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Abstract

The path from adolescence to adulthood is ever-changing and often extremely challenging. There is growing consensus that today it is an even more difficult journey than ever before. The purpose of this paper is to synthesize current knowledge regarding adolescent depression and its relationship to normal adolescent development. In addition, the origin, nature and characteristics of adolescent depression will be discussed. The paper will conclude with suggested interventions for educators to address the issue of adolescent depression in a preventative as well as treatment manner.

ADOLESCENT DEPRESSION: A SCHOOL PERSPECTIVE

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Adolescent Depression: A School Perspective

The path from adolescence to adulthood is ever-changing and often extremely challenging. There is growing consensus that today it is an even more difficult journey than ever before (Bettleheim, 1990 as cited in Butman & Arp, 1990). Some factors that contribute to this difficulty are the adolescents' disjunction between biological and social development, their confusion about adult roles, their difficulty in projecting into the future, their greater access to potentially life-threatening activities, and the erosion of family and social support networks. The result of the combination of these factors for today's adolescents is a high level of uncertainty in all aspects of their lives. This may negatively affect decision making capabilities and stress management potential, both of which are necessary for success in a learning environment (Hamburg & Takaniski, 1989).

With this in mind, it is not surprising that results of a recent thirteen year comparison of students show that students' emotional and behavioral problems have increased significantly as competency levels have decreased (Achenbach, 1991 as cited in Mick, 1994). Teachers report that more American students exhibit feelings of sadness, unhappiness, and depression. The arduous trail through adolescence is further complicated by the fact that these feelings have an enormous

effect not only on current social relationships and academic achievement, but that they also have been found to negatively influence future interpersonal success and opportunities for higher education and careers (Kovacs, 1989). Therefore, it is quite evident that as caring educators we need to address the emotional and behavioral struggles experienced by our students for their present, as well as their future well-being.

It is imperative that schools recognize that the challenges and struggles facing an adolescent in the 1990's cannot be compared to those of the 1970's or even the 1980's (Butman & Arp, 1990; Achenbach & Howell, 1993). The roadblocks to emotional health are often bigger and more difficult to overcome. They are ever present in all aspects of teenagers' lives and adversely affect their current, as well as their future, social abilities and academic achievement (Hamburg & Takaniski, 1989; Kovacs, 1989). Within the school setting, school counselors are uniquely qualified to increase the awareness of these challenges and to facilitate effective school-wide interventions.

The purpose of this paper is to synthesize current knowledge regarding adolescent depression and its relationship to normal adolescent development. In addition, the origin, nature and characteristics of adolescent depression will be discussed. The paper will conclude with suggested interventions for educators to

address the issue of adolescent depression in a preventative as well as treatment manner.

Normal Adolescent Development

As we approach the turn of the century, professionals and lay persons alike have directed their thinking about normal adolescent development from a period of inherent struggles and stress to one of “opportunities for growth and positive development” (Compas, Hinden, & Gerhardt, 1995, p. 265). Several models of adolescent development now recognize the interrelatedness of various factors upon healthy and maladaptive development (Compas et al., 1995). One model recognizes the interrelatedness of physical, biological and social development. Using these biopsychosocial models of adolescent development, researchers have recently attempted to investigate the relationships between hormonal changes and aspects of cognitive, emotional, behavioral, and interpersonal development (Belsky, Steinberg, & Draper, 1991; Buchanan, Eccles, & Becker, 1992; Trickett & Putnam, 1993). Evidence suggests that hormonal changes are linked to mood and behavior (Buchanan et al., 1992; Crockett & Petersen, 1993 as cited in Compas et al., 1995; Richards & Larson, 1993), but that mood and behavior may be mediated by the responses that the pubertal changes elicit from others in the social environment (Petersen, Sarigiani, & Kennedy, 1991). All this research

points to the “recognition of the wide variability that characterizes psychological development during the second decade of life” (Compas et al., 1995, p. 271).

Therefore, it may be said that the passage through adolescence is biologically and socially “set up” for mood and behavior variability. Early adolescence, which ranges in age from 10 to 14 or 15 (Dusek, 1991), is characterized by moodiness and emotional variations which are often accompanied by emotional outbursts (Newman & Newman, 1991). It is also a time of great cognitive leaps as young people move from concrete operational thinking to more formal operational thinking. Since cognitive processes are fluctuating between those two levels, adolescents’ ability to cope with the increased emotionality also varies. At times, the range of emotions may become overwhelming, and youth in the early stages of adolescent development often use denial as a coping strategy. They attempt to solve the problem for themselves instead of seeking help from others in order to avoid feeling ashamed or embarrassed (Vernon, 1993). Learning effective strategies for coping with these feelings is a major task for the early adolescent (Vernon, 1993).

By the time a student reaches middle adolescence, the emotionality marked by early adolescence has generally stabilized. For the most part, students between the ages of 15 and 18 are no longer overwhelmed by their emotions. Through

increasing formal operational thinking, students are less likely to think in either-or terms and are better able to problem solve (Dusek, 1991). Because they are more able to problem solve and more able to see possibilities, there is a decrease in denial of feelings associated with various problems. Students become more introspective and may seek help more readily (Vernon, 1993).

In summary, adolescence is naturally a period of fluctuating abilities in thinking, behaving, feeling, and coping. Petersen et al. (1991) summarize well by stating that, “early adolescents experience change in every aspect of individual development and in every major social context. All this change is likely to challenge youngsters, stimulating some to further development but overwhelming others” (p.252).

Adolescent Depression

According to Petersen et al. (1991), the nature and number of changes in early adolescence appear to be related to depressed affect in early adolescence. Normal developmental changes and issues, their number, and timing may trigger a downward trend of affect. Since all adolescents journey through developmental stages, it is reasonable to assume that at some point nearly all adolescents will deal with depressed affect to some degree. But despite having to cope with developmental changes in nearly all aspects of their lives, 70-75% of teenagers

negotiate early adolescence without extreme difficulty (Klimek, & Anderson, 1989; LeFrancois, 1992; Powers, Hauser, & Kilner, 1989 as cited in Vernon, 1993). In addition, Lewinsohn (1991 as cited in Compas et al., 1995) noted that “even the subgroup of adolescents who experience the most persistent pattern of depression will experience sustained periods in which they do not meet diagnostic criteria for a depressive disorder” (p.281). Therefore, it seems that the most beneficial manner for counselors to conceptualize adolescent depression is in terms of normal adolescent development which itself varies in timing, duration and intensity. With an understanding of the following criteria for adolescent depression and the effects of normal development on affect and thought processes, school counselors have the potential to serve students across a broad continuum of adolescent development and depression.

Levels of Depression

According to Petersen, Compas, Brooks-Gunn, Stemmler, Ey, and Grant (1993), recent research methods have investigated adolescent depression on three levels, with each level being a subgroup of the previous one. These levels are depressed mood, depressive syndrome, and clinical depression. Not only do these represent three distinct levels of depression, but they are also representative of differing investigative methods.

Depressed Mood

The concept of depressed mood has arisen from the study of depressive emotions and is characterized by a period of sadness or unhappy mood which may be in response to a situation such as the loss of a significant relationship or failure on a semester test. The period over which these feelings occur may be brief or extended. Depressed mood can be likened to Dixon's (1987) view of "normal depression" in adolescence which Allen (1990) conceptualized as a "state" rather than "trait". It may be brief, but also may be characterized by a longer, more protracted depressive reaction due to grief and bereavement associated with death, major illness, or a major loss or change in a student's life (Ramsey, 1994).

Depressed mood is also often experienced with other negative emotions such as fear, guilt, anger, contempt, or disgust (Watson & Kendall, 1989 as cited in Petersen et al., 1993). In addition, depressed mood is linked with anxiety and/or social withdrawal. The student with depressed mood, however, remains able to function in all settings (Dixon, 1987). Therefore, depressed mood might be viewed as a "developmentally appropriate response to maturational issues" (Butman & Arp, 1990, p.37). Adolescents with changing hormonal levels and with developing cognitive, social, and emotional skills may not possess adequate coping skills for life's stressors. Indeed, Butman & Arp (1990) also posit that,

“the very absence of these kinds of struggles might be more correctly taken to suggest that the adolescent is more ill than well” (p.37).

Depressive Syndrome

A co-occurrence of behaviors and emotions characterizes the approach to defining depressive syndromes (Petersen et al., 1993). Both anxiety and depression occur in depressive syndrome. Symptoms include crying; worry; fear of doing bad things; feeling the need to be perfect; feeling unloved; feelings of worthlessness; feeling nervous, fearful, guilty, self conscious, suspicious, and sad (Achenbach, 1991 as cited in Petersen et al., 1993). Students exhibiting these characteristics may be socially, physically, and cognitively impaired (Achenbach, 1991 as cited in Petersen et al., 1993; Dixon, 1987). According to Petersen et al. (1993), depressive syndrome has been reliably identified in adolescents through self-reports and through reports by parents and teachers. Students who exhibit these characteristics may or may not be identified as at-risk. With the help of all school staff, helping professionals within the school setting must be able to recognize, assess and intervene on behalf of students with depressive syndrome.

Clinical Depression

Of the three levels of adolescent depression identified in this paper, clinical depression is the most serious level an adolescent may experience. The most

widely used diagnostic model for clinical depression was developed by the American Psychiatric Association (Maser, Kaelber, & Weiss, 1991). The Diagnostic and Statistical Manual of Mental Disorders (IV) (1994) is used as a reference for this model. It bases a diagnosis on a review of the presence, duration, and severity of sets of symptoms. It assumes the presence of an identifiable syndrome of associated symptoms and also assumes that the symptoms are associated with significant levels of current distress or disability with increased risk for impairment in current functioning. Under the category of depressive disorders, adolescents may be diagnosed as experiencing Major Depressive Disorder, Dysthymic Disorder, or both.

Major depressive disorder. For a diagnosis of Major Depressive Disorder, an adolescent must have experienced five or more of the following symptoms during the same two week period: depressed or irritable mood for most of the day, nearly every day; diminished interest or pleasure in all or almost all activities for most of the day, nearly every day; significant weight loss or gain, or decrease or increase in appetite nearly every day; insomnia or hypersomnia nearly every day; psychomotor agitation or retardation nearly every day; fatigue or loss of energy nearly every day; feeling of worthlessness or excessive or inappropriate guilt nearly every day; diminished ability to think or concentrate or indecisiveness nearly every

day; recurrent thoughts of death, recurrent suicidal ideation without specific plan, suicide attempt or specific plan for suicide attempt. These symptoms must also represent a change from previous functioning and must cause clinically significant distress or impairment in social, occupational or other important areas of functioning such as academics (p.344).

Dysthymic disorder. Dysthymic Disorder and Major Depressive Disorder are differentiated based on the severity, chronicity and persistence of symptoms. Dysthymic disorder is characterized by less severe symptoms which are present for a period of at least one year in adolescents. A diagnosis of Dysthymic Disorder is suggested when an adolescent has exhibited a depressed mood for most of the day, more days than not, over a period of one year during which he or she has not been symptom free for more than two months. The adolescent must also exhibit the presence of two or more of the following symptoms while depressed: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, feelings of hopelessness. In addition, the adolescent must have been without a diagnosis for a Major Depressive Episode during the first year of disturbance (p.349).

The majority of teenagers navigate adolescence without severe depressive problems. Normal developmental stressors may become overwhelming for a

period of time, but evolving coping skills may stop further progression of a depressed mood toward depressive syndrome. School counselors can spearhead a prevention and treatment program for adolescent depression with a focus on normal development and normal developmental issues.

Related Variables

The research cited in the following paragraphs identifies several variables related to adolescent depression. In the majority of cases, these variables have been found to be correlational instead of causal. Therefore, the following list can be thought of as flashing yellow lights to warn of possible danger. Loneliness is one such variable. According to Woodward (1988 as cited in Brage & Meredith, 1994), adolescence is frequently characterized by alienation, solitude and loneliness. In addition, for some teenagers suicidal ideation may accompany either depression or feelings of loneliness (Brent, Perper, Goldstein, Kolko, Allen, Allman, & Zelenak, 1988; Carlson & Conrad, 1991; Lamb & Puster, 1991 as cited in Brage, 1995). Depressed students withdraw from social activities. They are lonely and hopeless. Failure to see an end to these feelings may result in suicidal ideation.

Another variable related to adolescent depression is self-esteem. Studies have found a negative relationship between depression and self-esteem (Anderson

& Harvey, 1988; Brage, Meredith, & Woodward, 1993 as cited in Brage & Meredith, 1994). According to Brage & Meredith (1994), feelings of low self-worth are likely related to depression because of the developmental tasks associated with adolescence. An important task in adolescence is establishing a strong, worthwhile identity; issues of status, independence, and competence become important (Lee & Brage, 1989). Low self-esteem may be a result of perceived difficulties in these areas.

Other warning signals for depression are stressful life events. Stressful life events for adolescents may include parental divorce, experiencing puberty before school transition, and school transition itself (Petersen et al., 1991). Researchers propose that negative life events may exacerbate feelings of helplessness and external locus of control (Mullins, Siegel & Hodges, 1985 as cited in Brage & Meredith, 1994).

Eating disorders and acting out behaviors have also been found to relate to depression in adolescents. Eckert, Goldberg, Halmi, Casper, & Davis (as cited by Brage & Meredith, 1994) reported that depressive symptomatology lessens with weight gain among anorexia nervosa patients. In addition, discipline problems and alcohol abuse may also mask depression in adolescence. With the complexity of adolescents' lives in today's society, it is important to keep in mind that these

warning signs may coexist with depression. Having school staff who are aware of these variables and of the referral procedure would potentially benefit many students sometime during their adolescent years.

Predictors

Various factors can be identified as predictors of depression. Researchers indicate that low self-esteem, family issues, failure to meet high standards, low self-efficacy, loss or threatened loss of a love object, hopelessness, attention to negative events, and poor self control skills are such factors (Asarnow & Bates, 1988; Gallimore & Kurdek, 1992; Simmons-Alling, 1990 as cited in Brage, 1995).

Family issues and self-esteem are intertwined in relationship to predictors of depression. Family strengths have been found to have an indirect effect upon adolescent depression through self-esteem. Brage & Meredith (1994) indicated that, "an important context for the evolution of individual self-esteem is the family and the kinds of interaction that occur among family members" (p. 464). Those types of interaction that may be predictors of depression include low parental support; parental abuse, neglect, or rejection; authoritative discipline; marital conflict; or loss of a parent. Another familial issue that predicates adolescent depression is the condition of being genetically related to adults with affective disorders (Simmons-Alling, 1990; Cummings & Davies, 1994). There appear to

be many mechanisms involved in the transmission of depressive disorders from parents to their children: genetic predisposition, emotional unavailability of parents, dysfunctional parent-child interactions, and marital conflict (Weissman, 1990; Lee & Gotlib, 1991; Burge & Hammen, 1991; Downey & Coyne, 1990 as cited in Petersen et al., 1993).

To elaborate on the importance of familial issues in relationship to the emotional well-being of adolescents, Petersen et al. (1991) suggested that closeness with parents, and especially with fathers, appear to moderate the effects of early adolescent changes. Both normal developmental changes and these non-normative changes have the potential to become overwhelming stressors and precursors of depressive symptoms. The Petersen et al. (1991) study found that closeness with mothers buffers negative effects of family changes, while closeness with fathers buffers family change. In addition, closeness with fathers also buffers synchronous school and pubertal change which their study indicates has a negative effect on subsequent levels of depressed mood.

In addition, family members may hold high standards for adolescents. Students may eventually internalize these standards as their own. Failure to meet such high goals can become a predictor of depression and lead to feelings of hopelessness (Dixon, 1987). As mentioned earlier, the degree to which a person's

depression affects daily functioning determines the severity of the depression, and one manner in which to determine this degree is by assessing the level of hopelessness and the ability to see positive futures. Persistently attending to negative events may also predict hopelessness and depression. Along with this, students who punish themselves for their failures, never rewarding themselves for their successes often become depressed (Rehm, 1977 as cited in Brage, 1995). These adolescents may also maintain an external locus of control and attribute positive events to external forces rather than internal ones. In addition, students who exhibit these patterns may display low levels of self-efficacy. A logical step from maintaining an external locus of control is difficulty in believing that one is capable of successes. So along with a low level of self-efficacy arises another predictor of depression, a tendency to self-evaluate in a negative manner. This also relates to the act of focusing on the negative events in life. Such thought patterns remain warning signals for depression.

Finally, an adolescent's disturbance of equilibrium due to the loss or threatened loss of a love object, status, role or other psychosocially determined support may predicate depression (Ramsey, 1994). The social aspect of an adolescent's life is often the perceived center of emotional well-being. Poor self-control is another predictor of depression related to the social dimension (Ramsey,

1994). It is very important in adolescence to control oneself in public. Poor skills in this area may serve to alienate others, thus also affecting the social equilibrium.

Risk Factors

Researchers have identified other variables as risk factors contributing to adolescent depression. Brage & Meredith (1994) noted that gender is significantly related to adolescent depression through self-esteem. Their study indicated that boys have higher levels of self-esteem than girls. Therefore, girls are at higher risk for depression. Baron & Campbell (1993), however, suggested that the widely used Beck Depression Inventory and the Reynolds Adolescent Depression Scale measure depressive symptoms that are more characteristic of females, and that if femininity were measured and statistically controlled, the differentiation might be much less.

A longitudinal study by Petersen et al. (1991), however, found no significant sex differences in measures of depressed affect or number of depressive episodes in early adolescence, but discovered significant gender differences in the twelfth grade follow-up assessment. Girls begin to show an increased level of depressed affect in the eighth grade while boys remain relatively stable. By the twelfth grade, girls score significantly worse on measures of depressed affect and emotional tone and have a significantly higher number of depressive episodes than

do boys. These researchers attributed these differences to the females experiencing more challenges in early adolescence: early pubertal development, peak pubertal change prior to or simultaneous with school change, and change in the family. Despite differing opinions as to the etiology of sex differences for adolescent depressed mood and negative affect, knowledge of the discrepancy of diagnosis between males and females may benefit adolescents within the school setting.

Another risk factor is the age of the adolescent. Petersen et al. (1991) found a larger discrepancy in reports of depressed mood and negative affect for females in grade twelve than in grade six, but attribute this to experiences in early adolescence. Brage & Meredith (1994) also reported an indirect effect of age on adolescent depression through loneliness. Their study indicated that older adolescents are more lonely and are reported as more depressed than younger adolescents. Issues students face become more complicated with maturity. They encounter new situations, new choices, and more responsibility and social expectations (Kashani, Rosenberg, & Reid, 1989 as cited in Brage & Meredith, 1994). Major life events include greater reliance on peers for social relationships and support, deeper relationships with the opposite sex, post high school and career decisions, and approaching self-reliance. It is plausible that any one of these

issues can become an activating event for depression or may combine to form persistent, every day stressors which may lead to depression.

Lack of social support is another risk factor. A study by McFarlane, Norman, Streiner, & Roy (1985) found that this is primarily an issue of poor family support. Families wrestling with personal issues may not be capable of offering much support to their adolescents. Petersen et al. (1991) stated that, "close relationships with parents may mediate the long term effects of early adolescent changes on depressive mood through the provision of one important sphere of *security and comfort in the adolescent's rapidly changing world*" (p.267). This is an area where families and schools can collaborate. Indeed, several studies indicate that inadequate social support in school settings is itself a major risk factor for depression (Johnson, Johnson, & Smith, 1991; Maughan, 1988). Families and schools can work together to identify needs and to offer social support to adolescents of all ages and developmental levels.

Another risk factor for adolescent depression which is associated with the school setting is a learning disability. As mentioned previously, low levels of self-esteem are a predictor in identifying depression in adolescents. Learning disabled students have lower self-concepts and higher levels of anxiety (Huntington & Bender, 1993). Therefore, students with learning disabilities-either diagnosed or

undiagnosed-are at greater risk of depression.

Finally, a history of affective disorder-whether diagnosed or undiagnosed-can also be a risk factor for teenagers. Depression in adolescence shows continuity-once a person has experienced a significant depressive episode, he or she is at substantially increased risk for a recurrence in the future (Lewinsohn, Rohde, Seeley, & Hops, 1991 as cited in Compas et al., 1995). Garber, Kriss, Koch, & Lindholm (1988) indicated that the recurrence rate in adolescents with depressive disorders is 64%. This also carries an increased risk for disorder and dysfunction in young adulthood.

Many predictors and risk factors for depression exist. Awareness of these indicators and factors is of utmost importance for school counselors in order to intercede on behalf of our students. It is not enough, however, for only the counselors to have this knowledge. The entire school staff must obtain this information and learn how to use it in a manner that is beneficial for the student as well as for the entire school community.

School Interventions

Counselor Role

The role the school counselor plays is of utmost importance in identifying and treating adolescent depression. Counselors must be as knowledgeable as

possible on the subject of adolescent depression. Butman & Arp (1990) posited that adolescent mood disturbance might be a “developmentally appropriate response to maturational issues” and that, “the very absence of these kinds of struggles might be more correctly taken to suggest that the adolescent is more ill than well” (p. 37). This underlines the pervasiveness of depressive symptomatology among adolescents and consequently serves to reinforce the necessity of a greater understanding of this issue. Maughan (1988) summarized well when he stated that schools (and school counselors) are “uniquely well placed as a focus for interventions if appropriate targets can be identified” (p.200).

Identifying Depressed Students

One method to identify depressed students would be to conduct screenings of at-risk students. The counselor could easily interview these students each semester to screen for depressive symptomatology. Most schools have various criteria they use to identify at-risk students. Those students considered at-risk for depression, however, may be the ones lacking prior protective factors against mental illness in the form of good experiences at school. These experiences may come in the form of social relationships, athletic prowess, musical success or scholastic achievement.

Screenings of at-risk students as well as other referred youth may include

assessments in the form of personal interviews, checklists, rating scales, unfinished sentences, self-monitoring, writing activities, and art activities. These tools can be used to assess the frequency, intensity and duration of symptoms for a better understanding of the problem. In addition to using information gathered from students themselves, an effective school counseling program enlists the help of the entire school community-including parents, in the assessment process. Therefore, counselors may also assess a student's status by interviewing school staff, parents, and friends or by asking them to complete checklists, rating scales, or unfinished sentences.

Problems may arise, however, when teachers and parents are asked to refer students. Studies indicate that teachers recognize only global characteristics of depression (Maag, Rutherford, & Parks, 1988). In addition, interviews of teachers to identify adolescent depression conducted by Carlson & Cantwell (1980) resulted in false negatives for 60% of depressed subjects. This lack of knowledge of depressive symptoms may prohibit teachers from making referrals, therefore inhibiting the success of diagnosing depressive symptoms and potentially threatening the well-being of students.

In addition, when Carlson & Cantwell (1980) interviewed parents to identify adolescent depression, the result was also false negatives for 60% of

depressed subjects. Parental assessment of depressed adolescents can conflict with adolescents' perceptions of depression in the form of minimization of distress levels (Hodgman & McAnarney, 1992). Therefore, it is important to interview parents regarding their perceptions of their student's condition, but it is also important to take into account information from a variety of sources concerning the condition of the student.

Coordinating

Another role performed by the school counselor in terms of treating adolescent depression is that of coordinator. The school counselor is again uniquely placed to coordinate communication between student, teacher, and family. Heward, Dardig, & Rosselt (1979 as cited in Maag & Forness, 1991) suggested that positive parent-teacher relationships promote parental feedback to practitioners, enhance treatment outcomes, and extend the positive effect of school programming in the home. One common method in which to perform this service is through a problem-solving procedure by the School Assistance Team.

School counselors may also address teachers' lack of knowledge on the topic of adolescent depression. Mick (1994) suggested an in-service so that teachers may be sensitized to factors which place students at greater risk for depression. A knowledgeable school counselor is the logical person to coordinate

the dissemination of information on depression. In addition to information regarding the risk factors of depression, the in-service should contain information on depressive symptomatology, how to make referrals to the counseling office, and effective ways to make parental contacts. Teachers may also be made aware of the importance of social support in preventing and treating adolescent depression.

School counselors can stress the appropriateness and beneficial aspects of cooperative learning. Emotional maturity, well-adjusted social relationships, strong personal identity, and high self-esteem are all positively related to cooperativeness (Johnson et al., 1991). Fostering this type of environment within the classroom as well as throughout the school, could go a long way in promoting the well-being of students. It may be propitious for the school counselor to conduct an in-service specifically on the process of cooperative learning.

In addition to coordinating in-services on depression and cooperative learning, counselors may also coordinate other preventative measures by assisting teachers in the development of affective education lessons for use in the classroom. Counselors may provide sources of information, materials for lessons, and classroom support. Topics may include normal developmental changes and their effect on adolescents' lives, how to cope with developmental and non-normative changes, self-esteem, healthy ways to express feelings, relationship issues,

communication skills, and conflict management. Addressing these issues as a normal part of the educational process has the potential to provide students with the skills and knowledge to better cope with low affect and perhaps prevent the development of serious clinical depression.

Counseling

For students. Another important role of the school counselor is to provide counseling services for students. Counselors may address depression through individual counseling. Petersen et al. (1993) stated that interventions “need to address dysfunctional cognitive processes, skills for coping with acute and chronic stress, and strategies to deal with interpersonal relationships and problems” (p.163). Two specific interventions that can address these issues include bibliotherapy and journaling. Bibliotherapy normalizes the thoughts, feelings and behaviors of depressed adolescents. In addition, it can be used to address the dysfunctional cognitive processes which the characters and the adolescent use. Relationship issues within the book can also be discussed and can act as a bridge to a discussion of the adolescent’s own relationship issues. Journaling allows students to express their thoughts and feelings. This catharsis is one way for adolescents to work through their depression.

Group counseling is another aspect of counseling services provided by

school counselors. The onset and perpetuation of depressive episodes sometimes occur in an interpersonal context and negatively affect social abilities. Therefore, a group including depressed adolescents would potentially become a mutual support system and would provide an opportunity to develop and practice interpersonal skills such as communication in the form of “I” statements and conflict resolution. In addition, counseling groups would also benefit students by addressing such developmental issues as coping with feelings, coping with chronic and acute stressors such as family and school changes, and changing dysfunctional cognitive processes which may lead to self-defeating behaviors. Counseling groups can also normalize the emotions associated with normal development and depressed mood.

For parents. Not only can a school counselor provide counseling groups for students, but for parents as well. As noted earlier in this paper, family support is extremely important in the emotional well-being of adolescents. In addition, parent programs in general have resulted in decreases in maternal depression and increases in family cohesion (Eyberg & Robinson, 1982 as cited in Maag & Forness, 1991). Any groups involving parents may indirectly benefit students by addressing parenting issues, communication skills, flexibility, and stress management (Clarke, 1978 as cited in Brage & Meredith, 1994). Direct benefits

to students may involve developing a curriculum for parent/adolescent groups on topics relative to normal adolescent development and adolescent depression.

Normalizing adolescent ups and downs would be an important aspect of these groups in addition to helping parents find ways in which to help their students effectively deal with their depression as well as helping them find ways to cope with their own sense of powerlessness over these issues.

In addition to offering groups for parents, another way to indirectly impact students would be to offer one-session classes which require less time commitment from busy parents. Topics for classes could include parenting, communication skills, conflict resolution, normal adolescent development and developmental issues. In addition to requiring a shorter time commitment, classes may appear less threatening and therefore attract a greater participation. This would have the added appeal of benefitting even more students.

Providing Opportunities for Family Interaction

The school counselor can also coordinate opportunities for family interaction as a way to address the needs of depressed adolescents. Open gym for families or informal family volleyball leagues are interventions which would foster family togetherness. Research indicates that a social policy that enhances opportunities for effective family functioning should influence the prevalence of

depression in adolescents in a preventative manner (McFarlane, Bellissimo, Norman, & Lange, 1994).

Referring

In addition to providing counseling services for students and parents and opportunities to interact, school counselors also must provide referral services. With an ever-increasing work load, today's counselors may find it difficult to treat more severe cases of adolescent depression. Outside help may be necessary. School counselors must realize their limitations and refer when necessary to outside agencies or individuals. Counselors may prepare a list of local helping professionals by conferring with other school counselors in the same geographic area.

Teacher Role

Learning About Depression

The first and most important action for teachers is to gain a better understanding of adolescent depression. Teachers must be informed of the symptoms and risk factors involved in this issue. In addition to being able to identify depression, teachers need to be aware of the most effective procedure for making referrals to the school counselor.

Modeling

Modeling is another important task teachers engage in every day. It is even more important in relationship to students with affective disorders. Effective communication skills need to be modeled inside as well as outside the classroom. Depressive symptomatology is tied to ineffective, unsatisfactory interpersonal relationships and loneliness (McFarlane et al., 1994; Curry & Craighead, 1990). Effective communication can go a long way in repairing and developing better, more satisfying relationships. The more students see these skills practiced, the more likely they are to see the benefits and engage in them. Students will also respond to teacher modeling of a caring, nonjudgmental attitude. In order for students to develop their own social support system, they need to feel secure in their relationships. If they know they will be accepted as they are, they are much more likely to go beyond their comfort zone to initiate relationships which may be followed by a higher level of social self-efficacy and self-esteem. Teacher modeling of this attitude is a significant step toward greater trust among students and teachers, and among students themselves and is a significant step toward greater self-esteem for students.

Planning Classroom Strategies

Within the classroom, teachers may indirectly address the affective well-being of students by planning a variety of activities which provide opportunities for success for all students and that will positively affect self-esteem. This may include more hands-on activities or activities which foster a sense of community within the classroom. Utilizing cooperative learning is one way to build a sense of community and assist in the development of social skills. This type of approach to classroom procedures may go a long way in preventing depression.

Other prevention strategies may include incorporating into various subject areas such topics as what to expect from normal developmental physical and emotional changes, how to cope with these changes, how to cope with stress, how to build stronger relationships, and how to communicate effectively. Even informal classroom discussions on such topics provide opportunities for teachers and students to interact on a more equal level and to build a sense of community within the classroom.

Administrator Role

Learning About Depression

Once again, knowledge is the key. Armed with a thorough understanding of the symptoms and risk factors involved in adolescent depression, a school

administrator can support the work of teachers and counselors. Ways in which administrators can offer support include providing time to develop and carry out plans to address this issue both within and outside the classroom, providing money for salaries, and providing encouragement to students and staff.

Modeling

In addition, it is imperative that the people in charge of the school and with a position of power in the community model effective communication skills. In doing so, they will also maintain open communication with parents and members of the community who may have more expertise to offer on this issue. The role of the administrator may be the most important one within the school setting because the administrator sets the tone for the entire school community. If the administration is supportive of both students and staff, it is easier to address the specific needs of adolescents, lessen their stressors, and encourage their education.

Conclusion

Adolescence can be a challenging road to travel. Many hazards exist; any one of them may signal the beginning of a depressive episode. Whether the depression lasts only a few days or a few years, school staff, and especially school counselors need to be aware of its predictors, symptoms, and related variables. The school community can be a powerful form of social support to all adolescents

by fostering an encouraging atmosphere and facilitating the well-being of its students through classroom activities and counseling services.

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