Depression in Adolescence: Implications for School Counsellors

Kenneth G. Rice
Michigan State University
Nancy Leffert
Search Institute, Minneapolis Minnesota

Abstract

This paper briefly reviews literature on adolescent depression relevant to school counselling activities and practices. A model of adolescent mental health is presented that serves to underscore the multi-dimensional nature of the development of depression and suggests a variety of strategies to address adolescent depression. We limit discussion to activities involving assessment and referral, counselling, and prevention. Case examples are used to illustrate the application of conceptual issues to actual practice.

Résumé

Cet article donne un aperçu de la bibliographie de la dépression parmi les adolescents, en ce qui concerne les activités et les pratiques des conseillers d'orientation. L'auteur présente un modèle de la santé mentale parmi les adolescents; ce modèle souligne la nature multidimensionnelle de la manifestation de la dépression et propose plusieurs stratégies pour aborder la dépression parmi les adolescents. Cette étude se limite aux activités ayant trait à l'évaluation et à l'envoi, au counseling et à la prévention. On démontre par des exemples de cas l'application des questions conceptuelles à la pratique actuelle.

The purpose of this paper is to examine selected literature on adolescent depression in a manner that is relevant and applicable to the work of school counsellors. The goal is to address three major topics: a) the relevance of adolescent depression for the work of school counsellors; b) a model for understanding the development of depression and for conceptualizing interventions; and c) activities that school counselors can undertake to assess, prevent, and intervene in adolescent depression. The topics are presented each in turn, and woven into the discussion are case examples and examples of programs that demonstrate the application of conceptual issues and processes to practice.

ADOLESCENT DEPRESSION

Schools are the sole institutions with a significant and sustained access to children and adolescents (Weissberg & Allen, 1986). Because of the compulsory education laws, schools occupy thousands of hours of time during one's childhood and adolescence. Most adolescents spend one-half of their average waking hours in school. Furthermore, schools are located in geographically consolidated settings, which enable them to target larger populations of children and adolescents. In sum, schools

have ready access to a large population of young people and are ideally positioned to initiate and maintain activities and service to enhance the psychological development and well-being of youth. In particular, school counselling professionals could play a critical role in assessment, intervention, and prevention of adolescent depression.

Adolescent depression is a serious mental health problem. Although depression in adolescents has been conceptualized and measured in a variety of ways, it is conservative to conclude that approximately 5-7% of adolescents in the general population experience significant depression and that from 10-40% of adolescents report some depressed or unhappy mood (see Petersen, Compas, Brooks-Bunn, Stemmler, Ey, & Grant, 1993, for a recent review). Rates of depression increase significantly throughout the adolescent period. Gender differences in the rates of depression typically emerge beginning at around age 13 or 14, with girls twice as likely to become depressed as boys (Nolen-Hoeksema & Girgus, 1994). Because of the incidence rates of depression among adolescents and because most adolescents attend school, it is quite likely that school counsellors will encounter depressed adolescents at some time.

Depression is a major mental health problem because the features of depressed mood may be compounded by the conditions that often co-exist with depression. Other than depressed or irritable mood, typical diagnostic features of depression among adolescents include increased emotional sensitivity, a noticeable lack of interest or ability to delight in otherwise pleasurable experiences or activities, decreased energy level and increased fatigue, low self-worth or excessive feelings of guilt, recurrent thoughts about death or dying (e.g., suicidal ideation with or without a specific plan), withdrawal from friends, sleep and/or appetite disturbances (e.g., restless sleep, weight gain/loss or failure to make expected weight gains), change in school performance and/or change in attitude toward school, and reduced ability to think clearly or make decisions (American Psychiatric Association, 1994; Weinberg, Rutman, Sullivan, Penick, & Dietz, 1973). The intensity, duration, distress, and impact on social and academic functioning set clinically-significant depression apart from normal fluctuations of mood which are observed among many adolescents. The following example illustrates these points.

> To most observers, Andrea had everything going for her. She had always been popular with her friends and with her teachers. She was an ideal student, always turning in assignments on time and with impeccable attention to detail. She was very active and seemed capable of doing many things well. No one was quite sure when things began to slip for Andrea, or why. Over a period of approximately four weeks, her teachers noticed a decline in her work and she often seemed inattentive in class. She became overly sensitive to benign comments and extremely sensitive to critical feedback about her schoolwork, at one point bursting into tears during a brief meeting with a teacher after class. She began dropping activities she once enjoyed and excelled in, and she seemed less interested in talking with her friends. A teacher consulted the school counsellor and a conference was sched-

uled with her parents. Both parents reported noticeable changes in Andrea at home, such as sleeping much more than usual, spending a great deal of time in her bedroom (much more time than in previous weeks), refusal to attend family outings, missing meals, and a general "gloomy" mood about her.

Depression often covaries with one of more other mental health problems. Substance abuse and eating disorders often are comorbid with depression (APA, 1994; Attie, Brooks-Gunn, & Petersen, 1990). Conduct disorder, a disruptive behavioural problem, is also often observed with depression among adolescent populations (Zoccolillo, 1992), at rates of approximately 10-35% (Kovacs, Paulauskas, Gatsonis, & Richards, 1988). Rohde, Lewinsohn, and Seeley (1991) reported that 42% of the depressed adolescents in a large, community sample had a comorbid disorder, with boys more likely to have co-existing disruptive behavioral problems and girls more likely to have co-existing eating disorders. Anxiety is also observed to covary with depression at rates from 21-70%, depending upon the population surveyed (Kovacs, 1990; Rohde et al., 1991).

One implication of the various features of depression and co-occurrence of depression with many other psychological problems is that depressed mood may not always be the presenting problem among adolescents. Indeed, school counsellors may be more likely to hear reports of academic difficulties, concentration problems, somatic complaints (e.g., headaches, stomachaches), nervousness, peer problems, and substance abuse rather than reports of depressed mood. Certainly not all students with concentration problems have depression. However, it is in the best interests of the student and the school if the possibility of depression is at least considered. The most obvious reason for being concerned about depression is the increased risk of suicide when an adolescent is depressed. The rate of suicide among adolescents and young adults with a mood disorder is 25 times greater than the rate of suicide among the general population (Blumenthal & Hirschfeld, 1984). Currently, suicide is the third leading cause of death in the 15-19-year age group (Garland & Zigler, 1993) and schools are frequent sites of debriefing programs after a community experiences an adolescent suicide. School counsellors may be called upon to coordinate such programs in order to prevent negative modeling (i.e., additional suicides) as well as to help survivors process their grief reactions (Clarizio, 1994).

A MODEL FOR UNDERSTANDING THE DEVELOPMENT OF DEPRESSION

There are many theoretical models regarding the development of depression in adolescents. (Interested readers should refer to the recent thorough reviews and edited volumes by Clarizio, 1994; Nolen-Hoeksema & Girgus, 1994, and Reynolds & Johnston, 1994.) The model of mental health trajectories developed by Petersen and colleagues

(Petersen & Ebata, 1987; Petersen, Kennedy, & Sullivan, 1991; Rice, Herman, & Petersen, 1993) is well-suited for understanding adolescent depression, intervention, and prevention. This model is based in part on contributions from areas of life-span development (Baltes & Reese, 1984), developmental psychopathology (e.g., Garmezy & Rutter, 1983), stress and adjustment (e.g., Kessler, Price, & Wortmann, 1985), and coping (e.g., Compas, 1987).

The model describes how the number and timing of changes in early adolescence affect mental health. Moderators of these effects include parental and peer support as well as the coping skills of the adolescent. It suggests that the manner in which adolescents adjust to situational and developmental challenges or stressful life events and hassles (e.g., a bad grade, relationship break-up, parental divorce) is determined by the internal and external resources available to adolescents.

Challenges during adolescence can involve normative life events, non-normative events, and hassles. Normative life events are experienced by most adolescents and occur for many adolescents at approximately the same point in the life course. Examples include school entry, school transitions, and puberty. Some of these events are fixed by societal policies (e.g., age of school entry or school structure); some are based on individual or family decisions (e.g., moving), often within the framework of societal norms; and others are developmentally based (e.g., puberty). These events confront individuals with new demands and expectations emanating from self, family, peers, or society. For example, the physical changes resulting from puberty may produce body image changes in the individuals (e.g., Petersen, Leffert, Graham, Ding, & Overbey, 1994), or increases in expectations from family members and others in the society as a result of the physical appearance of maturity.

Other challenges involve events that are non-normative, such as the experience of parental death or divorce. Non-normative life events are less commonly experienced than normative events or occur at less predictable points in the life course. Physical or sexual abuse, for example, are particularly disturbing examples of non-normative events. Girls are at greater risk for experiencing sexual abuse than boys. The risk for girls to be victims of sexual abuse increases between the ages of 10-15, with girls ages 14-15 at the highest level of risk (Nolen-Hoeksema & Girgus, 1994). Furthermore, history of sexual abuse prior to age 18 places victims, both male and female, at increased risk for depression and suicide (Beitchman, Zucker, Hood, & Decosta, 1991; Stein, Golding, Siegel, Burnam, & Sorenson, 1988).

Major normative and non-normative life events affect adjustment in part by increasing the number of much more frequently occurring stressors commonly referred to as hassles (Kessler et al., 1985). For example, parental divorce not only changes the adolescent's relation-

ships with each parent and perhaps siblings, it may alter the school attended, peer relationships, opportunities to participate in extracurricular activities, family economic stability, and the regularity of daily life. In addition to the type of challenges (normative and non-normative) and hassles, the sheer number of changes experienced during adolescence, the timing of those changes, and the synchronicity with which they occur, have an impact on mental health outcomes.

> During the summer, the divorce of Jim's parents became final. Shortly thereafter, he and his mother moved to an apartment on the other side of the large city they lived near. As a result of the move, Jim had to change schools. He also was making the transition from grade 6 to grade 7 at about the same time. For a time, it seemed like he could not do anything right, he felt sad and angry about his parent's divorce, he wondered what he had done to contribute to their unhappiness, and he had difficulty making new friends and tended to keep to himself. It seemed like something went wrong almost daily for Jim (late for the bus, misplaced his homework, forgot to study for a test, etc.).

Internal and external resources may interact with the effects of major life events or developmental challenges. Internal resources refer to aspects of the individual's personality, such as attributional style, coping skills, intelligence, and perceived locus of control. For example, the attributional styles associated with depression are those in which adolescents interpret negative experiences as being caused by something within (e.g., "I'm a bad/stupid/worthless person, that's why she broke-up with me"), as being indicative of characteristics that will be stable over time (e.g., "I'm a failure with the girls and I always will be, so why bother"), and as signs of more generalized or global deficits (e.g, "I don't just fail with relationships but I mess-up everything I do, in school, on the team, at home") (Abramson, Seligman, & Teasdale, 1978; Kaslow, Rehm, & Siegel, 1984). Likewise, adolescents (typically girls) are at increased risk for depression when they use affect-focused coping strategies that intensify already existing dysphoric mood (e.g., ruminating over troubles) while avoiding direct or more approach- or problem-focused coping strategies (Herman-Stahl, Stemmler, & Petersen, 1995; Nolen-Hoeksema & Girgus, 1994).

Perfectionism is an example of an internal factor that may enhance or buffer the deleterious consequences of negative life circumstances. Two factors emerge when defining and measuring perfectionism: maladaptive evaluative concerns and positive achievement striving (Blatt, 1995; Frost, Marten, Lahart, & Rosenblate, 1990;; Hewitt & Flett, 1989). An adolescent with adaptive perfectionism would strive to excel but would accept personal or environmental factors limiting performance. Maladaptive perfectionism is an attitudinal style in which the adolescent harbours unreasonably rigid expectations for self and perhaps others. Less-than-acceptable performance on an exam, for example, would be a significant blow to the maladaptive perfectionist's self-esteem (even

though acceptable performance likely would not be enjoyed). In contrast, the adaptive perfectionist might view poor performance as disappointing but not as indicative of low self-worth. As expected, depression consistently has been associated with maladaptive perfectionism. In turn, maladaptive perfectionism has been linked to increased risk for suicide (Blatt, 1995) and may be especially detrimental for adolescents (Delisle, 1986; Shaffer, 1988).

External resources refer to interpersonal sources of support and guidance, such as a solid relationship with a teacher, counsellor, parent, or friend. Deficits in external resources also place adolescents at risk for developing depression. For example, having a depressed parent is a significant risk factor for the adolescent depression. Poor parenting practices have also been linked to childhood depression (Reinherz, Stewart-Berghauer, Pakiz, & Frost, 1989). Poor quality of attachment to parents and to peers has predicted adolescent depression as well (e.g., Armsden & Greenberg, 1987; Kenny, Moilanen, Lomax, & Brabeck, 1993). In one study examining both internal and external resources, Bennett and Bates (1995) found that lower social support, more so than attributional style, was a significant predictor of subsequent depression (6 months later) in a sample of 11 to 13 year-olds.

In addition to resources and their interaction with developmental challenges, it is important to consider specific sub-populations of young people who are at particular risk for developing depression. Because of increased incidence of depression among these groups, they also are at risk for increased rates of suicide or suicide attempts. For example many gay, lesbian, and bisexual youth are thought to be at risk for special problems. They are at risk of receiving negative reactions from family and friends if they reveal their homsexuality; they often are rejected by their peers; they often are physically assaulted or abused; and many have problems in school, abuse substances, run away from home, and are involved in delinquency (Center for Population Options, 1992; Katchadourian, 1990; Petersen, Leffert, & Graham, 1995; Remafedi, 1987; Savin-Williams, 1994). As a result of overt and subtle individual and societal reactions to sexual orientation, these youth often feel vulnerable, isolated, and depressed (Martin & Hetrick, 1988). Gay, lesbian, and bisexual youth are but one example of special populations and school counsellors should be alert and sensitive to the particular needs or risk factors of various subgroups of adolescents.

The final assumption of the model is that the manner in which an adolescent copes with challenges not only influences his or her adjustment at that time but also determines, in part, the personal and social resources that will be available to the adolescent in subsequent developmental periods. This may explain, in part, why there is a greater likelihood of experiencing subsequent depressive episodes once a person has

had a depressive episode (Lewinsohn et al., 1989). For example, adolescents who become depressed may alienate themselves and withdraw from peers or caring adults, thus removing themselves even further from the very resources that might be able to assist them in managing their depression. Another possibility is that adolescents come to believe certain things about themselves (e.g., inadequacy, worthlessness) and then subsequently behave in ways that confirm such conclusions, similar to a self-fulfilling prophecy.

This conceptual model suggests several considerations for interventions. First, challenges need to be considered from a developmental and age-appropriate perspective; that is, the timing of the intervention and the intervention components should be developmentally informed. Second, enhancing or modifying internal resources (e.g., coping style) and external resources (e.g., social support) through intervention should affect the impact that challenges have on mental health. Further, internal resources could also affect external resources, and vice versa, such that altering one may benefit the other. The availability and utility of resources to meet the challenges of adolescence can have implications for present and future mental health (Petersen et al., 1991; Rice, et al., 1993). Therefore, interventions for adolescents should attend to the normative (e.g., puberty, school transitions) and non-normative (e.g., parental divorce, death in the family) challenges confronting youth, and the enhancement of internal and external resources for meeting those challenges.

> The counsellor at Jim's new school was aware of his circumstances and facilitated his participation in a "partner program" for students new to the school. He also met with Jim occasionally to talk about the divorce and Jim's reactions; their discussions helped Jim alleviate his guilt about the divorce. The counsellor had learned that Jim enjoyed swimming and encouraged him to consider joining the swim team at school, which he did after the counsellor introduced Jim to the swim coach. After about a month, Jim was making friends and his mood had significantly improved.

The importance of the school counsellor is evident here. He facilitated the availability of external resources by involving Jim in the "partner program" and by introducing him to the swimming coach. Both of these external resources could have been accessed by Jim without the help of the school counselor. However, depressive affect can get in the way of one's ability to act on one's own behalf because of the interference of feelings of worthlessness and powerlessness, not to mention the lack of energy and other associated somatic symptoms of depression. An advocate in the form of a school counselor can go a long way toward helping a student get "back to normal."

The school counsellor in the above case example also met with Jim to discuss his feelings about his parents' divorce, allowing him an important outlet for working through the event. It is easy to see, even in this brief

example, that talking with a concerned and caring adult combined with help in enlisting other external resources may have circumvented a full-blown depressive episode.

ASSESSMENT, PREVENTION, AND INTERVENTION: THE ROLE OF THE SCHOOL COUNSELLOR

Adolescents do not necessarily display the same symptomatic picture of depression as that of adults and, therefore, may go unrecognized and not be referred for treatment. Even if properly identified, the number of adolescents who could benefit from counselling or other intervention exceeds the capacities of most community professionals and paraprofessionals. In general, it is estimated that 12-15% of youth under the age of 18 experience emotional and behavioural problems serious enough to justify treatment, yet 70-90% of these children who require intervention do not receive services (AMA, 1990; Weissberg, Caplan, & Sivo, 1989). The reactive nature of tertiary interventions and the likelihood that many adolescents in need of treatment may not be recognized by the mental health care system warrant the development of proactive, primary interventions and prevention programs (Albee, 1985).

Assessment and Referral

An awareness and understanding of depression in adolescence can serve several useful functions. First, knowledge about depression (e.g., signs, symptoms, co-occurring conditions) and sensitivity to a conceptual model about the development of depression (e.g., normative and non-normative challenges, internal and external resources) arms the school counsellor with an array of emotional, behavioural, and cognitive factors to explore and evaluate. Such an evaluation can occur through a variety of methods. The counsellor may individually interview a student identified by a teacher as withdrawn and/or irritable, or whose functioning has changed. The counselor may also tap the teacher's considerable exposure to the student and knowledge of other factors possibly contributing to the student's difficulties. Parent input may also be solicited for additional confirming or disconfirming information about the student. Generally, a comprehensive approach to assessment (multiple methods of information gathering from multiple sources) is the best strategy (Clarizio, 1994).

Assessment results inform subsequent decisions regarding additional assessment and intervention. The obvious crisis nature of some situations (e.g., suicidal ideation with clear plan and means) dictates an entire set of subsequent decisions and activities. School counsellors should be comfortably familiar with their institution's policies and procedures regarding crisis management, and work to develop such procedures if none exist. A frequently encountered experience as a result of an assess-

ment process described above is less, not necessarily more, certainty about the intensity, severity, duration, and impact of depression. An assessment may need to be more thorough or formal, and perhaps could involve the services of a school psychologist or other professional trained to administer and interpret psychological assessments. Both assessment and intervention options may be more or less limited, given resources and capabilities within the school. Some schools may have on-site facilities in which students can receive assessment services and individual counselling, although as Myrick (1993) noted, "individual counseling is a luxury in the schools." (P. 182) Other schools may refer students to off-site locations for extensive assessment and counselling services. Thus, the school counsellor plays a crucial role in the initial assessment, coordination of referrals, and also may become involved in an eventual treatment or follow-up plan. In addition, the school is sometimes ideally suited to explain the necessity of such referrals to the student and to parents, serving perhaps as a liaison between the referral agency and the family.

Counselling

Approaches to work directly with adolescents include individual and family counseling and psychotherapy, group counselling, and prevention. As might be expected, there exists a rather large literature on interventions for adolescents. (Interested readers may refer to Reynolds and Johnston, 1994, for a more thorough exploration of that literature.)

Individual and group counselling and prevention efforts can draw upon the conceptual model described above for possible intervention strategies, content ideas, and expected results. For example, short-term individual counselling usually begins by developing a working alliance with the adolescent (developing an external resource). The counselor can then implement strategies to enhance the student's internal as well as other external resources. Coping or problem-solving strategies could be explored and improved. Students can learn how to match appropriate coping strategies to the type of problem situations they encounter. For example, active problem-solving in which an adolescent sets a goal, brainstorms possible solutions, anticipates consequences, and implements a plan of action, generally works for events or circumstances that are under an adolescent's control. Emotion-focussed strategies (e.g., relaxation) may be used when circumstances are not under the adolescent's control but are nevertheless upsetting. Cognitive interventions could be implemented to challenge and revise inaccurate perceptions of self and others. Social skills (e.g., assertiveness training) could be addressed and practiced in order to increase the quantity and quality of relationships with peers and family members.

Group counselling strategies can be similar to those used in individual counselling, although the opportunity for development and enhance-

ment of external resources may be greater in a group context than in an individual context. In addition, the confrontation of attributional errors may be more potent in group counselling than in individual counselling, when the challenges occur in numbers from peers rather than from the counsellor.

Prevention

Problems associated with the identification of adolescents with depression and with matching existing resources to treatment (Albee, 1985) argue for the implementation of primary and secondary prevention activities (Kazdin, 1993). Current approaches to adolescent mental health promotion focus on either primary or secondary prevention efforts. Primary prevention programs are those programs that are targeted to reduce the incidence of dysfunctional mental health by blocking problems before they begin. Secondary prevention is aimed at reducing the severity of expression in those individuals who have already shown signs of problems (Kazdin, 1993).

Primary Prevention. Primary or "population-wide" preventive interventions target the entire population of adolescents because all adolescents are likely to experience at least some risk factors for depression. The general idea behind primary prevention is to prevent depression before it starts. Helping an entire population of adolescents to develop internal and external resources should help to either prevent the later development of depression or lessen its intensity when those adolescents are confronted with normative and non-normative challenges. Moreover, enhancing resources through primary prevention may place adolescents on a different mental health trajectory, one that emphasizes health and the building of new skills on past successes. Thus, both overall risk as well as incidence of depression can be reduced.

An example of a primary prevention and mental health promotion program is the Penn State Adolescent Study (PSAS) developed and evaluated by Petersen and her colleagues (Petersen, Leffert, Graham, Alwin, & Ding, in press; Rice & Meyer, 1994; Rice et al., 1993). Students were recruited from two successive, randomly-selected cohorts of sixth graders from two Northeast communities ($N = 335$). Approximately half of the students were randomly assigned to intervention and control groups. All subjects underwent extensive assessments of coping, challenge, relationships, and mental health, conducted at multiple points in time throughout the study in order to assess the short-term and long-term effects of the prevention program.

The intervention program occurred over eight weeks in 16 sessions, using a psycho-educational, school-based approach to teaching emotional, cognitive, and behavioural responses to adolescent stressors and challenges. Special emphasis was placed on adaptive ways of coping with

normal levels of distressed affect that are typical reactions to developmental transitions and challenges. The program attempted to intervene by bolstering internal and external resources or buffers to challenge. Each session focused on a particular social skill, coping method, or challenge and began with an activity designed to stimulate the small group (8-12 students) and to have members interact with one another under pleasurable circumstances. Topics were presented in an interactive fashion, with comments from the group consistently encouraged. The main focus of each session was typically an activity (or series of activities) designed to demonstrate the session's topic through experiential activities (e.g., small group problem-solving, cooperative and competitive games). Activities permitted the practicing of specific problem-solving methods (e.g., role playing) and applying those strategies to specific developmental challenges confronted in early adolescence (e.g., peer pressure, making and keeping friends, and problems in the family). Each session closed with an interactive review/discussion of the major points from the session and were linked to subsequent sessions (see Petersen et al., in press, for more specific program information).

The program appeared to improve coping skills but the effects were not apparent one year later. Lasting effects probably are not surprising given all of the changes that occur during early adolescence and the relative brevity of the intervention program. Such results suggest the need for "booster sessions," longer "doses" of initial interventions, or perhaps more systematic infusion of prevention program materials, as in school-based and/or community-based programs, throughout adolescence. The most effective interventions with adolescent behaviour have found that it is important to engage booster sessions as well as to change the environment. (e.g., Leventhal & Keeshan, 1993; Perry & Kelder, 1992).

Secondary Prevention. Activities or interventions that target a specific audience who have been exposed to known risk factors are considered secondary prevention. Examples include a program that targets adolescents for intervention who have at least one parent with a depressive disorder (Beardslee, Hoke, Wheelock, Rothberg, van de Velde, & Swatling, 1992), programs that help young people adjust to the divorce of their parents (Garvin, Leber, & Kalter, 1991; Grych & Fincham, 1992), and programs that attempt to prevent dysphoric mood from becoming severe depression (Clarke, Hawkins, Murphy, Sheeber, Lewinsohn, & Seeley, 1995). Outreach to selected groups represents another set of secondary prevention activities, such as psycho-educational presentations on stress management, test anxiety, and racism, or informational lecture and discussion that increase awareness of services and referral procedures.

In one study of a secondary prevention effort, Clarke et al. (1995) targeted 150 "demoralized" adolescents who reported elevated depressed mood, did not meet criteria for a diagnosis of a major depressive disorder, but were considered at-risk for future depressive episodes. Adolescents were assigned to either a five-week (15 session) prevention course on "coping with stress" or they were assigned to a no-treatment, usual care condition. The program, a modified version of the "Adolescent Coping with Depression Course," was an after-schoool cognitive group intervention that was designed to enhance adolescent coping skills, especially skills that would challenge their depressive mood and cognitions and replace them with more adaptive thoughts (Clarke, Lewinsohn, & Hops, 1990). Sessions were 45 minutes long, three times a week, over five weeks.

Across a one-year follow-up period, Clarke et al. (1995) found fewer cases of mood disorders among adolescents who had experienced the course when compared with adolescents who had not. The incidence of depression among adolescents in the intervention group was one-half that of those young people not enrolled in the intervention. The authors expect, however, that the effects of the intervention will "fade over time;" they also suggest brief "booster" sessions to renew the cognitive techniques presented in the intervention (Clarke, et al., 1995).

Consultation

Consultation is an indirect form of service delivery in that it generally refers to a voluntary, collaborative relationship between two professional or a professional and an interested person (e.g., parent). Consultation in the schools occurs most often between the school counsellor and the teacher or parent with the goal of the collaboration to improve the functioning of a third person (e.g., child) or organization (Conoley & Conoley, 1992; Dustin & Ehly, 1992). Consultation might occur when a teacher suspects that a student is experiencing a depressed affect and the teacher contacts the school counsellor to discuss the situation. The school counsellor would then work toward enhancing the teacher's ability to assess depression, provide intervention, and/or make a referral. (Brown, Pryzwansky, & Schulte, 1995, and Conoley & Conoley, 1992, provide more complete descriptions of consultation models than can be accommodated in the present article. Interested readers might also refer to the special issue on consultation and school counselling in Elementary School Guidance and Counseling, Vol. 26, 1992.)

Consultants often begin by assessing the factor(s) experienced by the consultee that keep him or her from intervening appropriately. Typically, those factors include lack of knowledge, lack of skill, lack of objectivity, or lack of confidence. For example, a teacher may be unaware of gender differences in coping and depression, risk factors for adolescent de-

pression, developmental transitions, normative and non-normative life events, or the roles of internal and external resources in the development of depression. A school counsellor/consultant could provide the teacher with greater understanding of depression in adolescence.

In some approaches to consultation, a thorough behavioural assessment of the problem situation is recommended (e.g., base rates, antecedents, consequences). Consultant interventions then take the form of clearly defined steps, implemented by the consultee and aimed at client behavioural change. For example, members of the school or family system may have observed an adolescent experiencing low self-worth and withdrawing from social situations. The school counsellor could surmise that, through negative reinforcement (avoiding aversive situations), the adolescent is increasingly likely to miss opportunities for potentially pleasurable experiences. Teachers or parents could be instructed to provide the adolescent with positive consequences (e.g., minimal encouragers or verbal praise) for even minimal attempts at social interaction.

Hansen, Himes, and Meier (1990) identified several issues that affect school-based consultation efforts. School counsellors may encounter teachers or parents who are reluctant to engage in consultation. Reasons for such reluctance might include lack of administrative support for consultation, scheduling, transportation limits, reluctance to express vulnerabilities and seek assistance, concern about multiple roles of the school counsellor, or simple lack of awareness that the school counsellor is willing and able to provide consultation. Flexibility in scheduling (e.g., before and after school, or evening availability), brief consultation sessions, in-service presentations on consultation services and procedures, presentations to parent groups in the school or community, and other action-oriented strategies can enhance the school counsellor/consultant's credibility and impact.

The Role of the School Counsellor

There are often many demands for time and expertise placed on school counsellors. Depending upon the school setting, counsellors may be called upon to conduct individual counselling and group counselling, crisis intervention, training, teaching, program development, course scheduling, and a variety of coordination activities. Time and efficiency become highly valued among many school counsellors.

Adolescent depression is likely best treated through a thoughtful set of efforts, perhaps initiated and/or coordinated by a school counsellor. Although individual counselling can help adolescents who are depressed, it also is clear that individual counselling provided by the school counsellor to every adolescent suspected of being depressed will not be in the best interests of any member of the school community. Other effi-

cient and beneficial uses of a school counsellor's time may involve a combination of primary prevention, secondary prevention, and consultation services (Conoley & Conoley, 1992; Kurpius & Rozecki, 1992) such that larger groups of adolescents are served and the responsibility for helping depressed adolescents is shared across the school. Such activities could include in-service presentations to school personnel regarding the identification of depression and interventions that help improve depression (e.g., help increase internal and external resources), curriculum revision and infusion of depression-relevant content in appropriate classes, and small group counselling for students sharing some risk factors.

CONCLUDING REMARKS

Adolescent depression varies in intensity, duration, and severity. Schools and school counsellors in particular should be concerned about adolescent depression because (a) depression can significantly interfere with the learning process, (b) depression is often associated with other emotional and behavioural problems (e.g., anxiety, conduct disorder, eating disorders, substance abuse), and (c) depression is linked to youth suicide.

We have presented a model that places depression in the developmental context of adolescence. Most adolescents manage the challenges of adolescence without significant problems, but others are at-risk for the development of depression based on the presence of one or more factors frequently associated with it. Some adolescents become depressed as a result of experiencing stressful events in the face of lacking the skills necessary to help them cope with those events.

School counsellors can work individually, in groups, and in larger-scale programmatic efforts to help adolescents prepare for difficult situations through the enhancement of internal and external resources. Indeed, given the compulsory nature of education, the time that children spend in school, schools have access to a large number of young people. Schools are uniquely positioned to have considerable opportunity to intervene in, and to prevent, adolescent depression.

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Address correspondence to: Kenneth G. Rice, Department of Counseling, Educational Psychology and Special Education, 440 Erickson Hall, Michigan State University, East Lansing, MI 48824-1034. Electronic mail may be sent via the Internet to kgr1@pilot.msu.edu.