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## Adolescent depression : an overview of the symptoms, causes, assessments, and treatment

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## Adolescent depression : an overview of the symptoms, causes, assessments, and treatment

### Abstract

Adolescence is said to be the most stressful time in a person's life (Greenberg, 1989). Although the majority of adolescents adapt without much trouble, there are those who do not accept the changes as successfully as others (Greenberg, 1989). The pressures from parents, peers, school, and society can often lead to temporary periods of depression. In the 1960s, adolescent depression was unusual. However, depression in the 1990s has become the 'common cold' of mental illness (Seligman, 1995).

ADOLESCENT DEPRESSION: AN OVERVIEW OF THE SYMPTOMS,  
CAUSES, ASSESSMENTS, AND TREATMENT

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Master of Arts in Education

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By

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Adolescence is said to be the most stressful time in a person's life (Greenberg, 1989). Although the majority of adolescents adapt without much trouble, there are those who do not accept the changes as successfully as others (Greenberg, 1989). The pressures from parents, peers, school, and society can often lead to temporary periods of depression. In the 1960s, adolescent depression was unusual. However, depression in the 1990s has become the 'common cold' of mental illness (Seligman, 1995).

In the 1990s there has been an increase in the amount of detected cases of adolescent depression (Lewinsohn, Clarke, Seeley, & Rohde, 1994). Approximately 15-20% of the general adolescent population has been found to demonstrate depressive symptoms (Birmaher et al., 1996). An additional study concluded that as many as one out of every four adolescents was found to have depressive symptoms (Wicks-Nelson & Israel, 1997). Consequently, there has also been a rise in the amount of research conducted to help understand depression in this age group (Carter & Dacey, 1996).

Current studies have shown that adolescent females are twice as likely to develop depressive symptoms as

adolescent males (Birmaher et al., 1996). Marcotte (1997) found 20-30% of adolescent males and 25-40% of adolescent females were likely to develop depressive symptoms. The average length for depressive episodes was seven to ten months (Kovacs & Goldston, 1991). Recent studies have shown that adolescents and adults have similar symptoms of depression (Roberts, Lewinsohn, & Seeley, 1995).

Depression can affect every aspect of an adolescent's life, from the ability to concentrate on homework to the capacity to make friends (Greenberg, 1989). Depression can range from mild depression to severe depression. When adolescents are depressed, their world changes. Their thoughts, feelings, and behavior are also affected.

The purpose of the paper is to describe adolescent depression and treatment. The author will address common symptoms found in depressed adolescents, potential causes and risk factors, effective ways to assess adolescent depression, and how it can be effectively treated.

#### What is Depression

Depression is the state of feeling sad, being pessimistic, feeling irritable, and experiencing a loss

of interest and pleasure in things that were once found to have interest and pleasure (Roberts et al., 1995). When adolescents suffer from depression, their feelings range from feeling blue to having a terribly black mood (Greenberg, 1989). Life appears to be hopeless and not worth living. The combination of symptoms will help determine if an adolescent is suffering from depression.

#### Symptoms of Depression

Many adolescents are affected by depression, and the worst thing about being depressed is how terrible it feels (Seligman, 1995). When adolescents are depressed, you can almost feel their pain. It is therefore important to identify common symptoms in order to understand depression.

According to the DSM-IV, "When an individual is in a depressed mood for most of the day, for more days than not, but not over two years, dysthymic depression may be present" (American Psychiatric Association, 1994, p. 349). A change in weight, sleep problems, fatigue, feelings of guilt or worthlessness, or the inability to think and concentrate may also indicate depression (Roberts et al., 1995). Psychomotor agitation or retardation is also a sign of depression.

Adolescents who blame themselves for negative situations are more likely to have depressive symptoms, according to Gladstone and Kaslow (1995). When adolescents blame themselves every time something goes wrong, they are likely to put themselves down, which creates low self-esteem. Furthermore, they are more likely to experience unhappy moods and have a pessimistic outlook in life because of the blame and the low self-esteem (Wicks-Nelson & Israel, 1997).

#### What Causes Depression

In addition to identifying symptoms, finding possible causes for depression is also important. Studies have shown factors that may precede depression, but there has not been one single factor that causes it, according to Lewinsohn, Clarke, Seeley, and Rohde (1994).

Birmaher and his colleagues (1996) found stressful life events such as divorce to contribute to depression. Other possible factors that may contribute to depression include psychosocial factors such as family conflicts and socio-economic status (Olsson, Nordstrom, Arinell, & Liis von Knorring, 1999). An example of family conflict could be when a parent gives the children power in the family to make decisions over



the other parent. When this happens, family conflict is likely to occur. Socio-economic status can also play a role in depression. When an adolescent lives in poverty, depression is likely to occur due to the stress in the home environment.

Environment is another factor contributing to depression in many adolescents. King, Ghaziuddin, McGovern, Brand, Hill, and Naylor (1996) conducted a study on adolescent depression and alcohol abuse. This study revealed that adolescents who were suffering from depression were likely to be abusing alcohol or had the potential to abuse alcohol.

Goodyer, Herbert, Tamplin, Secher, and Pearson (1997) demonstrated the impact that parents had on adolescent depression. When there was lack of involvement with the father, adolescents were more likely to develop depressive symptoms. Silverberg, Marczak, and Gondoli (1996) also showed the impact of maternal depression on adolescent children. Mothers who were suffering from depression had children who were more likely to suffer from depression than compared to mothers who did not have depressive symptoms (Silverberg et al., 1996). Another study conducted by Olsson et al. (1999) found that, when

there was little affection within the family, the children risked suffering from depression.

Cognitive distortions, or thought processes that are dysfunctional, have also been a common contributing factor in depression (Seligman, 1995). Magnification, minimization, overgeneralization, personalization, and polarized thinking are all types of cognitive distortions.

Magnification occurs when the individual makes the situation seem much larger than it truly is. An example would be if the student said the wrong answer in class, the student would interpret the situation as assuming the whole class was laughing and thinking he/she was dumb. The student may think the incident, which was actually minor, was a totally devastating loss.

Another type of cognitive distortion is minimization (Corey, 1996). Minimizing is when the student makes the situation seem like no big deal, and it usually occurs when something good happens. For example, if a student earned an A on a test, he or she would think that it was an easy test and that everyone could have gotten a good grade.

Overgeneralization is a process of holding extreme beliefs on the basis of a single incident (Corey, 1996). For example, if there is difficulty with one subject, he or she may believe there will be difficulty with every subject.

Personalization is when the individuals relate external events to themselves (Corey, 1996), and it occurs when individuals assume things are their fault. Even when there is no relationship to them, they continue to hold themselves responsible.

Polarization is an all-or-nothing type of thinking. There is no gray area when polarization is demonstrated. In this distortion, the student either always succeeds or believes he or she is a failure.

#### Negative Side Effects

In some cases, extreme negative side effects, such as substance abuse and eating disorders, were likely to occur as a result of depression (Seligman, 1995). Adolescents may be unaccustomed to their new thoughts, feelings, and behaviors, and as a way to cope with the depressed feelings, they may turn to behaviors that cover up the real issue of depression. As a way of coping with their depression, they avoid it by focusing on eating disorders or substance abuse.

The most alarming effect of depression is suicide. Adolescent suicide has increased about 28 percent in fifteen to nineteen-year-olds from 1980-1992 (Corey, 1996). Adolescents who are at an extremely low point in their lives see little or no hope or happiness for the future. As a last resort, they may turn to suicide. Shaffer, Garland, Gould, Fisher, and Trautman (1988) reported that 21 percent of adolescent males and 50 percent of adolescent females with depression committed suicide.

There are also less drastic, yet devastating effects of adolescent depression. When adolescents believe their worlds are looking bleak, they may turn to alcohol to help themselves feel better temporarily. They are avoiding the issue of depression by participating in dangerous behaviors. The alcohol abuse could lead to sex, teen pregnancy, sexually transmitted diseases, and feeling worse about themselves when they become sober and recall what they have done (Greenberg, 1989).

Greenberg (1989) noted that an eating disorder may occur as a result of depression. Eating disorders have been found in one to three percent of adolescent females (Wicks-Nelson & Israel, 1997). Because they

are confused by their thoughts and feelings, adolescents may develop eating disorders as a way to deal with the pain and the stress they are feeling (Corey, 1996). The eating disorder is reinforced since it allows the adolescents to avoid their negative thoughts, feelings, and fears by focusing on the eating disorder (Wicks-Nelson & Israel, 1997).

Rebellion and disobedience to authority figures and peers may be another side effect of depression (Greenberg, 1989). For example, it is common for adolescents who are depressed to defy authority and have trouble with authority figures.

Depressed adolescents appear to have a more difficult time in school. As a way to raise their spirits, adolescents may turn to sex and other risk-taking behaviors, such as alcohol and drug use (Seligman, 1995). Depressed adolescents also appear to become more withdrawn and demonstrated more antisocial behavior than compared to adolescents who did not have depressive symptoms (Roberts et al., 1995).

Academically, depressed students produce poor school-work due to the inability to concentrate and the failure to participate in activities (Wicks-Nelson & Israel, 1997). Attention problems in school may also

lead to poor school-work (Kovacs & Goldston, 1991). In order to help the depressed adolescent, accurate assessment is critical. Different assessments to help diagnose depression will subsequently be described.

### Assessment

The development of assessment instruments has contributed considerably to the increasing attention to adolescent depression (Wicks-Nelson & Israel, 1997). The purpose of an assessment is to ensure an accurate diagnosis and indicate the presence of depressive symptoms, to formulate a treatment plan, and provide preventative strategies that may decrease possible future episodes.

There are several different types of assessments: assessments for the client to complete and assessments completed by parents, peers, or teachers. They can be in the form of self-reports, checklists, rating scales, questionnaires, and interviews. Self-report instruments are the most common measure of assessment (Wicks-Nelson & Israel, 1997).

The Childrens' Depression Inventory (CDI) is the most commonly used measure of self-report (Wicks-Nelson & Israel, 1997). The CDI assessment is geared primarily towards children and adolescents between the

ages of six and seventeen (Crowley & Emerson, 1996). The twenty-seven item self-report asks youngsters to choose which of the three alternatives best characterizes them during the past two weeks (Wicks-Nelson & Israel, 1997). The items on the self-report are related to affective, cognitive, or behavioral aspects (Crowley & Emerson, 1996). The CDI has been shown to have high internal consistency and moderate test-retest reliability within six months (Crowley & Emerson, 1996).

Reynolds developed the Reynolds Child Depression Scale (RCDC), a self-report measurement designed to assess depressive symptoms for adolescents between the ages of twelve and eighteen (Wicks-Nelson & Israel, 1997). The RCDC includes 30 items for the children to respond on a five point scale ranging from zero (almost never) to four (all of the time) (Crowley & Emerson, 1996). The questions are either phrased to indicate the presence of depressive symptoms (such as, I feel sad) and the absence of depressive symptoms (I feel happy). The RCDC is scored by totalling all thirty items. It has high internal consistency and high test-retest reliability over a two to four week period (Crowley & Emerson, 1996).

The third common self-report is the Beck Depression Inventory (BDI) (Carter & Dacey, 1996). The BDI can be used for children between the ages of six and seventeen. The client is asked to rate the twenty-one items with a zero, one, or two. The higher the number, the more severe the depression (Carter & Dacey, 1996). The questions are geared towards four domains: affective, behavioral, cognitive, and somatic symptoms. The BDI had a 67% accuracy rate, and it had a high predictive ability (Carter & Dacey, 1996).

The Child Behavior Checklist (CBC) (Wicks-Nelson & Israel, 1997) is another commonly used assessment. The Child Behavior Checklist measure has been created for the child to complete and also rephrased for the parents to complete (Wicks-Nelson & Israel, 1997). The CBC assessment has 118 items. Each item is rated on a three-point scale. The assessment divides the questions into eight different syndromes. The syndromes included the following: withdrawn, somatic complaints, anxious, social problems, thought problems, attention problems, delinquent behaviors, and aggressive behaviors.

An additional self-report rating scale is the Center for Epidemiologic Studies Depression Scale (CES-



D) (Garrison, Waller, Cuffe, McKeon, Addy, & Jackson 1997). The twenty item rating scale has been widely used on children and adolescents (Chen, Mechanic, & Hansell 1998). The CED-S measures depressive symptoms that include three suicide items (Garrison et al., 1997). The domains covered on the CES-D are affective, somatic, and interpersonal. The instrument has excellent reliability and validity (Chen et al., 1998).

An assessment can also be in the form of a questionnaire. A commonly used questionnaire is The Mood and Feelings Questionnaire, which includes thirty-three items that parallel the symptoms that were discussed in the DSM-III-R (1987). The Mood and Feelings Questionnaire was found to have good test-retest reliability (Goodyer, Herbert, Secher, & Pearson, 1997).

Interviews can also be administered as a way to measure depression. The Diagnostic Interview Schedule (DIS) is a structured interview that lists exactly what the therapist must cover (Garrison et al., 1997). This highly structured interview minimizes judgement by using exact wording and questioning. However, the DIS prohibits probing for symptoms by the interviewer (Garrison et al., 1997).

In addition to the client and the parents completing the assessment, other adults may complete the assessments. An example would be the Peer Nomination Inventory of Depression, which is an assessment that the client's peers complete. The inventory asks questions that are related to depression, happiness, and popularity (Wicks-Nelson & Israel, 1997).

Assessments can be combined with other measures of assessments to ensure higher validity and reliability. The best assessment will depend upon the client and the therapist. After an assessment has been administered, a treatment plan could be established.

#### Treatment

Despite the high prevalence of depression in adolescents, the literature is nearly non-existent for specific treatment plans for adolescents suffering from depression (Mufson, Moreau, Weissman, Wickramaratne, Martin, & Samoilov, 1994). Of the adolescents who are treated, 80-90% have been treated effectively (Wicks-Nelson & Isreal, 1997). A treatment plan can involve medication, therapy, or both.

There are different theories that are helpful in treating depression in adolescents: Interpersonal

Therapy, Behavior Therapy, Cognitive-Behavioral Therapy, and Rational Emotive Behavior Therapy.

### Interpersonal Therapy

Interpersonal psychotherapy has been shown to be an effective and brief type of treatment (Mufson et al., 1994). Interpersonal psychotherapy focuses on reducing the symptoms and addressing current interpersonal problems that are associated with depressive symptoms (Mufson et al., 1994). Mufson and his colleagues (1994) found that 90.3% of the adolescents who had been involved in Interpersonal Therapy had a significant decrease in depressive symptoms and an improvement in their functioning within 12 weeks of therapy.

### Behavior Therapy

Behavior Therapy is largely educational and goal-orientated. Behavior therapy deals with the clients' current problems and factors that influence them (Corey, 1996). Behavior Therapy focuses on inappropriately learned behavior and engages in specific actions to change the inappropriately learned behavior (Corey, 1996). For example, when working with an adolescent who has depression, the therapist would work on increasing their self-esteem, reducing the

self-blame, and teaching more effective ways of thinking and behaving.

### Cognitive-Behavioral Therapy

Cognitive-Behavioral Therapy has also been effective when working with depressed adolescents (Kaslow & Thompson, 1998). Cognitive-Behavioral therapists teach clients to work on their thought patterns and examine their behavior. Beck, who is the foremost authority in Cognitive-Behavioral therapy and depression, has the adolescents focus on what they are thinking and doing rather than how they are feeling. They are taught to be role detectives who need to be taught how to judge the accuracy of their pessimism (Seligman, 1995).

In employing this theory, adolescents are taught to recognize their feelings when they are feeling the worst, to evaluate their automatic negative thoughts (automatically thinking the worst in any given situation), and then find a more accurate and positive way to think (Seligman, 1995).

The ultimate goal is to have the clients recognize and change their self-defeating cognitions and beliefs (Corey, 1996). Research has shown that when adolescents received Cognitive-Behavioral Therapy, they

were twice as likely to recover than those who received only medication (Seligman, 1995).

### Rational-Emotive Behavior Therapy

Rational-Emotive Behavior Therapy (REBT) is another effective theory that helps adolescents deal with depression. Marcotte (1997) conducted a 12 week study for adolescents between the ages of 14 and 17. During the 12 weeks, the adolescents were taught about the tendency to dramatize, low tolerance for frustration, and beliefs about self-value (Marcotte, 1997). Marcotte (1997) found that after 12 weeks of REBT, the depression decreased.

REBT theorists believe people contribute to their own psychological problems (Ellis, 1993; Seligman, 1995). Therefore, the goal is to teach the clients new ways of dealing with their problems by restructuring their behaviors and thoughts. One way to accomplish this is by teaching the ABC model. The A is the adversity or negative event, B is the belief and interpretation of A, and C is the emotional and behavioral consequence (Ellis, 1990).

REBT therapists further teach clients how to identify the three core irrational beliefs: shoulds, self-downing, and low-frustration tolerance. By

learning how to dispute these irrational beliefs that create emotional upset, adolescents can reduce their depressed feelings. REBT therapists also reinforce that the clients are in control and have the power to change the disturbances with which they are faced by challenging their pattern of thinking.

### Interventions

There are a variety of interventions that can be used to treat adolescent depression. A study conducted by Kaslow and Thompson (1998) taught cognitive-behavioral techniques such as self-control skills, problem solving, relaxation, social skills, and cognitive restructuring. In the study, there was no data to indicate which intervention was the most effective (Kaslow & Thompson, 1998).

Lamarine (1995) conducted a study that had the clients focus on their thoughts, a common cognitive-behavioral technique. As clients focused on their thoughts of the present and the future, the therapist would help them identify the cognitive distortions and deficits and help find new ways of rational thinking (Lamarine, 1995). Another way to reduce the distortion is by using thought bubbles (Seligman, 1995), where the adolescent learns to identify thoughts in relation to

the given situation. To elaborate on the activity, the therapist could then help the client dispute the negative thoughts.

Marcotte (1997) found role-playing to be an effective way to teach social skills and problem solving techniques. In role-playing, the client and the therapist work together to find more appropriate ways of thinking and behaving by acting out the behaviors, patterns, and reactions to the situation.

Liberman (1995) found role rehearsal to be effective. In role rehearsal, the client and the therapist work through the problem by acting out the situation (Nichols & Schwartz, 1995). One way role rehearsal can help depressed adolescents is to have them pretend they are strong and self-reliant. Throughout the therapy, the adolescents could continue practicing what they would ideally like to be.

In addition to therapy, adolescents can be given the option of medication to help alleviate their depressive symptoms. Although there has been little research to support the effectiveness of medication to reduce depressive symptoms (Sommers-Flannagan & Sommers-Flannagan, 1996), Tricyclic antidepressant (TCA) and Serotonin-specific reuptake inhibitors (SSRI)

have been given (Sommers-Flanagan & Sommers-Flanagan, 1996). According to Sommers-Flannagan and Sommers-Flannagan (1996), 42 adolescents were given either a placebo or the antidepressant. When an adolescent was given tricyclic antidepressants (TCA), the medication did not hold a promise for effectiveness because only 20% of the children recovered after receiving the antidepressant.

The same study also showed the side effects including excitement, irritability, nightmares, insomnia, headaches, abdominal cramps, drowsiness, and dizziness (Sommers-Flannagan & Sommers-Flannagan, 1996). Due to the lack of research on medication for treating adolescent depression, the safety of taking the medication is uncertain (Wicks-Nelson & Israel, 1997).

### Conclusion

Adolescent depression has become a significant problem that has received increasing attention within the past ten years. The disorder affects as much as 20% of the adolescent population. Depression is a disorder that leaves adolescents feeling helpless and overwhelmed. They are likely to withdraw from their family and friends. They blame themselves, have



difficulty paying attention, and struggle to enjoy their surroundings.

Current research has identified possible assessments, interventions, and treatments that have been found to be effective. Assessments have contributed greatly to detecting adolescent depression. Self-rating scales, checklists, questionnaires, and interviews have contributed to the diagnosis of depression. Different types of theories, such as Cognitive-Behavioral and REBT have also been found to reduce depression in adolescents.

Techniques such as role playing and disputing irrational thoughts can play a vital role in treatment. Medication is also a viable option for treatment of depression. Advances in the diagnosis and treatment of depression offer hope that adolescents may no longer need to suffer from this malady.

## References

- American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4<sup>th</sup> ed.). Washington DC: American Psychiatric Association.
- Birmaher, B., Ryan, N.D., Williamson, D.E., Brent, D. A., Kaufman, J., Dahl, R.E., Perel, J., & Nelson, B. (1996). Childhood and adolescent depression: A review of the past 10 years, Part I. Journal of the American Academy of Child and Adolescent Psychiatry, 35(11), 1427-1439.
- Carter, C.L., & Dacey, C.M. (1996). Validity of the Beck Depression Inventory, MMPI, and Rorschach in assessing adolescent depression. The Association for Professionals in Services for Adolescents, (19), 223-231.
- Chen, H., Mechanic, D., & Hansell, S. (1998). A longitudinal study of self-awareness and depressed mood in adolescence. Journal of Youth and Adolescence, 27(6), 719-734.
- Corey, G. (1996). Theory and practice of counseling and psychotherapy (5<sup>th</sup> ed.). Pacific Grove, CA: Brooks/Cole Publishing Company.

Crowley, S.L., & Emerson, E.N. (1996).

Discriminant validity of self-reported anxiety and depression in children: Negative affectivity or independent constructs? Journal of Clinical Child Psychology, 25(2), 139-146.

Ellis, A. (1990). Rational-emotive therapy. In J.K. Zeig & W.M. Munion (Eds.), What is psychotherapy? Contemporary perspectives (pp. 146-151). San Francisco: Jossey-Bass.

Garrison, C.Z., Waller, J.L., Cuffe, S.P., McKeown, R.E., Addy, C.L., & Jackson, K.L. (1997). Incidence of major depressive disorder and dysthymia in young adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 36(4), 458-465.

Gladstone, T.R., & Kaslow, N.J. (1995). Depression and attributions in children and adolescents: A meta-analytic review. Journal of Abnormal Child Psychology, 23(5), 597-605.

Goodyer, I.M., Herbert, J., Tamplin, A., Secher, S.M., & Pearson, J. (1997). Short-term outcome of major depression: II. Life events, family dysfunction, and friendship difficulties as predictors of persistent disorder. Journal of the American Academy of Child and Adolescent Psychiatry, 36(4), 474-480.

Greenberg, H.R., (1989). Emotional illness in your family: Helping your relatives, helping yourself. New York, NY: Macmillian Publishing Company.

Kaslow, N.J., & Thompson, M.P. (1998). Applying the criteria for empirically supported treatments to studies of psychosocial interventions for child and adolescent depression. Journal of Clinical Child Psychology, 27(2), 146-155.

King, C.A., Ghaziuddin, N., McGovern, L., Brand, E., Hill, E., & Naylor, M. (1996). Predictors of comorbid alcohol and substance abuse in depressed adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 35(6), 743-751.

Kovacs, M., & Goldston, D. (1991). Cognitive and social cognitive development of depressed children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 30, 388-392.

Lamarine, R.J. (1995). Child and adolescent depression. Journal of School Health, 65(9), 390-393.

Lewinsohn, P.M., Clarke, G. N., Seeley, J.R., & Rohde, P. (1994). Major depression in community adolescents: Age at onset, episode duration, and time to recurrence. Journal of the American Academy of Child and Adolescent Psychiatry, 33(6), 809-818.

Marcotte, D. (1997). Treating depression in adolescence: A review of the effectiveness of cognitive-behavioral treatments. Journal of Youth and Adolescence, 26(3), 273-283.

Mufson, L., Moreau, D., Weissman, M.M., Wickramaratne, P., Martin, J., & Samoilov, A. (1994). Modification of interpersonal psychotherapy with depressed adolescents (IPT): Phase I and II studies. Journal of the American Academy of Child and Adolescent Psychiatry, 33(5), 695-706).

Nichols, M.P., & Schwartz, R.C. (1995). Family therapy concepts and methods (3<sup>rd</sup> ed.). Needham Heights, MA: Allyn and Bacon Publishing Company.

Olsson, G.I., Nordstrom, M.L., Arinell, H., & Liis von Knorring, A. (1999). Adolescent depression: Social network and family climate-a case-control study. Journal of Child Psychology and Psychiatry, 40(2), 227-237.

Roberts, R.E., Lewinsohn, P.M., & Seeley, J.R. (1995). Symptoms of DSM-III-R major depression in adolescence: Evidence from an epidemiological survey. Journal of the American Academy of Child and Adolescent Psychiatry, 34(12), 1608-1617.

Seligman, M.E. (1995). The optimistic child. New York, New York: Houghton Mifflin Company.

Shaffer, D., Garland, A., Gould, M., Fisher, P., & Trautman, P. (1988). Preventing teenage suicide: A critical review. Journal of the American Academy of Child and Adolescent Psychiatry, 27, 675-687.

Silverberg, S.B., Marczak, M.S., & Gondoli, D.M. (1996). Maternal depressive symptoms and achievement-related outcomes among adolescent daughters: Variations by family structure. Journal of Early Adolescence, 16(1), 90-107.

Sommers-Flanagan, J., & Sommers-Flanagan, R. (1996). Efficacy of antidepressant medication with depressed youth: What psychologists should know. Professional Psychology: Research and Practice, 27(2), 145-153.

Wicks-Nelson, R., & Israel, A.C. (1997). Behavior disorders of childhood. Upper Saddle River, NJ: Prentice Hall.