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Article 77

Major Depression and Dysthymic Disorder in Adolescents: The Critical Role of School Counselors

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Adolescents' Major Depressive Disorder (MDD) and Dysthymic Disorder (DD) are a growing public health problem (Lamarine, 1995; Sung & Kirchner, 2000). These disorders, which may be recurrent or chronic in nature, are associated with significant impairment and mortality (Birmaher et al., 1996; U.S. Department of Health and Human Services, 1999) and are frequently overlooked and undertreated (Hazler & Mellin, 2004; Kessler et al., 2003; Kramer, Miller, Phillips, & Robbins, 2008; Ramsey, 1994). This is an unacceptable situation because both MDD and DD respond to psychosocial interventions (Coyle et al., 2003; Lewinsohn & Clarke, 1999).

MDD and DD often significantly impact the adolescent school experience. For example, depressed students are at high risk of school failure, interpersonal difficulties, and high suicide rates (Cash & Bridge, 2009; Lewinsohn & Clarke, 1999). Therefore, helping adolescents suffering from depression constitutes a major school challenge. Schools can play a critical role in providing and implementing comprehensive programs for students who are suffering from MDD or DD to succeed academically. Furthermore, school counselors can play a key role in the development of these programs (Hazler & Mellin, 2004; Ramsey, 1994). Therefore, school counselors need to know the most current information regarding these mental health disorders.

The purpose of this article is to present current information on the following topics: prevalence and impact of MDD and DD disorders in adolescents and their schoolwork; detection, treatment, and prevention of MDD and DD disorders; and interventions that can be implemented in schools.

Depression in Adolescents: A Critical Issue

Depression in adolescents is an issue that must be actively addressed within our schools. Current statistics suggest that approximately 100 of every 1000 students in a school may be experiencing severe depression or mood swings (Cash, 2003; Sung &

Kirchner, 2000). MDD is a very common disorder that starts early in life and usually interferes with an adolescent's actions, thoughts, mood, activity level, and physical health. Depressed adolescents think poorly of themselves and act in ways that will cause others to also think poorly of them. If left untreated, depression can lead to adverse outcomes later in life (Lewinsohn & Clarke, 1999). Depressed adolescents may become involved in the criminal justice system or attempt suicide later in life (National Institute of Mental Health [NIMH], 2000). Approximately 7% of adolescents who develop MDD may attempt to take their own life during their young adult years (NIMH, n.d.). In addition, experiencing an episode of MDD during adolescence greatly increases the probability of becoming depressed again, failing in school, or developing substance abuse during young adulthood (Lewinsohn & Clarke, 1999). Furthermore, young adults (to age 24) who were depressed as adolescents are less likely to complete college, tend to make less money, are more likely to have become the unwed parent of a child, and are more likely to experience stressful life events (Lewinsohn, Rohde & Seeley, 1998a). In addition, these young adults rarely seek help, and sometimes the only option they can see is suicide (Slaby & Garfinkel, 1994).

The suicide rate in adolescents has increased dramatically over the past decades (NIMH, 2004). Depression in adolescents is associated with an increased risk of suicidal behavior (Birmaher, Brent & Benson, 1998; Cash & Bridge, 2009; Lewinsohn & Clarke, 1999). MDD is the strongest risk factor for adolescent suicide (Brent et al., 1993b) and adolescent suicidal ideation (Cash & Bridge, 2009). The longer the duration of MDD, the greater the risk of committing suicide (Birmaher et al., 1996). Early detection and treatment of depression and accurate assessment of suicidal thinking are the most effective ways to prevent suicide (Barbe, Bridge, Birmaher, Kolko, & Brent, 2004; NIMH, 2004).

Given these potentially negative outcomes, it is essential to accurately assess adolescent depressive disorders and to provide prompt referral for treatment, appropriate treatment, and preventive interventions (Birmaher et al., 1996; Sung & Kirchner, 2000). Early identification, treatment, and prevention of adolescent depression can reduce or prevent its negative consequences. Sung and Kirchner (2000) suggest that close collaboration between school counselors and mental health professionals may prevent or reduce the impact of depression and lessen the risk of suicide in adolescents.

The Elusive Disorder

Depression in adolescents is often undetected and undiagnosed (Evans, Velsor & Schumacher, 2002). Adolescents are referred and treated for symptoms other than their depression (Cash, 2003) or receive inadequate treatment (Kessler et al., 2003). Parents, pediatricians, and school personnel often cannot tell the difference between a moody youngster and one who is suffering from depression (Cash, 2003; Lewinsohn & Clarke, 1999). The following are some of the factors that make identification of MDD and DD in adolescents difficult. The behavioral, hormonal, psychological, and social changes naturally occurring during this developmental period make it difficult to distinguish depression from the effects of these changes (Birmaher et al., 1998). Also, pediatricians and family doctors frequently miss the depression symptoms of depressed adolescents due to lack of training in the diagnosis of this disorder (Kessler et al., 2003).

Furthermore, managed health care company demands for cost effectiveness leads physicians to reduce time spent with patients, and opportunities to assess for possible depression during adolescents' visits (Cassidy & Jellinek, 1998).

Many parents and other significant adults hold the misperception that depression is a problem adolescents "will grow out of," when in reality many do not (Lewinsohn & Clarke, 1999). According to Cassidy and Jellinek (1998), only 1/3 of parents who had mental health concerns about their children planned to discuss them with their pediatrician. When parents did initiate this discussion, only 40 percent of pediatricians responded to their concerns.

Also, within the school setting, teachers are not prepared to identify depressive symptoms (Cash, 2003). Auger (2004) examined the ability of teachers to identify depressive characteristics among middle school students and found a correlation of only .22 between teachers' ratings of student depression and students' self-reported depressed moods. Even school counselors sometimes overlook the possibility of depression when assessing children referred to them for learning and behavior problems. The majority of children and adolescents (70%) with mental disorder will not get the care that they need (Cash, 2003). Nonetheless, it is important to recognize that of those students who receive mental health support, the majority had that opportunity through contacts in their school (Cash, 2003).

How to Distinguish Between Adolescents' Moodiness and Depression

Depression must be distinguished from normal grief, adjustment disorders, moodiness and other behaviors presented by adolescents. Most adolescent students experience brief, sometimes intense, episodes of the blues, irritability, or rebellions. On the other hand, depressed adolescents 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. These symptoms can manifest themselves in school as behavior problems, lack of attention in class, an unexplained drop in grades, cutting class, dropping out of activities, or fights with (or withdrawal from) friends.

The question becomes; how can teachers, school counselors, administrators, and parents tell the difference between a moody adolescent and one who may be suffering from MDD or DD? Differentiation between normal adolescent behavior and depressed adolescent behavior is based on the observed persistence of symptoms (duration), the level of distress observed in the student (intensity), and the degree of interference with normal functioning (dysfunction). Diagnostic systems, such as the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM –IV-TR; American Psychiatric Association [APA], 2000), have been developed with criteria to diminish the variability in the interpretation of symptoms and standardize diagnostic procedure (Birmaher et al., 1996).

Definition of Depression

The criteria used to define depression are derived from the DSM-IV-TR (APA, 2000). MDD generally refers to a series of symptoms that mainly includes a sad,

depressed, hopeless, or “down” mood with a noticeable loss of interest or pleasure in previously enjoyable activities (Zalaquett & Stens, 2006). It is diagnosed when individuals experience a single Major Depressive Episode that is not explained by any thought disorder and there has never been a manic episode (APA, 2000, p. 375). A Major Depressive Episode occurs when, during the same two week period nearly every day, at least five of the following symptoms are present for most of the day: depressed mood; markedly diminished interest or pleasure in activities; significant weight loss/gain; decrease/increase in appetite; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive guilt; diminished ability to think or concentrate; recurrent thoughts of death; suicidal thoughts/attempts (APA, p. 375).

The DSM-IV-TR indicates that symptoms may manifest or demonstrate themselves in slightly different ways according to age, from children to the older adult (APA, 2000). According to the DSM-IV-TR adolescents may present the following symptoms:

- academic problems, such as school failure or truancy;
- inability to concentrate;
- persistent feelings of unhappiness or emptiness, or of irritable mood (their irritability may lead to aggressive behavior);
- loss of interest or pleasure in almost all activities;
- change in eating and sleeping habits;
- overly active or slower;
- fatigue, lack of energy;
- excessive guilt or anxiety;
- withdrawal from friends and classmates;
- withdrawal from activities; and
- thoughts or talk of death or suicide. (pp. 349-354)

Dysthymic disorder is a depressive disorder like MDD, but it has fewer symptoms and is more chronic. DD (also called Dysthymia) is diagnosed when depressed mood is present for nearly every day for two years, and at least two additional criteria are present, including poor appetite; insomnia or hypersomnia; low energy or fatigue; low self-esteem; poor concentration; feeling hopeless (APA, 2000, pp. 380-381). Because of its persistent nature, the disorder is especially likely to interfere with normal adjustment.

The onset of DD is usually in childhood or adolescence (U.S. Department of Health and Human Services, 1999). DD is considered a "gateway" disorder because of its relatively early age of onset and increased risk of subsequent mood disorders (Kovacs et al., 1984; Sung & Kirchner, 2000). The adolescent is depressed for most of the day, on most days, and symptoms continue for several years. Sometimes adolescents are depressed for so long that they may not complain of feeling depressed because they do not recognize their mood as out of the ordinary (U.S. Department of Health and Human Services, 1999). About 70 percent of adolescents with DD eventually experience an episode of MDD. The occurrence of both major depression and Dysthymia is referred to as double depression (APA, 2000; Comer, 2010).

Prevalence and Duration

The prevalence of MDD is approximately 5 to 8 percent of adolescents. In 2007, the Substance Abuse and Mental Health Services Administration [SAMSHA] (2009), found that in the past year, 8.2 percent of adolescents experienced at least one major depressive episode. The prevalence of DD is approximately 1.6 to 8 percent in adolescents (Kovacs, Akiskal, Gatsonis & Parrone, 1994; Sung & Kirchner, 2000). Prevalence increases with age, and sharply rises around puberty. Preadolescent boys and girls are affected equally, but depression is seen more frequently among adolescent girls than boys (Birmaher et al., 1996; Costello, 1989; Jellinek & Snyder, 1998; Lewinsohn, Rohde & Seeley, 1998a, 1998b). The adolescent female-to-male ratio for depression is 2:1 (Birmaher et al., 1998; Hazler & Mellin, 2004). Major depressive episodes in adolescence are long in duration, with a high risk of relapse, (Milin, Walker & Chow, 2003; American Academy of Child and Adolescent Psychiatry [AACAP], 2007). Community, high risk, and clinical studies have shown that the mean length of an episode of early-onset MDD is 6 to 9 months. Kaminski and Garber's (2002) study of high-risk and clinical samples of adolescents found a median duration for MDD ranging from 12 to 16 weeks. The longer the duration, the greater the severity of MDD (Goodyer, Herbert, Secher, & Pearson, 1997; Kaminski & Garber, 2002; Kovacs et al., 1984; Lewinsohn, Clarke, Seeley & Rohde, 1994).

Risk Factors

Risk factors include a family history of depression, previous depressive episodes, family conflict, uncertainty regarding sexual orientation, poor academic performance, and comorbid conditions such as dysthymia, anxiety disorders, and substance abuse disorders (Sung & Kirchner, 2000). In addition, according to Hazler and Mellin (2004), social development tasks of early adolescence can be very stressful, especially for young women (e.g., going through an underlying social milieu of friendships, exploring one's sexuality, and establishing autonomy from parents).

Another risk factor for the onset of MDD is the exposure of an adolescent to a peer's suicide (Brent et al., 1993a, 1993b). The onset of depression occurs mostly within the first month after exposure. Adolescents exposed to a friend's suicide are 28 times more likely to develop a MDD within 1 month of the suicide compared to those who were unexposed. Furthermore, adolescents that are identified as having a family history of MDD or ADHD, whose last contact with the victim occurred within 24 hours prior to the death, or those who have expressed feelings of accountability for the death need to be monitored closely, especially during the first few weeks after the death (Bridge et al., 2003). The presence of these factors should alert the school counselor about the need to monitor these students, and to appropriately refer them to a mental health professional for evaluation and treatment.

Comorbidity

Clinical and epidemiologic studies show that 40% to 93% of adolescents with depression exhibit comorbid disorders (AACAP, 2007; Birmaher et al, 1996; Goodyer et

al., 1997). Comorbidity, includes the superimposition of DD and MDD (Comer, 2010). Other comorbid disorders include anxiety disorders, disruptive disorders, and substance use disorders, which frequently worsen MDD symptoms (AACAP, 2007; Goodyer et al., 1997; Greenberg, Domitrovich, & Bumbarger, 2001; King et al., 1996). The presence of known depressive symptoms and comorbid disorders should lead the school counselor to request the students to seek treatment.

Treatment for Depressive Disorders

A national survey conducted by Kessler et al. (2003) found that more than half of all people with MDD (including adolescents) now receive treatment, but only 1 in 5 receives adequate medication and/or psychotherapy. Lewinsohn et al. (1998b) found that 60% of adolescents with MDD receive some type of treatment within our communities. SAMHSA (2009) found that of the estimated 2 million adolescents that had a major depressive episode in the past year, around two-fifths received some type of treatment for depression (SAMHSA, 2009). However, the treatments provided to them arise from research with adults (Coyle et al., 2003). Most of the treatments are relatively unsystematic and brief, and do not seem to use recent research advances in the treatment of depression (Lewinsohn & Clarke, 1999). Eder and Whiston (2006) found in a review of psychotherapy for children and adolescents that many adolescents could benefit from psychotherapy, but most were currently not being treated by services that were empirically supported. Treatment of MDD in this population is quite brief. According to Lewinsohn et al. (1994), 22% of these depressed adolescents received one or two sessions and 27% received three to seven sessions. Kramer and colleagues (2008) found that less than half of the 208 depressed adolescents studied had received at least 8 outpatient sessions or follow-up. Furthermore, those who received treatment were as likely to relapse into another episode of depression during young adulthood as those who had not received treatment.

Evidence-based therapies refer to those interventions for which there is scientific evidence supporting their effectiveness and safety (McClellan & Werry, 2003). School personnel would benefit from knowing this information because it can assist in referring depressed students to interventions that are shown to be effective in helping with this disorder (Coyle et al., 2003). Current research has documented the beneficial effects of cognitive-behavioral therapy (CBT; Clarke, Hawkins, Murphy, & Sheeber, 1995; Jayson, Wood, Kroll, Fraser, & Harrington, 1998; Kazdin, 2000) and interpersonal psychotherapy (IPT) in the treatment of MDD in adolescents (Mufson et al., 2004).

Cognitive-Behavioral Therapy (CBT)

CBT has been defined by the National Association of Cognitive-Behavioral Therapists (1996) as a form of psychotherapy that emphasizes the importance of thinking in how we feel and what we do. CBT is based on the premise that depressed individuals have cognitive distortions in how they view themselves, the world, and the future (Beck, 1976; Dobson & Dobson, 2009). CBT helps individuals change the negative cognitions about themselves and the world that contribute to their depression by teaching them how to identify and counteract these distortions (Comer, 2010). It is important to identify distorted thinking processes that are causing negative feelings and behaviors. This way of

thinking can then be replaced with rational thoughts. Reynolds and Coats (1986) found that CBT and relaxation therapy were both superior to controls in the treatment of adolescents with high depression symptom ratings. Lewinsohn and Clarke (1999), based on their meta-analysis of the existing CBT studies, estimated an overall effect size of 1.27. Most adolescents (63%) showed clinically significant improvement with this therapy. Rohde et al. (2004) evaluated the effectiveness of CBT treatments for adolescents with MDD. The study used 93 adolescents with MDD and conduct disorder between the ages of 13 and 17 years old. The intervention appeared to be an effective acute treatment for depression among adolescents with conduct disorder. The odds of recovering from MDD after treatment were more than doubled for participants in the cognitive therapy condition as compared with those in the comparison treatment. It seems reasonable to conclude that CBT has been demonstrated to be an effective treatment for depressed adolescents.

Interpersonal Therapy (IPT)

Interpersonal Therapy has generally been described as exploratory with focus on interpersonal roles and conflicts (Kennedy & Tanenbaum, 2000; Zalaquett & Stens, 2006). IPT focuses on problem areas of grief, interpersonal roles, disputes, role transitions, and interpersonal difficulties (Gatz et al., 1998). Hinrichsen (1999) describes three phases of IPT treatment that focus on two of the main areas. During the first phase of treatment, a review of the individual's presenting symptoms is completed, diagnoses are assigned, and one or two problem areas are defined with goals established for continuation of therapy. The second phase of therapy involves working on achieving the established goals of treatment using various techniques such as reflection, exploration, and encouragement. In the final phase of therapy, focus is generally on termination of therapy, and processing the difficulties involved in ending therapy. During this phase, treatment goals are reviewed, changes that have been made are discussed, and anticipated problems that may arise after termination of therapy are discussed (Zalaquett & Stens, 2006).

A study on the effectiveness of interpersonal psychotherapy for depressed adolescents (Mufson et al., 2004) designed a 16-week randomized clinical trial for five school-based mental health clinics in New York City. Sixty-three adolescents were referred for a mental health intake. Eligible patients met DSM-IV criteria for major depressive disorder, dysthymia, depression disorder, or adjustment disorder. Patients were randomly assigned to receive IPT-A or TAU (treatment as usual). Adolescents treated with IPT showed greater symptom reduction in overall functioning, had fewer depressive symptoms, and had better psychosocial functioning. IPT has been shown to be useful in the acute treatment of adolescents with MDD, but have not yet been sufficiently tested to confidently conclude that this is an effective treatment (Lewinsohn & Clarke, 1999).

School: The First Line of Defense Against Depression in Adolescents

Schools are the first line of defense in combating depression in adolescents. They are ideal settings for the identification and referral for treatment of adolescents suffering from MDD or DD (Cash, 2003; Kazdin & Johnson, 1994). Adolescents spend much of

their time in school with skilled, caring professionals. Therefore, school counselors and teachers have considerable opportunities to observe a range of normal child and adolescent behaviors; consequently, they are in a favorable position to identify students who are sad, experiencing a “blue” mood, or withdrawn.

Schools must join the ongoing efforts in addressing this public mental health issue of depression (Kazdin & Johnson, 1994). Early identification and treatment are necessary (Cash, 2003) given the effect of depression on school success and the huge rise in teen suicides in the last 30 years (Coyle et al., 2003). Schools can provide early identification, referral, intervention, and prevention programs. Furthermore, school-based programs have demonstrated efficacy in helping students to overcome depression (Rohde, Clarke, Mace, Jorgensen, & Seeley, 1993). For example, primary prevention of child and adolescent depression has been implemented successfully in different school settings. These programs include the teaching of coping strategies, which have contributed to student resilience in adjusting to high levels of stress (Rohde et al., 1993).

Why should schools assume the responsibility for implementing these services? Schools need to take on this responsibility because failure to do so has serious consequences for adolescents, including suicide. Without treatment, depressed teens are at increased risk for school failure, social isolation, drug and alcohol abuse, and long-term life problems. Conversely, the majority of those who receive timely and appropriate intervention can be helped. The school and its personnel are the first line of defense to address depression in adolescents. Therefore, it is essential that they are knowledgeable and trained to identify the warning signs of depression.

Critical Role of the School Counselor

School counselors can play a critical role in helping their schools address depression in adolescents. The involvement of school counselors in the early and accurate detection of depressive disorders is important because students cannot afford to lose several months of their lives to depression, which can lead to school failure or to suicide. This goal can be achieved in many different ways. School counselors can work with principals and other administrators to educate students, staff, and parents about depression and the benefits offered by effective treatment. School counselors can implement comprehensive programs based upon the national standards created by the American School Counselors Association (ASCA, 2003). These programs can prevent or modify the negative impact produced by depression in the three areas included in the national standards: academic development, career development, and personal/social development. Furthermore, school counselors can collaborate with the entire school community to help depressed students to obtain an appropriate academic preparation, develop career awareness, and achieve the personal and social growth essential to choose from a wide range of substantial postsecondary options, including college.

The following section describes a set of interventions that can be implemented in schools under the leadership of school counselors to help depressed adolescents. The suggested interventions can be used as they are described, or they may be modified to the context of the school setting.

Interventions

Fostering a Culture of Commitment to Understanding and Learning About Depression

Knowledge. Learning about depression can help dispel the myths and stigma associated with this mental health disorder, and increase awareness of the opportunities for treatment among school personnel. The key element of prevention and early intervention concerning depression is for all school personnel to become aware and knowledgeable about depression. School personnel should be made aware of the cognitive effects of these disorders, the risk of suicide, and the associated academic and interpersonal dysfunction that can help identify children at high risk (Coyle et al., 2003). A school culture that fosters understanding, education, and dissemination of crucial information is critical to helping children who may be at risk for depression or who are already displaying signs. It is critical that systematic and efficient dissemination of current and useful information concerning depression is made available to all school personnel.

Training. Training can be conducted that covers topics that help school personnel learn how to distinguish between moodiness and depression, become familiar with warning signs, and identify the symptoms and specific criteria of depression (e.g., DSM-IV-TR; McCarthy & Cavanaugh 1998), identify potential risk factors, and become aware of cognitions that are characteristic of depressed children (Evans et al., 2002). The training should include guidelines for reaching out and responding to students who may be depressed and providing appropriate ways to observe and to refer students to mental health services. The inclusion of students in the training programs will help them begin to recognize signs of depression in themselves and break the code of silence that often prevents them from telling responsible adults when they or their friends are depressed and contemplating suicide or violence.

Skills vs. counseling. It should be noted that school personnel and students are not trained mental health professionals and may not want to "counsel" depressed students. Given the school counselor's unique position to recognize adolescent depression and to initiate school-based prevention programs, providing them with information and training to develop the skills to recognize possible depression in adolescents, implement preventative strategies, and make referrals is a worthy objective.

Conclusion

Adolescent depression is a significant mental health problem. Prevention and early detection of MDD and DD can significantly curtail the taxing effects of these disorders. Many depressed students fail school, develop interpersonal difficulties, get in troubles with the law, and attempt suicide. Prompt and appropriate referral to treatment can help depressed adolescents to succeed academically, professionally, and personally. Research shows that CBT and IPT are useful treatments for depressive adolescents. These evidence-based treatments also appear to be effective with minority students (Rossello & Bernal, 1999). Current statistics demonstrate that a significant number of adolescents attending school are at risk of suffering MDD or DD. As counselors, we cannot ignore these statistics and are responsible for learning as much as possible about

the unique needs of these students. With additional knowledge, we can offer effective support and advocacy on their behalf. This is particularly important given the fact that many adolescents benefit from the psychosocial interventions currently available. Ultimately, improved recognition and treatment of depression will make their school years more enjoyable and productive for the depressed adolescents, their families, and schools.

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