from depression, in contrast to the lower prevalence rate of 1%-5% in children without mental retardation (Cantwell, 1990).

Clinical depression is usually determined by a psychologist or psychiatrist, who uses the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV; American Psychiatric Association, 1994) to make the diagnosis. To be formally diagnosed as "depressed," a child must experience *five different clinical signs of depression* over a 2-week period. The primary symptom is that the student exhibits either an overall depressed mood or a loss of interest in daily activities (also called *anhedonia*). Some students may express this depressed mood in the form of persistent irritability, rather than by sadness or withdrawal.

The remaining four symptoms are expressed as *changes* in a student's usual functioning. These changes may be expressed as either an increase or decrease in any of the following areas: (a) appetite or weight; (b) sleep habits; (c) activity level; (d) energy level; (e) feelings of worthlessness or guilt; (f) difficulty thinking, concentrating, or making decisions; or (g) recurrent thoughts of death or suicidal ideations, plans, or attempts (see Figure 1).

Causes of Depression

Students may experience depression as a result of a negative life event, such as the loss of a parent, stresses at home, or adjustment to a new environment. This type of reactive depression is normal and is not a cause for concern unless the de-

Figure 1. Signs of Major Depression

Look for five or more of these symptoms in the same 2-week period. These symptoms should represent a *change* from the person's previous typical level of functioning:

- **Depressed or irritable mood most of the day, nearly every day.**
- **Decreased interest in pleasurable activities.**
- **Significant weight loss or weight gain.**
- **Sleeping problems.**
- **Activity level has increased or decreased.**
- **Fatigue or energy loss.**
- **Feelings of worthlessness or guilt.**
- **Loss of concentration.**
- **Thoughts of death.**

***Source:* Adapted from the *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition*, by the American Psychiatric Association, 1994, Washington, DC: Author.**

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pressive symptoms linger and significantly interfere with a student's typical level of functioning. In other cases, there may not be a clear precursor for the depression, yet the student consistently is in a depressed mood. It is when this mood persists over a 2-week period that a teacher should observe the child for other signs of depression.

Students with *mild* mental retardation seem to be at risk for depression because they often can perceive that their peers without disabilities are able to accomplish tasks that they themselves cannot (Eaton & Menolascino, 1982). They may also be aware, via negative peer experiences, that they are different and viewed negatively by society. These observations can then lead to a higher risk for depression and low self-esteem. Conversely, people with *severe* mental retardation are not as likely to be diagnosed with depression as those with mild retardation, but this may be because of their limited ability to verbally express feelings of sadness or hopelessness, rather than an actual decreased risk for depression (Charlot, Doucette, & Mezzacappa, 1993; Pawlarcyzk & Beckwith, 1987). As a result, depression may be easily overlooked in people with severe mental retardation.

One method for treating depression is to develop nonverbal means for student expression like music, dance, or art.

Difficulty of Detection and Diagnosis in Students with Mental Retardation

Teachers, parents, and direct care workers are usually the first to notice that a child with mental retardation is having a problem; however, they often find it hard to determine if the problem is behavioral or emotional (Borthwick-Duffy, 1994). Often, diagnosticians and psychologists tend to attribute symptoms of depression to a student's limited cognitive functioning, rather than to the depression that the student is experiencing. This underdiagnosis of depression is called *diagnostic overshadowing*, in that the depression is deemphasized because the student additionally is labeled as mentally retarded (Crews et al., 1994; White et al., 1995).

The lack of understanding that most psychologists have about students with mental retardation usually results from the lack of exposure that psychologists have had with this population. Phelps and Hammer estimated that fewer than 25% of professionals in the area of psychology receive information about mental retardation in their graduate programs (as cited by Nezu, 1994). As a result, the teacher's input to the psychologist about a student's emotional well-being is extremely important.

The classroom teacher continually monitors the cognitive, social, and emotional well-being of students. Although many students with mild mental retardation can verbalize their feelings of depression, those with more severe limitations tend to express their depression primarily through changes in their behavior. The teacher can help detect these changes in students' behavior by being sensitive to variations in their overall mood or activity level. Teachers can help identify when a student's behavior has changed in its frequency, intensity, or duration.

For example, some students with mental retardation who are experiencing depression become more aggressive (Reiss & Rojahn, 1993). In these cases, the teacher can give valuable input about how typical the aggressive behavior is and when the behavior first was exhibited by the student. Such input can offset the previously mentioned "overshadowing" in correctly diagnosing depression in students with mental retardation.

Detecting Symptoms in the Classroom

Behavioral Markers

It is most common for a person who is depressed to exhibit an overall mood of sadness. Children with mental retardation, however, may express their sadness through withdrawing and decreasing their social interactions with their peers. Alternatively, they may change the way in which they interact with their peers, becoming irritable or even aggressive toward them. Also, teachers should pay attention when students exhibit new, inappropriate behavior, such as noncompliance or distractibility. In some cases, students may even begin to express their depression through self-injurious behavior. Although behavioral markers such as these may stand out, they may also be quite subtle: A depressed student may simply not seem to take pleasure in activities that he or she previously enjoyed.

As many as 10% of children with mental retardation suffer from depression, in contrast to the lower prevalence rate of 1%-5% in children without mental retardation.

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Physical Markers

People with depression usually experience changes in their *vegetative functioning*, or eating and sleeping patterns. Students with mental retardation may also exhibit these signs. Teachers should be aware of changes in overall activity level (either a decrease or an increase) in their students. A student who usually is calm and methodical may show signs of hyperactivity, whereas a student who usually maintains a high level of activity may become withdrawn and slow to respond to stimuli. Changes in weight or interest in food can also be markers of depression. Again, the teacher should look for changes in usual student patterns: the formerly thin student who puts on a substantial amount of weight quickly or the voracious eater who suddenly has no appetite.

Sleep behavior can also be a sign of depression, either increased sleeping or a decrease in the hours the student sleeps. A common occurrence for someone who is depressed is to have little difficulty going to sleep but then awaken in the early morning. Teachers should be aware that sleepy or lethargic students may be suffering from these sleep disturbances during the night.

Treatment of Depression in Children with Mental Retardation

The Individuals with Disabilities Education Act (IDEA) not only ensures the right to free and appropriate educational services, but also to related services, such as psychological assessment and counseling. Many times the school district has programs or staff that can help a student diagnosed as depressed. Once the student has been assessed, the teacher can work closely with the school psychologist or counselor to provide supportive therapy for the student.

Students with *mild* mental retardation seem to be at risk for depression because they often can perceive that their peers without disabilities are able to accomplish tasks that they themselves cannot.

The teacher can also discuss with the family any additional support needs that they might have as these needs may contribute to the stress that the student is experiencing. Loss of employment, death of a family member, or economic hardships can all affect the student's level of depression. Teachers should be aware of changes in their students' home environments to help determine if a student is depressed—as opposed to, for example, simply being oppositional. These support needs often occur across settings, for example, at family outings or at recreational activities (see Figure 2).

Examining the settings in which a student functions on a regular basis can help pinpoint obstacles or difficulties that the student is experiencing in these areas, for example, appropriately talking to peers at the community pool. Knowledge of these difficulties thus can help the teacher target instructional objectives for the student in the classroom, such as learning social skills training.

Psychological Services

Psychological services in the mental health community are limited for people with mental retardation. One reason for this may be the bureaucratic structure of these services. Typically, services for people with mental retardation and services for people with mental health needs are provided separately. This separation of services often results in a quandary between agencies as to who should provide services and, often, in a lack of services for the person who is "dually diagnosed."

The most popular forms of psychological services used for children without cognitive limitations experiencing depression may also be used with children with mental retardation. The most popular forms of therapy for children with depression are behavioral therapy, social and adaptive skills training, psychotherapy, and the use of psychiatric medications. These and additional treatment modalities are listed in Figure 3.

Because children with mental retardation are a heterogeneous group, the mental health provider must make modifications in these approaches and techniques. Rubin (1983) suggested that providers should consider the following characteristics of a child when providing psychological services to a student with mental retardation:

- Intellectual aptitude.
- Capacity for relationships.
- Neurological functioning.
- Communication skills.

Figure 2. Ideas for Treating Students' Depression Across Life Settings

Skill Building
- **Develop the student's communication skills.**
- **Try a social skills unit to develop interpersonal skills.**
- **Focus on problem-solving.**
- **Teach conflict resolution.**

Resource Networking
- **Work with the family to find needed community resources.**
- **Start a parent support group in your school.**
- **Obtain literature from a mental health center about depression.**

Expression Opportunities
- **Develop nonverbal means for student expression: music, dance, art.**
- **Role-play potentially stressful situations and appropriate solutions.**
- **Use films and stories to teach problem-solving.**

Relationship Opportunities
- **Have pets in class.**
- **Have students write or draw to pen pals.**
- **Provide appropriate peer-group opportunities.**
- **Invite volunteers from the community to develop supportive friendships.**
- **Find group activities outside the school setting appropriate for the student.**

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In addition, the mental health provider should always be apprised of the student's current medication intake and medical history.

Final Thoughts

Intellectual functioning does not seem to offset depression; in fact, those with mild mental retardation seem to be at an even greater risk for depression. We say, "seem to be," because of the paucity of recent research in this important area. In addition, many treatment techniques for depression that have proven successful in persons without retardation remain untested in those with mental retardation (Sevin & Matson, 1994).

Children with mental retardation experience pain, loss, and depression as do other people. When we ignore signs of depression in children with mental retardation, these children become at risk for being misunderstood, underestimated, and untreated.

Read More About It

General Information on Depression and Mental Retardation

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Figure 3. Possible Types of Therapy Appropriate for Use with Students with Depression

Individual psychotherapy: The student discusses issues with a counselor or psychologist on an individual basis. The focus is on the student's perceptions and behaviors. The student is usually guided to make his or her own interpretations and goals for change.

Group psychotherapy: Usually a group is formed around a common problem that each member of the group shares to some degree. Groups are usually facilitated by a professional counselor or psychologist. The involvement and support of the other group members are part of the therapeutic treatment.

Family therapy: The family meets with a psychologist or counselor who moderates while problems and solutions are generated by the family members. Family interactions, perceptions, and roles are the areas of focus and change.

Skills training: Building social skills allows the student to engage in social situations while he or she receives modeling and coaching from a therapist or teacher. These social situations allow the student to practice skills in particular deficit areas.

Psychodrama: Guided by a psychologist or counselor, the student acts out themes or roles that represent areas of concern and unresolved conflict. The drama provides emotional release and insight into these areas of concern.

Art therapy: A nonverbal therapy, usually directed by a psychologist, counselor, or art therapist, art therapy uses art as the milieu in which emotions and thoughts can be expressed freely.

Music therapy: A nonverbal therapy, usually directed by a psychologist, counselor, or music therapist, music therapy uses music to help students express and release emotions.

Play therapy: A psychologist or counselor works with the student as he or she plays with toys or other materials that permit expression of conflict issues.

Psychopharmacology: This type of therapy uses prescription drugs to treat medical problems associated with mental disorders.

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