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"Epidemic" depression in school-age youth

Abstract

With the traditional image of children as happy and care-free, it has been troubling to think of them suffering the effects of major depression and dysthymia. Successful intervention for.depressive youth is complicated by failure to diagnose, limited referral or consultation, and resolute parental denial.

The purpose of this paper is to inform the reader about depression in today's student population. Depression will be defined and described as it is manifested in youth. Typical symptoms and proposed etiologies will be discussed. Finally, suggested interventions will be addressed, although research concerning interventions for depressed youth, particularly children, has been sparse.

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"EPIDEMIC" DEPRESSION IN SCHOOL-AGE YOUTH

A Research Paper

Presented to

The Department of Educational Leadership, Counseling,

and Postsecondary Education

University of Northern Iowa

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

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by

Trudy L. Erickson

August 1999

This Research Paper by: Trudy L. Erickson

Entitled: "EPIDEMIC" DEPRESSION IN SCHOOL-AGE YOUTH

has been approved as meeting the research paper requirements for the Degree of

Master of Arts in Education.

6-4-99
Date Approved

Adviser/Director of Research Paper

6-4-99
Date Approved

Terry Kottman
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6.7.99
Date Received

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"In spite of the natural optimism children have as toddlers and in spite of the new opportunities that are now unfolding in our society, our children are experiencing pessimism, sadness, and passivity on an unprecedented scale" (Seligman, 1995, p. 37). Seligman noted that depression has become the "common cold of mental illness" (p. 37). According to this author, the most noteworthy change in mental health over the past century is the "life-time prevalence of depression" (p. 38), referring to the expanded portion of the population experiencing diagnosable depression at least once.

Prior to the 1960s, depression was diagnosed in only a few middle-aged women (Seligman, 1995). It recently was designated the most pervasive mental health disorder, with victims of all ages. According to the American Psychiatric Association (APA, 1994b), there are 9.4 million Americans with depression in any six month period. Depression is one of the most easily remediated disorders but often goes undetected or misdiagnosed (APA, 1994b). Eighty to ninety percent of those troubled could be freed of the disorder if depression was accurately diagnosed (APA, 1994b) .

Only within the last twenty years have psychiatrists acknowledged that youth experience depression (Black, 1995; Ramsey, 1994). Although some therapists thought children had not developed the psychological capacity to feel depression, Davison and Neale (1998) found that even preschoolers can exhibit significant changes in mood, sleep habits, appetite, energy level, ability to concentrate, and interest in typically enjoyable activities--the same symptoms that characterize adult depression. With the traditional image of children as happy and care-free, it has

been troubling to think of them suffering the effects of major depression and dysthymia (Davison & Neale,1998). Successful intervention for depressive youth is complicated by failure to diagnose, limited referral or consultation, and resolute parental denial (Ramsey,1994).

The purpose of this paper is to inform the reader about depression in today's student population. Depression will be defined and described as it is manifested in youth. Typical symptoms and proposed etiologies will be discussed. Finally, suggested interventions will be addressed, although research concerning interventions for depressed youth, particularly children, has been sparse (Black, 1995; Kaslow, Morris, & Rehm, 1998).

Prevalence

Correlating a recent American Medical Association study with other demographic research, Kerns (1993, as cited in Black, 1995) concluded that as many as six million youth in America are troubled by some form of depression. Hart (1991) estimated that 20% of school-age children suffer from depression, and 51% to 59% of children in psychiatric clinics are also victims of depression. Depression can set in at any age, but the age of onset for the disorder has steadily lowered (APA, 1994b; Davison & Neale, 1998). According to Davison and Neale (1998), early maturation and high expectations for school and sports performance, coupled with an absence of environmental support (close-knit family, extended family, conventional values, religious structure) have exacerbated this disorder.

One percent of preschool children have been diagnosed with major depression (Kashani & Carlson, 1987), while anywhere from 2% to 5% of school age children have been diagnosed with depression (Cohen et al., 1993; Kaslow et al., 1998). In

a 1990 study (cited in Wilkes, Belsher, Rush, & Frank, 1994) conducted by Emslie and colleagues, 13% to 18% of the adolescents in a large urban area reported depressive symptomatology, and three percent indicated suicidal ideation. The investigators pointed out that only by clinical interview could it be determined if the subjects actually had major depression., since the presence, duration, and effect of symptoms on everyday life are all benchmarks of a diagnosis.

Epidemiological studies have recently recorded a 15% to 20% incidence of major depressive disorder in adolescents (Cicchetti & Toth,1998). Adding to the concern over these staggering numbers, Seligman (1995) pointed out that half of children and adolescents who suffer depression will have recurrences. Longitudinal studies have actually shown depressive symptomatology persistent in some diagnosed youth four to eight years beyond onset (Davison & Neale, 1998). Many who fall short of the major depression clinical diagnosis exhibit aspects of the disorder. Merikangas and Angst (1995) reported that studies show at least 50% of adolescents exhibit some depressive symptomatology.

There is no gender difference in the numbers of young children with depressive disorder. Beginning with adolescence, however, a gender difference is noted. According to the American Psychiatric Association (1994a), girls exhibit depression in greater numbers than boys, reaching a gender ratio of 2:1 by adulthood (10-25% depressed females compared to 5-12% depressed males). The average life-time prevalence of major depression is 17% (Blazer, Kessler, & McGonagle, 1994).

The consequences of depression have been devastating--social, academic, and psychological development dysfunction (Merikangas & Angst, 1995). School

absences, deficiencies, and eventual dropout by normally intelligent adolescents have been directly related to depression (Emslie et al., 1997). These school-age episodes then increase the risk for eventual employment problems, unstable relationships, substance abuse, and suicidal ideation (Kovacs, 1996). In fact, suicide is the third major cause of mortality in15-24 year olds. Depression has been targeted as a major precipitator of suicides in children and adolescents (APA, 1994b).

Definition of Depression

The diagnosis of depression in youth has been complicated by the difficulty in discriminating between what is a normal depressed mood or an abnormal depressive disorder (Merikangas & Angst, 1995). Lack of universal depressive characteristics or a direct genetic causation of depression has resulted in diagnostic uncertainties. In the DSM-IV, (APA, 1994a) children and adolescents are now included in the classification for mood disorders. Of these, Major Depression and Dysthymic Disorder are the most prevalent.

Major Depression

According to the DSM-IV (APA, 1994a), a diagnosis for major depression requires at least five of the following symptoms to be evidenced for less than two weeks, along with a significant impairment in daily functioning. Indicative symptoms are sad or depressed mood, loss of pleasure in daily activities, marked weight loss or gain, sleeplessness or wakefulness, noticeable motor stimulation or retardation, exhaustion or energy loss, extreme thoughts of worthlessness or guilt, problems with focusing and concentration, and repeated thoughts of death or suicide. These symptoms should persist at least two weeks and without the

presence of other disorders, substance abuse, or bereavement. In the DSM-IV (APA, 1994a), the diagnosis of major depression can consist of one episode or can be recurring, with two or more episodes separated by two intervening months. The episodes cannot be better diagnosed as other disorders.

Dysthymic Disorder

The DSM-IV (APA, 1994a) designates dysthymia, though not as severe as major depression, as the presence of a pervasive depressed mood for a period of one year in children and adolescents. The difference between major depression and dysthymia is the severity and constancy of the symptoms. Two or more of the following symptoms must also be present: diminished or heightened appetite, pronounced sleepiness or wakefulness, lethargy or reduced energy level, lack of self-esteem, diminished concentration, and thoughts of hopelessness. No other disorders should be evident, but difficulty carrying out life functions should be present for the diagnosis.

Symptomatology

As depression does not look the same in all children or adolescents, it is important to review the possible symptomatic expressions of the disorder. Sadness is requisite to depression but not sufficient (Berkson, 1993). Sad or depressed mood, extreme lack of interest in enjoyable activities, notable weight change, sleeplessness or increased demand for sleep, mental agitation or slowing, weariness, thoughts of inadequacy or guilt, difficulty with concentration, and persistent thoughts of death and suicide are possible expressions of major depression (APA, 1994a). Dysthymia is expressed through appetite extremes, reduced energy or weariness, deficient self-esteem, lack of concentration, and

enduring feelings of hopelessness. These symptoms are used to diagnose dysthymia in children and adolescents, as well as adults, because the fundamental characteristics of mood disorders in children and adults are the same. There are, however, developmental differences in depressive expression, so children and adolescents often do manifest depression differently than adults (Lamarine, 1995).

In Children

Children under nine are less likely verbalize depressed feelings, but rather to express them behaviorally by acting out (Vernon, 1993). They tend to feel guilty even for circumstances beyond their control and have low self-concepts, exhibit somatic problems, crankiness, and social isolation. Wilkes, Brusher, Rush, and Frank (1994) pointed out that children may manifest their prolonged unhappiness as moodiness, irritability, eating and sleep disturbances, self-harm behaviors, social seclusion, persistent disinterest and weariness, unwarranted weeping, somberness, feelings of desolation, and self-directed anger.

Social deficiencies, common in depressive children, are manifested as apathy, lack of motivation or inattention, laziness, boredom, inactivity, anhedonia (absence of pleasure), inability to focus, immaturity, opposition, or dispassion (Lamarine, 1995). Poor school achievement, accident-proneness, separation anxiety, fears, and attention-getting behaviors are also evident (Carlson & Kashani, 1988).

The 9-12 year old children are more likely to verbalize their feelings of depression (Morris & Kratochwill, 1998). Middle childhood depression is often exhibited by gloom and frustration, or feeling deprived or unwanted. Children in later childhood manifest low self-esteem (Newman & Newman, 1991, as cited in Vernon, 1993). They also often exhibit irritability, sad affect, lethargy, poor school

performance, guilt, fears, and separation anxiety (Carlson & Kashani, 1988; Weisz et al., 1992). A study by Laurent, Landau, and Stark (1993) of 4th through 7th graders reported risk factors for depression in children: sadness, depressed disposition, disapproving self-image, weariness or exhaustion, distractibility, feeling unloved, sleep deprivation, anger, shame or guilt, and loss of pleasure.

In Adolescents

Adolescents actually experience fluctuating symptoms as they react to their environment (Lamarine, 1995). Not feeling good, moodiness, and irritability, (rather than sadness) are often adolescent signs of depression (Wilkes et al., 1994). While child depressive symptoms may continue on into adolescence, slowed or agitated thought processes, hypersomnia (excessive sleep) and delusions are more common in adolescents than in children (APA, 1994a).

Anhedonia (the loss of interest in pleasurable activities) may lead to a depressed teen dropping out of sports, clubs, or former peer groups. School performance may suffer (Wilkes et al., 1995). Significant weight changes may also be symptomatic but less noticeable, due to the physical growth and changes occurring developmentally. Dropping off to sleep or sleep deprivation is often symptomatic of depression in teens, as is a lack of concentration, which can lead to hours spent on homework with little results.

The typical depressed adolescent exhibits boredom or irritability (Kaslow et al., 1998). Often peer friendships are dropped for new groups that mirror the teen's own dysfunction (Wilkes et al., 1994). Interpersonal difficulties, eating excesses, sleep deprivation, and death and dying obsessions are more typical of teens, according to Lamarine (1995).

Rather than expressing feelings of worthlessness directly, depressed adolescents often are angry and hostile or profoundly passive (Lamarine, 1995). Interpersonal difficulties; refusal to go to school; and destructive activities such as social withdrawal, antisocial behavior, and inappropriate sexual activity are displayed by depressed adolescents (Fleming & Offord, 1990).

If questioned, the adolescent will often disclose suicidal ideation, as adolescents have more sensations of hopelessness and helplessness than younger children and tend to experience more suicidal ideation than any other age group (Newman & Newman, 1991, as cited in Vernon, 1993). Because this age group is developmentally prone to exaggeration and awfulizing, important clues about depression can be overlooked by those close to the youth. A Clark and Watson (1991) study reported beliefs about feeling unloved, anhedonia, magnified sadness, and profound guilt as the predominate characteristics of depression in teens.

Both Children and Adolescents

Actually there are more similarities than differences between childhood and adolescent depression. Somatic symptoms repeatedly reported by depressed children as well as adolescents included: nausea, palpitations, chest pains, and dizziness. Adolescents exhibiting comorbid anxiety and depression reported additional somatic complaints: headaches, sweating, gastrointestinal and muscular distress (Bernstein et al., 1996). Interestingly, there were no gender differences in somatic complaints, though muscular distress was more frequent in older adolescents (Bernstein et al., 1996).

Some differences should be pointed out between child and adolescent depressives. More adolescents suffer from depression than children (Seligman,

1995). Unlike the gender equivalence of childhood, significantly more (two to one) adolescent girls have become afflicted with depression than boys. Eccles, Lord, and Roeser (1996) reported that academic ambivalence, low achievement, and borderline delinquency of early teens are frequently the antecedent of mental health deficiencies in later adolescence (Cicchetti & Toth, 1998). Weissman and Klerman's study (1994, as cited in Black, 1995) reported that teenage female depression frequently foreshadows relational inadequacies, prescription drug misuse, and clinical psychopathological disturbances. Some of the symptoms of major depression in children and adolescents are similar to those of adults (e.g., depressed mood, lack of a pleasure response, pessimistic perspective, fatigue, lack of focus, recurrent episodes, and suicidal ideation) (APA, 1994a). However, children and adolescents experience more guilt, and adolescents make more suicide attempts than either children or adults (Davison & Neale, 1998). Depression can be defined many ways and can be manifested differently at different ages and in different clients within the same age group (Davison & Neale, 1998).

Onset

No consistent variable has been found to predict the onset or length of depressive episodes in youth (Kovacs, Obrosky, Gatsonis, & Richards, 1997). Kovacs and cohorts studied 112 children experiencing the onset of depressive disorders. The age of onset of major depression spanned 7 3/4 years to 14 years of age; dysthymia onset was 5 years to almost 13 years of age. Recovery rates within two years of onset for major depressives and dysthymics were 86% and 7%, respectively. Seventy nine of eighty seven children with major depression recovered from their episode, most in the ninth month after onset; 45 of 55

recovered from their dysthymic disorder within eight years of onset, most after four years. The prognosis of recovery from the first depressive episode could statistically be expected, but the duration was long and seemed to "run its own course" (p. 783).

Depression in adolescents is significantly comorbid, particularly with anxiety disorders and conduct disorders (Merikangas & Angst, 1995). The accompanying disorders have tended to be precipitators of the depression. Evidence has pointed to the increased severity and chronicity of comorbid depression. Anxiety disorders have been most common, with three-quarters of depressed adolescents also exhibiting anxiety disorder; while conduct disorder has been comorbid with depression in one third of the depressives (Merikangas & Angst, 1995).

Profile

Since referrals to school counselors and clinicians have often been for inappropriate behaviors, a depressive disorder often remains undetected (Black, 1995). Depression in children is often manifested in unpredictable behaviors--moodiness, withdrawal, defiance, or hyperactivity (Black, 1995; Ramsey, 1994). A despairing outlook (Davison & Neale,1998), unwillingness to solve interpersonal problems (Lewinsohn, Clark, Seeley, & Rohde, 1994), minimization of academic abilities, self-expectation of unrealistic achievement (Davison & Neale, 1998), and assumption of oppositional motivations in others (Quiggle et al., 1992, as cited in Lamarine, 1995) were targeted expressions of depression. Hamilton, Asarnow, and Thompson (1996) reported typical scholastic achievement but extreme social deficiencies in youth diagnosed with depression.

Classroom social climate was found to be an area of concern for students with depressive tendencies (Russell & Russell, 1996). Feelings of friendship, trust, and acceptance were missing in the interactions between depressed children and the classroom environment. Russell and Russell demonstrated that more severely depressed children had fewer feelings of affiliation and were less involved in classroom intellectual and social endeavors. Depression in children was reportedly manifested in difficulty making friends, garnering energy, and thinking rapidly.

Assessment

Targeting the symptoms and appraising the frequency, duration, and severity are crucial to selection of appropriate interventions (Davison & Neale, 1998). The DSM-IV (APA, 1994a) outlines clinical parameters for diagnosing depression. Self-report inventories such as Kovacs (1983) Children's Depression Inventory are used in documenting depression in children aged 8-17 and younger, if verbally administered. "Structured interviews, self-report questionaires, peer nomination methods and parent and teacher rating forms" have been used, but the results are inconsistent. As an example, peer and teacher ratings do not coincide with children's perceptions of their own level of depression"(Kendall & Hammen, 1995, p. 523).

Children are sometimes unhappy. It is important to assess the severity of the symptoms; the possibility of a stressful event reaction; and the recurrence, chronicity, and persistentence of the condition. Morris and Kratochwill (1998) recommended assessment of involvement levels, appropriateness of social skills and interpersonal relations, justified acceptance of responsibility, rationality of

beliefs, demonstration of self-control behaviors, level of self-esteem and perceived competence, andperception of family functioning and life incidents.

Regardless of the rating measures used, initial assessment with the child and family must provide critical information (Briesmiester, 1997). An evaluation of the child's functioning, the stage and maturity of development, and the tenacity of the symptomatology of depression should all be assessed (Briesmiester). The diagnosis, techniques of therapy sessions, and the eventual therapeutic goals are determined by this assessment.

Investigators often suggest that assessment of the child be done without the parents present, as they may not be aware of their child's private cognitions and experiences (Kendall & Hammen,1995). Listening to a child's verbalization of feelings through interview, story, or play is more indicative of depression than either the child's written self-report or teacher appraisal (Wolfe et al., 1987). However, the self-reportis often utilized in the assessment of the child's mental state (Kendall & Hammen, 1995).

Particularly in adolescents, but also with children, depression has been connected to substance abuse and suicide ideation or even completed suicide (Davison & Neale, 1998). Feelings of depression, poor self-esteem, hopelessness, guilt, and worthlessness are associated with suicidal ideation (Lamarine, 1995). Any threat of suicide or previous attempt, isolation, withdrawal or accentuated activity, loss of appetite, sleeplessness, dramatic change in behavior, giving away possessions, concluding unfinished projects, or significant loss are warning signs of suicide risk.

Etiology

Merikangas and Angst (1995) enumerated some risk factors of depression in children and adolescents: increasing age, feminine gender, lower economic and social strata, bereavement, family separation or divorce, and other pressure-laden situations. Children with learning disabilities, attention-deficit disorders, and mental retardation have more severe depression (Berkson, 1993), although the mood disorder is not unilaterally found in handicapped children.

Biological Factors

A biological precipitator of depression has been investigated, relating biochemical and genetic stimuli (Berkson, 1993). The factors questioned in research have been chemical (neurotransmitters, e.g., serotonin and norephinephrine) and hormone (e.g., cortisol, growth hormone) imbalances (Davison & Neale, 1998). Sleep disorders, irritable mood, and anxiety may be prompted by low serotonin levels (APA, 1994b). Lethargy and pronounced sadness may be caused by low norepinephrine (APA, 1994b). Persistent arousal in response to anxiousness, anger, or apprehension may be fostered by high levels of cortisol. In general, the studies attempting to attribute depression to biological or genetic causes have been inconclusive (Merikangas & Angst, 1995).

Genetic Factors

Some studies found family tendencies--a congenital susceptibility for mood disorders (Davison & Neale, 1998). Researchers have been trying to target the gene that might transmit predisposition to depression. Recent studies have dealt with deficiencies in neurological receptors and the endocrine system. Earlier theories (Merikangas & Angst, 1995) of genetic factors in depression reported that

depressive children are likely to have a mood disordered parent. Merikangas and Angst (1995) noted that the etiology of depression was still uncertain, though parental psychological disorder was the single strongest predictor of depressive psychological disorder. Depression in one generation was actually more correlated with anxiety disorder in offspring (Merikangas & Angst).

Environmental Factors

External factors have also been considered antecedents of depression. Both strained family relationships and situational complications have been implicated in depression literature.

Family relations. Families of depressive children show less affection, more conflict, and inadequate social competence (Lewinsohn et al., 1994). These characteristics may be cause and consequence of the depression (Davison & Neale, 1998). Parental criticism and peer rejection are detrimental to the child's feeling of self-confidence. Depressed children report less participation in decision-making and more feelings of helplessness (Stark et al., 1990). Episodes at home, chiefly with parents, precipitate the cognitions (perhaps distorted) that lead to depression (Stark , Schmidt, Joiner, & Lux, in press, as cited in Davison & Neale, 1998).

Russell and Russell (1996) reported that the more severe the depression in children, the less the child's perception of his/her family's unity. Detached families lack communication and emotional connectedness. Kazdin (1990) also reported that families with depressed members encourage less independence than families without depressives.

Family adaptability is the degree to which family members are able to adjust to stress and progressive developmental change. The more severe the child's

depression, the more deficient family adaptive functioning (Kazdin, 1990). Stark, Humphrey, Crook, and Lewis (1990) found that depressed children and adolescents viewed their families as more rigid.

A study by Nilzon and Palmerus (1997) of the effects of familial relationships and interaction on childhood depression and anxiety produced noteworthy results. Depressed children came from families with major family problems, changes in the family structure, a parent co-habiting with a new companion, a mother treated for depression, an anxious father, and parental overprotection. Intermittent-to-constant controversy were characteristic of the depressives' families. The study concluded that "family factors provide clues to patterns of depression in children of middle school age and early adolescents" (p. 941).

Situational Factors. Certain environmental events can trigger an episode of situational depression. Ramsey (1994) divided the explanations for depression into two categories: loss of a love figure, position, role, or other "psychosocially determined support needed to sustain psychic equilibium" (p. 258) and defeat in accomplishing internatized values, goals, expectations or standards . Depression that results from bereavement, extreme grief or loss, early separation from a parent (due to death, separation, or divorce), serious or chronic illness, sexual and/or physical abuse (Reinherz et al., 1989, cited in Merikangas & Angst, 1995), or a major change in life is considered a grief reaction, initiated by external events and endured from two months to a year (Ramsey, 1994). The pivotal event may be embarrassment, social problems, extreme confusion, authority, peer, or love-interest discord, perceived failure, severe illness, or death (Allen, 1990, cited in Ramsey, 1994).

The depression can reappear on the anniversary of the precipitating event, but the child or adolescent is still able to function. Interests may be reduced, but sad and painful feelings can be set aside for social obligations and committments. With this normal depression, guilt and loss of self-esteem are limited. The child or adolescent is not self-destructive but able to give an explanation for the depression and move to alleviate it.

Personal Factors

The immediate triggers of childhood depression have been theorized as cognitive distortions by Lamarine (1995). The child's interpretation of experiences and how others react to experiences are pivotal in the activation of depressive symptoms (Berkson, 1993). "Biology, early social history, a continuing pattern of success and failure, and current social and work requirements" (Berkson, 1993, p. 224) have affected children's cognitions about themselves and their personal fortitude to take on the unknown. The cloud of depression has obscured the child/adolescent's view of his/her positive characteristics, potential, or surroundings (Merikangas & Angst, 1995).

Beck's theory of depression pointed to cognitive distortions in early experience, stored, and eventually released by environmental factors (Miezitis, 1992). Beck believed the activation of distorted thought patterns leads to the affective, motivational, and physical symptomatology of depression. In response to stressful life events, individuals who distort their experiences in a negative direction are more likely to experience the symptoms of depression. Typical cognitive distortions of personalization, over-generalization and all-or-nothing thinking are found in depressed adolescents (Miezitis, 1992). Distorted cognitions

are often about schoolwork or work in general--feeling like a failure. Perfectionistic irrational beliefs could underlie the maladaptive cognition. Concern about an absent family member, usually a parent,or feelings of rejection by peers, feeling of loss of control, insecurity in dating and sexual interactions, feelings of inferiority or inadequacy, feelings of irresponsibility and incompetence can be magnified and distorted by the developing adolescent (Wilkes et al., 1994).

Wilkes and colleagues (1994) adapted a list of typical cognitive distortions, from the most often found to the least often detected distortion, to reflect adolescent depressive tendencies. There are several examples of these typical adolescent cognitive distortions: binocular magnification--making problems or disappointments look bigger than they are in reality; binocular shringing--making positive or pleasant things seem smaller or insignificant; black-and-white thinking--seeing things totally one way or another; dark glasses--focussing on the dark or undesirable aspects of events or life; fortune telling--predicting bad outcomes in the future; heart talk--listening to feelings rather than reality; personalizing--taking personal responsibility for things beyond one's control; overgeneralizing--using one example to draw conclusions about other things; labeling-- suggesting that the entire self or other person is bad; disqualifying the positive--turning somethings positive into something negative; should-y/must-y thinking--demanding what should or must be done.

Developmental Considerations

Several issues must be considered when working with an adolescent (Wilkes et al., 1994), as this time of life is fraught with so much growth and change-- biological, emotional, cognitive, and social. Biological changes are greater during

this time than at any other stage of development, while issues such as "dependency, obedience to discipline, sexuality, separation from the family, and the development of a new 'self' and 'work' identity, including new associations with peer groups in the community" (Wilkes et al., 1994, p. 69) become important and pivotal in the adolescent's maturing personality formation.

The most important ingredient is the developmental thrust of separation-individuation (Wilkes et al., 1994). Issues of identity formation, splitting from the family, relationship challenges with formation of peer groups and love attachments, as well as complex physical and mental advancement must be considered during this adolescent age (Mueller & Orvaschel, 1997, as cited in Vernon, 1993). Even though some manage the transition to adulthood without experiencing depression, "some of these adolescents will still become depressed if their biological, intrapsychic, or interpersonal resources are overwhelmed"(Wilkes et al., 1994, p. 70).

Puberty marks major developmental changes--physical, mental, emotional--in personal identity (Nilzon & Palmerus, 1997). The early adolescent is self-centered and striving for more independence (Schave & Schave, 1989, as cited in Vernon, 1993).

Major changes in cognitive capabilities, dramatic changes in moods (shifts from extreme sadness to intense elation in rapid succession), and a heightened sensitivity are, however, part of normal early adolescent development common to this age. Three fourths of the teens make the transition into adolescence with few problems. The other one fourth, however, exhibit many signs of inability to adjust with the many changes. Boys, in particular, react overtly with inappropriate and destructive

behaviors. Girls react with more pronounced mood change, poor self-concept, and depression (Klimek and Anderson, 1989, cited in Vernon, 1993).

The increase in negative moods and emotions is often credited to hormonal changes. Many authors now think that high stress or isolation from family or friends may cause the lower mood (Colton & Gore, 1991, as cited in Vernon, 1993). The cognitive changes at this time, result in awider range of emotions such as guilt, anxiety, depression and anger, and the adolescent feels more insecure and vulnerable. Johnson and Kottman (1992) noted these mood swings are usually erratic and difficult to manage but are more a result of typical adolescent development than of major consequence.

Mid-adolescence is a more stable time than early adolescence (Schave & Schave, 1989). New freedoms and responsibilities mark this age, and most feel a self-confidence and can deal with the stressful and emotional situations that they face. They try out roles as they interact with people of different lifestyles and ideals. This period of identity formation--a process of achieving a unique self--occurs while negotiating new relationships with peers, a new position in the family--particularly in relations with parents, and a decision-making transition into the world of career and work (Schave & Schave, ascited in Vernon).

Dusek (1991, cited in Vernon) pointed out that some of these identity-integration steps are more difficult to negotiate for today's adolescent than for previous generations. Elkind (1988, cited in Vernon, 1993) that by the time children become adolescents, they want to experiment with adult behaviors, particularly with tobacco, alcohol, and sex. This age-inappropriate experimentation can cause dangerous and lasting consequences. Elkind (1988, as

cited in Vernon, 1993) also noted that adolescent stress, criminal activity, violence, depression and suicide result from the push for early maturity--disregarding developmental maturity.

Identity formation is a pivotal accomplishment during adolescence. This becomes extremely important due to enhanced sexual stimulus, expected achievement, and competition (Vernon, 1993). Erickson (1968, as cited in Vernon, 1993) pointed out the importance of self-formation. During the struggle to become the separate, unique individual, an emotional crisis precipitates change--forward thrust toward adulthood or a backward plunge into an earlier developmental phase. Many adolescents are able to deal with the trials of this age, but others remain ungrounded, feeling little proclivity toward future goals. They become angry, oppositional, or depressed.

Developmental literature points to several factors related to depression in youth at the adolescent ages (Morris & Kratchowill, 1998)--cognitive processing may be altered by learning problems, volatile temperaments, and distressing relationships. Poor school performance or drop-out, accentuated irritability, drug abuse, and promiscuity are depressive expressions in adolescents. The therapist must distinguish between the depressed adolescent, the adolescent negotiating the adolescent transition, and the individual's developing personality/disposition (Morris & Kratchowill, 1998).

The pubescent/adolescent stages of human development, coupled with family interrelations, are critical in the emotional adjustment during this stage of development. Research (Brent & Moritz, 1996, as cited in Cicchetti & Toth, 1998) found difficult cultural changes and transitions prompted depressive

symptomatology and even suicide. "Numerous disadvantageous family and societal circumstances...may detract from children's ability to competently resolve developmental challenges, thereby contributing to risk for a depressotypic organization and depressive outcomes" (Cicchettti & Toth, p. 236).

A report by the Children's Defense Fund (Glosoff & Koprowicz, 1990, as cited in Vernon, 1993) revealed that suicide rates for adolescents have increased dramatically--to suicide completion by six teens daily--in recent years. Suicide is often seen by the teen as the only solution to a perceived hopeless situation. This drastic conclusion to the inadequate feelings of identity integration, goal and value formation and inappropriate abilities of problem solving points to the importance for depression intervention.

Treatment

Many depressed individuals recover without treatment (Davison & Neale, 1998). However, the extended duration of depression, the externalizing problems, and the possibility of comorbid disorders underline how essential early aggressive treatment is (Kovacs et al., 1997). Little research has been conducted on treatments for depressed youth (Davison & Neale, 1998), and the limited research studies that have been conducted have relied on adult treatments.

Studies have indicated detrimental circumstances that hinder recovery from depression. Goodyer, Herbert, Tamplin, Secher, and Pearson (1996) found attributes that maintained or affected the course of major depression: lack of a trusting relationship in the mother's life, family dysfunction, poor personal relationships, and extremely upsetting life events. A noteworthy finding of the Kovacs and colleagues' study (1997) was that major depression lasted almost four

times longer in clinically treated youth removed from their natural setting, implicating a residential treatment as a major contributor to prolonged disorder. When intervention is indicated, the two treatment choices are pharmacotherapy and psychotherapy.

Pharmacotherapy

Surprisingly, one of the prime therapies for adult depressive disorder--rescriptive anti-depressants--has been reported ineffective with children (Davison & Neale, 1998; Kendall & Hammen, 1995). Worse, pharmacotherapy has triggered serious side effects in children (Kendall & Hammen, 1995). A survey of 12 placebo-controlled research studies of tricyclic antidepressants (TCAs) in school-age children and adolescents was recorded by Emslie and colleagues (1997). The report revealed an insignificant difference between the chemically treated subjects and the placebo controls.

These negative findings, along with a variety of serious side effects with early antidepressants, have led to research into the viability of seretonin reuptake inhibitors (SSRI) in adolescents (Emslie et al., 1997). Although studies have not demonstrated the effectiveness of antidepressant medication for treating depression in children, prescriptions are widely distributed to the school-age group based on the adult efficacy of the drugs (Emslie et al., 1997). Ambrosini and colleagues (1992) admonished that the surge to intervene with depressive kids, immediately and cost-effectively, has spurred the use of anti-depressants, with minimal chance of truly helping children and adolescents break the depressive cycle (Black, 1995). Proclaimed conquest over symptomatology with serotonin

reuptake inhibitors might be promising, but concomitant individual and family therapy has been concurrently endorsed (Lamarine, 1995).

Psychotherapy

With the efficacy of the medical model seriously questioned, the hope for an effective therapy against depression has rested with psychotherapeutic approaches to depression. In the area of child treatment, a gulf exists between research and practical implementation (Weisz, Thurber, Sweeney, Proffitt, & Le Gagnoux, 1997), particularly in actual treatment time of children. Most of the research trials that have produced efficacious treatments for disorders in children have been 12 to 27 sessions in length. However, surveys of outpatient clinic-care (e. g., Weisz & Weiss, 1989) have shown that most patients, due to drop-out or cost- limitations imposed by managed care, receive a limited number of treatment sessions. Additionally, ."...a great deal of mental health care in the United States is directed to children who have mild-to-moderate problems, much of this takes place in a school setting...."(Weisz et al., 1997, p. 707). The child and adolescent treatment that takes place in schools must be modified and condensed.

Some considerations for school counselors were offered by Hart (1991): build self-esteem through support and reassurance; give children involved in a life-stress situation a way to express feelings; team with teachers, parents, and outside agencies to provide help; make classroom accommodations for success; provide practice in positive self-talk; develop any needed coping and social skills; offer preventive classroom guidance in management of thoughts and feelings.

Individual counseling. Virtually all research dealing with depression in children has tested the effficacy of cognitive-behavioral treatment (Briesmiester,

1994). The techniques aim at negative thought and perception restructuring. More effective social skills (e.g., eye-to-eye communication, decision making, problem solving, diffusing techniques, assertiveness training) are taught to compensate for social deficits and learned helplessness (Black, 1995). Improved social skills and problem solving training are critical for depressed children (Briesmiester, 1994).

Beck (1979, as cited in Miezietez, 1992) designed a procedure for depression in adults that would identify these distortions, supply a reality-check, and alter maladaptive cognitions. The client needs to recognize the association between thoughts, feelings, and actions. Beck endorsed a proactive, directive, time-limited approach to depression reduction. Depressed people often have a negative view of self, see experiences in a negative manner, and have a negative outlook for the future (Beck, 1979, cited in Corey, 1996). The intent is to challenge the distorted view of the self, world as it is, and the future. Focus on thoughts and feelings and the relationship with external behaviors will help the client understand and learn to deal with the distortions. Self-talk training and problem-solving interventions used with children and adolescents are modifications of the tenets of Beck's cognitive therapy (Miezitis, 1992).

Ellis's REBT approach helps the child or adolescent with the emotional and behavioral problems resulting from depression by teaching that the child has control over emotions. The identification of feelings and whether those feelings are useful or healthy, understanding the difference between thoughts and feelings, realizing the self-talk link to feelings, and learning rational coping thoughts are the goals of REBT for young children (Waters, 1981, cited in Vernon, 1999). Older

youth are educated in the use of the ABCs of REBT--identifying an activating event, recognizing beliefs about the event, realizing consequences (resulting feelings and behaviors) (Vernon, 1995).

McWhirter and colleagues (1996, as cited in Vernon, 1999) pointed to the success of cognitive-behavioral interventions with depressed youth. Endorsed techniques would include "reducing automatic negative thoughts, providing education about the connections between thoughts, feelings, and behaviors, modifying distorted cognitions, and identifying and altering dysfunctional beliefs" (Vernon, 1999, p. 288). Improvement of social skills, engaging in developmentally-appropriate activities, and achieving positive lifestyle changes would be positive goals for the depressed adolescent.

Until the Wood, Harrington, and Moore (1996) study, it was not known if a cognitive behavioral treatment plan for an individual child would lessen depressive symptomatology. Two treatment plans were compared and evaluated--cognitive-behavioral depression treatment program (DPT) and relaxation training. At the end of the 5-8 treatment sessions, the DPT achieved significant mitigation of depression. The efficacy of this treatment surpassed the relaxation control method in self-esteem, client contentment, remission, and global functioning.

Wood and colleagues (1996) reported that DTP provided "clinically important short-term improvements in depressed young people....there were significant between group differences on...all the measures of 'clinical significance'," (Wood et al., p. 744). Unfortunately, DTP did not reduce anxiety or problem behaviors, and depression is often comorbid. A long-term reduction of depressive symptoms was not demonstrated.

Black (1995) suggested play therapy for both assessing and treating depression in very young children in individual therapy. There is increasing support for the use of play therapy as an intervention for many emotional and behavioral concerns (Kottman, 1999). Through the use of toys, children can expose and declare feelings, build "self-acceptance, self confidence, and self reliance," while learning about self, others, problem-solving, and individual responsibility (Kottman, 1999, p. 101). "By showing genuine concern, empathic understanding and consistent positive regard, the play therapist can further counteract the negative images about self and others" (Kottman, 1999, p. 100). Social skills training, modeling and role-playing can also be incorporated into the play therapy format to improve relationships and reduce the social withdrawal and negative behavior patterns that usually accompany depression (Briesmiester, 1994).

Techniques for individual therapy with younger and older children utilizing art, music, journaling, and pet therapy (a new approach to communicate with hard to reach depressives) were endorsed by Black (1995). Puppetry, role-playing, games, and modeling can help teach, practice, and reinforce positive cognitions.

Cicchetti and Toth (1998) point out that the treatment of depression in adolescents must consider physical, cognitive, and emotional changes; identity formation; family detachment, and peer and love relationships. Interventions by the school counselor may need to go beyond individual counseling and focus on "both family therapy and parent training that promote open and healthy communication, training in problem-solving and conflict resolution, and training in active listening skills" (Vernon, 1999, p. 286).

Music is one of the proposed individual counseling interventions that may have an added benefit. Some studies of adolescents have reported stress and anxiety reduction and reasoning enhancement benefits of music (Mornhinweg, 1992; Rauscher, Shaw, & Ky, 1993; Stratton, 1992, as cited in Field et al., 1998). Music actually alters mood, as it affects left frontal brain activity and cortisol levels in depressed adolescents. Additional research by Field and colleagues (1998) demonstrated the positive effect of music on cortisol levels and frontal lobe activity. Relaxation has also been shown to lower the high cortisol levels associated with depression in adolescents (Field et al., 1992).

Group counseling. Being able to relate to others will short-circuit the "depression-negative behavior-rejection from others cycle..."(Davison & Neale, 1998, p. 250). In a study by Butler, Miezitis, Friedman, and Cole (1980), early group therapy endeavors in school settings indicated that in ten sessions fifth and sixth graders alleviated depressive symptoms with group role-playing that bolstered social interactions and decision making. The other treatment group used cognitive restructuring for negative depressive cognitions, but the role play group demonstrated more success in combating the depressive symptomatology.

Stark, Reynolds, and Kaslow (1987) utilized social skills instruction with depressive youth to encourage actions and verbalizations for enjoyable, encouraging social situations. Treatment groups learned self-control strategies such as self-monitoring and self-evaluation. The other treatment group learned problem-solving for enhanced social interaction. Both interventions were successful in alleviating depression.

Additionally, cognitive-behavioral benefits in a school-setting have helped and endured in adolescents after a two year follow-up (Lewinsohn, Clarke, Hops, & Andrews, 1990). Skills for focusing and expanding enjoyment, managing negative cognitions, encouraging interpersonal activities, and solving discord were emphasized. Parental education about depression and encouragement of supportive responses to teens' acquired adaptive skills was implemented. Reduction (only evidenced in the two treatment groups, not in the wait-list group) in depressive manifestations was still significant and maintained after two years. A cognitive-behavioral/ psycho-educational group treatment was also reported successful with adolescents and their parents (Clarke et al., 1992).

More recently, a five year cognitive-behavioral investigation (Jaycox, Reivich, Gillham, and Seligman, 1994) of fifth and sixth grade students reduced at-risk symptomatology significantly. Cognitive and problem-solving strategies were taught in the group format in a suburban setting. Treatment gains were maintained at the six-month follow-up. Other prevention treatments in school settings taught coping and adjustment skills to temper stress (Rhodes, Reyes, & Jason, 1993) and foster self-esteem (Lamarine, 1995). Recent research (Stark et al., in press, as cited in Davison & Neale, 1998) demonstrated that some children have mental knowledge of social skills but fail to use them due to negative cognitions and fear. This supported the implementation of cognitive and relaxation interventions.

Weisz et al. (1997) developed an eight session depression treatment program used in treatment targeting non-referred, moderately symptomatic children in their school setting. The Primary and Secondary Control Enhancement Training (PASCET) program was based on the belief that depression could be diminished

by learning to use primary control (making occurrences harmonize with one's desires) and secondary control (adjusting one's beliefs to correspond to outcomes). In six sessions, this cognitive-behavioral intervention used role plays, a game, video, and homework that taught coping strategies. Primary control skills were emphasized (Weisz et al., 1997): identifying activities that the child found mood enhancing and skill building through goal setting and participation in valued activities. Three secondary control skills were emphasized: changing depressive thoughts, cognitive structuring for mood enhancement, and utilizing relaxation and positive mental vision. The last two sessions involved the therapist relating the coping strategies to the individual child's circumstances and a game that reviewed the important strategies of the program.

The children who were part of the treatment group showed significant reduction of depressive symptoms compared to the control group (eisz et al., 1997). Results showed two and three times greater improvement over the control group and maintained at 9-months. It was noted results were dramatic for mild-to-moderately depressed school children but cannot be directly applied to severely depressed children. It might be expected, however, that results with a more severely disordered sample would show even greater gains.

Empirical research (e.g., Lewinsohn, Clarke, Hops, & Andrews, 1990) that implemented cognitive-behavioral methods with depressed adolescents demonstrated success in alleviating depressive symptoms. Self control strategies, problem resolution, relaxation, affect management, interpersonal skills, and cognitive reframing resulted in consistent reductions in adolescent depression. No specific intervention was determined to be superior.

Interpersonal Therapy for Adolescents (IPT-A) was developed by Mufson et al. (1994). It was a modified adult psychoeducational therapy used with 12-18 year-old adolescents with major depression. The program successfully concentrated on developmental adolescent dilemmas of teen stress, detachment from parents, authority/respect issues, peer conflicts, and romantic relationships. Unfortunately, only a small sample of 14 adolescents was treated, and there was no follow-up.

Ideally, there would be no depression in youth or preventative programs would limit the negative cognitions and detrimental self-talk that plague so many teenagers. Mc Whirter and colleagues (1998, as cited in Vernon, 1999) pointed to "prevention, early intervention, or treatment strategies that involve the family, the school, and the community"...(p. 287) as necessary for counseling depressed youth. Group or classroom guidance programs that emphasize "interpersonal communication skills, problem-solving and decision-making skills and anxiety coping skills, such as the use of relaxation, imagery, and exercise" can provide counseling intervention in the school arena (McWhirter et al., 1996, as cited in Vernon, 1999, p. 288) .

Family and environment. Some studies (e.g. Kashani et al., 1994) indicated a need for concurrent private counseling and family counseling. Conclusions from the Russell and Russell (1996) study indicated a need for family counseling within the school setting or an independent agency. Individual or small group counseling alone cannot help the child build the feelings of connectedness and acceptance within the classroom and the family unit.

Lamarine (1995) endorsed family therapy, whether the parents were symptomatic or not. Effects of a depressive in the family unit can be devastating. Depressed children and parents could gain from investigating ways to thoughtfully make known their anger (Kashani et al., 1995). Cognitive structuring to help children "stop-and-think" will limit spontaneous and inappropriate discharge and foster acceptable release. "Guidance, modeling, and reinforcement" (p. 325)are endorsed for helping the depressive/angry child. Parental guidance and modeling of appropriate anger management is crucial.

Looking at non-empirical literature, Morris and Kratochwill (1998) recommended a treatment sequence for depressed children and adolescents. A very careful behavioral assessment of the child and the family to target deficits and form a stepped treatment plan is first. In families where it appears that the functioning is interrelated with the depression in the child, the family should receive family interaction intervention or parent education. Family support and participation in implemented interventions should be sought. Then the treatment model can be followed to systematically identify and mediate the most prominent deficits with the ultimate goal of depression reduction. The proposed model assesses comorbidity first, as the associated disorder should be treated first. Then low activity level, social-skills deficit, self-control deficit, depressive attributional style, low self-esteem and hopelessness, and limited self-interpersonal awareness are confronted one-by-one with developmentally appropriate interventions.

Implementing effective treatment plans for depressed children at any age is a challenge for the school counselor (Russell & Russell, 1996). The family dynamics of depressed children must be considered (Fuller, 1992). Classroom affiliation and

participation are critically related to depression (Russell & Russell, 1996). Counselors need to consult with teachers to enhance the classroom social climate and help children become more a part of projects, procedures, and social relationships. Psychoeducational sessions to build "self-control..., self-monitoring, self-evaluation, self-reinforcement, teacher-mediated interventions, and other cognitive-behavioral techniques have been found to decrease children's depressive symptoms" (Russell & Russell, 1996, p. 12-13).

Implications of a Goodyer and colleagues (1996) study of social characteristics that prolong depression point to the necessity of interpersonal interventions that amend or enhance the quality of peer interactions. Intimacy among small groups of age-companions is an important part of adolescent psychosocial development. To the depressed adolescent, even small misunderstandings or mistranslations of the supportive environment may be construed as failures or calamities. Goodyer and colleagues (1985) concluded that informing the peer group and family about depression and its consequences was an essential part of successful treatment.

Since classroom connectedness and affiliation are significantly related to depression, the school counselor should work with the teachers to provide accepting, supportive social environments for depressed children (Russell & Russell, 1996). Positive involvements in classroom discussions, activities, projects, and social events are very important. Additionally, counselor and teacher implemented interventions helping the child or adolescent develop self-control, through coping and social skills, self-evaluation and self-reinforcement, and

self-esteem through success in the school setting have been targeted for decreasing depressive symptoms (Kazdin, 1990).

Conclusion

Considering the pervasiveness of this mood disorder in children and dolescents and the devastating and long-term effects, it is distressing that so little investigative research has been undertaken to pinpoint the etiology and the successful theoretical approaches, techniques, and interventions (Kaslow & Thompson, 1998). The wide range of symptomatology in children and adolescents has been documented. Many theories about the etiology of depression have been proposed. While some psychosocial intervention methods have reported reduced symptomatology in clinical and school settings, there still remains little definitive research dealing with depressive youth treatments (Kaslow & Thompson, 1998). Noted areas for subsequent research are : (a) specific developmental stages using various interventions; (b) diversity in experimental communities with culturally-appropriate interventions; (c) matching successful interventions to particular children or symptomatology.

Meanwhile, school-age children and adolescents need prevention, attention, assessment, and intervention when necessary. The school counselor is a logical person to provide these services. "The primary implication...for school counselors is the importance of providing comprehensive treatment for the depressed child through family counseling and classroom-based interventions, in addition to the traditional individual or small group counseling" (Russell & Russell, 1996, p.13).

Thought: If child and adolescent depression could be prevented, would there be shyness, profound sadness, inattention, weight disorder, withdrawal, behavior disorder, school absence, substance abuse, promiscuity, or suicide?

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