

Home/Hospital Instruction:
Instructional Approach to Working with Students with Major Depressive Disorder

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Abstract

School districts throughout the United States provide in-home schooling for students whose health problems, both physical and mental, prevent them from attending regular classes. This service is an outgrowth of the federal legislation which addressed the provision of education to all children with special needs. Home/Hospital teachers who serve the population of students with major depressive disorder find that it takes away a student's ability to learn. How can a student population that has restricted learning abilities be best served in a home-hospital instructional environment?

The research literature is limited in dealing with the pedagogical needs of this population. It is through personal experience and discussions with experienced colleagues that effective instructional technique is passed along to those who are beginning to work with this population.

This study follows narrative research design and is qualitative in nature. Information on working with these students was gathered to describe this population and how they learn, and to offer insights for teachers who are working with these students.

Findings indicate that these students are trying hard and have nothing to show for it. They read and cannot remember details. They cannot organize material. They cannot make decisions about their work. They have a great deal of difficulty focusing on work, and though they may be able to work when a teacher is present, they can seldom complete homework. Teachers working with this population must consider how to make a practical application of research information in working with these students. This study works to operationalize research and observational findings into practical approaches for the HHI instructor or the classroom teacher.

Chapter 1 Introduction

I joined the Two Rivers Unified School District Home Hospital (HHI) Instruction department in 2002, after one year of classroom teaching. There was little induction: One was given a time card, a copy of material that was also given to parents about the restrictions and requirements of the program, access to a small library of materials, and some resource phone lists. One is not required to know about the various illnesses that will be encountered as an instructor, those illnesses being the reason the student is in the program, while the injuries that put a child into the program are generally self-explanatory.

HHI students are identified as students so ill that they will miss four weeks or more of school due to the illness and/or recovery process. On entering the job, I thought that this meant “ill”, as in sick or recovering from sickness such as measles or mononucleosis, or injury. I had had little experience with chronic and terminal conditions and their effects on the student as a person or as an academic performer, and none with the effects of such an illness on the home life of the student or on the resilience of the student's family.

So, there is a learning curve for an HHI teacher that has nothing to do with classroom management or the meeting of state standards, and everything to do with making it possible for the affected student to do the best and to learn the most that the student can.

For students with relatively short-term troubles, such as the effects of surgery or a broken limb, their condition was a temporary frustration, and the child's overall health was not compromised. Generally, these students felt good for some time every day, could have friends over, felt like chatting, and could do homework on their own. They were anxious to get back to

school. Their parents could see an end to the tiring schedule of doctors' appointments, physical therapy sessions, and "My child is at home alone" anxiety and monitoring.

For students with chronic physical illnesses, however, the ability to do work and the home situation were different. These students were not only injured, they were isolated from their friends. The bulk of a child's social interactions occur at school. Chronic illnesses, cancer or cystic fibrosis, for instance, come with an increased danger from common infections, and so visiting is curtailed. Their parents were stressed, and they spent a good deal of time at doctor's offices or in treatment situations. These students were pushing through pain or discomfort and a medicine fog almost daily and, the arrival of the HHI teacher was a nice break from a generally boring day. However, because they were often tired or medicated, homework completion could be haphazard and learning truncated. Parents and family, with a long-term and often irresolvable health crisis to handle, were tired, overworked, and often frightened. However, I found that students who had definite diagnoses or visible problems were more mentally capable of completing work, or at least starting it, than a third general group of students, described below.

One of my first students was a senior in the district's high-status, high-pressure International Baccalaureate program. He had decompensated under the continuing pressure, had made a suicide attempt, and then had been diagnosed with severe depression. He was placed on HHI after he had stabilized enough to come home, and I was assigned to work with him. He had about two weeks left in the semester, and a whole semester's worth of work to complete, and finals looming. When I arrived at his house, he was blockaded in his room crying and did not want to come out, as there was no point and he was going to fail anyway. This was true. I sat down in the hallway by the door and tried to reason with him, saying we could try to recover part

of the grades and could we just work on something, please. Basically, I had a bright, near-suicidal student on my hands, and my job was to review physics with him.

This was not something I had run into in dealing with the first two types of students. I could frown if they had not done their reading, but they would bounce back from that and my comments, though remembered, were not seen as a threat or a comment on their worth. With this depressive senior, it was quite possible that I could say or do something that would put him back on the edge, or even right over it. Here was a student for whom perspective was not working at all, and it was frightening and puzzling.

Soon after, I was assigned another high school student who had a major depression and anxiety diagnosis. She could converse, she could read, and she could not do a scrap of work unless I was sitting with her. When I was with her, she could quietly read and ask questions and write answers. When I was gone, nothing whatsoever happened until our next appointment. I asked if she just forgot the work, and she said no. She had been worried about it and tried to do it all week, she just could not do it. I asked what else she had done that week, and basically, she had stayed at home, seen no friends, just stayed at home and worried about her homework. It was frightening and puzzling.

Another student, a straight-A high achiever, had begun to pull Cs and Ds and to cut school. He began to suffer insomnia, weight loss, disorganization; he no longer played tennis. When I checked his daily planner, I could see when the severe illness had hit. Within one week the student's notes went from detailed and logical to sporadic and random, then to non-existent. There it was, severe depression. His parents, both doctors, thought that he was just going through a rebellious phase.

I was doing reading at the time on depression, the onset of depression, and depressive symptoms, and I began to realize that student after student was manifesting the practical effects of major depression. Other things turned up, but one particular issue caught my attention: adults generally thought these students were being sulky, or being "angsty" teenagers, or just being lazy. And the students, whose illness literally prevented them from staying organized, staying focused, and being emotionally stable, not only saw themselves as failures but also blamed themselves for the symptoms of their illness.

Statement of Problem

Depression is a physical disease that negatively affects memory, initiative, mood, organization, attention, fatigue levels, pain perception, sleep patterns, and most cognitive processes (Mayo Clinic). The process of achieving a high school education demands that a student be fully functional in all areas for academic and social success. Juggling the intellectual demands, multiple assignments, class transitions, and social experiences of high school, in addition to dealing with the physical and emotional stresses of adolescence itself, places a huge demand on an individual's internal resources. If a student is experiencing a depressive episode, or has a long-term, clinical depression, then that student does not have the internal resources available for academic and social success.

Purpose Statement

The purpose of this study is to find a set of instructional tools and techniques that allow adolescents with major depressive disorder to function in a home-hospital learning environment.

Research Question

What are research- and practically-based methods of enabling learning in the depressive adolescent?

Theoretical Rationale

Homebound and Hospitalized Instruction was in place in California before the passage by Congress of Public Law 94-142, which said that a free and public education was guaranteed to all students, appropriate to a child's needs. However, such instruction was aimed primarily at students who suffered physical impairment, or who had a long-term debilitating illness such as tuberculosis, which required either isolation or hospitalization. When students with mental health issues became eligible for home/hospital services, the school districts needed to have teachers who could work within the constraints of the children's health issues.

Students who have mental health issues can benefit from individual instruction, but they require an instructional skill set from their teachers that the teachers generally achieve only after considerable experience.

The hope of this paper is to provide HHI teachers a set of instructional modifications that can be made to accommodate students with Major Depressive Disorder. The following is a summary from several sources of adolescent symptoms of major depression:

- 1) Feelings of sadness, guilt, worthlessness, unhappiness, self-blame
- 2) Trouble thinking, remembering, and deciding – whirling thoughts
- 3) Indecisiveness, distractibility, decreased concentration, lack of organization
- 4) Physical exhaustion/psychomotor retardation – slowed thinking, speaking, or body movements
- 5) Agitation or restlessness — for example, pacing, hand-wringing or an inability to sit still
- 6) extreme irritability and angry outbursts with parents and siblings, some irritability with close friends
- 7) irritability or frustration with small tasks or setbacks

- 8) a reduced inability to read social cues, poor communication, social isolation
- 9) Alcohol or substance abuse
- 10) Frequent thoughts of death, suicide, and dying

All of these behaviors are symptoms of the disease, and, just as modifications are made for students in special education or for students with physical impairments, it makes sense to explore modifications that can be made around the symptoms of MDD.

Assumptions

Many people do not know the nature of major depression, its biochemical basis, its symptoms, and the effects of those symptoms on the lives of those afflicted by the disease. Many people do not understand what this population faces in dealing with the requirements of school.

There a number of specific actions a teacher can take to enable learning in the student with major depressive disorder. Learning itself is impaired in the depressive individual, so “enabling learning” does not mean to suggest that these techniques will allow a student to perform at non-depressive levels, but that they will help a student perform at level higher than they might without the techniques.

Finally, schools are generally not structured to accommodate mental illness in students. Teaching a student with MDD is not so much teaching as adapting to a handicap. It is not that the student does not want to learn, it is that the brain literally cannot learn. Home and Hospital Instruction programs are more accommodating, but the range of symptoms in Major Depressive Disorder faced can demand a reinterpretation of pedagogical methods.

Background and Need

Between one in thirty and one in ten high school students have a major depressive episode (MDE) during a given year. That episode interferes with learning, social abilities, and overall

health. For those students with Major Depressive Disorder, the demands of school become nearly impossible to meet.

Home and Hospital Instruction exists to continue the education of students unable to attend regular school. With only five hours a week to teach all subjects, the instructor needs to use every possible means to keep the student at grade level. It follows that the more an instructor knows about dealing with MDD, the less time is spent with experimentation to find effective basic techniques. If research and observational findings could be operationalized into practical approaches for the HHI instructor or the classroom teacher, then both student and teacher would benefit.

While the existence of adult depression has been long recognized, prior to the 1970s, depression in adolescents and children was not. However, the idea that adolescent depression is an illness that can be medically treated has been on the rise in the past ten to twenty years. The recognition of the dangers of depression is also on the rise, as a teenager who has depression severe enough to require hospitalization has a high incidence of attempted and successful suicide.

With a rate of teenage depression at around 10% occurrence over the high-school years (NIMH), it is reasonable to assume that any given high-school instructor will have at least one depressed student in every class. Most likely, that student will be untreated, as “the percentage of youth with MDE receiving treatment for depression, defined as seeing or talking to a medical doctor or other professional about the depressive episode and/or using prescription medication for depression in the past year, declined from 40 percent in 2004 to 35 percent in 2009” (Family Interagency Forum on Child and Family Statistics, 2011. para.6).

The Two Rivers Home Hospital program is organized around teaching students who have impairments of limited duration, injuries or recovery from major illness, or those who have long-

term or terminal conditions such as cancer, brain tumor, leukemia, cystic fibrosis, for which a doctor can provide a fairly accurate prediction of the duration of home care needed. The district requires a renewal of services form every four weeks, with proof of treatment each time, but for the mentioned conditions, they can write a note that allows the student extended time in the program. Major Depressive Disorder does not follow either type of timeline. It may move rapidly into remission, or may become a long-term illness that does not respond to the range of treatments currently available.

It makes sense, then, for HHI teachers to have a basic set of instructional techniques that can be put in place when a MDD student is placed in the program.

Chapter 2 Review of the Literature

Review of the Previous Literature

First, let us define “depression” in the medical sense. *From the Diagnostic and Statistical Manual of Mental Disorders (IV)*, we find the criteria for diagnosis of major depression:

“Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
Note: In children and adolescents, can be irritable mood.
2. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
3. significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
4. insomnia or hypersomnia nearly every day.
5. psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings or restlessness or being slowed down).
6. fatigue or loss of energy nearly every day.
7. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. diminished ability to think or concentrate, or indecisiveness, nearly every day (either subjective account or as observed by others).
9. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

In addition:

- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one; the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

From an educational standpoint, compare how the depression symptoms work to interfere with even the lowest of the cognitive levels of Bloom's Revised Taxonomy (Anderson & Krathwohl, 2001, pp. 67-68):

- Remembering: Retrieving, recognizing, and recalling relevant knowledge from long-term memory.
- Understanding: Constructing meaning from oral, written, and graphic messages through interpreting, exemplifying, classifying, summarizing, inferring, comparing, and explaining.
- Applying: Carrying out or using a procedure through executing, or implementing.

- Analyzing: Breaking material into constituent parts, determining how the parts relate to one another and to an overall structure or purpose through differentiating, organizing, and attributing.
- Evaluating: Making judgments based on criteria and standards through checking and critiquing.
- Creating: Putting elements together to form a coherent or functional whole; reorganizing elements into a new pattern or structure through generating, planning, or producing.

Internalized symptoms can only be identified by an individual “saying it”, such as having difficulty in thinking clearly, being anxious, or having overwhelming negative thoughts. Students describe the negative thoughts as being like having the nastiest person imaginable saying terrible things about them at every moment, criticizing everything they do or that they do not do.

Externalized symptoms include psychomotor retardation: a generalized slowing of motor activity related to a state of severe depression or dementia and physical aggression (Mosby's Medical Dictionary, 8th ed.). This allows depression to be detectable in a classroom setting. According to a 2007 study of Los Angeles area students, teachers are able to recognize more than 60% of depressed students in their classrooms, particularly those that have externalizing symptoms -- symptoms visible to an outsider. While this may not seem like a large percentage for so serious illness, what was remarkable was the very low rate of false positives. If a classroom teacher identifies a student as depressed, that student is extremely likely to be depressed (Mattison, Carlson, Cantwell, & Asarnow, 2007).

Treatment of Major Depression is found to most successful when it combines both medical intervention, in the form of medication, and psychological counseling. It is important

for an educator to know that the percentage of youth with MDE receiving treatment for depression, defined as seeing or talking to a medical doctor or other professional about the depressive episode and/or using prescription medication for depression in the past year, was around 35% in 2008 (Family Interagency Forum on Child and Family Statistics). The average duration of a major depressive episode is around eight (8) months (Remedy's Health Communities). In 2009, 72 percent of youth with MDE (5.8 percent of the population ages 12–17) reported that the MDE caused severe problems in at least one major role domain - home, school/work, family relationships or social life (Family Interagency Forum on Child and Family Statistics).

Some symptoms of depression can be reduced through interventional training. A small study used three groups of adolescent males to examine the effectiveness of two cognitive-behavioral interventions: anxiety management training and cognitive restructuring of maladaptive self-statements. In individual and group sessions, students were taught to recognize emotional arousal, identify its source, and to examine and restructure self-defeating thoughts around those emotional arousals. They were also taught to self-monitor and to rehearse these skills in advance of a stressful situation. Both treatments were shown to reduce depressive symptoms significantly, state and trait anxiety, state anger, anger expression, and depression, as compared to a waiting-list control group. Of note is the increase reported in the boys' self-esteem, and the large reduction of "anxious self statement" following training, and particularly that the treatment gains were maintained over an 11-week period (Hains, 1992).

The effects of adolescent depression do not go away at the end of adolescence. A longitudinal Swedish study evaluated the long-term educational effects of depression on adolescents, finding that depressed students were not only less likely to enter college, but that

they were less likely to complete a four-year degree once in college. College itself took longer to complete for depressed students than for non-depressed students. The net result was that adolescent depression has a long-term impact on scholastic, and therefore professional, advancement.

Statistical Information

According to the National Institutes of Mental Health, the incidence of dysthemic disorder in general USA adolescent population ages 13-18 years is 11.2%, with 3.3% having a “severe” or “major” depressive episode in a given year. A Major Depressive Episode (MDE) is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities plus at least 4 additional symptoms of depression such as problems with sleep, eating, energy, concentration and feelings of self-worth) as described in the 4th edition of *DSM-IV*. Other sites give a much higher rate of major depression in the adolescent population. According to Family Interagency Forum on Child and Family Statistics, 8 percent of the population ages 12–17 had a Major Depressive Episode (MDE) during in 2009, with that number rising from 5% for 12-13 year-olds to 10% of youth ages 16-17.

This suggests that 60 to 65 percent of students with major depressive disorder are untreated in any way. The net result is that 6% of students in high school have MDD, and are untreated for the illness, figuring $0.6 \times 0.1 = .06$. For schools and educators, this means that at least one cognitively and emotionally impaired student with an undiagnosed medical condition is in every classroom, unhappy and underperforming.

Students are aware that their depression is interfering in their lives. In 2009, 72 percent of youth with MDE, ages 12–17, reported that the MDD caused severe problems in at least one

major role domain -- home, school/work, family relationships, and social life (Family Interagency Forum on Child and Family Statistics).

Treatment for adolescent depression is generally a combination of medication and psychological therapy. Core treatments for moderate and severe depression are serotonin reuptake inhibitor, antidepressant therapy and/or proven therapies: cognitive behavioral therapy and interpersonal therapy. IPT, especially with teens, given the developmental need to establish identity, may have additional benefits as compared to CBT, but both have been found to be very effective. Most studies suggest a minimum of 14 sessions, and then maintenance sessions specific to the patient's needs (University of Louisville, 2012).

Depression can change the brain. According to a meta-analysis of MRI studies, one physical sign of major depression is a shrinking of the hippocampus by as much as 10% as compared to non-depressed subjects. The hippocampus is involved in episodic, declarative, contextual, and spatial learning and memory, deficits which often accompany depression (Videbech, 2004).

Chapter 3 Method

Introduction

This is a narrative project. It is a combination of non-experimental, qualitative methods including a combination of literature review and anecdotal evidence. Several home/hospital students from the 2011/2012 school year are specific case studies, with additional information, anecdotes, and experience based on my experience with Home/Hospital students from the 2003-2011 school years.

Sample and Site

The students observed for this study include public and private high school students in the Twin River School District boundaries who were assigned to the HHI program because of a major depressive disorder diagnosis. Most students were observed in the family home. Other locations included local public and college libraries, coffee shops, or fast food establishments. In addition, HHI teachers with experience with several students with major depressive disorder were interviewed.

Data Gathering Strategies

Data gathering strategies included research reading, observations of students placed in the HHI program because of major depressive disorder, and interviews with HHI teachers who have specific experience with students who have major depressive disorder. Students and parents were observed in a naturalistic setting and asked if they perceived the instructional techniques to be useful. Students were frequently asked what methods of instructor assistance were most helpful for them. Parents were questioned periodically as to student progress and function in the home environment.

Ethical Standards

This paper adheres to ethical standards in the treatment of human subjects in research as articulated by the American Psychological Association (2010). Additionally, the research proposal was reviewed by the Dominican University of California Institutional Review Board for the Protection of Human Subjects (IRBPHS), approved, and assigned number #9020.

Confidentiality of the participants, schools, and district was preserved by the use of pseudonyms.

Access and Permissions

Permission was granted for teacher interviews by the Dominican University HRB. Access to students was part of the Home/Hospital teaching arrangement.

Data Analysis Approach

Data is in narrative and literature review format. Analysis was performed by looking for commonalities in student response to various techniques, observing if students include strategies in their learning process. Data has been organized in a narrative fashion with observation notes made during teaching sessions with students.

Chapter 4 Findings

Overall Findings, Themes

Findings are presented in the form of observations of students and anecdotes from other HHI teachers. Themes follow in the “Some Notes” section. Specific teaching and management suggestions are in the “Appendix”.

First, here are some quotes and paraphrases from students with MDD.

"I can work while you're here."

"I just read it and I don't remember it."

"My parents make me so angry."

One student described her thoughts as being like “the bits of paper in whirlwind.”

“Don't doubt us, don't ridicule us, be there for us, don't get upset and make it worse.”

“They are always on my case, judging me.”

And here are some long and short observations of several MDD students, with names and initials changed for privacy.

TD (9th grade Major Depression/Drug Use) He is a classic example of a student with MDD. Has had depression for a long time, and recently took to self-medicating with marijuana. That move got his depression diagnosed, as well as expelled. His grandmother asked why he wanted to hang out with the “drug kids”, and he said that they didn't judge him. He is irritable with his parents and grandparents, and the family cat is fairly annoying, too. When we looked for binder paper, he went to his room to get some, while his binder – right in front of him -- had at least an inch of paper. It didn't occur to him to look there first. He feels okay when he is doing yard work for his grandparents or when walking the dog. He feels much better after he has

exercised. He holds very still on some days, and is slow to reach out for a pencil. He was very happy to hear that the effort he has to put into grooming is a common symptom of depression (depressives have a hard time brushing their teeth, though face-washing is generally easy). We both agreed that slip-on shoes are much, much easier than lace-ups. Math is a source of frustration for him, and it seems that it comes from the fluid (read: ambiguous) way that most instructors use mathematical terms. When he says he “gets” a math problem, it seems to be to keep me happy – when I have him do it on the white board, his accuracy is about 50%. Like most MDD students, he is very interested in the list of adolescent depression symptoms, and seemed relieved when I pointed out that his situation was so common that there had been lists made to describe it. He doesn’t really talk about his friends.

JS (10th grade Major Depression) She had been heavily stressed by the course load of the International Baccalaureate Program -- she wanted regular school, and her parents wanted IB level -- and then a major family stress event hit, triggering the depression. Had lost weight and cried for an hour or two every day. Could not hold a pencil to write. Parents were ashamed of her condition. Negotiated with parents to reduce her course load from IB level to regular education classes. The IB level classes were guaranteed to produce failure – there was no way she could catch up on the work, even without the depression. Some sessions involved me sitting across the table while she cried for an hour or two. Her parents had gotten her a dog to make her feel better, then taken it away when the mother became fearful of the dog. I never tried to talk her out of her misery, but I did ask questions about it. Sometimes I would bring her onto the patio to get sun while we worked, where the neighbor’s cat would come and visit. I counted her reading as “work”, while I sat and acted as a catalyst. On some days, when she could not focus, we looked at interior design magazines so she could plan her new bedroom layout.

On my final day there, her mother, with whom I had not particularly spoken -- we had a language gap -- followed me out of the house with a fixed smile and damp eyes. She started to tell me “Thank you” and then broke down crying. I reached out and hugged her and kept repeating to her, “It’s very hard, it’s been hard, and so scary for you and you had to be strong” and she cried and cried.

LR (10th grade, PTSD/major depression)

LR came to HHI after some time a psych facility – she had had some sort of break associated with her PTSD and had attacked her mother. By the time she was placed in HHI, she was weeks behind in all of her classes. Her main worry was Algebra I, which she had failed once already, especially around graphing. She would check with me every day to make sure we weren’t going to graph, and would become wide-eyed and agitated anytime I mentioned it. We jumped over the graphing chapter and worked to clear up some basic computational misunderstandings. We met a few times at her mother’s house, and then decided it was quieter in the local burger shop. She was dropped off by her mother or by the mother’s boyfriend each day, with her bag of work. LS and her mother entered counseling together, and it seemed to improve their relationship over the months. LS transferred to the district Independent Study program.

FH (9th grade, Major Depression)

One of the first depression students I encountered, and whose severe depression was one of the least of the difficulties the family was going through. The father was so overwrought and discouraged with his own mental health issues that he asked me if I could foster his son, because he couldn’t take the situation anymore. Depression ran on both sides of the family.

CR – (11th grade, Major Depression) from notes made at the time:

Missed last week because he had a UCD neurology appointment to check if there was residual damage from his fall in October (he overtook (inadvertently) his meds and clonked his head on the kitchen counter as he fell). Saw him Wednesday – he was not happy with the appointment, which seems to have been lots of verbally administered questions, things along the lines of “Why is a creek louder when it is shallow?” (pretty Zen for a 16 year old). He felt irritated by the process. He also was asked to audition for the school play (West Side Story) and I am now the Algebra II teacher to Tony/CR, who will be in rehearsal most afternoons until 5pm. I’m going to reschedule my meetings with him to Monday nights to reduce conflict. His mother says she’s worried about the effect of the additional responsibilities and time commitment on him, which I see as a valid concern. She did point out that the schedule is for 8 weeks of rehearsal, and will be done by mid-April, but still...

He is feeling stressed with the new schedule, too. Theater teacher wants everyone there for all rehearsals (my bet is that will change), and that eats about 2.5 hours out of CR’s day. We talked about getting work done during down time in rehearsal – how to bring one subject with him and do the rote work while waiting for his time on stage. Right now, he’s moving at about half-speed through the algebra work. He gets bogged down by problems and will spend extended periods reworking them, when the error is in calculation rather than concept. He does have a problem with translating the book examples to the book problems: don’t know if that’s new with the depression or a long-term situation.

Last week, I had broken the chapter down into fairly small subsets of problems. For instance, on, say, assignment 4.6, the book guide suggested about 15 problems on the assignment. I made up a list (this was the week CR was at UCD) of three subsets of the problems, with no more than about six problems in each group. Then I put a “check-off” box to the left of each

small assignment. The idea was that he could do a small chunk of a chapter section and check it off in a much shorter period of time than if he had to do the entire problem set at one go.

Problem with this: I was not there to explain the system to him – his parents passed on the assignment sheet to him, and he did not notice the clever system I had put in place.

I pointed it out to him when we met this past Wednesday (15th Feb), and he thought it was a great idea. He'll give it a try.

Also, I gave him an idea I had been given by a psychologist, which was: Limit the amount of time you make available for the work. Do NOT look at the evening and tell yourself that you have to work non-stop for the three hours before bed. Instead, set yourself a 15 minute limit. Tell yourself you have ONLY 15 minutes available to go work on the assignment. After 15 minutes, you MUST walk away from the work. It is suggested that this is effective because it puts a boundary on the amount of energy that the student may spend on an assignment.

CR really liked that idea, too. He has shown problems to me that he has spent 30 minutes on, circling around and around and not seeing an escape. I am a HUGE fan of working through problems and sticking with it, but I don't see how circling a drain is of any benefit. I think his responsibilities stretch in from of him like an endless chain, and that this idea lets him break a link. Possible problems with implementation: again, we talked it through, rather than demonstrated it. I will practice this with him next time we meet, and the time after – I think he's got a better chance of using it if he can apply some sort of a body memory to it, rather than trying to recall once-heard words and apply them. Will see in a week and a half, when we're back from President's Week vacation. Three weeks ago, I got tired of watch him shuffle papers, and hounded him into getting a folder from his mother in which to store his work to date and his work to do.

KW (12th grade, Major Depression)

Tried to get her into graduation ceremony at her home school when she had spent the bulk of senior year on HHI – the principal did not want to let her walk graduation, because she had not spent her senior year in the school. I honestly expect that the principal may have been punishing the parent (an extraordinarily difficult-to-deal-with individual). Arguably disturbed mother, an angry father, and the house was a hoarder's dream --who knows what else the kid went through? I gave her PE credit for working with me to clean her– we couldn't get other work done, so I figured health and fitness credits might be gained by de-junking.

She became catatonic between one session and the next – her mother called me to cancel the appointment because she had been sent to a 72-hour observation in the pediatric psych ward. I went there to “teach” her – she came out in sweats and a robe, moving like the walking dead – weeks later, did not remember being there or that I had been there. Wish I had known more about the whole thing at the time I had her.

AF – (10th Major Depression/Anxiety Disorder) directly from notes:

Was out with depression all last week – talked with her today: she had her first session with a psychologist yesterday, after four months out of school this year, mother had to gather \$400 for session: family doesn't have health insurance: talked with me today about trying to get out of bed, how she makes herself walk everyday, how she's the one in the family who doesn't get to show how bothered she is by everybody else's behavior (father is bipolar, brother depressive, grandfather depressive, one aunt with borderline personality disorder, younger sister is showing signs of depression). Most days, she is very judgmental and seems to be angry – today was very quiet in speech.

I worked with her last year, and she was both unmedicated and without treatment. She did have a doctor's diagnoses for her depression, though. This seemed like getting a diabetes diagnosis without any information on how to handle it. Her father had decided that she could be strong enough to deal with it. Her depressed brother has been telling her that she does not need medication, that she is strong enough to overcome this without help. She can be very decisive, and of all the 2012 students, she is the one who seems able to harm herself. She can project a moderately unpleasant persona when she is having a bad day – irritable, judgmental, and very much ready for the teacher to leave.

AF is greatly disturbed by injustice on any level – it has affected our literature reading. She can be overwhelmed by the implications of a poem or of a short story, and unable to move beyond the emotions it arouses. We are using the Independent Study packets for her English requirements, and she enjoys crossing off completed work. Has not been able to complete an essay, though, even with me typing for her. Has very few friends, and when her boyfriend broke up with her, she went into a two-week tailspin.

Some Notes on Attitude, Truthfulness, and Listening to the Silence

Two senior HHI instructors, each with 15+ years experience, offered experiences and insights into dealing with this population. HHI instructor Mary Schaeffer (a pseudonym) described watching an MDD student sink into near-catatonia over the hour their session. She noticed that he was moving slower and slower as the hour progressed. He was hospitalized later that day. Several weeks later, when he was in remission, he told her that he didn't remember anything about that day or for several days afterward.

Mary's basic tenet in working with depressive students is to show up as scheduled. Period. She has gone into student's bedrooms when they couldn't get out of bed, talked them out of bed

and to the worktable. “Showing up, being consistent and dependable, and helping them is what they need.”

John Hendrickson (a pseudonym) agrees. He recommends active listening, being calm and persistent, and most especially, listening to what isn't being said. He finds that adolescents do not have the vocabulary or experience to use the technical terms of depression, but that they talk around the experience.

Do not try to cheer them up. Anhedonia – the inability to feel pleasure -- and guilt are two major symptoms of major depressive disorder. A depressed student cannot feel pleasure, but they can feel guilty that they are unable to feel pleasure when you want them to.

What you can do is agree with them that they are having a rough time. They are. Every step they take is through a gummy mire and demands a huge expenditure of energy. Tell them, and believe it yourself, that they are doing the very best their disease will let them.

Do not try to argue with a student who says, “Why bother?”. This is a crazy-making thing for a non-depressive to hear, but it makes absolute sense to a depressive. They get no reward from “bothering” – decreased dopamine levels and anhedonia mean that there is, for them, no internal pleasure in accomplishing a task, no internal reward for a job well done. My most successful answer to the “Why bother” question has been to say that what we are doing now is practicing getting through the day. We are making their brain work when it does not want to, and it is resisting us.

In addition, depression removes any sense of delight in the world. A depressive student does not feel a thrill of pleasure in making a connection between subjects, or in seeing how their knowledge can work in the world. Do not assume that this applies only to school. Ask the student if they feel happy holding a puppy or a kitten, or watching a sunset. Most likely, the

answer will be “no”. Do not try to tell the student that he or she is not suffering, or that things are not so bad, or that other people have it worse. Depression takes away the ability to enjoy, let alone feel happiness.

Students with MDD can be extraordinarily irritable. Though it cannot be seen, they are also expending huge amounts of energy restraining themselves from outbursts at their family, sometimes their friends, and after a level of comfort has been reached, their teacher. It is worthwhile to ask the student early on whether or not he or she finds certain people – family – irritating. The answer will be yes. Ask if the student has to work very hard not to yell at them. The answer will be yes.

Along with irritability, a large of an adolescent’s experience with major depression is shame and frustration. Performing simple tasks, such as tooth brushing, can take an hour, most of which is spent building up enough energy to pick up the brush. They know that everyone else is moving smoothly through the day, and that they are stumped by the simplest things. Here is an analogy that the student will understand: If you had a broken leg, you would have a nice big cast on it, and everyone would know that you are injured. They would not get upset if you couldn’t walk fast, and they would understand if you got tired. They would not expect you to run a marathon. You have a bad disease that we are working to fix. If you had a cast on your head that showed everyone how bad off you were, no one would expect you to run a marathon, because it would be impossible. But that is what you are doing every day, and no one can see how hard it is for you.

Ask yourself, as a teacher and a person, what you want as an outcome to the student’s HHI time. I hope that the child’s therapy and medication will put their depression into permanent remission, but I have to recognize that not only does healing take a very long time,

but it also is not a sure thing. I want them to have a structure that will allow them to do something productive, rather than spinning in circles. I want them to use reference material. I want them to understand that though their memory is not working for them, they can ask themselves, “What book can I pick up to get this formula?” or, “This problem must have had an example. Where is the example and its solution?” Depression produces adolescents who can tell that they need the reference work, but who cannot generate the energy to reach out and get it. I also, like Mr. Hendrickson, want them to be there for the next meeting.

Homework will not be done. Be ready for that fact, and not judgmental at all. The student will be extremely alert to any sense of disappointment you may feel, especially if they see it as letting you, personally, down. They wanted to do it, they just couldn't. So, tell them that you will take care of it together, and that you'll walk them through it.

Some students are entered in the HHI program with only one of two possible diagnoses listed on the paperwork. The depression diagnosis is not officially transmitted to the teacher because the parents want the fact of their child's depression kept secret. The stigma surrounding mental illness is particularly hard on teens, because they want to fit in. They are very aware of a parent's difficulty in admitting the existence of the illness, and the parent may be so caught up in the perceived social failing of depression that it endangers the child. HHI teacher Mary Schaeffer worked with a junior-high school student who attempted suicide, and whose parent drove the child to the hospital rather than call 911. The parent did not want the neighbors to see the ambulance, and ask questions.

The sense of stigma around a health issue has been overcome before. Death caused by cancer has only been acknowledged in obituaries in with any regular with the acknowledgement of cancer, which used to appear in obituaries as a cause of death identified as

“a long illness”, as though cancer were a failure of character, rather than a glitch in the cell replication process or the result of nasty life events. Likewise, depressive disorders may manifest themselves in what appears to be laziness, disinterest, and verbally and physically aggressive behaviors towards family, all of which appear to be character flaws to be hidden or denied.

Treat the depression as a fact. Speak of the symptoms as symptoms, and the disease as a disease. Several students have been told by friends or family that they just need to be strong, get happy, and not depend on drugs to make them feel better. This is not effective support. A diabetic needs to modify aspects of life and take medication to survive the diabetes: a depressive must modify in the same way. Medication, treatment, and finding ways to have a life around the illness are imperative for a person with major depression.

Working with MDD students is stressful for a teacher. One symptom of MDD is attempted suicide. When a parent calls in that a student with major depression is “sick” and can’t make a session – is it a euphemism? Is the child ill with a virus, or have they fallen off the edge of depression? HHI teacher John Hendrikson tells his students to call him if they feel “like they are going to the Dark Side”, and he has fielded those calls. This is a skill not covered in credentialing programs.

So what do you do when you’re sitting across the table from a kid who is silent, immobile, angry, miserable, and unable to think? One basic guideline: Do not increase the stress level of the student. Stress is overwhelmingly implicated as a causative factor of depression. Stress hormones, adrenaline and cortisol, allow the body to respond rapidly to a short-term threat. A long-term state of stress, either from an actual physical threat or from, and this is important, from

a perceived possible threat, can send the body into depression. The stress of not meeting expectations, of social isolation, or of plain internal fretting, can produce stress chemicals.

The long-term activation of the stress-response system — and the subsequent overexposure to cortisol and other stress hormones — can disrupt almost all your body's processes. This puts you at increased risk of numerous health problems, including...depression and memory impairment (Mayo Clinic, 2012b, para. 9)

Check in with them and ask what kind of a day they are having. This is where listening and asking neutral questions will come into play. The student knows how he is doing on the outset of a session, though that may change as the hour(s) goes on. There may be what feels like very loopy reasoning at this point, and the students may express much of their frustration or emotional pain in the form of irritable and angry pronouncements or interpretations of events. The student needs to reach a transition point at which I can move us into the day's work, and if he is overwhelmed by the depression, that transition point may take a long while to occur. Ask if there is anything in particular with the work that is bothering them, and address that with action — tell them you will help them do it.

Check in on any work they have already completed, and ask if they need help on anything particular. Paraphrase the question to “What is giving you trouble with this subject?” - - different answers come with each rephrasing. Also ask, “What was it about this that made it doable?” Part of the goal is to get the information into the student's head, but another part of the goal is to help the student identify components of the work that they can tackle on their own. If work isn't completed, and work won't be completed, ask, “What was it about this that kept you from doing it?” Even though the student spends most of their time alone and at home, they

probably did not start the work until the teacher called ½ hour before class. Short deadlines are important.

When you create a homework checklist, include rote tasks such as labeling papers, cleaning out backpacks, and even sharpening pencils.

Play to their strengths. A person in a major depressive state does not form new neural connections. Acquiring new skills is extremely difficult for someone with MDD, and requires vast effort, far beyond anything a non-depressed person must expend to gain the same skills. A student's acquisition of study skills and strategies stopped when the depression started. Do not try to teach new skills to "make things easier". Instead, help them to rely on habitual actions acquired in earlier grades. They can write their name, date, and the assignment on the paper. In math, have them copy the problems, neatly, to their paper, leaving room to solve each one. They are to box their answers. In social studies or English, they are to head their papers and copy the questions. If they feel they can answer the question, they do. If they can't, they put a question mark in the answer space and keep copying.

Remember that their performance with you has little to do with the student's efforts or with your teaching skill, and everything to do with the physical nature of depression. Find out when the student's depression began -- not when they were diagnosed, which is generally weeks to months after the real depression began. The student knows when the trouble started, so ask them. The best question I've found for getting an accurate date is, "When did things start getting hard?" Cross-check with the student's assignment calendar if they use one – right around the time things got hard, the student stopped writing in the calendar.

On days when I'm not feeling well, I will tell the student that I am having a "bad day", and ask if she be okay with us having a quiet work session. I will tell them (within limits) why I

am feeling down or tired – it is amazing how interested adolescents can be in what can affect adults' emotions. Model appropriate responses to frustration for them, and be honest about it. Identify and describe your problem – car problems or the dog being an escape artist are appealing – and say how you feel about it. Then tell them your plan to fix it. Simple daily problems are exhausting for a depressed child: a broken shoelace can throw them off track and take lots of energy to repair or replace. Knowing that someone else has problems with daily things is very soothing to them.

Difficulty in making decisions is a symptom of major depression. Therefore, do not force the student to make decisions. I tell them what subject we will work on, providing they had no questions of their own: if they have a subject they want to work on, by all means start with that one, but most likely they won't care what gets done, and tell them what problems we will do. I do ask them to read the problems to see if they find one that they want help on, and go to that one first. I might offer them a choice of essay topics, but I do not ask them to generate their own question, or even their own topic sentence. Note for English and writing teachers: Depressed students get stuck on transition sentences. The ability to form a verbal link between two ideas seems to be quite impaired. If they are having a "bad day", ask yes or no questions.

Limit the amount of time spent on a given task. This may seem surprising, as we generally want a given assignment completed, but depressed students do not seem to see the light at the end of the tunnel. If the student is absolutely befuddled by a math problem, skip it. When giving standardized tests, do one section per day, unless the student is willing to try more. Make a tiny mark on the answer sheet to show them how far they have to go. Create assignment sheets with each task broken into subtasks, each subtask with a check-off box.

A person with major depressive disorder has a diminished ability to concentrate. Monitor the student for non-verbal clues of drifting attention– staring into space, re-reading the same line of text to themselves. Ask the student what is confusing them about the work, and address it immediately.

Sit with the student while they work. Bring your own work to do if they find themselves able to continue independently. More than one student has said something like “I can get the work done if you’re sitting here” to me, or I have said it for them: “We can just sit here and you can get the work done.”

Use analogies. Build simple bridges between what the student already knows or has experienced to what the new lesson is intended to impart. Depression reduces the brain’s ability to form new neural connections. Respect that limitation and work around it, and allow the student’s brain to try to attach the new information to old constructs.

Immediately include at least partial PE-type credits and exercise into the student’s HHI curriculum. Yoga, walking, biking – any kind of life-time activities could be documented by either the student or the student with the assistance of the HHI teacher and counted towards “elective” credits if not to the student’s physical education requirements. Why? Because physical activity is something a depressive student can do, can do for credit, and it can help ameliorate depression symptoms. On a bad day, it may be the one thing the student can do, and even then, the teacher may have to lead the student through the activity. With due respect to the rigors of high-school physical education, my students generally pass PE by showing up to class, clean and dressed and willing to try to focus for two hours, and willing to come for a walk. The level of effort these students use to get out of bed and then get dressed is more that most people use in a day’s worth of activities. For documentation, the student keeps a log of daily exercise.

Again, do not expect it to be done. Check the log every other day and have the student fill in any exercise they have done. The log may seem like the simplest homework ever offered, but few depression students will complete it.

Reconsider assessment strategies and what “learning the material” looks like in light of how depression interferes with the levels of Bloom’s Revised Taxonomy (Anderson and Krathwohl, 2001). Must one have a chapter test in math, or can the student do the chapter review? Pros – the completed test shows the level of mastery of the chapter information. It can document the student’s progress for the school. Cons: In five hours of instruction per week, with all subjects to be covered in that time, is it worth it to spend an hour proctoring a test? Could that hour be used to cover several sections in the next chapter? Could the student take the chapter test from the book and have the weekend to do it, so they could flip back in the book to find the specific lesson the question is based upon? Could the student demonstrate understanding by “teaching” a problem back to you?

Depression students are generally not great essay-writers. What seems to work is for the teacher to rephrase the prompt and give examples that fit it. Modify the essay structure down it a one or two sentence introduction and conclusion, and talk the student through the writing. Be the typist and type what the student says as she is saying it. Plan on re-writing rough drafts several times. Also, tell the student that you will read aloud a poor paragraph in a flat, uninflected voice. The student can often hear sentences that need to be reworked when reading it seems ineffective.

Keeping students out of their own mess is a hefty portion of the battle. Telling a depressed student to straighten out their binder is a non-starter. Depressives with anxiety issues may well have very neat binders, but they often are not organized. If they have only depression, as a rule, their binders and backpacks are a mess. They do not know what to throw away, and it

really does not occur to them to do that. They just shuffle papers from side to side.

Disorganization and memory issues are awful things when you have six classes a day to keep track of, and are trying to learn brand new subjects for which you will be assessed.. You need to walk them through it. Have them take out the binder. Tell them to find three pieces of junk paper – something that does not count for points – and throw them away.

Sometimes going to a busy place to work can help a student to focus. The noise and activity of a coffee shop or fast food restaurant can push them over an activation threshold that triggers the ability to focus. Basically, they get energy from the motion around them. There are hazards in coffee/fast food shops in the form of too much noise and in the presence of other students known to your student, both of which can be quite distracting. Check with the store manager ahead of time that it's okay to be there over a long period of time. Buy a coffee to pay the chair rent.

One question that comes up frequently from parents as well as the administrator of the HHI program is whether or not the student can transfer to the Independent Study programs available in the district. These include charter schools, distance computer learning, and the district independent study school, in which a student meets with an instructor once or twice a week and completes coursework for one class at a time. If the student falls back into depression, he will most likely not be able to complete independent work.

Another frequently expressed parental concern is how the lower grades a depressed student will get affect a student's college prospects. Both the parent and the child need to know that the grade blip on the high-school transcript can be explained very well in the college entrance essay. When an essay question asks something like, "What was the most difficult time in your life? How did you overcome these difficulties?" or "Have you ever struggled for

something and failed? How did you respond?”, the student who has survived Major Depressive Disorder has a ready-made answer.

On days when I’m not feeling well, I will tell the student that I am having a “bad day”, and ask if she be okay with us having a quiet work session. I will tell them (within limits) why I am feeling down or tired – it is amazing how interested adolescents can be in what affects and adult’s emotions, and in how the adult expresses the affect, both verbally and physically.

Chapter 5 Discussion /Analysis

Summary of Major Findings

I was trying to find a few instructional techniques that work consistently with depressed students. I feel as though I ended up using therapeutic actions that ended up helping the student to produce work that could be counted for credit against the work that a student in a regular high-school level class would produce.

I found that my own experience with depressed students affected my instructional practice. For instance, I might arrive at a house and find student crying and unable to tell me why they were crying. I did not tell immediately the student to buck up and get on with it, to take official full advantage of my limited instructional time. I did learn to spend time and talk with the student, trying to help them get perspective on what it was that was bothering them. At that point, I generally found it worthwhile to move on to some sort of non-emotional task that would allow the student to recover, calm down, and to help accomplish an academic activity.

Apples and trees. Adolescent depression does not seem to happen in a vacuum. There is evidence for it being a heritable trait, and there is evidence that it can be triggered by a single stressful event or a series of stressful events in a person's life.

1. Specific genetic markers for teen depression have been identified. Eleven blood markers “were able to differentiate between depressed and non-depressed adolescents. In addition, 18 of the 26 markers distinguished between patients that had only major depression and those who had major depression combined with anxiety disorder” (ScienceDaily, 2012, para.1).
2. If the apple and the tree don't seem to be similar, take a look at what being around the tree is doing to the apple. One HHI student, so deep into depressive psychomotor

retardation that she was unresponsive, was taken to a psych facility by her parents. The parents presented as so off-balance to the facility staff that the staff tried to retain the parents in the facility.

Comparison of Findings to Literature Review

Findings parallel the literature review, providing the symptomology of depression is viewed in practical terms. While a symptom of depression might be “diminished ability to think or concentrate”, the high-school version of that equals diminished abilities on critical thinking and questions involving analysis. It also means that the student cannot prioritize work, cannot ask reasonable questions in class, and cannot make use of study time. For a teacher, this can be annoying behavior. So, the symptoms have an effect on the teacher. Unless the teacher knows that the annoying behavior is a predictable symptom of the disease, rather than something done to distract the class, the student is likely to be punished in some way.

Limitations/Gaps in the Study

The narratives that informed this research were not of a broad spectrum of students. All of the students were from the Two Rivers School District Home and Hospital Instruction Program. Most were from middle and upper middle-income families. All of them had at least one person in the family who was able to navigate the medical and district paperwork and permissions, and who could act as a contact for the program. These students had a diagnosis from a psychologist, and several of them had had depression so severe that they were hospitalized prior to entering HHI. The family had some access to health care and insurance which covers mental health issues. They probably had a counselor or classroom teacher who knew about HHI and suggested it to the parents.

In addition, many of the students had not only major depression but also some other mental health condition (co-morbidity) such as anxiety, or Post-Traumatic Stress Disorder.

Implications for Future Research

The most effective teaching strategy has been a combination of teaching academics and practical ways of handling depressive symptoms. “Recent research shows that certain types of short-term psychotherapy, particularly cognitive-behavioral therapy (CBT), can help relieve depression in children and adolescents. CBT is based on the premise that people with depression have cognitive distortions in their views of themselves, the world, and the future. CBT, designed to be a time-limited therapy, focuses on changing these distortions. An NIMH-supported study that compared different types of psychotherapy for major depression in adolescents found that CBT led to remission in nearly 65 percent of cases, a higher rate than either supportive therapy or family therapy. CBT also resulted in a more rapid treatment response” (About Teen Depression, n.d.,para. 16).

It may well be that persons trained in CBT techniques as well as pedagogy will prove to be the most effective at both teaching students and in supporting the recovery of students with Major Depressive Disorder. In addition, approaching CBT within the framework of schoolwork might relieve the pressure a student feels at “going to the psychologist”. On the practical side, it would mean that the student is getting treatment and getting work done. This may be too much a burden for a school district to assume, but it might be explored in terms of a tutorial framework inside or outside the school.

Exercise in general, and walking in particular, has a beneficial effect for depressives: “Doing 30 minutes or more of exercise a day for three to five days a week can significantly improve depression symptoms” (Mayo Clinic, 2012a, para1). Exercise increases serotonin levels

(lacking in depressives) and reduces stress hormones, which are strongly implicated in the onset of depression. It would be interesting to study whether or not schools with four-year PE requirements have a lower rate of depression in their student bodies. A high school may consider including daily P.E. courses as a four-year graduation requirement, rather than a two-year requirement, as part of its effort to increase graduation rate and academic test scores.

Can training teachers in the practical effects of depression symptoms increase student performance, reduce stress, and possibly reduce the stress-related incidence of adolescent depression?

Finally, a system of auditing classes in conjunction with HHI instruction should be explored. Let students attend a class or two at their school, without the pressure of grades – let the Home Hospital instructor be responsible for assessment and grading. Students can bring papers from class and receive HHI credit for them, as well as following the program laid out by the HHI instructor. This would keep them active in school, allow for peer interaction if the student feels capable of it, and let them test their recovery without the possibility of failure. Auditing would serve several functions. If a student can't meet an auditing schedule – say, 11AM to 1:30PM daily – for at least two weeks, then they are not ready to transition to a full academic schedule. It maintains some level of physical stamina. It gives the student a specific schedule to meet and a purpose to meet the schedule. Many MDD students have a very difficult time getting up, getting ready, and getting out on time to meet school. Auditing provides a reason for personal maintenance and grooming. It also gives the parents two or three hours in a day or week in which they know the child is supervised, and allows them time to relax.

Overall Significance of the Study

Whether the goal of our educational system is to produce life-long learners, higher test scores, or to leave no child behind, this disease is firmly in the way. If a high school had a head lice problem that affected 10% of the student body, one can be assured that there would be a school-wide effort to respond to it. If 10% of the student body had broken legs, those 10% would not be considered failures in the physical education program. Yet, depression is an illness that is a major impairment to learning that is far more dangerous than lice and longer-lasting than a broken leg, and for which little or no instructional or organizational accommodation is made. Given the severity and the prevalence of this disease, all teachers should have information and training in dealing with this population.

Depression it is an illness of hidden pain. Unless a student is prone to outbursts, it is unlikely to be noticed in an educational setting. Even in a one-on-one situation, it is tempting to accuse the student of “not paying attention” or “just not wanting to do the work.” It is immensely important to acknowledge these and other behaviors as symptoms of a disease, and to make practical accommodations for these students.

About the Author

Cara Newman received her BA in English and American Literature from UC Santa Cruz in 1987, and her teaching credential from Dominican University San Rafael in 2000. She has taken a wide range of classes through the UC Berkeley Extension and San Francisco State University. By day, she teaches in a Home/Hospital Instruction program. By night, she works on independent films and plays and draws tiny little animals.

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Appendix

A Home and Hospital Teacher's Pragmatic Approach to Teaching Students with Major Depressive Disorder Or: Things That Work, Mostly

The Bad Day List: This list is given to students. The list is based on experience over the years, additional reading, questions I have asked students regarding what is effective for them, and suggestions from teachers and counselors with experience in working with this population. It is limited to the third level of Bloom's Taxonomy, "applying", and makes use of activities that the child already knows how to do. These are not activities that the child needs to learn, for the most part. "Diet, sleep hygiene, relaxation techniques, and physical exercise should be included as adjunctive therapies (Guidelines for the Assessment and Treatment of Major Depression In Children and Adolescents, University of Louisville Depression Center).

THINGS TO DO ON A BAD DAY

A bad day means it is hard to do most things. Your brain may be saying mean things to you, or being particularly nasty to you, and people may seem especially irritating. It is probably very difficult to move, even though you want to. Your thoughts are whirling around as though they were in a blender. Your body might hurt. The things you can on a bad day is automatic stuff – things you've done a lot of times in the past, and that don't require organization.

Some things to do on a bad day:

Get up

Put on clothes

Put on socks

Put on shoes

Take care of your pet(s) – clean water, fresh food

Wash face

Brush teeth

Take meds/vitamins

Eat a piece of fruit

Eat a vegetable

Make your bed

Put books on bookshelf

Put dirty clothes in hamper

Take a bath or shower

Vacuum or sweep room

Drink some tea or water

Empty garbage cans

Dust dresser or shelves

Wipe kitchen counters/table

Do laundry

Listen to a book on tape

Listen to music (some people don't like music when they are depressed)

Walk or brush the dog/parrot/ferret/sloth

Throw toys for or brush the cat/dog/domestic mammal

Rake or mow the yard

Pull weeds

Do 10 sit-ups

Sit outside for 10 minutes

Walk to the end of the block and back/to the coffee shop/library/ fast food shop

Have a friend take you to a movie (let them choose the movie – just go)

Go to the school with a friend/parent/whatever and walk on the running track.

Go to bed by 10pm (you don't have to sleep, just lie down & turn out the lights)

Stay away from video games!

School things for a bad day:

Label paper – name, date, page, class, problem numbers

Put your name on papers

Write assignment on papers

Number papers

Copy problems to paper – leave room to solve problem or write answers

Put the paper in your “to-do” folder

Take care of PE – go for a walk/bike ride/jog/stretch/walk the dog

Sharpen pencils

Check that pens have ink (throw away dry pens)

Check teacher websites – copy assignments into assignment book

Throw out 3 pieces of scrap paper

Tricks that can help you get some of the work done:

- Keep all of your school stuff together and in one place. (a backpack or messenger bag is good)

- Find or have someone help you get an audio version of the novel your class is reading – library download, CD, tape – listening counts as reading
- Copy math problems down to your paper, then leave 4-8 lines for solving them later (copying is half the work). Leave that paper in your binder or “to-do” folder when you’re done.
- If you’re on a roll, stay with it. If not, make yourself copy 10 problems, or read 10 paragraphs, or listen for 10 minutes. You can do 10. Then get up and do something else. Rest. You did well.
- In English and History, do the first two questions on the assignment. These are usually the ones about facts, rather than interpretation.

THINGS TO DO ON AN OKAY DAY

An Okay Day is one where you slept the night before and were able to get up on your own. You don’t have to work as hard to do basic things, and people are less irritating than on a bad day. It is easy to make a phone call to a friend.

Get up and dressed

Eat breakfast – no soda!

Walk, jog, run, bike, go to the gym

Take your meds and vitamins

Drink plenty of water

Meet friends after school

Check around the house – anything messy that is your stuff or that you can fix? Take care of it.

School things to do on an “okay” day:

Look at your assignments and break the work into small actions

Answer all of the questions you can on an assignment. Put a question mark next to the ones you're not sure of.

Check teacher websites: copy assignments to your planner

Check with friends – email or phone – on what the class is doing

Do medium work first

Put papers together by subject

THINGS TO DO ON A GOOD DAY

You know when you are having a good day.

School things for a “good” day:

Do the hard work first – save the easier stuff for “okay” days.

Update your school planner – check off completed work

Put your papers in order

Other tips for teachers

- Use the Good Day/Bad Day sheets to reduce student anxiety (and to remind yourself what you are up against)
- Check in on any work they have already completed, and ask if they need help on anything particular. Paraphrase the question to “What is giving you trouble with this subject?” -- different answers come with each rephrasing. Also ask, “What was it about this that made it doable?” Part of the goal is to get the information into the student’s head,

but another part of the goal is to help the student identify components of the work that they can tackle on their own.

- If work isn't completed, and work won't be completed, ask, "What was it about this that kept you from doing it?" They may say it was too hard, or they didn't understand it. It is more likely that they couldn't muster the energy to read it.
- Even though the student spends most of their time alone and at home, they probably did not start the work until the teacher called ½ hour before class. Short deadlines are important.
- When you create a homework checklist, include rote tasks such as labeling papers, cleaning out backpacks, and even sharpening pencils.
- Get the student an audio version of short stories, novels and, if possible, history or science texts. Reading may be too difficult for them, and if they can listen, they will at least have a framework of information for you to work with. Alternatively, read short stories or social studies aloud to them, and trade off paragraphs – you read one, they read one.
- Play to their strengths. A person in a major depressive state does not form new neural connections. Acquiring new skills is extremely difficult for someone with MDD, and requires vast effort, far beyond anything a non-depressed person must expend to gain the same skills. A student's acquisition of study skills and strategies stopped when the depression started. Do not try to teach new skills to "make things easier". Instead, help them to rely on habitual actions acquired in earlier grades. They can write their name, date, and the assignment on the paper. In math, have them copy the problems, neatly, to their paper, leaving room to solve each one. They are to box their answers. In social

studies or English, they are to head their papers and copy the questions. If they feel they can answer the question, they do. If they can't, they put a question mark in the answer space and keep copying.

- Do not assume that because they can or will use a new skill in your presence that they can or will do it without your presence. I repeatedly succumb to the temptation to “teach” my depressed students a study skill that I know will make their lives easier, like writing the assignment in one’s organizer and then breaking it into chunks. Then, I leave them to apply it to their work by themselves. I know that the learning process itself is greatly impaired by the depression. Depending on how impaired a student is, a teacher may have to talk and walk them through the application of the skill every time the student needs to use it.
- Spell out what you want them to do. They may not be able to extrapolate a suggestion into practical reality. Even if they do something eminently practical in your presence, they may not be able to do keep on doing it without you. Guide a student through creating an assignment sheet so that student the student’s assignment is in check-off form and so that it matches exactly what you have written as the assignment.
- Review Bloom’s Taxonomy -- On a Bad Day, the student might be able to “apply” previously learned material. On an “Okay Day”, that may increase to “remember and apply”.
- Use limited and extremely clear instructions with command words (“Do”, “Solve” “Write”) and make the goal a very small piece of work.
- Limited and extremely clear expectations: “We will get through X work today”, and be prepared to modify that expectation upward or downward.

- Guide a student through creating an assignment sheet so that student the student's assignment would exactly match the teacher's.
- For math – use a whiteboard for problem solving. Depression students can become completely distracted by seeing an incorrectly solved problem on a sheet of paper, and will either feel defeated by it or will spend inordinate amounts of time erasing the problem. The whiteboard makes mistakes disappear. Whiteboard tips: use two boards, and solve the problem on your own while the student is doing it. You are modeling not only the problem-solving algorithm, but also how to deal with an error in calculation – when I make one (sometimes on purpose, sometimes because I made an error) I identify the mistake, show it to the student, wipe the board clean, and try it again.
- Call the student ½ hour before the appointment and remind them what materials they need to set out for your meeting. Ask them to do two more problems before you arrive – and tell them the subject to do it in. This gives them a deadline and helps to keep them awake.
- Give assignments and instruction using a check-off list, rather than paragraph form.
- Create assignment sheets with each task broken into subtasks, each subtask with a check-off box.
- If a student cannot come up with a short or paragraph answer, hand the pencil and paper to them, and tell them to copy what you say. This moves their hands and hopefully brains through analyzing and creating.
- A person with major depressive disorder has a diminished ability to concentrate. Monitor the student for non-verbal clues of drifting attention– staring into space or re-reading the

same line of text. Ask the student what is confusing them about the work, and address it immediately.

- Sit with the student while they work. Bring your own work to do if they find themselves able to continue independently. More than one student has said something like “I can get the work done if you’re sitting here” to me, or I have said it for them: “We can just sit here and you can get the work done.”
- Use analogies. Build simple bridges between what the student already knows or has experienced to what the new lesson is intended to impart. Depression reduces the brain’s ability to form new neural connections. Respect that limitation and work around it, and allow the student’s brain to try to attach the new information to old constructs.
- Tell students to put a question mark next to problem that confuse them. They are to try to work the problem, but if they’re just not getting it, put a question and move on. However, they are to copy the problem to their paper before putting a question mark.
- Take an hour and watch Robert Sapolsky’s 2009 lecture on depression at Stanford University (<http://www.youtube.com/watch?v=NOAgplgTxfc>) .