DEPRESSION IN ADOLESCENTS: WHEN IT REALLY HURTS TO BE A TEENAGER

By Ralph E. Cash, PhD, NCSP
Nova Southeastern University

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Depression, particularly in teenagers, is often described as the invisible illness. Its symptoms can easily masquerade as part of the normal tumult of adolescence, a time not noted for level moods or stable behavior. Rapid changes in hormonal balance, physical and cognitive development, perceptions of the world, and response to peer pressure, coupled with conflicting desires to be independent but free of responsibilities, combine to make adolescence a time of emotional turmoil and behavioral extremes. Most middle and high school students experience brief, sometimes intense episodes of the blues, irritability, and/or rebellion. Even common adolescent behavior—slavish adherence to fads, body piercing, erratic sleep habits, and cyber socializing—can at times seem pathological to adults.

How, then, can parents and educators differentiate between those adolescent characteristics that, no matter how outrageous, are "just being a teenager" and those that suggest serious clinical depression? What is the responsibility of schools to do so?

Rationale for Addressing Depression at School

Prevalence of depression among teens. The answers to the above questions are not just academic. Depression is the most common mental illness among teens. Statistically, in a school of 1,000 students, as many as 100 may be experiencing depression or mood swings severe enough to warrant a psychiatric diagnosis. Approximately 13 of those students will attempt suicide this year, the third leading cause of death among teens. Fortunately, most will not succeed, but 15 of the 100 are likely to die eventually by their own hands. Approximately 90% of those who complete suicide have a treatable mental disorder at the time they die. Depression is at the top of this list, but about 70 of those 100 depressed teens will never see a mental health professional. Of the 30 who do, 20 or so will only have that contact in school. If the school has a higher than average proportion of students living in poverty, the picture will be even worse.

Role of schools. Schools are an essential first line of defense in combating mental health problems like depression. Teens spend much of their time there with skilled and caring professionals who have the opportunity to observe and intervene when a student exhibits signs of a problem. School personnel work together to strengthen protective factors in the school environment and to teach students, staff, and parents about the illness and the hope offered by effective treatment. Schools can also provide critical early identification, intervention, and referral services. Failure to do so has serious consequences beyond suicide—depression's most tragic and irreversible outcome. Without treatment, depressed teens are at increased risk for school failure, social isolation, unsafe sexual behavior, drug and alcohol abuse, and long-term life problems. Conversely, virtually everyone who receives proper, timely intervention can be helped, but *early* diagnosis and treatment are critical.

What Is Depression

Depression is not a personal weakness, a character flaw, or the result of poor parenting, but a mental illness that affects the entire person, changing the way that person feels, thinks, and acts. A depressive disorder, sometimes referred to as *clinical depression,* is generally defined as a persistent sad or irritable mood as well as *anhedonia,* a loss of the ability to experience pleasure in nearly all activities. It is more than just feeling down or having a bad day, and is different from normal, healthy feelings of grief that usually follow a significant loss, such as a divorce, a break up with a boyfriend or girlfriend, or the death of a loved one.

Symptoms: Differentiating Depression From Moodiness

Depressed teens can experience a range of symptoms including change in appetite, disrupted sleep patterns, increased or diminished activity level, impaired concentration, and decreased feelings of self-

worth. Teens are often more defiant and/or oppositional than depressed adults. Symptoms can manifest themselves in school as behavior problems, lack off attention in class, an unexplained drop in grades, cutting class, dropping out of activities, and/or fights with or withdrawal from friends. These behaviors are distinguished from normal teenage behavior by their duration, intensity, and the degree of dysfunction they cause.

Symptoms or behaviors that last longer than 2 weeks are markedly out of proportion to an event or situation, and impair a student's academic or social performance, are cause for professional evaluation. Although episodes of clinical depression are sometimes self-limiting (meaning that a student may appear to get better), depressed teens cannot just snap out of it on their own and are likely to experience further episodes in the future.

Characteristics of Depression and Other Mood Disorders

Depression, like teens themselves, comes in all shapes and sizes:

Mood disorders. Teens can suffer from a variety of depressive disorders, sometimes called *mood disorders.* These can include *adjustment disorder,* an extremely intense reaction to life stressors that is in excess of what would ordinarily be expected and can be dangerous, but usually does not become chronic; *dysthymic disorder or mild, chronic depression,* a few or milder symptoms occurring either continuously or most of the time for a year or more, but with relatively good functioning; *major depressive disorder,* a severe, serious condition characterized by extreme depressive symptoms including hopelessness, lethargy, feelings of worthlessness or unrealistic guilt, and recurrent thoughts of death, suicidal plans, and/or suicidal attempts; and *bipolar disorder,* severe moods swings from depressive depths to unrealistic and uncharacteristic elation, grandiosity, behavioral excesses, verbosity, and/or belligerence. Teens exhibiting symptoms of a depressive disorder should be referred for a mental health evaluation. They should not be left alone if suspected of being suicidal.

Other characteristics. Depression in teens may also be masked by other problems or behaviors such as anxiety disorder, frustration over learning problems, sexual promiscuity, and substance abuse. Depressed teens often self-medicate or seek thrills to alleviate their pain. Some seek relief through self-injury such as cutting or extreme physical risk-taking. Students who are identified as engaging in these behaviors should be referred for depression screening at once.

Risk Factors

Depression does not discriminate, but there are certain risk factors that predispose teens to depressive disorders. Clinical depression usually has a genetic component, and those who have a family history of depression, particularly among close relatives, are more vulnerable. More than half of teens diagnosed with a depressive disorder have one or more coexisting mental disorders, so those who already have emotional or behavior problems are at greater risk. Other risk factors include poverty, being female, having low self-esteem, uncertainty about sexual orientation, poor academic functioning, poor physical health, ineffective coping skills, substance abuse, and frequent conflicts with family, friends, and teachers. Additionally, students who have experienced significant trauma or abuse, are bullied, or do not feel welcome or accepted at school are much more susceptible to depression.

How Schools Can Help

The best intervention is prevention and early intervention. Schools can provide a number of supports to help decrease the occurrence of severe depressive reactions and prompt appropriate early treatment.

De-stigmatize and shed light on the illness. Perhaps the most important thing schools can do to combat depression is to make the illness easier to identify. Support personnel and administrators can help educate staff and students about depression, include helping students recognize the difference between their normal feelings of sadness, confusion, or disconnnection and depression. Students should be encouraged to talk openly about the illness and other mental health problems with friends and trusted adults.

Train staff, students, and parents in appropriate interventions. Schools with effective training programs for teachers and other staff members (e.g., bus drivers, school safety officers, coaches, office workers), parents, and students are much better at intervening early and appropriately on behalf of depressed teens. This should include developing a protocol for reaching out/responding to students who may be depressed and providing appropriate ways to observe and to refer students to mental health services. Be clear that teachers are not trained mental health professionals and should not "counsel" depressed students. It is critical to include students in the training programs, not only so that they can begin to recognize signs of depression in themselves, but also to help break the code of silence that often prevents teenagers from telling responsible adults when they or a friend is depressed and contemplating suicide or violence.

Create a caring, supportive school environment. An impersonal, alienating school culture can contribute

to students' risk of depression. Effective interventions must involve collaboration among schools, parents, and communities to counter conditions that produce the frustration, apathy, alienation, and hopelessness experienced by many of our youth. All students and parents should feel welcome in the building. Central to this is developing trust between school personnel and students and to ensure that each student has at least one adult at school who takes a special interest in him or her. Knowing individual students personally is particularly important in recognizing significant change in behavior, one of the key indicators of depression. Bullying prevention is also critical.

Develop a suicide prevention and intervention plan. Depression and suicide prevention programs are intertwined. It is important to educate the school community about the warning signs of suicide and to have a clear intervention plan in place that includes a trained crisis intervention team. All staff members need to be trained in what to do if they think a student is suicidal. It is critical that students are partners in suicide prevention efforts, because they are most likely to be aware of classmates' plans to hurt themselves or others. In the vast majority of cases, students who attempt suicide or perpetrate violent acts have warned someone before hand, and it is most often another student who keeps the information private. Emphasize the responsibility of all students and staff to report any threat of suicide or violence. Have a well-defined, confidential procedure established for doing so.

Be mindful of at-risk students. These students should be monitored, particularly during periods of high stress, either on a personal level or in the school community. Examples of high stress situations can range from exam time to the death of a family member to the suicide of another student to the aftermath of a major event like 9/11.

Utilize school mental health professionals. School psychologists, social workers, and counselors are excellent resources for designing and implementing training programs for all groups. They can also be invaluable in developing suicide prevention and violence prevention programs as well as in providing direct intervention and ongoing counseling to students. Intervention plans must include mechanisms for connecting students and parents with appropriate and affordable community resources for treatment and monitoring.

Provide students with appropriate supports. These are usually recommended by the school psychologist or the student's private clinician, but may include individual or group counseling, continued observation, offering appropriate academic accommodations, providing opportunities for creative expression, administering prescribed medication during the day, and identifying self-monitoring strategies and steps for seeking help. It may also be appropriate with permission to reach out to the student's social network to help generate social support. It should be made clear, however, that students should not take on responsibility for managing or fixing their friend's depression and should seek adult help if their friend seems to be deteriorating.

Encourage cooperation with parents. This encompasses educating parents and opening up lines of communication. Some parents of depressed teens will want significant help from the school; others who can afford to do so will prefer to keep their child's illness and treatment separate from school. In this case, the school should make every effort to establish some coordination with the student's private clinician either directly or through the parents. This will make it easier to provide appropriate supports in school and be aware of the student's progress. However, be sensitive to parents' concern for privacy and what information may or may not go into their child's school record.

Summary

There is no excuse for depression to remain invisible or untreated today. There is a tremendous amount of research and numerous successful programs designed for schools, many of which are available from the resources below. Schools need to de-stigmatize depression, educate and engage stakeholders, and provide appropriate interventions.

Resources

U.S. Public Health Service. (1999). *Mental health: A report of the Surgeon General.* Washington, DC: Author. Available: *www.surgeongeneral.gov*

U.S. Public Health Service. (1999). *The Surgeon General's Call to Action to Prevent Suicide.* Washington, DC: Author. Available: *www.surgeongeneral.gov*

U.S. Public Health Service. (2000). *Report of the Surgeon General's Conference on Children's Mental Health: A national action agenda.* Washington, DC: Author. Available: *www.surgeongeneral.gov*

World Health Organization. (2000). *Preventing suicide: A resource for teachers and other school staff.* Geneva: Mental and Behavioral Disorders, Department of Mental Health (WHO). Available: *www.who.int/en*

Organizations and Websites

American Academy for Child and Adolescent Psychiatry, 3615 Wisconsin Avenue, NW, Washington, DC 20016; *www.aacap.org*

American Academy of Family Physicians, P.O. Box 11210, Shawnee Mission, KS 66207; (800) 274-2237; *www.aafp.org*

American Association of Suicidology, Suite 310, 4201 Connecticut Avenue, NW, Washington, DC 20008; (202) 237-2280; *www.suicidology.org*

American Psychological Association, 750 First Street, NE, Washington, DC 20002; (202) 336-5500; *www.apa.org*

American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005; (202) 682-6000; *www.psych.org*

Depression and Bipolar Support Alliance (DBSA), Suite 501, 730 N. Franklin Street, Chicago, IL 60610-7204; (800) 826-3632; *www.dbsalliance.org*

National Association of School Psychologists, Suite 402, 4340 East West Highway, Bethesda, MD 20814; (301) 657-0270 (suicide resources); *www.nasponline.org/NEAT/suicide_resources.html*

National Hopeline Network: 1-800-SUICIDE provides access to trained telephone counselors, 24 hours a day, 7 days a week

National Institute of Mental Health, Room 8184, 6001 Executive Boulevard, MSC 9663, Bethesda, MD 20892; (310) 443-4513; *www.nimh.nih.gov*

National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314; (800) 969-NMHA; *www.nmha.org*

New York University Child Study Center, 577 First Avenue, New York, NY 10016; (212) 263-6622; *www.aboutourkids.org*

SOS High School Suicide Prevention Program, Screening for Mental Health, Suite 304, 1 Washington Street, Wellesley Hills, MA 02481; *www.mentalhealthscreening.org*

Yellow Ribbon Suicide Prevention Program, P.O. Box 644, Westminster, CO 80036-0644; (303) 429-3530; *www.yellowribbon.org*

Ralph E. "Gene" Cash, PhD, NCSP, is on the faculty of the School Psychology program at Nova Southeastern University in Ft. Lauderdale, FL. This handout is adapted from an article provided to the National Association of Secondary School Principals for publication in Principal Leadership, *October 2003 (volume 4, number 2); used with permission.*

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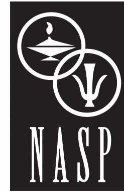

The National Association of School Psychologists (NASP) offers a wide variety of free or low cost online resources to parents, teachers, and others working with children and youth through the NASP website ***www.nasponline.org*** and the NASP Center for Children & Families website ***www.naspcenter.org.*** Or use the direct links below to access information that can help you improve outcomes for the children and youth in your care.

About School Psychology—Downloadable brochures, FAQs, and facts about training, practice, and career choices for the profession.
www.nasponline.org/about_nasp/spsych.html

Crisis Resources—Handouts, fact sheets, and links regarding crisis prevention/intervention, coping with trauma, suicide prevention, and school safety.
www.nasponline.org/crisisresources

Culturally Competent Practice—Materials and resources promoting culturally competent assessment and intervention, minority recruitment, and issues related to cultural diversity and tolerance.
www.nasponline.org/culturalcompetence

En Español—Parent handouts and materials translated into Spanish. ***www.naspcenter.org/espanol/***

IDEA Information—Information, resources, and advocacy tools regarding IDEA policy and practical implementation.
www.nasponline.org/advocacy/IDEAinformation.html

Information for Educators—Handouts, articles, and other resources on a variety of topics.
www.naspcenter.org/teachers/teachers.html

Information for Parents—Handouts and other resources a variety of topics.
www.naspcenter.org/parents/parents.html

Links to State Associations—Easy access to state association websites.
www.nasponline.org/information/links_state_orgs.html

NASP Books & Publications Store—Review tables of contents and chapters of NASP bestsellers.
www.nasponline.org/bestsellers
Order online. ***www.nasponline.org/store***

Position Papers—Official NASP policy positions on key issues.
www.nasponline.org/information/position_paper.html

Success in School/Skills for Life—Parent handouts that can be posted on your school's website.
www.naspcenter.org/resourcekit