2B. Workshop for Parents: What is Depression?

What is Depression? is designed to support learning for a facilitator and a group of parent participants. It offers interactive activities and reflective exercises.

This workshop can be adapted as a virtual offering. Refer to the National Center on Parent, Family, and Community Engagement resource **Leading Online Parent Meetings and Groups** as a guide.

Workshop Focus

Depression is a common condition that affects many people, including parents and staff in Head Start and early childhood programs. Research shows that 20% of adults will experience depression in their lifetime. Families experiencing poverty or other adversities may experience higher levels of depression. For example, up to 48% of Early Head Start parents screened positive for depression in a national study (Cohen et al, 2007).

This workshop will look at depression and how it can impact parenting. It is not meant to teach participants how to be therapists, but to provide useful information for parents to understand depression and its impact. People who receive effective treatment for depression can lead productive and fulfilling lives. However, when unrecognized and untreated, depression can negatively affect people's ability to work, parent, and maintain relationships.

Consider delivering **Workshop 1B: Partnering with Early Childhood Staff** prior to this workshop to review strategies for how to build and maintain trusting relationships with teachers and other staff.

We recommend that this session be facilitated by the program mental health consultant or another mental health professional. They may be joined by an experienced family services professional. Be sure that facilitators are aware of local resources for a referral if indicated.

In this resource, "parent" and "family" refer to all adults who interact with early childhood systems in support of their child, including biological, adoptive, and foster parents, pregnant women and expectant families, grandparents, legal and informal guardians, and adult siblings.

Goal

To introduce participants to the topic of depression.

Learning Objectives

Participants will:

- Learn the signs, symptoms, and causes of depression
- Learn how depression may affect individuals
- Explore fears, concerns, and myths about depression
- Learn that depression and responses to it can be considered along a continuum
- Learn strategies to enhance resilience
- Gain knowledge regarding resources and access to depression-related services

Method and Content

This workshop has three sequential sections:

- Exercise 1: Questions About Depression
- Exercise 2: Discussing Responses to Exercise 1
- Exercise 3: Encouraging Resilience

In Exercise 1 the participants are asked to respond to six questions about depression.

In Exercise 2 participants will focus on reviewing those responses and providing information.

In Exercise 3 the group will have the chance to discuss messages that encourage resilience.

The exercises provided are designed to bring out what participants' already think about depression, show how cultural beliefs provide different perspectives, and identify any gaps in knowledge or understanding.

It is important to encourage the group to accept the wide variety of emotions and reactions that the subject of depression can evoke. Acknowledging feelings can promote healing and change. Some common emotions and reactions are: periods of silence, sadness, unexpected humor, anger, anxiety, and self-doubt, among others.

Estimated Time

1.5-2 hours
This does not include facilitator preparation.

Learning Environment

- A space large enough for participants to engage in whole group discussions. Consider including two facilitators for large groups (e.g. more than 20 participants).
- Seating for the group.

Materials

- Seven large pieces of poster-sized paper.
- Markers for each participant.
- A packet for each participant with the following:
  - Handout 1: How Do I Know If a Person Is Depressed?
  - Handout 2: Three Messages for Parents to Encourage Resilience
  - Workshop Evaluation Form

Facilitator Preparation

Read through the workshop materials in advance. This will help prepare you for the variety of responses, questions, and concerns that may arise. Take time to reflect on your own responses to the exercise questions. It is important to consider your feelings and sensitivities concerning the topic of depression prior to the workshops.

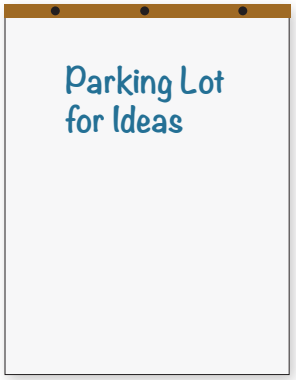
Consider that participants may have past or present experiences with depression. Or, they may have a loved one who has experienced depression. Others may have strong feelings about how depression is viewed within their community, culture or religion.

Read the Family Connections short papers entitled about depression (see Related Resources). These resources outline suggestions for best practice.

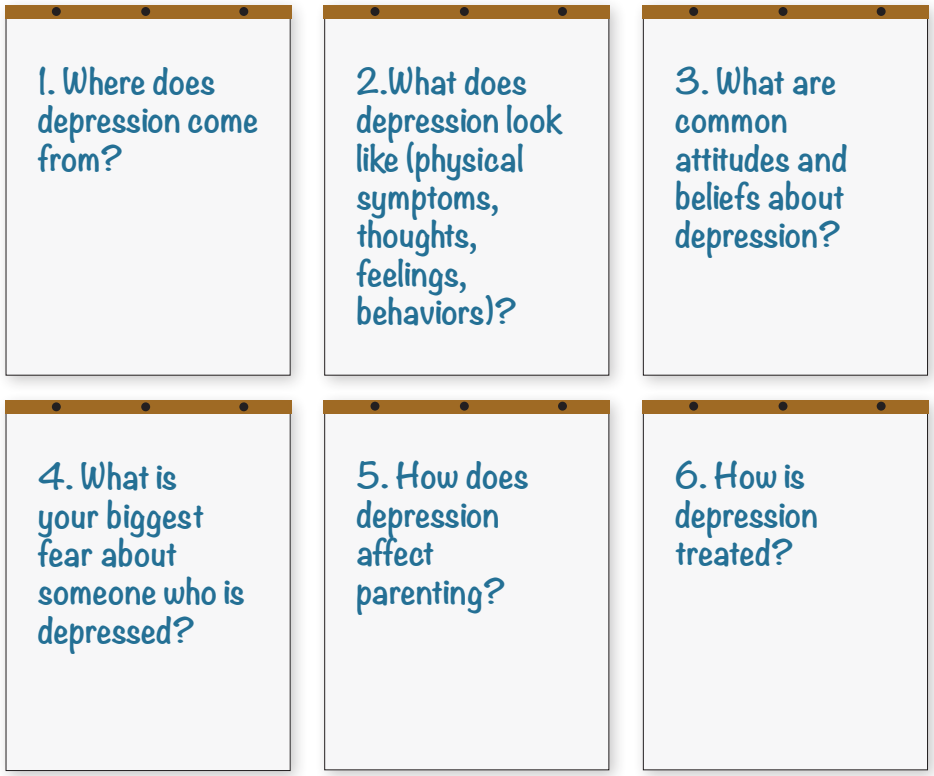
Some parents may require additional support after this workshop. Staff and the facilitator can prepare to provide support and to offer resources to those individuals. This requires an understanding of the resources available. It is important that program staff have also participated in this workshop. Together, program staff can move forward in their understanding of the complex subject of depression.

Preparing the Workshop Space

- Set up chairs so that the participants can begin as a large group. Plan in advance how you will move into smaller groups.
- Place a materials packet on each chair in the room.
- Prepare a large piece of paper titled “Parking Lot for Ideas.”



- Prepare six large pieces of paper with titles (see below).



- Display the large pieces of paper so that the whole group will be able to see them and write on them easily.
- Markers can be set out in front of the papers or given to each participant prior to the exercise.

Introduction

Facilitators are encouraged to use their own words to introduce the workshop. Some key points to consider are:

- Welcome the group and review logistics – general agenda, time frame, when to expect breaks, materials, sign-in sheet, etc.
- Introduce the topic. For example, you might say, "The title of this workshop is What Is Depression? The purpose of this workshop is to learn more about depression because knowledge is a powerful tool toward understanding. Depression is a common condition that affects many people, including parents and staff in Head Start and early childhood programs. Research shows that 20% of adults experience depression in their lifetime. A national study found that 48% of Early Head Start parents screened positive for depression. This workshop is not meant to teach you how to provide therapy for friends and family. It is meant to provide information that will be useful in understanding depression and its impact."
- Describe the objectives of this workshop:
  - Learn the signs, symptoms, and causes of depression
  - Learn how depression may affect individuals
  - Explore fears, concerns, and myths about depression
  - Learn that depression and responses to it can be considered along a continuum
  - Learn strategies to enhance resilience
  - Gain knowledge regarding resources and access to depression-related services
- Explain the "Parking Lot for Ideas" to the group. If a question, suggestion, or concern is offered that is related to the topic but unrelated to the specific exercise, the facilitator will record it on the "Parking Lot for Ideas". The facilitator will refer back to these ideas at the end of the workshop for further discussion as time permits.
- Create a Group Agreement with the participants. This is a short list of co-constructed statements intended to promote a safe, positive environment for all participants. Ask the participants what they will need to fully participate in the workshop. These can be printed on a large sheet of paper. Creating a Group Agreement is an important step before beginning the exercise. Depression is a topic that can evoke many feelings, reactions, and differing perspectives. For this reason, it is especially important to create a Group Agreement and refer to it as needed.

Sample Group Agreement

Treat each other with respect.
Agree to disagree.
Maintain confidentiality–what is shared in the group stays in the group.
Managing technology (use of phones, etc.).
Humor can be helpful.
(Additional suggestions to create a positive, safe environment.)

Exercise 1: Questions About Depression

This exercise gives participants the opportunity to share their knowledge, concerns, and perceptions about depression. The facilitator will ask participants to write their answers on posted sheets and then discuss responses with the group. The exercise is designed to encourage participation but allows for anonymity to promote honest responses and questions.

Invite the participants to move around the room and fill in their responses to the six questions on the posted sheets. The six posted questions are:

1. Where does depression come from?
2. What does depression look like (physical symptoms, thoughts, feelings, behaviors)?
3. What are common attitudes/beliefs about depression?
4. What is your biggest fear about someone who is depressed?
5. How does depression affect parenting?
6. How is depression treated?

Facilitator Strategy

Prepare yourself for Exercise 2 by reviewing what participants are writing on the posted sheets. Remember that depression is common and has significant impact on people's lives. The topic of depression can evoke strong feelings. Often, participants' responses are powerful and moving. Responses can also be critical or challenging.

You may read or hear things like:

- "Depression comes from your father telling you that you're nothing your whole life."
- "A treatment for depression is suicide."
- "Depression is an excuse for not getting on with your life."
- "Depression comes from long-term anxiety that was brought on by stress over things that seem impossible to change in your life."
- "Talking doesn't make anything better. You just pull yourself up and cope."

The examples listed above demonstrate how intensely and personally participants may respond. It is your responsibility to remain calm and respectful. Keep in mind that these responses hold the truth for the people in the workshop, even if you do not agree with them or have evidence to the contrary. Acknowledge that some believe these points to be true before offering new information. Refer to the Group Agreement if the group needs guidance for how to discuss difficult responses.

Exercise 2: Discussion of Reflections from Exercise 1

In Exercise 2, the group reviews and discusses the responses to the questions about depression. The facilitator uses the responses as a starting point for the discussion while adding information from the following Content Section to include information that may be missing, incomplete, or incorrect. Questions and comments are taken from the group throughout the workshop.

Start with the first question, acknowledging the written responses provided by the group. Use the part of the Content Section devoted to Question #1 as a reference for discussion points, common responses, and facts about depression. Repeat this process for all six questions.

Facilitator Strategies

Reviewing responses as a group can become stressful for some participants. As mentioned in the previous facilitator strategy, participants may offer responses that are complex, based on information different from your own views. Or, responses may be highly charged emotionally. Remember to remain calm, respectful, and patient with participants. You can acknowledge to the group that discussing depression can be difficult. It can feel overwhelming at times.

If the discussion becomes difficult, invite the group to pause and take a few deep breaths together before continuing. Remind participants that the purpose of this workshop is to help us all get better at understanding depression.

Do not be surprised if some participants seem exhausted, agitated, or have a hard time remaining focused. Other participants may insert humor during a serious discussion. These are all common responses to this subject matter. Make a note to yourself about which participants seem to have a hard time with this workshop. Follow-up with them to find out more about their experience.

Table 1. Sample Responses for Exercise 1

Examples of potential participant responses	Examples of potential facilitator responses
A treatment for depression is suicide.	Some would agree that to end one's life may be a response. In fact, some individuals with severe depression may think about ending their lives by suicide. Others wouldn't consider it a treatment because they consider treatment to be a means of becoming well. In any case, discussion of suicide must be taken very seriously and responded to as an emergency.
Depression is an excuse for not getting on with your life.	That may be how others view someone suffering from depression, but it also can be the way the depressed person views himself or herself. Depression can make a person feel very stuck and also affect self-esteem.

Content Section: About Depression

This section provides information about depression. It is organized to correspond with the six workshop questions. Facilitators can review this information in advance to be prepared for questions and comments that may emerge from the exercise. This information should not be distributed as a handout for participants.

1. **Where does depression come from?**

   Depression can occur for many reasons. Common responses about the origin of depression may include:

   - **Families/genes:** Clinical depression often runs in families, which suggests that its origins can be genetic (inherited). It is important to remember that depression in a family does not mean each member will experience depression. Other influences are also important to consider.
   - **The world/the community/the home:** Depression is influenced by one's experience of the world, community, and home events and experiences.
   - **Traumatic event(s):** Depression can be related to experiencing a traumatic event, such as a death, anniversary of a loss, exposure to violence, natural disasters, or a pandemic.
   - **Stressful event(s):** An episode of depression can result from a challenging life situation or stressful event such as unemployment, marital discord/divorce/separation, an ongoing high-conflict relationship, and/or homelessness. While depression may begin in response to a serious event, the feelings of sadness may linger even after the stressful event is over – often for months, even years. Symptoms sometimes worsen after the perceived stressful event has resolved.
   - **"Nowhere":** For some individuals, there is no apparent event or series of events that can be tied directly to the feelings of depression.
   - **The physical environment:** Depression can be related to the weather and changes in seasonal light (seasonal affective disorder).
   - **Life adversities:** Poverty, exposure to violence, social isolation, racism, or a dangerous immigration journey to this country may all be risk factors for depression.
   - **Separation from supports:** Being far away from loved ones and community and/or country can be a risk factor for depression.
   - **Pregnancy/childbirth:** Perinatal depression can be related to hormonal changes, including those that occur during pregnancy or after a child is born.
   - **Other mental illnesses:** Depression can be accompanied by, and even aggravated by, other mental illnesses (e.g., substance use disorders, anxiety, learning disabilities, attention deficit/hyperactivity disorder).
   - **Other chronic illnesses:** People who have chronic illnesses, including pain disorders, hypothyroidism, diabetes, and others may be vulnerable to depression.

   Depression may result from any one of these factors, or they may interact to contribute to the development of depression.

Incidence and prevalence information

- The peak years of the onset of depression are in people in their late teens and early twenties (Gould, et al., 2003; Yalin & Young, 2018).
- After age 15, girls and women are twice as likely as boys and men to have depression (Beardslee, 2002).
- 20 percent of all Americans suffer a major depression at some point during their lifetime (Hasin, Sarvet, Meyers, et al., 2018).
- An estimated 17.3 million adults in the United States had at least one major depressive episode in 2017 (7.1% of all US adults) (National Institute of Mental Health, 2020).
- 48 percent of eligible Early Head Start mothers experience symptoms of major depression; depression was chronic among 12 percent of these mothers (US Department of Health and Human Services (USDHHS), 2006).
- 18 percent of Early Head Start fathers show signs of depression (USDHHS, 2006).
- Depression can be a recurring illness (American Psychiatric Association, 2013).
- Depression is the most treatable of the major mental illnesses, yet it is largely unrecognized by those affected by it and largely untreated (Kocsis et al., 2008; Olfson et al., 2016).

2. **What is depression and what does it look like (e.g., feelings, behaviors, physical symptoms, thoughts)?**

   Depression affects a person's emotions, thoughts, and behaviors. Common responses when asked to describe depression include:

   - **Feelings and behaviors.** Descriptions of sadness, fatigue, confusion, loss of energy, or even laziness. It is important to note (especially if not included in the group responses) that people experiencing depression also may show signs of anger, anxiety, agitation, or a "quick temper." Depression impairs how people feel about themselves, their relationships, and the world. This can contribute to feelings and behaviors related to isolation and refusing to reach out for help.
   - **Physical symptoms.** Sleeping more or less than usual, a loss of appetite (significant weight loss) or over-eating (significant weight gain), or a "numbness" and a sense of being overwhelmed. Although these signs and symptoms seem to contradict one another, they are all common to the experience of depression.
   - **Thoughts.** Depression can have a negative impact on feelings of self-esteem and self-worth. The negative messages that can play out in one's thoughts, such as "I am nothing" or "If I were smarter I could figure out how to feel better." Depression also impacts one's sense of the future and the ability to visualize and plan things in a positive way. Thoughts that reflect this include: "This feeling will never go away," "Nothing is ever going to really change," or "What is the point in even trying?"

It is important to understand that depression exists across a continuum. (A continuum is a range, such as from a low level to a high level).

On one end of the continuum are the inevitable and normal "ups and downs" in emotions. Feeling sadness in response to stress is normal, and the healthy person typically will "bounce back" within a few days. At some point in their lives, people are likely to experience some symptoms of depression. For example, if one is going through a stressful period, one may have feelings of fatigue or irritability. A person might experience a change in sleeping habits (a period of either more or less sleep). Once the stressful situation is over, it is likely that these symptoms will fade.

Moving toward the middle of this continuum, a person's sad, depressed, or irritable mood may become more of a concern. There may be more persistent signs of impaired functioning. These might include: disturbances in sleep, appetite, energy level, or concentration; a decrease in self-esteem; experiencing less joy from favorite activities; and/or frequent crying, irritability, agitation, or apathy. Mild differences in the ability to do work or to be with family and friends may become apparent. This level of depression typically occurs in response to a significant environmental stressor (e.g., death, marital conflict, family illness, abuse, school problem, etc.).

When a person's depressed mood and functional impairment persist, we have moved to the other end of the continuum where depression becomes a serious disorder. This is especially true if there are thoughts of harming oneself, ending one's life, or harming others.

Figure 1. illustrates how depression might be understood along a spectrum:

3. **What are common attitudes/beliefs about depression?**

   People may have broad ideas about depression. This is a natural opportunity to emphasize how stigma and shame often discourage people from reporting mental illness. Highlight the importance of reducing stigma and its presence among many environments and cultures.

Facilitator Strategy

Remember: Participants are being asked this question to help them openly discuss some of the stereotypes and misconceptions associated with depression. It is important that you remind them that there are no "wrong" answers. Reassure participants that this exercise does not label them as holding these beliefs or attitudes. Encourage participants to share attitudes and beliefs while assuring them that the group will not hold them responsible for defending those beliefs.

Common responses when asked about attitudes or beliefs about depression may include:

- "Depressed people are crazy."
- "Depressed people are weak."
- "Depressed people should just pull themselves together."
- "Depressed people don't believe strongly enough in God."
- "Depression is an excuse for giving up."
- "Depression is just laziness."
- "Depression makes you a bad parent."
- "Needing mental health help is an embarrassment to one's family."
- "Depressed people could get over it if they really wanted to."
- "Depressed people are all on pills."

How do these attitudes and beliefs influence reactions and responses to depression?

Sometimes people who experience depression do not seek help or hide their attempts at recovery. They may do this because they are afraid of being labeled, losing their jobs, or being judged by those around them. These attitudes and beliefs can encourage an atmosphere in which depression cannot be discussed.

Where do attitudes and beliefs about depression come from?

Ideas about depression are influenced by society's perceptions, one's personal experience, and factors related to culture. What might work to counter some of the beliefs and attitudes that may get in the way of people feeling comfortable getting help or sharing their experience?

Facilitator Strategy

Participants may have strong viewpoints, beliefs, and attitudes about depression and treatment for depression. It is important to keep the influences of society, personal experience, and culture in mind when responding to these views. Remember to maintain an environment in which participants feel free to discuss their views. You can model this by being open to others' experiences and encouraging the sharing of information. This is also a good opportunity to review the Group Agreement.

An illustration of this strategy is provided in the following vignette:

During discussion of Question #3, a participant raised her hand and told the group that this idea of depression being "in the brain" was not what she was raised to believe. She went on to say that this notion–that talking about depression would make somebody feel better–was a very "American" idea and was not true in the country where she was born.

The facilitator acknowledged that the use of talk therapy was a popular response in this country, but that there were many ways to understand and respond to depression. The facilitator then asked the participant if she knew anyone in her own homeland that was depressed and if so, what did they do to feel better?

The participant said that she knew people who had problems – "a heaviness in the heart" – and she knew that they felt better when they prayed and others prayed with them. The facilitator acknowledged that some people gain great comfort from the practice of their religion. Some find talking to a member of the clergy much more comfortable than talking to a mental health or medical professional. People can approach depression in their own way and find what kind of response or treatment works for them.

While this vignette used the example of a participant who was from a country other than the United States, the individuals in any workshop bring cultural experiences that reflect ethnicity, race, gender, community, neighborhood, and family. The facilitator in this vignette was careful not to judge the participant's view and also didn't avoid the discussion of religious beliefs. Instead, she asked to hear more, so that the group could discuss a broader understanding of depression across cultures and experiences.

4. **What is your biggest fear about someone who is depressed?**

   Some people may have fears about interacting with a person experiencing depression. Common responses regarding one's biggest fears about a person with depression may include:

   - "The person is going crazy."
   - "The person will neglect his or her children."
   - "The person's children will be harmed."
   - "The person is going to have his or her children taken away."
   - "The person will never recover."
   - "I will say the wrong thing to him or her and make it worse."
   - "I will miss the warning signs and that person will hurt someone."
   - "The person will end their life by suicide."

Facilitator Strategy

Acknowledging fears about depression is a first step in addressing them. Point out what the responses seem to say about what is important to the group. Use this opportunity to remind parents that staff are a tremendous resource and are in a position to be a support to the families they serve.

It also is important to acknowledge that people who are seriously depressed may have thoughts of ending their lives. An individual who raises current suicidal thoughts should be taken very seriously. A further conversation with the person having those thoughts may require referral to emergency medical help through their Primary Care Physician, therapist, a local Hospital Emergency Room, or a Crisis Line.

5. **How does depression affect parenting?**

   Depression can be a family illness. If one person in a family suffers from depression, it affects the entire family. But it's important to stress that parents with depression are able to be good parents. With support and treatment, they can be responsible caregivers, enhancing a child's strengths and resilience. Understanding how depression affects parenting is a first step in building resilience in parents and families.

   The following information needs to be shared with sensitivity and awareness of the potential impact on the participants. Consider the following points of discussion:

   Effects of Depression on Children. Without intervention, depression may profoundly affect parenting functions for extended periods of time. This can put children in these families at risk for longstanding impairment.

   The parenting difficulties that arise as a result of depression often include:

   - Increased hostility and frustration
   - Intolerance toward the child
   - Unpredictability and inconsistent caregiving
   - Unresponsiveness and withdrawal from the child

   Unresponsive, inconsistent, or harsh relationships with a parent can have a negative impact on the emotional and cognitive development of very young children. These children are at higher risk for delays in language acquisition, behavioral acting-out, repeating kindergarten and first grade, and for lower achievement test scores later in school (National Research Council and Institute of Medicine, 2009).

   Depressed parents may have little energy with which to engage, manage, or monitor their young children at ages when children need extensive supervision. This may result in a less stimulating or rich environment for the child or an increased vulnerability of neglect or injury to the child because of unsupervised activity.

Children are never “too young” to be affected by their parents’ moods. Infants and young children need positive, nurturing, and warm interactions from the people around them, especially their parents, in order to build strong attachments and learn how to form relationships. Having a parent with depression does increase the likelihood of depression in the child at some point in their lives. It may indicate a genetic risk because a child may share genes with the parent (Beardslee, 2003; Dym Bartlett, J., 2017).

Messages That Can Support a Depressed Parent

- Biology is not destiny. In addition to offsetting risk factors, people can use their own resources and strengths. Depression occurs when risk factors overwhelm strengths and resources.
- Getting treatment can be lifesaving and can enable a parent to be the best parent he or she can be. Treatment can help parents identify additional supports, to use the supports available, and to bolster a child’s strengths and growth.

6. **How is depression treated?**

Effective treatment options are available for people experiencing depression. Responses and points of discussion may include:

- In the United States only one-third of people with depression receive treatment.
- Depression is a highly treatable illness. People seeking treatment should consider these steps:
    - Acknowledge that something is wrong. Recognize that the thoughts, feelings, sleep and energy disruptions, and other symptoms most likely will not go away on their own.
    - Accept that the depression is having an impact on one’s life and family.
    - Understand that help is available and that treatment can work.
    - Begin to break the silence. Let one’s partner and adult loved ones know how difficult things are.
    - Find someone to work with over time. Finding and accessing resources may require research or being on a wait list. Consider it an investment in well-being and health.

Remember…

- Just as depression can be understood as a continuum of experiences, treatment can be seen as a broad collection of responses. People may have very strong feelings about what they will and will not consider appropriate depending on their symptoms, history, cultures, and economic circumstances.
- People trying to overcome depression are engaging in a process of recovering from the illness. Just as one wouldn’t expect someone who had recently suffered a heart attack to recover alone or to jump back into previous activities quickly, those suffering from depression need time and support to recover.

Types of Treatment

- Psychotherapy and medications have been shown to be effective treatments. In most situations, psychotherapy is tried first. If the person does not improve, medication may be added. Medication may be recommended immediately if a person is severely depressed when first seeking treatment.
- Counseling can help focus on changing one's thinking, dealing with problems in relationships, and developing more effective strategies to cope with stress.
- Couples therapy can improve relationships, help parents to communicate, understand depression, share tasks, and enlist more support for their children.
- Family therapy can help family members better understand depression and each other, and learn to offer each other more support. Children will feel better when problems are being addressed. They will learn how to communicate more effectively with their parents and to ask for help.
- Group therapy can sometimes be helpful. Participants are able to interact with others and know that they are not alone in dealing with the illness.
- Electroconvulsive therapy (ECT) is a procedure which seems to cause changes in brain chemistry that can reverse symptoms of depression. ECT may be considered a good treatment option when other forms of therapy, talk, or medication, haven't worked.

Consider cultural context when thinking about treatments for depression. There are Indigenous healing approaches that can be helpful. For more information on how one's culture can impact the presentation and treatment of depression, please refer to the Family Connections Short Papers: "**Parenting, Depression, and Hope: Reaching Out to Parents Facing Adversity**" and "**Understanding Depression Across Cultures**".

Other supportive strategies include:

- Early treatment can be a protective factor.
- Having close, intimate, and confiding relationships is beneficial. This can include a marriage, partnership, friendship, pets, or a bond with a family member or a neighbor.
- Cardiovascular exercise can help manage depression and anxiety. Movement, such as going for a walk, provides opportunities for both exercise and making contact with the outside world.
- Getting out in nature or going somewhere beautiful like a public garden or museum can be helpful.
- Spirituality and a belief in something larger than oneself can be helpful for some people.
- Helping others can remind someone who is depressed about his or her own strengths and capacity to contribute.
- Talking to someone from a time "before depression" can also help remind a person with depression about people and activities he or she once enjoyed, and could again (Beardslee, 2002).

Other Frequently Asked Questions

How does clinical depression differ from a temporary stressful situation?

- Symptom severity (intensity, duration, thoughts of suicide)
- Ability to function (with family, in school, with peers, health)
- Burden of suffering (depth of distress, anguish, difficulty coping)
- High level of self-hatred
- Significant decrease in ability to concentrate, notably lower school/work performance
- Extremely high irritability, boredom, sleeping too much or not being able to sleep.

Why might it feel hard to be with people who are depressed?

- The person may have avoided many attempts at communication. You may be frustrated when finally having the opportunity to talk with him or her.
- The person may have little energy, difficult emotions or a flat affect, or be unwilling to talk. You may start to feel tired, irritated, or hopeless.

Facilitator Strategy

Using Handout 1: How Do I Know If a Person Is Depressed?

Handout 1 (see page 19) outlines the signs and symptoms of depression. It can be shared while you are discussing the questions or at the end of the workshop as a method of review.

Handout 1 acknowledges that individuals who are severely depressed can have thoughts about ending their lives. Consider this point before sharing the handout and prepare yourself for questions. Familiarize yourself with any existing procedures for responding to a mental health emergency. Support participants with the following messages:

- Thoughts of ending one's life should always be taken seriously
- Any time an individual shares thoughts of suicide, that person is asking for help
- Get support from another staff member immediately if a person shares suicidal thoughts with you

Exercise 3: Encouraging Resilience

Exercise 3 provides the opportunity to focus on the messages to share with families to encourage resilience.

- Draw the participants' attention to Handout 2 (see page 20). Review the messages provided and ask the group for their reaction to these messages. Ask the group to consider if and when they might hear these messages while at Head Start or early childhood programs.

Wrap Up

Bringing ideas together at the end of the workshop is an important step for everyone. As a workshop gets close to the end, it can be tempting to skip this step. Let people know that you will honor their time and end the workshop as scheduled, but want to take a few more minutes to wrap up the time you've spent together.

1. **Review Key Concepts**
   - Depression is a common and treatable illness that happens along a continuum of intensity.
   - Cultural beliefs have a significant impact on depressive signs and symptoms, recognition, and treatment
   - Fear of judgment and stereotypes about depression can keep people from asking for help.
   - Knowledge is power, and information about depression can be a first step towards feeling better.
2. **End on a positive note.** Remind participants that depression is treatable and that there are supports available within their Head Start or early childhood program. Reference the handouts and other resources available. Ask the group to reflect on the critical message that there is hope when dealing with depression and that a depressed person is not alone. How might a person experiencing depression find hope?
3. **Review some or all of the comments written on the "Parking Lot for Ideas" sheet posted on the wall.** Consider responding to one comment. Ask participants which of the others they would like to discuss in the time remaining. If you don't have time, acknowledge that the comments are important and think with the group about other ways to address them. These comments may lead to another parent workshop.
4. **Express your appreciation**. Let the group know how much you appreciate their time and hard work. Thank them for sharing their ideas with you and being willing to think about depression together.
5. **Make yourself available.** After the workshop, be willing to answer questions and respond to concerns on an ongoing basis. If a facilitator cannot be available, an on-site staff member may be designated in this role and announced at the end of the workshop. The mental health consultant may be an excellent resource.
6. **Collect attendance and evaluation forms**. Collect signed attendance sheet and pass out evaluation forms for the group to complete. Remind participants that these forms are anonymous and collected for the purpose of improving future workshops. During this time, you might also want to label and date any large group work so you can save it for future reference.

Facilitator Reflection

Take time to review the experience, read the evaluation forms, and summarize the results. Some additional questions to consider are:

Was I prepared? Did I have all the materials I needed? Was the room adequate? Did I feel confident with the topic?

Did the workshop go as I imagined it would? Did the group respond the way I thought they would? Were there any surprises? Were there any elements of the workshop that went especially well? Were there any parts that were especially challenging?

What would have made this workshop better? What could I have done differently? Why? How can I use that information to make the next workshop more successful?

Did I gain new knowledge from this workshop? What did I learn? Did I gain any new knowledge about the group or individuals in the group? Did I learn something new about myself as a facilitator?

Facilitator Reflection, cont.

What would have made this experience better? What could I have done differently? Why? How can I use that information to make the next workshop more successful?

Did I gain new knowledge from this workshop? What did I learn? Did I gain any new knowledge about the group or individuals in the group? Did I learn something new about myself as a facilitator?

Handout 1: How Do I Know If a Person Is Depressed?

Trying to decide whether a person seems depressed to you? Some signs to look for:

- **Moods:** observable sadness, irritability, anger, and/or tearfulness. Perhaps things that normally would be minor annoyances feel extremely upsetting, such as a child spilling food or having a hard time getting ready to go home at the end of the day.
- **Feelings:** exhausted, forgetful, disorganized, sad, rageful, irritable, hopeless, "empty" or "numb." Stress may make a person feel anxious, "jumpy," like he/she is "losing it," at times feeling "flooded" with emotion or "overwhelmed."
- **Behaviors:**
  - Forgetting appointments or commitments. Depression affects the ability to concentrate and remember, and can cause feelings of hopelessness that affect motivation and the ability to follow through.
  - Sleeping more or less than usual, having a hard time getting out of bed, difficulties falling asleep, waking up early in the morning and not being able to get back to sleep.
  - Eating more or less than usual with weight gain or loss of more than 10 pounds.
  - Risk-taking behaviors, including drug or alcohol use, sometimes in an attempt to numb out sorrow or pain.
  - Isolation: withdrawing from friends and family, wanting to be alone. May feel isolated from others or assume others have negative feelings towards them. May have a harder time using the supports that are available, such as Head Start or other early childhood programs.
  - Yelling or crying easily, then feeling guilty or profoundly embarrassed about "taking things out" on others or "falling apart."
  - Not being able to get things done, like shopping, cleaning, getting meals on the table or the kids ready for their day. Not having energy to shower, wear nice clothes, do hair, or put on makeup.
  - Not enjoying things that used to be enjoyable, such as a hobby, time with the kids, family get-togethers, or sexual intimacy with one's partner.
- **Thoughts:** pessimism, forgetting positive qualities, or low self-esteem. Some people report that their thoughts come more slowly or that they "get stuck." Other symptoms include vicious self-criticism, feelings of worthlessness, or thoughts such as "No one likes me"; "People are talking about me, criticizing me, or laughing at me"; "They think I am a bad person/mother/father"; "It's always been this way and always will be this bad." Some people with severe depression might have thoughts about ending their lives.
- **Different sensations/perceptual disturbances:** Some people might feel "heaviness" or pain in their body or heart. People with severe depression might hear voices or see shadows that are not there.

Handout 2: Three Messages for Parents to Encourage Resilience

A message of hope that encourages resilience is so important to hear.

1. **You and your child have strengths.** Reflect on what you like best about your child or what makes you happiest about your child. Recognize the strengths in your family, even when you are struggling. Consider when you and your child have been resilient.

2. **Reflect on what you need.** "What do you need?" may seem like a simple question, but many people require support in understanding their needs before they can ask for resources. This means reflecting on "the now" and imagining "the future"—something that families facing adversity may find difficult to do. something that families facing adversity may find difficult to do.

   A depressed parent may need extra support when trying to imagine their options because depression can make it challenging for a person to think beyond their day-to-day coping. Trusting relationships with early childhood professionals may provide opportunities for reflection and problem solving.

3. **Take care of yourself.** Many times parents will move toward changing their lives in the name of being a better parent. The energy you invest in self-care can have positive results for your children as well. Consider how you are taking care of yourself. There are many "first steps" for better self-care. For instance, a goal to change one's diet can be started by eating more fresh vegetables or cutting back on candy. A goal to exercise more can start with taking the stairs rather than the elevator. Consider other first steps that might work for you.

   Consider how you are taking care of yourself. There are many "first steps" for better self-care. For instance, a goal to change one's diet can be started by eating more fresh vegetables or cutting back on candy. A goal to exercise more can start with taking the stairs rather than the elevator. Consider other first steps that might work for you.

For more information about resilience, see the Family Connections Short Paper, **"The Ability to Cope: Building Resilience in You and Your Child"** on the Head Start Early Childhood Learning Knowledge Center (ECLKC) website.

Workshop Evaluation

Title of the Workshop: **What is Depression?**

1. Please rate the extent to which you agree that the workshop met each objective:

	Strongly Disagree	Mostly Disagree	Disagree a Little	Agree a Little	Mostly Agree	Strongly Agree
Objective 1: Participants will learn the signs, symptoms, and causes of depression.	☐	☐	☐	☐	☐	☐
Objective 2: Participants will learn how depression may affect individuals.	☐	☐	☐	☐	☐	☐
Objective 3: Participants will explore fears, concerns, and myths about depression.	☐	☐	☐	☐	☐	☐
Objective 4: Participants will learn that depression and responses to it can be considered along a continuum.	☐	☐	☐	☐	☐	☐
Objective 5: Participants will learn strategies to enhance resilience.	☐	☐	☐	☐	☐	☐
Objective 6: Participants will gain knowledge regarding resources and access to depression-related services.	☐	☐	☐	☐	☐	☐

2. Please rate the extent to which you agree with the following statements:

	Strongly Disagree	Mostly Disagree	Disagree a Little	Agree a Little	Mostly Agree	Strongly Agree
I was satisfied with this workshop.	☐	☐	☐	☐	☐	☐
The information presented was useful.	☐	☐	☐	☐	☐	☐
The workshop activities were useful.	☐	☐	☐	☐	☐	☐
The workshop activities were creative.	☐	☐	☐	☐	☐	☐
Facilitator was knowledgeable about the subject presented.	☐	☐	☐	☐	☐	☐
Facilitator's presentation style was engaging.	☐	☐	☐	☐	☐	☐

Workshop Evaluation, cont.

3. Is there anything you would have liked to learn more about this topic that was not presented?

4. Would you like more workshops that expand on this topic? (please select one)

- ☐ Yes
- ☐ No

5. I would like more learning opportunities about:

Additional Comments:

Related Resources

Explore the following resources on the ECLKC website:

Family Connections Short Papers
These short papers are designed to share information on topics that are central to understanding depression, resilience, and best practice in engaging parents facing adversities. They are intended to work as stand-alone handouts for parents and staff as well as materials used in workshops and in parent groups. Short papers for parents include:

- **The Ability to Cope: Building Resilience in Yourself and Your Child**
  Explore strategies for building resilience and facing adversity.
- **Parenting Through Tough Times: Coping with Depression**
  Learn how to recognize depression, understand how it can affect parents and children, and review suggestions for help.
- **Self-Reflection in Parenting: Help for Getting Through Stressful Times**
  Explore the benefits of using self-reflection as a parent, especially when facing stressful times, as well as strategies for practicing self-reflection.

Selected short papers for staff include:

- **Better Parent Communication: What Do I Say When a Parent Tells Me Something Difficult?**
  Explore strategies for responding effectively to parents and the difficult topics they can bring to Head Start staff.
- **The Challenges and Benefits of Making Parent Connections**
  Includes strategies for effective parent outreach.
- **Fostering Resilience in Families Coping With Depression: Practical Ways Head Start Staff Can Help Families Build on Their Power to Cope**
  Explore this resource to learn about the four levels of resilience and how to apply them in your work.
- **Parenting, Depression, and Hope: Reaching Out to Families Facing Adversity**
  Learn how to foster effective parenting and help parents build strengths and resilience in their families.
- **Self-Reflection and Shared Reflection as Professional Tools**
  Includes a discussion of the benefits of using self-reflection and shared reflection as tools that can enhance communication and service delivery.
- **Understanding Depression Across Cultures**
  Includes a discussion on the range of responses to mental health issues, including depression across cultures, and the importance of cultural sensitivity in mental health outreach.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association. doi:10.1176/appi.books.9780890425596.744053

Beardslee, W. (2002). *Out of the Darkened Room: Protecting the Children and Strengthening the Family When a Parent Is Depressed*. Little, Brown and Company.

Beardslee, W.R., Versage, E.M., & Gladstone, T.R. (1998). Children of affectively ill parents: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*(11), 1134-1141. doi:10.1097/00004583-199811000-00012

Chazan-Cohen, R., Ayoub, C., Pan, B., Roggman, L., Raikes, H., McKelvey, L., Whiteside-Mansell, L. & Hart, A. (2007). It takes time: Impacts of Early Head Start that lead to reductions in maternal depression two years later. *Infant Mental Health Journal, 28*(2), 151-170. doi: 10.1002/imhj.20127

Dym Bartlett, J. (2017). *5 Things to Know about Parental Depression.* Retrieved from Child Trends website.

Gould, M., Greenberg, T., Velting, D., & Shaffer, D. (2003). Youth suicide risk and prevention intervention: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(4), 386-405. doi:10.1097/01.CHI.0000046821.95464.CF

Hasin, D., Sarvet, A., Meyers, J., Saha, T., Ruan, W. J., Stohl, M. & Grant, B. (2018). Epidemiology of adult DSM-5 major depressive disorder and its specifiers in the United States. *JAMA Psychiatry, 75*(4), 336–346. doi:10.1001/jamapsychiatry.2017.4602

Kocsis, J. H., Gelenberg, A. J., Rothbaum, B., Klein, D. N., Trivedi, M. H., Manber, R., Keller, M. B., Howland, R., & Thase, M. E. (2008). Chronic forms of major depression are still undertreated in the 21st century: Systematic assessment of 801 patients presenting for treatment. *Journal of Affective Disorders, 110*(1-2), 55-61. doi: 10.1016/j.jad.2008.01.002

National Institute of Mental Health. (Revised 2020) *Depression in Women: 5 things You Should Know* [Brochure].

National Research Council and Institute of Medicine. (2009). *Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention. Committee on Depression, Parenting Practices, and the Healthy Development of Children.* Board on Children, Youth, and Families. Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

Olfson, M., Blanco, C., & Marcus, S. C. (2016). Treatment of adult depression in the United States. *JAMA Internal Medicine, 176*(10), 1482-1491. doi: 10.1001/jamainternmed.2016.5057

U.S. Department of Health and Human Services. (Revised 2006). *Depression in the Lives of Early Head Start Families: Research to Practice Brief*. Administration for Children and Families.

Yalin, N., & Young, A. H. (2018). The age of onset of unipolar depression. In G. de Girolamo, P. D. McGorry, & N. Sartorius (Eds.), *Age of onset of mental disorders.* (p. 111-124). Springer.

Acknowledgements

This workshop was adapted by Debra Sosin, Alyssa Chrobuck, and Catherine Ayoub. Thank you to the families and staff who have participated in Family Connections workshops and to the Brazelton Touchpoints Center.

Original content is from *Family Connections Training Module One*, authored by Mary Watson Avery, William R. Beardslee, Catherine C. Ayoub, and Caroline L. Watts. *Training Module One* was developed by the Family Connections Project at Children's Hospital Boston, under the Innovation and Improvement Project grant from the Office of Head Start, Administration for Children and Families, U.S. Department of Health and Human Services. Thank you to Ariel Botta, Alissa Coggins, Lisa Desrochers, John Hornstein, Ane Marinez Lora, Nadja Reilly, and Elisa Vele-Tabaddor for their contributions.

This resource was developed with funds from Grant #90HC0014 for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, and Office of Child Care by the National Center on Parent, Family, and Community Engagement.

For more information about this resource, please contact us:
PFCE@ecetta.info | 1-866-763-6481