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Adolescent depression : Implications for the high school counselor

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Abstract

For many teenagers, today depression is more thanjust a case of the blues. An estimated 6 - 30% percent of teenagers suffer from clinical depression. Life is not always happy and carefree, and for many adolescents, these are not the best years of their lives. Given the prevalence and seriousness of adolescent depression, it is important that teenagers suffering from this disorder receive quick and effective treatment. Since most teenagers spend a majority of their day in schools, school counselors play a critical role in addressing teenage depression. The importance of this paper was to examine the causes for depression and how depression manifests itself in adolescence. Three levels of prevention are examined on how school counselors can implement effective ways to address teenage depression within high schools

ADOLESCENT DEPRESSION: IMPLICATIONS FOR THE HIGH SCHOOL COUNSELOR

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Abstract

For many teenagers, today depression is more than just a case of the blues. An estimated 6 – 30% percent of teenagers suffer from clinical depression. Life is not always happy and carefree, and for many adolescents, these are not the best years of their lives. Given the prevalence and seriousness of adolescent depression, it is important that teenagers suffering from this disorder receive quick and effective treatment. Since most teenagers spend a majority of their day in schools, school counselors play a critical role in addressing teenage depression. The importance of this paper was to examine the causes for depression and how depression manifests itself in adolescence. Three levels of prevention are examined on how school counselors can implement effective ways to address teenage depression within high schools.

Everyone has days when they feel "down or blue," days when their patterns of concentration, eating and sleeping seem to change. Unexplained feelings of worry, anxiety, discouragement, isolation, hopelessness, and worthlessness seem to seep in. It is only when this happens day in and out that it becomes more than teenage moodiness or raging hormones. These kinds of feelings and patterns can be signs of depression. If adolescents experience several of these kinds of signs every day for two or more weeks, even when good things are going on around them and still they can not get back on track, then it may be depression. For kids experiencing depression, adolescence can be the worst years of their lives (Black, 1995).

Many people use the term depression in every day conversation. "I'm depressed that the Cyclones lost" or "It depresses me to think of all the work I have to do tonight." Sometimes it is difficult to tell the difference between regular mood swings and serious emotional problems. Feeling the blues, having a sad mood, or expressing grief is not the same as suffering from a depressive disorder (Merrell, 2001). Feelings of sadness after an emotional letdown or grieving after the loss of a loved one, though extremely painful, are normal for everyone since everyday living encompasses a wide rage of emotions, including both depressed and elevated states (Oster & Montgomery, 1995). A depressive disorder goes beyond normal mood swings. Depression is a medical illness,

which means that it is not all in your head or imagination (Cobain, 1998). Depressive disorders are neither normal developmental occurrences nor short-lived problems that dissipate with time. Depression is a mood disturbance continuum characterized by feelings of sadness, inferiority, inadequacy, hopelessness, dejection, guilt, or shame (Dixion, 1987). Depression often makes people overly tired, evokes intense feelings of inadequacy and worthlessness, and leads to a loss of interest in life (Oster & Montgomery, 1995). These kinds of feelings over time affect the adolescents' family relationships, peer relationships, school performance, and physical health. Depression can change a person's life style dramatically and may persist for weeks, months, or even years (Mondimore, 2002).

The purpose of this paper is to inform school counselors of the prevalence and seriousness of adolescent depression. Although school counselors are not expected to diagnose mental health disorders, gaining an awareness of depressive symptomatology and comorbid (co-occurring) conditions can help them identify students in need of referral to and treatment by appropriate mental health care providers. Armed with this knowledge about adolescent depression, the school counselor can then begin to explore and initiate school based preventative plans.

Symptoms of Depression

Depression is not just feeling bad, tired, or unhappy; there are many symptoms. Depression in adolescents is primarily characterized by the following symptoms: depressed mood or excessive sadness; loss of interest in activities; sleeping problems (either too much or not enough); psychomotor retardation or slowing of physical movement (or in some cases, physical agitation); fatigue or lack of energy; feelings of worthlessness or excessive guilt; difficulty in thinking, concentration, or making decisions; and a preoccupation with death (Merrel, 2001). The general citerion for a diagnosis of depression is that at least five of these symptoms are present most of the time for the same two week period, and at least one of the symptoms is depressed mood or loss of interest (Cobain, 1998).

Types of Depression

There are four types of depression along a continuum: normal depression; major depression, also known as clinical depression; Dysthymia, also known as chronic depression; and Bipolar disorder, also known as "manic depression". The distinction among these types is of degree, intensity, duration, cause and hopefulness, with seriousness determined by a student's level of psychosocial functioning and receptivity to treatment (Ramsey, 1994).

Normal Depression

In so-called normal depression, students typically talk about "feeling down" because of a specific external episode in their lives such as failing a test or being rejected by a friend. The American Psychiatric Association considers normal depression to be a transient state that generally lasts between a week and 10 days (Black, 1995). The key factor to recognize with normal depression is the short duration of the depressed mood.

Major Depression or Clinical Depression

Major depression is the name given to the mood disorder characterized by the development of the full blown depressive syndrome. Major depressive disorder is the most common mood disorder of adolescents and young adults (Mondimore, 2002). A major depressive episode lasts for months and maybe accompanied by poor appetite, weight loss, lack of interaction in normal activities, and repeated thoughts of death (Ramsey, 1994). Major depression often makes people overly tired, evokes intense feeling of inadequacy and worthlessness (Oster & Montgomery, 1995).

Dysthymia or Chronic Depression

Some kids don't bounce back from a bout with depression. For them, chronic depression might be a persistent trait and an unbroken sad mood rather than a temporary state. To be diagnosed with chronic depression, or what the American Psychiatric Association calls "dysthymic disorder," kids must show

symptoms of depression more often than not for at least one year (Black, 1995). Adolescents diagnosed with Dysthymia are usually able to carry out daily routines but it may take a lot of effort to do so. Adolescents who have Dysthymia might feel unloved, sad, angry or irritable, tired, guilty, self-critical, negative, hopeless, and anxious (Cobain, 1998). Persons with dysthymic disorder suffer from a smoldering low grade depressive syndrome that persists over a period of many months, sometimes for years. It is an illness that can remain undetected and thus untreated for a very long time (Mondimore, 2002). In the case of Dysthymia, depression is less a temporary state and has become a more stable trait. In effect, being depressed becomes part of one's personality or general way of being (Merrell, 2001). According to experts, 70% of young people with Dysthymia will eventually develop major depression, so it is important to get help as early as possible (Cobain, 1998).

Bipolar Disorder or Manic Depression

With bipolar or manic depression, there are different cycles or phases from high (manic) to low (depressed). Bipolar means that moods move back and forth between two (bi) opposite (polar) emotional states. When depressed, the adolescent may feel sad and hopeless. When manic, the adolescent feels extremely angry, irritable, or happy; has extraordinary mental and physical energy; and has boundless confidence. These cycles of depression and mania can

take place several times a year, or as rapidly as once a day or more. The adolescent may feel like he or she is riding a roller coaster of highs and lows (Garland, 1997). The signs of mania (a manic episode) include feelings of exceptionally high energy, happiness, and creativity. During a manic episode the adolescent might experience difficulty making decisions, demonstrate obnoxious behavior, deny that there is a problem, or engage in risk-taking behaviors, including drug/alcohol abuse (Cobain, 1998).

Adolescent Depression

Depression at one time was thought to be primarily an adult phenomenon (Maag, Rutherford, & Parks, 1988), and until the 1960's, there was considerable debate on whether or not depression even existed before adulthood. Depression in adolescents has long been conceptualized as a normal or transient phenomenon necessitating no therapeutic intervention (Marcotte, 1996). Parents and school professionals can mistake these signs as moodiness or raging hormones if not properly informed about adolescent depression. However, in Western society today, depression and depressive disorders are seen as a pervasive problem with adolescents as well as adults (Evans et al., 2002). Researchers and clinicians now concede that depression frequently occurs in children and adolescents (Maag et al., 1988).

Adolescent depression may be one of the most prevalent yet overlooked and under treated mental health problems. Estimates of the prevalence of clinical depression in adolescents in the United States range from 6% to 30% (Sands, 1998). These figures do not even address adolescents with masked depression, which often takes the form of alcohol and drug abuse, delinquency, hyperactivity, sexual acting-out behavior, and eventual suicidal behavior (Maag et al., 1988).

Depression in adolescents tends to be more enduring than in adults; the probability of a second or third episode is high (Sands, 1998). Children with clinical depression are under treated. In fact, 70% to 80% of depressed teenagers do not receive treatment (Cicchetti & Toth, 1998). Cobain (1998) noted that depression may have more harmful effects for the adolescent than for adults, as witnessed by the fact that the ultimate violence towards oneself, suicide, is more prevalent among depressed adolescents than adults. Furthermore, Cobain (1998) indicated that adolescents tend to have higher rates of lethality in their suicide attempts.

The need for intentional and culturally appropriate treatment developed specifically to meet the needs of adolescents diagnosed with depression is critical (Mellin & Beamish, 2002). The number of reported incidents of adolescent depression is significantly greater than the rate reported for children. A marked increase appears between the ages of 13 and 15, reaching a peak around 17 to 18

years of age, and later stabilizing at the adult rate (Marcotte, 1996). Childhood rates are fairly equally divided between the sexes, but by midadolescence the scenario is quite different. Studies consistently find that beginning at about age fourteen, the ratio of women reporting symptoms, compared to men is 2:1 or higher (Sands, 1998). In examining family structure, girls from single parent families and children of divorced parents have been found to exhibit increased levels of depression and anxiety as well as slower rates of recovery when they do experience a depressive episode. Moreover, low socioeconomic status also has been linked with an increased risk for depression. Acute and chronic life events, most typically involving significant losses through parental death, divorce, or separation, or involving child maltreatment, also have been associated with the occurrence of depression during childhood and adolescence (Cicchetti & Toth, 1998).

Sands' research regarding depressive disorders and gender relationships raises this question pertinent to female adolescents: Are there psychological differences and stresses at different age levels (developmental periods in life) that give rise to depressive disorders (Sands, 1998)? A review by the National Institute of Mental Health (NIMH) published in 1987 of epidemiological studies of depression acknowledged that significant gender differences were found and offered three explanations: (a) differences in rearing environment, (b) differences in social

roles, and (c) less favorable economic and social opportunities for females. The NIMH report emphasized the need to research treatment for depression appropriate for each gender (Schonert-Reichl, 1994).

Clinical as well as epidemiological investigations have shown that 40% to 70% of adolescents with depression have comorbid disorders, and at least 20% to 50% have two or more comorbid diagnosies (Evans, Velsor, & Schumacher, 2002). In psychology, the term comorbidity has been used to indicate similar relationships among various internalizing problems. The various internalizing problems, like many psychological disorders, may exist in a kind of symbiotic relationship; they may nurture and sustain each other, and may have developed through similar events, predispositions, and patterns of responding (Merrell, 2001). The most frequent of the comorbid diagnoses are anxiety and substance abuse. Conduct problems may also develop as a complication of the depressive disorder and persist after remission. Adolescent girls are more likely to have co-existing eating disorders. These comorbid diagnoses enhance the risk of recurrent depression and affect the duration of the depressive episode (Evans et al., 2002).

Probable Causes of Depression

What causes depression to be such a weighty and painful disorder? Often depression happens after teens have had many upsetting events happen one after another. They add up to such a big load that the adolescent runs out of coping

reserves, and one final disappointment or hurtful experience triggers the depression (Garland, 1997).

Cognitions

The cognitions of depressed adolescents are marked by distortions in attributions, self-evaluation, and information processing. Depressed youths are more likely to interpret positive events as occurring in response to external factors of which they have no control, and interpret negative events as entirely their own fault (Evans et al., 2002). Depressed adolescents' thoughts are dominated by a negative view of self as worthless, the world as bleak, and the future as hopeless (Cicchetti & Toth, 1998). In essence they have "learned helplessness" (Oster & Montgomery, 1995, p.52).

Highly-depressive adolescents demonstrate a stronger tendency to dramatize situations as reflected by "awfulizing". They also think in a way that makes them less tolerant of frustration than are nondepressed adolescents. Thus, depressed adolescents tend to make unrealistic demands on themselves (Marcotte, 1996). Through this negative view of the world, they distort experiences and display information processing errors such as over generalizing predictions of negative outcomes, catastrophising the consequences of negative events, and selectively attending to the negative features of the (Evans et al., 2002). It actually becomes a self fulfilling prophecy for the adolescent, so the prediction that things will go

badly leads adolescents to act in such a way that things do go badly for them (Garland, 1997). For example, no matter how bright the day is, how many goals are accomplished, or how many compliments are received, the adolescent with depression tends to find some flaw or reason for self-criticism (Evans et al., 2002). These negative beliefs then become the root for maintaining and increasing their depressive symptoms and suicidal thoughts (Oster & Montgomery, 1995).

Other Contributing Factors

Experts have different opinions about what causes depression. Many believe that depression is a result of chemical imbalances in the brain (Cobain, 1998). Others say that genes, environment, and coping skills play a big role in whether an adolescent develops depression. Most likely, depression is the result of a combination of factors. Some of those risk factors include family history of depression, stress, loss of a loved one, a romantic break up, abuse or neglect, perceived differences and anxiety disorders (Cobain, 1998).

Cicchetti & Toth (1998) noted that significant numbers of adolescents with a depressed parent are two to three times more likely to be depressed. Additionally, prolonged anxiety, sustained grieving and difficulty in resolving the loss may further contribute to problems in the organization of cognitive, affective, representational, and biological systems. Subsequent loss experiences, either real

or symbolic, may precipitate depressive episodes in adolescents. Although much study remains regarding the specification of family variables that are related to a depressive disorder in childhood and adolescence, it is clear that the family environment can exert significant influences on the development and maintenance of early-onset depression (Cicchetti & Toth, 1998).

Role of the Counselor in Assisting Depressed Adolescents

So what is the role of the school guidance counselor in offering help and assistance to depressed adolescents? Given the prevalence and seriousness of adolescent depression, it is important that teenagers suffering form this disorder receive quick and effective treatment (Evans et al., 2002). Secondary school professionals play a strategic role in the early identification of depression, which may lead to the prevention of many adolescent suicides since adolescents spend more time in school than in most other structured environments outside the home and have their most consistent and extensive contact with trained professionals in school (Maag et al., 1988). Student behaviors, interpersonal relationships, and academic performance, all-important indicators of mood and the ability to cope - are subject to ongoing scrutiny in the school setting. Accordingly, school personnel often may be the first professionals to note developing problems (Maag et al., 1988).

Thus far this paper has addressed information about depressive symptomatology, comordid disorders, and cognitions of depressed adolescents. This information helps equip school counselors to identify adolescents in need of further assessment and referral.

Prevention

In addition to recognizing the symptoms and signs of depression in adolescents, the school counselor can initiate school-based prevention programs. Preventive activities may address topics such as drug and alcohol use, physical and social development, and peer relationships. Preventive efforts may involve primary, secondary, and tertiary prevention (Evans et al., 2002).

Primary Prevention

Primary prevention targets the entire population of adolescents in school classrooms and focuses on normative events (e.g., puberty, school transitions). The school counselor can organize school efforts to provide all students with information about how to cope with the stresses of normal growth and development. Beneficial to all adolescents are programs focusing on the typical challenges of adolescence such as resisting peer pressure and negotiating friendships, as well as those that specifically address the topic of depressive feelings (Rice & Leffert, 1997). The counselor wishing to reduce or prevent depression in the school would do well to consider one of the many self-esteem

building programs available. In addition, helping students become aware of individual life stressors, teaching them stress management and how to alter negative nonproductive personal thinking patterns will be helpful in preventing depression or minimize symptoms (Forrest, 1983).

Secondary Prevention

Secondary prevention focuses on adolescents already exhibiting some signs of depression, as well as those exposed to known risk factors such as a parent with a depressive disorder. School counselors can conduct small group counseling with these at-risk adolescents, focusing the group session on the specific problem (low self-esteem, social isolation for example) or the particular risk factor (Evans et al., 2002). Teaching cognitive self-control enables adolescents in small groups to prevent unwanted thought intrusions and helps them substitute appropriate task-oriented thoughts. Thinking positively will help students act and feel more positively about themselves. Teaching the cognitive process of problem solving and challenging students' unrealistic attitudes and negative self-labels should also be the counselor's role in classroom guidance activities (Forrest, 1983). Since learning disabled students, gifted and talented students, and females appear more susceptible to depression, school counselors may need to focus secondary prevention efforts on these populations (Evans et al., 2002). Both regular and special education teachers could benefit from training to further develop their

skills in identifying high-risk students since many depressed adolescents exhibit behavior disorders and/or learning disabilities (Maag et al., 1988).

Tertiary Prevention

Tertiary prevention services for adolescent depression are designed to promote optimal function with students who have already developed some depressive symptoms and includes initial assessment and referral. The school counselor can conduct assessments by interviewing students individually, consulting with teachers who have considerable day-to –day contact with students, and / or by soliciting parent input (Rice & Leffert, 1997). Adolescents with severe depressions are likely to need therapy from clinical psychiatrists or other specialists and school counselors need to refer those deeply troubled students to hospitals, clinics, or professionals in private practice for treatment. Once students are assessed the counselor may want to engage the adolescents in both primary (school wide programs) and secondary (small counseling groups) prevention programs (Evans et al., 2002).

Collaboration

At all levels of prevention, collaboration with teachers, parents, and community mental health care providers is critical. Collaboration with teachers can strengthen the school counselor's ability to identify students in need. Teachers may refer students experiencing problems to school counselors and,

conversely, the counselor may provide the teachers with information to enhance their abilities to make referrals (Rice & Leffert, 1997). School counselors can increase teachers' understanding of depression by providing them with information about risk factors, developmental tasks and challenges, normative and non-normative life occurrences, and internal and external resources involved in the development of depression (Evans et al., 2002).

Collaborative efforts with parents may increase the chances for positive outcomes for students at risk for the development of depression or those already manifesting depressive symptoms. When consulting with parents individually or in small groups, it is helpful to remember that in a family the behaviors of its individual members are highly interdependent and that changing one person's behavior will have an effect on other family members. School counselors can more effectively assist and support parents and students so that their attempts at new behaviors will have an improved chance of being supported by other family members (Mullis & Edwards, 2001). Parents influence a child's cognitive development through modeling of thinking and behaving. The school counselor can help parents learn how to deal with adolescent's behavior more positively and to become actively involved in reinforcing prevention strategies or maximizing the use of community resources for evaluation and / or treatment (Rice & Leffert, 1997).

The school counselor who establishes collaborative relationships with mental health care professionals can seek them out for consultation and contact them if necessary (Evans et al., 2002). The use of psychiatric medications for the treatment of child and adolescent mental health disorders by health care providers has been steadily increasing for four decades. Because teachers and counselors are involved on a daily basis with children and adolescents who take these drugs, a working knowledge of the growing field of psychopharmacology seems necessary for school counselors. Familiarity with the language of child and adolescent psychopharmacology assists the counselor when consulting and collaborating with psychiatrists, psychologists, nurses, social workers, teachers, administrators and parents. A basic knowledge of drug side effects prepares the school counselor to monitor the adolescent's behavior and report any drug related problems to parents and physicians (James & Nims, 1996).

Finally, establishing mutually supportive and collaborative relationships with other community agencies providing youth services (e.g., churches, community centers) may provide a safety net for vulnerable youth. A network of school counselors, parents, teachers, and community personnel can maximize the effectiveness of youth prevention programs for depression (Evans et al., 2002).

Conclusion

School counselors are in a unique position to help identify adolescent depression given the amount of time teenagers spend in school. For school counselors to effectively address the prevalence of adolescent depression in their schools they must become knowledgeable about this emotional condition. Given knowledge about the types of depression, the symptoms of depression, and the probable causes of depression, school counselors can then identify students in need of assistance or referral. Once students are identified the school counselor can address their needs by developing a school-based prevention program. Through on-going collaborative efforts with school staff, parents, and community personnel, the school counselor can begin to create a strong foundation of support for adolescents suffering from depression.

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