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Teenage depression journal articles pdf

Depression is the leading cause of illness and disability in the world. The World Health Organization (WHO) has been issuing warnings about this pathology for years, given that it affects more than 300 million people around the world and is characterized by a high risk of suicide (the second most common cause of death in people between the age of 15 and 29) [World Health Organization (WHO), 2017]. Studies on the child population using self-reporting to evaluate severe symptoms of depression, in particular the Children's Depression Inventory (CDI, Kovacs, 1992) and the Children's Depression Scale (CDS, Lang and Tisher, 1978), have observed prevalence rates of, for example, 4% in Spain (Demir et al., 2011; Bernaras et al., 2013), 6% in Finland (Puura et al., 1997), 8% in Greece (Klietaras and Didaskalos, 2006), 10% in Australia (McCabe et al., 2011) and 25% in Colombia (Vinaccia et al., 2006). The main classifications of mental disorders are the Diagnostic and Statistical Manual of Mental Disorders, DSM-5 (American Psychiatric Association, 2014), published by the American Psychiatric Association, which has become an important reference in clinical practice, and version 10 of the International Classification of Diseases (ICD-10, 1992), published by the WHO, which classifies and codifies all diseases, although the initial intention was to map mortality rates. The new ICD-11 classification will be submitted to Member States for approval at the World Health Assembly in May 2019 and is expected to enter into force on 1 January 2022 [World Health Organization (WHO), 2018]. The two classifications offer different categorizations of depressive disorders, although certain similarities exist, and it should also be kept in mind that both have been criticized for barely distinguishing at all between child and adult depression. Throughout history, there have been many different explanatory theories of depression. Biological and psychological theories are those that have mainly tried to explain the origin of this mental disorder. Biological theories have been postulated, from a variety of different perspectives, that depression can occur due to norepinephrine defects (e.g., Schildkraut, 1965; Narbona, 2014), endocrine disorders (e.g., Burmaher et al., 1996), sleep-related disorders (e.g., Sivertsen et al., 2014; Pariante, 2017), changes in brain structure (Whittle et al., 2014), or the influence of genetics (Scourfield et al., 2003). Psychological theories have tried to explain depression based on psychoanalysis and, more specifically, in terms of attachment theories (e.g., Bowlby, 1976; Ainsworth et al., 1978; Blatt, 2004; Bigelow et al., 2018), behavioural models (for example, Skinner, 1953; 1966; Lewinsohn, 1975), cognitive models (e.g., Seligman, 1975; Abramson et al., 1978; Beck, 1987), the self-control model (including Rehm, 1977; Rehm et al., 1979), interpersonal theory (e.g., Markowitz and Weissman, 1995; Milrod et al., 2014), stressful life events (Reinherz et al., 1993; Frank et al., 1994), and socio-cultural models (e.g., Lorenzo-Blanco et al., 2012; Chang et al., 2013; Reeves et al., 2014). The accurate evaluation of depression is another concern that psychology has focused on, with attention specifically focused on diagnosing this pathology in childhood and adolescence. Although many diagnostic tools have been developed and validated, especially for the adolescent and adult life stages, it is still difficult to find diagnostic tests for evaluating depression in children. The prevention of depression is another aspect of which is of great importance by the World Health Organization (WHO) (2017), which states that school programs, interventions aimed at parents and specific exercises for the older population help reduce the prevalence of this pathology. Depression prevention programs exist, but they are primarily aimed at adolescents and focus very little on children under the age of 10. The treatment of depression is another aspect that should not be overlooked. In 2016, the WHO and the World Bank announced that investing in the treatment of depression and anxiety leads to a fourfold increase, as these pathologies cost the global economy a trillion U.S. dollars each year. They also claimed that humanitarian emergencies and conflicts indicate an urgent need to expand current therapeutic options. In this sense, the multiple different explanatory theories of depression have given rise to a plethora of different treatments (psychotherapeutic, behavioral, cognitive-behavioral, interpersonal, etc.) that are currently analyzed with a high degree of precision and scientific rigor. In light of the various aspects related to depression outlined above, this study has the following objectives: (1) Analyzing the construction of depression offered by the two main classifications of mental disorders (DSM-5 and ICD-10); (2) Provide an overview of the main explanatory theories on depression; (3) Sketching the evaluation tools for depression of children and adolescents most commonly used in the scientific literature; (4) Provide a brief overview of prevention programmes for depression of children and adolescents in the school environment; and (5) Describe the most scientifically rigorous and effective clinical treatments for this mental disorder. The databases used to perform the searches were PubMed, PsycINFO, Web of Science, Scopus, Science Direct and Google Scholar, along with a series of different manuscripts. With the constant keyword depression, the search for information cross-referenced a series of other key words as well, namely: childhood, adolescence, theories, etiology, evaluation tools, prevention programs, and treatment. Searches were carried out for information published between 1970 and 2017. In this way, we first describe the construction of depression and summarize the most important explanatory theories. We then present the main evaluation tools measuring depression in children and adolescents and reporting the results of a bibliographic evaluation of prevention programs in school environments. Finally, we outline the main clinical treatments used today to treat depression in children and adolescents. The Construct of Depression: DSM-5 and ICD-10 Depression features in both of the two main global classifications: the DSM-5 and the ICD-10. As stated earlier in the introduction, the new ICD-11 classification will be submitted to Member States for approval at the World Health Assembly in May 2019 and is expected to enter into force on 1 January 2022. The presentation of the new classification in 2019 will allow countries to plan their implementation, prepare the necessary translations and train professionals accordingly [World Health Organization (WHO), 2018]. Texts published by WHO staff (Luciano, 2017) have suggested that the ICD-11 will include mood disorders within the category of mental and behavioral disorders. However, until the final version is published, this information cannot be fully verified. The two classifications (DSM-5 e ICD-10) offer different categorizations of depressive disorders, as shown in Table 1. The WHO includes depressive disorders in the mood disorders category, although this assessment focuses only on sections F32, F33, F34 and F38, which include the most common depressive disorders and which in turn contain subsections that will be further specified later. Table 1. Depressive disorders according to the DSM-5 and the ICD-10. According to the DSM-5, depressive disorders all have one common characteristic, namely the presence of a sad, empty or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's ability to function (DSM-5). They can become a serious health problem if they are allowed to persist for a long time and occur with moderate to severe intensity. A major consequence of depression is the risk of suicide, which according to the World Health Organization (WHO) (2017) is the second most common cause of death among young people between the age of 15 and 29. The main novelty offered by the DSM-5 in its section on depressive disorders is the introduction to Disruptive mood disorder (which should not be diagnosed before the age of 6 or after the age of 18). This condition is characterized by severe recurrent temper outbursts manifested verbally (e.g. verbal anger) and/or behavioral (for example, physical aggression towards people or property). These eruptions are common due to frustration and to be considered a diagnostic criterion must be contrary to the level of development the individual, occur three or more times a week for at least a year in a number of different institutions (at home, at school, etc.) and be serious in at least one of these. This condition was added to present the DSM-5 due to doubts arising regarding how to classify and treat children presenting chronic irritable irritability unlike other related conditions, especially pediatric bipolar disorder. The prevalence of this condition has been estimated at between 2 and 5%, with male children and teenage boys being more likely to suffer from it than their female counterparts. Depressive disorder Depressive disorder is characterized by depressive mood most of the day, almost every day, although in children and adolescents this mood can be irritable rather than depressed. The condition causes a significantly decreased interest or pleasure in all, or almost all, activities most of the day, almost every day, significant weight loss or gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness, or excessive or undue guilt, decreased ability to think or concentrate, recurring thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific suicide plan. These symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning. In the United States, the 12-month prevalence is ~7%, although it is three times higher among people between 18 and 29 than among people aged 60 or over. In addition, prevalence rates for women are ~1.5-3 times higher than for men. Persistent depressive disorder (Dysthymic) Persistent depressive disorder (dysthymia) is a consolidation of DSM-5-defined chronic depressive disorder and dysthymic disorder, and has been characterized by depressive mood for most of the day, for more days than not, for at least 2 years. In children and adolescents, the mood can be irritable and the duration should be at least 1 year. The DSM-5 specifies that patients who show symptoms that meet the diagnostic criteria for depressive disorder for 2 years should also be diagnosed with persistent depressive disorder. When the individual in question experiences a depressive mood episode, they must also present at least two of the following symptoms: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration, or difficulty decision-making and sense of hopelessness. The prevalence of this condition in the United States is 0.5%. Premenstrual dysphoric disorder The diagnostic criterion for premenstrual dysphoric disorder states that in the majority of menstrual cycles at least five symptoms should be present in the last week before the onset of menstruation, and individuals should start to feel better a few days later, with all symptoms completely or almost completely disappearing in week after menstruation. The main features of this condition are affective lability, intense irritability or anger, or increased interpersonal conflict, distinctly depressed mood and/or over-excitation, and symptoms of anxiety that may be accompanied by behavioral and somatic somatic Symptoms should be present during most menstrual cycles in the past year and should have a negative impact on personal and social functioning. The most rigorous estimates of the prevalence of this condition claim that 1.8% of women meet the criterion but have no functional disorder, while 1.3% meet the criterion and suffer from functional disorder and other simultaneous symptoms of another mental disorder. Substance/Medication-induced depressive disorder Dysthymic disorder is characterized by the presence of symptoms of a depressive disorder, such as depressive disorder, caused by the consumption, inhalation or injection of a substance, with these symptoms persisting after the physiological effects or the effects of intoxication or withdrawal have disappeared. Some medications can generate depressive symptoms, which is why it is important to determine whether the symptoms were actually caused by taking the drug or whether the depressive disorder simply appeared during the period in which the medication was taken. The prevalence of this condition in the United States is 0.26%. Depressive disorder Due to another medical condition Depressive disorder due to another medical condition is characterized by the appearance of a depressed mood and a significantly decreased interest or pleasure in all activities within the context of another medical condition. The DSM-5 does not provide information on the prevalence of this condition. The category Other specified depressive disorder is used when symptoms characteristic of depressive disorder appear and lead to significant distress or impairment in social, occupational or other areas of functioning, but do not meet all the criteria of a depressive disorder, and the doctor chooses to communicate the specific reason for this. In the other unspecified category of depressive disorder, on the other hand, the difference is that the doctor prefers not to specify the reason why the presentation does not meet all the criteria of a specific condition and contains presentations about which there is insufficient information for giving a more specific diagnosis. In the ICD-10, depressive disorders are included in the category of mood disorders. The following disorders are analyzed below: some depressive episode, recurrent depressive disorder, and persistent mood (affective) disorders. Single Depressive Episode The classification Single depressive episode distinguishes between depressive episodes of varying severity: mild, moderate and severe without psychotic symptoms. Characteristics common to all of them include lowering mood, reducing energy, and decrease in daily There is a loss of interest in previously pleasurable pursuits, a decrease in concentration capacity and an increase in fatigue, even during activities that require minimal effort. Changes occur in appetite, sleep is disturbed, self-esteem and self-confidence ideas of guilt or worthlessness are present and symptoms vary little from day to day. In its mildest form, two or three of the symptoms described above may be present and the patient can continue with most of their daily activities. When the episode is moderate, four or more of the symptoms are usually present and the patient will likely struggle to continue with ordinary activities. In its most severe form, some of the symptoms are obvious and distressing, usually loss of self-esteem and ideas of worthlessness or guilt. Suicidal thoughts and actions are common and a number of somatic symptoms are usually present. If the depressive episode is with psychotic symptoms, it is characterized by the presence of hallucinations, delusions, psychomotor retardation, or stupor so severe that ordinary social activities are impossible; there may be danger to life due to suicide, dehydration, or hunger. Recurrent depressive disorder Recurrent depressive disorder is characterized by repeated episodes of depression similar to those described above for some depressive episodes without mania. There may be short episodes of mild mood enhancement and overactivity (hypomania) immediately after a depressive episode, sometimes precipitated by antidepressant treatment. The more severe forms of this condition are very similar to manic-depressive depression, melancholy, vital depression, and endogenous depression. The first episode can take place at any age, from childhood to old age. The beginning can be acute or treacherous and can take several weeks to many months. Recurrent depressive disorder can be mild or moderate, but in none of these there is a history of mania. This section also includes recurrent depressive disorder currently in remission, in which the patient may have had two or more depressive episodes in the past, but has been free of depressive symptoms for several months. Persistent Mood [Affective] Disorders Persistent mood [affective] disorders are persistent and usually fluctuating disorders in which the majority of episodes are not sufficient sufficient severity to warrant being diagnosed as hypomanic or mild depressive episodes. Because they last for many years and affect the normal life of the patient, they bring with them considerable distress and disability. This section also contains cyclothymia and dysthymia. Cyclothymia is a persistent mood instability involving numerous periods of depression and mild elation, none of which are sufficiently prolonged to warrant a diagnosis of bipolar affective disorder or recurrent depressive disorder. This condition is often found in the relatives of patients with bipolar affective disorder and some patients with cyclothymia eventually develop bipolar affective disorder. Dysthymy is from a chronic mood depression, lasting at least several years, which is not severe enough, or where individual episodes are not sufficiently prolonged, in order to diagnose mild, moderate, moderate, severe recurrent depressive disorder. Other Mood (Affective) Disorders Finally, other mood (affective) disorders include any mood disorders that do not fall into the categories described above because they are not of sufficient severity or duration. They can be separate, recurring (short) or specified episodes. The manifestations and symptoms of depression vary in accordance with age and level of development. However, it is clear that the DSM-5 and ICD-10 do not distinguish between depression of adults and children, although the DSM-5 does take into account the fact that children and adolescents between the age of 7 and 18 can express their distress in other ways, due to chronic, severe and recurrent irritability that manifests itself verbally and/or behaviourally. Similarly, depressive disorder determines that in children the mood can be irritable rather than depressed. However, no distinction of this kind are found in the ICD-10, an absence that can lead to the flawed inference that the characteristics of depression of children and adolescents are similar to those of adult depression. Explanatory theories of depression Depressive disorders cannot be explained by a single theory, because many different variables are involved in their onset and persistence. The most important biological and psychological theories were therefore taken as the most important references for this section. Subsequently, the contributions of each of these theories related to depression were studied by conducting searches in PubMed, Web of Science, Science directly, and Google Scholar. With the constant keywords being depression, child depression and adolescent depression, the search for information cross-references a range of other keywords also consistent with the specific theory in question. Because of the importance of some groundbreaking works related to the development of psychological theories of depression, certain authors have remained important references for decades. A total of 64 bibliographic references were used. The following is a summary of the various explanations for the onset of depression, according to the different theoretical frameworks. Biological theories If a mood disorder cannot be explained by family history or stressful life events, then the child or adolescent in question may be suffering from a neurological disease. In such a case, depressive symptoms may manifest early in children and adolescents as epileptic syndromes, sleep disorders, chronic recurrent cephalalgias, various neuroendocrine diseases and intracranial tumors (Narbona, 2014). Norepinephalin Deficit Serotonin is a monoamine linked to norepinephrine, and dopamine that plays an important role, especially in the brain, because it is involved in important functions for regulating life (appetite, sleep, memory, learning, temperature regulation, and social behavior, etc.), as well as many psychiatric pathologies (Nique et al., 2014). Serotonin modulates especially during the early years of life, and dysfunctions in both systems contribute to the physiopathology of depression (Kraus et al., 2017). MRI tests in animals have shown that a reduction in neuron density and size, as well as a reduction in hippocampal volume in depressed patients may be due to serotonergic neuroplasticity changes. Branchi (2011), however, argues that improving serotonin levels can increase the likelihood of both developing and recovering from psychopathology, and underscores the role played by the social environment in this process. In this sense, Curley et al. (2011) points out that the quality of the social environment can influence the development and activity of neural systems, which in turn has an impact on behavioral, physiological and emotional responses. Endocrine changes Age-related changes and the presence of biological risk factors, including endocrine, inflammatory, immune, cardiovascular and neuroanatomical factors, make people more vulnerable to depression (Clarke and Currie, 2009). Some studies even suggest that depression may be linked to endocrine changes: nocturnal cortisola secretions (Burmaher et al., 1996), nocturnal growth hormone secretion (Ryan et al., 1994), thyroid-stimulating hormone secretion (Puig-Antich, 1987), melatonin and prolactina secretions (Aguaruis et al., 1994), high cortisol levels (Herane-Vives et al., 2018), or reduced production of growth hormone (Dahl et al., 2000). Puberty and associated hormonal and physical changes require special attention because it has been suggested that they may be associated with an increased incidence of depression (Reinecke and Simons, 2005). Sleep disorders Sleep problems are often associated with situations of social deprivation, unemployment or stressful life events (divorce, bad living habits or poor working conditions) (Garbarino et al., 2016). However, it also seems that sleep disorders are related to the development of depression. This relationship occurs as a result of how insufficient sleep affects the hippocampus, causing neural sensitivity to excitotoxic insult and vulnerability to neurotoxic challenges, resulting in a net decrease in gray matter in the hippocampus (in the left orbitofrontal cortex (Novati et al., 2012). Franzen and Buysse (2008) argue that bidirectional associations between sleep disorders (especially insomnia) and depression make it more difficult to distinguish cause-and-effect relationships between them. It is therefore unclear whether depression causes sleep disorders or whether chronic sleep disorders lead to the appearance of depression. What seems clear, however, is that treating sleep disorders (both insomnia and hypersomnia) can help reduce the severity of depression and recovery (Franzen and Buysse, 2008). Longitudinal studies have identified insomnia as a risk factor for the onset or recurrence of depression in adolescents and adult adults et al., 2014). Compared to the non-clinical population, depressed children and adolescents report both sleep problems and longer sleep duration (Accardo et al., 2012). Foley and Weinraub (2017) noted that in preadolescent girls early and later sleep problems directly or indirectly predict a wide range of social and emotional adjustment disorders (depressive symptoms, low school competence, poor emotion regulation, and risk behavior). Altered Neurotransmission Studies conducted over the past 20 years have shown that increased inflammation and hyperactivity of the hypothalamic-pituitary-adrenal gland (HPA) axis can explain severe depression (Pariante, 2017). Some of the pathophysiological mechanisms of depression include altered transmission, HPA axis abnormalities involved in chronic stress, inflammation, impaired neuroplasticity and network dysfunction (Dean and Keshavan, 2017). Other studies report changes in brain structure: smaller hippocampus, amygdala and frontal lobe (Whittle et al., 2014). However, the underlying molecular and clinical mechanisms have yet to be discovered (Pariante, 2017). Major depressive disorder in children and adolescents is associated with increased intracortical facilitation, a direct neurophysiological result of excessive glutamatergic transmission. However, contrary to the findings in adults with depression, no deficiencies in cortical inhibition were found in children and adolescents with depressive disorder (Croarkin et al., 2013). Genetic factors Other studies have revealed the importance of genetics at the onset of depression (40%) (Scourfield et al., 2003). It is important to recognize that a genetic predisposition to an excessive amygdala response to stress, or a hyperactive HPA axis (moderate hyperphenylalaninaemia) due to stress during early childhood, can cause an excessive effect or alter an otherwise healthy psychological system (Dean and Keshavan, 2017). Kaufman et al. (2018) support a possible role for genes related to the homeobox 2 gene of Orthodentox (OTX2) and the OTX2-related gene in the physiopathology of stress-related depressive disorders in children. In addition, genetic abnormalities in serotonergic transmission are linked to depression. The serotonin-bound polymorphic region (5-HTTLPR) is a degenerate recurrence in the gene that codes for the serotonin carrier (SLC6A4). The s/s genotype of this region is associated with a reduction in serotonin expression, in turn linked to greater vulnerability to depression (Caspi et al., 2010). Oken et al. (2015) claim that psychological disorders can cause changes in physiological parameters, such as DNA transcription, or lead to epigenetic changes that alter the sensitivity of the neurotransmitter receptor. Psychological theories section outlines the various psychological theories that have tried to Depression is a very complex condition influenced by multiple factors, and it is clear that no theory can fully explain its etiology and persistence. It is likely that a more eclectic vision should be adopted if we are to make any progress in determining the origin, development and maintenance of this pathology. Attachment-Informed Theories Attachment theory was the term used by Bowlby (1976) to refer to a specific conceptualization of man's tendency to establish strong and long-lasting affective ties with other people. Bowlby (1969, 1973) proposes that consistency, nurturance, protection, and responsiveness in early interactions with caregivers contribute to the development of schedules or mental representations about their relationships with others, and that these schemes serve as models for later relationships. Bowlby's ethological model of attachment postulates that vulnerability to depression stems from early experiences that fail to meet the child's need for safety, care and comfort, as well as from the current state of their intimate relationships (Bowlby, 1969, 1973, 1988). Unfavorable early experiences may contribute to disruptions in early attachments, which may be associated with vulnerability to depression (Cummings and Cicchetti, 1990; Joiner and Coyne, 1999). Links have been reported between uncertain attachment among children and a negative self-concept, sensitivity to loss and an increased risk of depression in childhood and adolescence (Armsden et al., 1990; Koback et al., 1991; Kenny et al., 1993; Roelofs et al., 2006; Allen et al., 2007; Chorot et al., 2017). Relationships between safe attachment and depression also seem to be mediated by the development of inappropriate beliefs or schedules (Roberts et al., 1996; Reinecke and Rogers, 2001). For example, attachment theory has become a useful construction for conceptualizing many different disorders and provides valuable information for the treatment of depression (Reinecke and Simons, 2005). Ainsworth described three attachment styles, in accordance with the child's response to the presence, absence and return of the mother (or main caregiver): safe, anxious-avoiding and anxious-resistant (Ainsworth et al., 1978). The least safe attachment styles can give rise to traumatic experiences during childhood, which in turn can lead to the appearance of depressive symptoms. Hesse and Main (2000) also argued that the central mechanism that governs children's emotional survival was the proximity of attachment rates, i.e. the figures that help the child cope with terrifying situations. Using Ainsworth's strange situation procedure, Main (1996) found that abused children engaged in more disorganized, disruptive, aggressive dissociative behavior during both childhood and adolescence. Main (1996) also found that many people with clinical conditions have an uncertain attachment and that psychologically disoriented and disorganized children are more vulnerable. Are his part, Blatt (2004) examined the nature of depression and the life experiences that contribute to appearance in greater depth, identifying two types of depression that, despite a common set of symptoms, nevertheless have very different roots: (1) anaclitic depression, which results from feelings of loneliness and abandonment; and (2) introjective depression, which stems from feelings of failure and worthlessness. This distinction is consistent with psychoanalytic formulations, as it considers defenses/defenselessness/dependence and despair/negative feelings about itself to be two key issues in depression. Brazelton et al. (1975) found that at age 3 weeks, babies exhibit a range of interactive behaviors during face-to-face mother-baby interactions. These behaviors were found not to be present in more disturbed interactions, which can lead to fear of infants. In a longitudinal study focusing on the relationship between the risk of maternal depression and baby attachment behavior, Bigelow et al. (2018) analyzed babies at the age of 6 weeks, 4 and 12 months, finding that mothers who are at risk of depression shortly after the birth of their child may struggle to adequately respond to their child's attachment needs, giving rise to disorganized attachment, with any psychological consequences that this may lead to. Also, Beghly et al. (2017) found that among infants between 2 and 18 months of age, greater maternal social support was associated with decreasing levels of maternal depressive symptoms over time, and that boys were more vulnerable than girls to early care risks such as maternal-severe depression, with negative consequences for maternal and child attachment security during preschool. Authors such as Shedler and Westen (2004) have been trying to find solutions to the problems that arise with regard to the DSM diagnostic categories, developing the Shedler West Assessment Procedure (SWAP-200) to capture the richness and complexity of clinical personality descriptions and identify possible diagnostic criteria that can better define personality disorders. Ju and Lee (2018) argue that peer attachment reduces depression levels in at-risk children and also highlights the curative aspect of attachment between adolescent peers. Behavioral models The first explanations proposed by this model stated that depression occurs as a result of the lack of strengthening of previously strengthened behavior (Skinner, 1953; Ferster, 1966; Lewinsohn, 1975), an excess of avoided behavior and lack of positive reinforcement (Ferster, 1966) or loss of efficiency of positive reinforcements (Costello, 1972). A child with depression initially receives a lot of attention from his social environment (family, and behaviour such as crying, complaints or expressions of guilt are reinforced. When these depressive behaviors increase, the relationship with the child becomes aversive, and the people who used to accompany the child avoid being with him, him, contributes to worsening his depression (Lewinsohn, 1974). Low rates of reinforcement can be explained by maternal rejection and lower parental support (Simons and Miller, 1987), by a lower rate of reinforcement offered by mothers of depressed children to their children (Cole and Rehm, 1986), or by low social competence (Shah and Morgan, 1996). Depression is primarily a learned phenomenon, related to negative interactions between the individual and his or her environment (e.g. low strengthening rates or unsatisfactory social relationships). These interactions are influenced by cognitions, behaviors and emotions (Antonuccio et al., 1989). Cognitive models The attributional reformulation of the learned helplessness model (Abramson et al., 1978) and Beck's cognitive theory (Beck et al., 1979) are the two most widely accepted cognitive theories among contemporary cognitive models of depression (Vázquez et al., 2000). Learned helplessness is related to cognitive attributions, which can be specific/ global, internal/external and stable/unstable (Hiroto and Seligman, 1975; Abramson et al., 1978). Global attribution implies the belief that the negative event is contextually consistent rather than specific to a particular circumstance. Internal attribution is related to the belief that the aversive situation occurs due to individual circumstances rather than external circumstances. Stable attribution is the belief that the aversive situation is immutable over time (Miller and Seligman, 1975). People prone to depression attribute negative events to internal, stable, and global factors and make external, unstable and specific attributions for success (Abramson et al., 1978; Peterson et al., 1993), a cognitive style also present in children and adolescents with depression (Gladstone and Kaslow, 1995). The information processing model (Beck, 1967; Beck et al., 1979) states that depression is caused by particular stresses that trigger the activation of a scheme that screens and codes the depressed individual experience in a negative way (Ingram, 1984, p. 443). Beck suggests that this distortion of reality is expressed in three areas, which he calls the cognitive triad: negative views of themselves, the world and the future due to their learning history (Beck et al., 1983). These beliefs are triggered by life events that have a special meaning for the subject (Beck and Alford, 2009). Self-Control Model This theory assumes that depression is due to deficits in the self-control process, which consists of three phases: self-control, self-evaluation and self-governance of the consequences (Rehm, 1977; Rehm et al., 1979). In the self-control phase, individuals only participate in negative events and have the to recognize only immediate short-term consequences. In the self-evaluation phase, depressed individuals set unrealistic evaluation criteria and attribute their successes and failures inaccurately. If self-evaluation is negative, effects phase the individual tends to engage very little in self-reinforcement and very often in self-punishment. Both Rehm's self-control model (Rehm, 1977) and Bandura's conception of child depression (Bandura, 1977) assume that children internalize the guidelines for external control. These guidelines are related to family interaction patterns, and both may contribute to the etiology or persistence of depression in children. In a study conducted with children between 8 and 12 years of age, Kaslow et al. (1988) found that depressed children had a more depressed attributional style and more self-control problems. Interpersonal theory This model, which is closely linked to attachment theories, is aimed at identifying and finding solutions to the problems of an individual with depression in their interpersonal functioning. It suggests that the difficulties encountered are related to unresolved mourning, interpersonal disputes, attributional style and interpersonal deficits (Markowitz and Weissman, 1995). Milrod et al. (2014) argues that pathological attachment during early childhood has serious consequences for the ability of adults to experience and internalize positive relationships. Similarly, several studies have highlighted the fact that one of the variables that best predicts depression in children is peer relations (Bernaras et al., 2013; Garaigordobil et al., 2017). Stressful Life Events Studies focused on the adult population have reported that between 60 and 70% of depressed adults experienced one or more stressful events during the year leading up to the onset of severe depression (Frank et al., 1994). In children and adolescents, modest associations have been found between stressful life events and depression (Williamson et al., 1995). Shapero et al. (2013) found that people who had experienced severe emotional abuse in childhood experienced higher levels of depressive symptoms when confronted with current stressors. Sokratous et al. (2013) claim that the onset of depression is not only caused by large stressful events, but rather small life events (dropping out of school, your father losing his job, financial problems in the family, losing friends, or the illness of a family member) can also affect the appearance of depressive symptoms. Events such as the loss of loved ones, divorce from parents, bereavement or exposure to suicide (individual or collective) have all been associated with the onset of childhood depression (Reinherz et al., 1993). Factors such as a history of additional interpersonal loss, additional stress factors, a history of psychiatric problems in the family and previous psychopathology (including depression) increase the risk of depression adolescents (Brent et al., 1993). Burmaher et al. (1996) found that prior research into stressful life events related to early depression was based on data obtained from self-reports, making it difficult to determine causation because events both the cause and the consequence of depression. However, not everyone exposed to this kind of traumatic experience becomes depressed. Personality and the moment when events occur are both involved in the relationship between depression and stressful life events, although biological factors such as serotonergic function (Caspi et al., 2010) also exert an influence. Sociocultural models These models state that cultural variables are responsible for the appearance of depressive symptoms. These variables are mainly acculturation and enculturation. In acculturation structural changes are observed (economic, political and demographic), together with changes in the psychological behavior of humans (Casullo, 2001). Some studies link increased suicide rates to economic recession (Chang et al., 2013; Reeves et al., 2014). Enculturation occurs when the older generation invites, induces or forces the younger generation to adopt traditional mentality and behavior. In an effort to better understand the influence of culture and family on depressive symptoms, Lorenzo-Blanco et al. (2012) tested an acculturation, cultural values and family work model with Hispanic students born in the United States. The results showed that both family conflict and family cohesion were related to depressive symptoms. Another study conducted with girls aged 7-10 years (Evans et al., 2013) noted that internalization of an unrealistically thin ideal body predicted disordered eating postures through body dissatisfaction, diet restraint and depression. Finally, the importance of family interactions at the onset of depressive symptoms cannot be overlooked. Parenting style has been identified as an important factor in the psychosocial adaptation of children and adolescents (Lengua and Kovacs, 2005). Parental behaviour has been studied from two different perspectives: warmth and control. Warmth is linked to aspects such as involvement and expression of affection, respect and positive care of parents and/or primary caregivers (Rohner and Khaleque, 2003). In this sense, previous studies have shown a significant link between parental heat and positive adaptation among adolescents (Barber et al., 2005; Heider et al., 2006). Rohner and Khaieque (2003) argue that the psychological adjustment of children is closely linked to their perception of being accepted or rejected by their main caregivers, and other studies have shown that weaker parental support is associated with higher levels of depression and anxiety among adolescents (Yap et al., 2014). Jaureguizar et al. (2018) also found that low levels of perceived parental heat were linked to high levels of clinical and school literacy, and that the weaker parental control, the greater the clinical. These authors also found that young people with negligent mothers and authoritarian fathers had higher levels of clinical disability. In short, according to the various theories, theories, may be for (1) biological reasons; 2. unsafe attachment; (3) lack of reinforcement of previously strengthened behaviour; (4) negative interpersonal relations and relations with the environment and the resulting negative consequences; (5) attributions by individuals about themselves, the world and their future; and (6) socio-cultural changes. It is likely that no theory can fully explain the onset and persistence of depression, although currently, negative interpersonal relationships and relationships with one's environment and socio-cultural changes (economic, political and demographic) may explain the observed increase in the prevalence of depression. Evaluation tools Many different evaluation tools can be used to measure depression of children and adolescents. Tables 2, 3 describe the most commonly used in the scientific literature. Table 2 provides an overview of the main self-administered tests that specifically measure depression in children and adolescents, while Table 3 presents tests that measure childhood and adolescent depression (i.e. broader or more general tests). Finally, Table 4 summarizes the most important hetero-administered psychometric tests for assessing this pathology. Table 2. Self-administered psychometric tests designed specifically for the evaluation of depression of children and adolescents. Table 3. Self-administered general psychometric tests that, among other variables, also assess child and adolescent depression. Table 4. Hetero-administered psychometric tests for the assessment of depression of children and adolescents. As indicated in the above tables, there are several self-administered instruments that can be used in children aged 6 to 7 years, although their duration should be taken into account to avoid over-reordering of subjects. While it is clear that efforts have been made to design shorter measures (for example, compare the 66 components of the CDS with the 16 points of the longest version of the KADS), the duration of the test should not be the only aspect taken into account when selecting an evaluation instrument. One of the most commonly used tools to measure childhood depression in the scientific literature is the Children's Depression Inventory-CDI (Kovacs, 1985), which is

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