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Difficulties in the Recognition of Adolescent Depression

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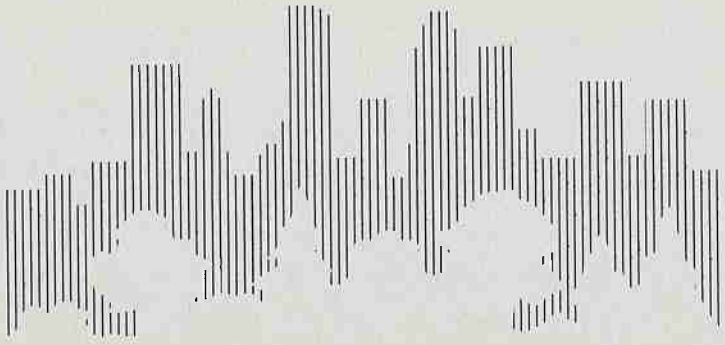

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MASTERS IN SOCIAL WORK THESIS

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Difficulties in the Recognition of Adolescent Depression

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Difficulties in the Recognition of Adolescent Depression

by
Laurel L. Klawitter

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CERTIFICATE OF APPROVAL

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Dedication

This thesis is dedicated to the memory of
Ron Klawitter,
whose presence I still feel in my cheering section.

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There were so many family members and friends who supported me throughout the MSW program and completion of this thesis. I want to express my sincere gratitude...

To Ed Skarnulis, my thesis advisor, whose calm demeanor brought me back to earth when my emotions were flying high.

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Thank you!

ABSTRACT OF THESIS

DIFFICULTIES IN THE RECOGNITION OF ADOLESCENT DEPRESSION

BY
LAUREL L. KLAWITTER

May 5, 1997

Adolescent depression is a significant problem in today's society. Because of adolescent depression's unique symptoms and behaviors, such depression is often difficult to recognize. The purpose of this study was to determine if rural county human service social workers in Minnesota have the skills to recognize adolescent depression. Seventy social workers were polled from six different rural counties in Minnesota. The survey instrument measured the participants' perceptions about the prevalence of adolescent depression, particular behaviors of such depression, and their own skills in recognizing depression in adolescents. The findings of the study indicated that although responding social workers have some knowledge about the different types of behavior presented in adolescent depression, further training may be advantageous.

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I. Introduction : Statement of the Problem

Adolescent depression is a significant problem in today's society. Findings from a study by Allgood-Merton, Lewinsohn, and Hops (1990) reveal an evident increase of depression during the adolescent developmental period and an unusually high prevalence of depressive symptoms as compared with adult samples. Another study completed by Gjerde, Block and Block (1988) reveals that the frequency and occurrence of depressive symptoms increase as individuals pass through puberty. Although causality of adolescent depression is still undergoing research, Rubin et. al. (1992) believe that the increase of depression during adolescence may be due in part to high levels of stress experienced during this developmental period. Adolescents experience normative life changes including the onset of puberty, changes in school expectations, social situations, and increased responsibilities, all of which are confronted simultaneously.

Depression is commonly noted as a precursor to suicide or suicidal ideation. In a study by Carey (1993), statistics are cited showing a sharp rise in adolescent suicide in the past twenty years, and a doubled suicide rate for adolescents just in the past decade.

In addition to the obvious necessity for a proactive approach toward depression to prevent suicide, there are other important implications for further research in the area of depression in adolescents. Adult depression represents a major health problem in society with as much as 20% of the adult population reporting clinically significant manifestations of depression (Siegel and Griffin, 1984). Depressive moods during adolescence may develop into later psychological maladjustment and interpersonal problems in adulthood, according to Gjerde, Block and Block (1988). The depressed adolescent of today may well become the chronically ill adult of tomorrow.

The studies of clinical depression and its manifestations have not historically focused on the adolescent period. Finch, Nelson, and Ott (1993) write that interest in and study of depression in adolescents have increased in the past fifteen years. This increased interest may be stimulated by the prevalence and marked increase of depression in adolescents in the past two decades.

Adolescent depression is a unique clinical entity which differs from depression in adults. Behaviors displayed by depressed adolescents are often different than those exhibited by depressed adults. Adolescents may mask their underlying depressive feelings with unconventional behaviors and symptoms. Such behaviors may conceal depression in adolescents and/or be missed by traditional assessment techniques. According to research conducted by Allen-Meares (1987), customary methods of assessing depression in adolescents with the use of diagnostic criteria for adult depression missed detection of depression in youth by as much as 60%. Ehrenberg, Cox, and Koopman (1990) refer to empirical evidence that supports apparent underdiagnosis of adolescent depression and suggest that this underdiagnosis is due to the fact that, "adolescent depression may be more difficult to recognize than its adult counterpart" (p. 905). Because adolescents may not express depression directly, it must be inferred from other behaviors or symptoms.

Most experts are familiar with conventional depressive symptoms in children and adolescents including feelings of unhappiness or hopelessness, low self-esteem and/or self-deprecation, suicidal ideation, drop in school performance or concentration, social withdrawal, sleep or eating disorders, fatigue, and somatic complaints. However, other behaviors in adolescents are also recognized as possible depressive indicators and may hide depression from those seeking to assess a problem. Delinquent behaviors including conduct disorders, hyperactivity, irritability, truancy, and aggressiveness may be masks for unexpressed depression in adolescents.

Hostile and aggressive behaviors and/or affects may be either attempts to cope with depressed feelings or to react to such feelings, according to a study completed by Gjerde, Block and Block (1988). Undercontrolled behaviors may be, in fact, an attempt to ward off depression. Gjerde, Block and Block (1988) also propose that hostile and aggressive acts may be a precursor to depression by explaining that such behaviors are aversive to others and may elicit negative reactions, resulting in less support or unrealistic or skewed interpretations of others' behaviors.

Aggressive behaviors may be expressed differently according to gender. Hostility in close family relationships was expressed by females with depressive tendencies in the Gjerde, Block and Block (1988) study while males expressed more externalized (delinquent) types of aggression. Although not all adolescents with behavior problems are depressed, it was noted in the Gjerde, Block and Block (1988) study that behavior problems often postdated the onset of depressive symptoms in the subjects studied.

Acting-out is a common type of depressive expression among adolescents. Defiance, antisocial acts, truancy, and underachievement are common masking symptoms of adolescent depression. Irritability, self-deprecation, aggression, diminished socialization, changes in school performance and attitude are listed by Carey (1993) as major depressive symptoms observed in children and adolescents. Other behavioral masks may include restlessness, feelings of consuming boredom, isolation, and emptiness. Allen-Meares (1987) agrees that depression may be camouflaged by conduct disorders and writes that delinquent behaviors including aggression and destruction may be an attempt to combat depressive feelings that threaten to become overt. Such delinquent-type behaviors may motivate parents to seek consultation and professional help for their teen. In turn, consulted professionals may direct their attention to the decrease or elimination of inappropriate behaviors and miss the potential of depression. Subsequent unrecognized adolescent depression may misdirect the energies of

professionals. Intervention efforts designed to modify behaviors may miss the underlying cause of those behaviors.

Direct service social workers in county human service agencies are often the first resource contact in rural Minnesota for adolescents and their families who may be experiencing problems. These social workers often determine the need for further diagnostic processes, out of home placement interventions, and support services to the family unit. The assessment skills of front line social workers are critically important, therefore, in directing appropriate and helpful intervention strategies. Because of the unique manifestation differences between adult and adolescent depression, intervening social workers may not identify the indicators of depression in adolescents and may design case plans or interventions which delay or misdirect effective help.

This thesis explores the complexities of adolescent depression symptoms, the skills of direct line social workers in recognizing those symptoms, and attempts to ascertain whether adolescent depression is recognized and how well help is directed toward the adolescent. It is a beginning attempt to determine the extent to which county social workers are knowledgeable about adolescent depression and its correlates. Direct service social workers working with an adolescent caseload in six randomly selected rural Minnesota county human service agencies were surveyed for this study with a mailed questionnaire. The questionnaire was designed to gather information on the perceptions of the participating social workers as to the prevalence, manifestations and interventions used with depressed adolescents in their caseloads. It also asked participating social workers to personally assess their own training and skills in the area of adolescent depression.

In addition, this thesis was intended to sensitize social workers to the prevalence and unique symptoms of adolescent depression and the need for appropriate and timely interventions for prevention efforts and effective practice.

If a correlation can be found between early identification of depression in adolescence and earlier more effective treatment/intervention strategies, the importance of gaining skills toward the recognition of depression in adolescents should be emphasized. From a proactive perspective, considering the sharp rise in adolescent suicide and the findings that initial depressive episodes increase the likelihood that further episodes will occur and continue into adulthood, further attention needs to be given to the early recognition of depression in adolescents (Allgood-Merton, Lewinsohn and Hops, 1990). In a study completed by Allen-Meares (1987), social workers are urged to expand their knowledge about the risk factors and unique characteristics associated with depression in the adolescent population in order to design effective prevention and treatment interventions.

Skilled and proactive efforts may well prevent the adolescents of today from becoming the chronic adult patients of tomorrow. A greater importance may be placed on the provision of education to direct service line social workers toward the recognition of adolescent depression and appropriate early intervention strategies.

II. Review of Literature

Criteria set for the selection of literature sources to be reviewed for this thesis were the year of publication and relevant topic. The review was limited to 1982 and later, hoping to secure the more contemporary theories, research data, and opinions. Social Work Abstracts (1977 -March 1996) were searched using the key words adolescent, depression, affect, symptoms, and placements in various forms and combinations. As pertinent articles in professional journals were reviewed, other useful resources were identified and reviewed through bibliographical listings. Several texts on the subject of adolescent depression, its symptoms and treatment issues were also critiqued for this study.

Definition

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, (1994), (DSM-IV), categorizes Major Depressive Episode under Mood Disorders. According to the DSM-IV, clinical depression is generally recognized by a group of emotional reactions most usually characterized by sadness, despair, diminished activity, excessive fatigue, and pessimism about the future. Some individuals experience mild, intermittent traits of depression while others experience depressive traits on a more constant and intense level. Other common signs of clinical depression documented among children, adolescents, and adults include negative self-image, change in eating habits, sleep disturbances, difficulties with concentration, and thoughts of suicide (DSM-IV, 1994). Depression in adolescents is often conceptualized in terms of these common, adult based criteria, and as such, symptoms of depression more unique to the adolescent population often go unnoticed (Klein and Wender, 1993).

Although the DSM-IV (1994) does not designate a specific section of criteria for depression in children and adolescents, it does suggest differences under most of the

symptom categories as compared with adult manifestations. Wilkes et al. (1994) address each of the criterion from the DSM-IV and emphasize what they feel are unique aspects of symptoms in adolescents. Beckham and Leber (1995) also address the unique behaviors of adolescent depression and compare, contrast, and substitute these behaviors with the DSM IV criteria. The following list of criteria is taken from the DSM-IV (1994). The list is followed with a summary of aspects of each symptom unique to depression in adolescents.

Criteria for Major Depressive Disorder

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful). **Note:** In children and adolescents, can be irritable mood
(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
(3) significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day, (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

DSM-IV (1994)

Using criteria related specifically to depression in adolescents increases the reliability of a correct diagnosis. Wilkes et al. (1994) address the unique criteria presented by depressed adolescents in the symptom categories specified in the DSM-IV. Also incorporated in comparison with DSM IV criteria are specific behaviors often displayed by adolescents with depression as substitutes for the more conventional manifestations (Beckham and Leber ,1995).

Depressed mood may present itself in adolescents through moody, or irritable affect and may be influenced more by the surrounding environment than adults. These irritable moods may be expressed by oppositionality Beckham and Leber (1995).

Anhedonia (a lack of capacity to feel pleasure in situations normally pleasurable to others), may be expressed in adolescents by the dropping of usual activities such as extracurricular or community sports and activities or the changing of peer relationships. Wilkes et al., (1994) write that total Anhedonia is rare in the adolescent age group, but a marked change in pleasure or interest in activities is often noted. An adolescent previously involved in outside activities may suddenly prefer to stay at home, indicating an expression of loss of interest or energy (Beckham and Leber, 1995). This decreased interest or pleasure may be justified by the adolescent with reasons of age, social group, or other excuses, making this symptom more difficult for the assessor to recognize. A change in peer group is often to one less acceptable to parents, according to Wilkes et al., (1994).

Weight loss/gain is less commonly reported for adolescents than adults. This may be due to the normal fluctuations and rapid growth states in the adolescent

developmental stage. More commonly reported for adolescents is the failure to gain weight rather than a loss of weight. Weights may often fluctuate in teens due to erratic eating patterns or to the development of anorexia or bulimia (Beckham and Leber,1995).

Insomnia hypersomnia may be difficult symptoms to assess in adolescents without knowledge about normal adolescent sleep patterns. Wilkes et al., (1994) write that adolescents normally tend to sleep less during the week and more on the weekends. Initial insomnia (trouble falling asleep) may be rationalized by the adolescent as staying up late for other reasons. Late night hours may result in trouble awakening in the morning.

Psychomotor agitation retardation must be assessed through actions observable by others (e.g., parents or teachers). In order to get an accurate report of this possible symptom, the reporters must have observed the adolescent prior to the depressed state.

In order to determine a symptom of *fatigue,* the assessor must be able to differentiate between what the adolescent considers pleasant or unpleasant activities and not to confuse loss of energy with loss of interest. Wilkes et al. (1994) write that this symptom is commonly expressed by adolescents as a feeling of being bored.

Adolescents may express the symptoms/feelings of *worthlessness* through assertions of being teased, picked on, or called names. He/she may refuse to attend school with the excuse of needing to avoid persecution by peers. Self esteem is generally low and often fragile, (Beckham and Leber, 1995).

Wilkes et al. (1994) write that school performance is an especially reliable measure of depression in adolescents as a drop in school performance may be a result of *decreased concentration.* An adolescent who previously had no trouble in submitting assignments or in completing school work within a designated time period may develop a pattern of incomplete assignments, leading to a drop in grades. Abstract thinking may be slowed, academic performance lowered, and school attendance affected, (Beckham and Leber, 1995).

Morbid ideation suicidal thoughts are readily admitted to by adolescents, according to Wilkes et al. (1994). The adolescent may be preoccupied with music and art relating to death themes, but, unless specifically addressed, parents may not report such tendencies as they may consider such interests to be a normal part of adolescence.

Prevalence

Much of the literature reviewed for this research project focused on the prevalence and noted increase of adolescent depression in the past two decades. The prevalence of depression in adolescents may be difficult to accurately estimate due to the use of different assessment methods, altered criteria, and diverse populations studied, (Beckham and Leber, 1995). Mood disorders, however, have been shown as "... the most common psychiatric disorders of childhood and adolescence" (Beckham and Leber, 1995, p.470). Recent studies (Blackman, 1995) reveal that more than 20% of the adolescent population has emotional problems with one third of this percentage suffering from depression. Despite the difficulty in determining the prevalence of depressive disorder among adolescents, depression is considered to be one of the most prevalent and pervasive concerns for this age group.

Other research addressed an alarming increase in incidents of adolescent suicide. Statistics cited in a study by Carey (1993), show a doubled rate of adolescent suicide in the past ten years. Blackman (1995) writes that the suicide rate for adolescents has increased more than 200% during the past decade and that adolescent suicide is responsible for more deaths in teens than cardiovascular disease or cancer. Ehrenberg, Cox, and Koopman (1990) agree with the increase of depression in the adolescent age group and write, "...suicide rates are increasing at a faster rate for adolescents than for any other age group" (p.905).

Many of the studies compared the prevalence of depressive symptoms found in the adolescent age group with those of other age groups. Allgood-Merton, Lewinsohn,

and Hops (1990) believe that adolescents are substantially more depressed than children and suggest that the adolescent age group may even display more depression than adults. Beckham and Leber (1995) cite a study showing that clinical depression has greatly increased in the past ten years over all age groups and note that the age of onset of the first depressive episode is lowering.

It appears that the frequency and nature of depressive symptoms increase as individuals approach and pass through adolescence and that this increase may be related to other considerable changes faced by adolescents during this developmental period (Gjerde, Block, and Block,1988). The authors critiqued for this research study generally concluded that depression tends to be more common in adolescents than in children, as well as more common in female adolescents than males.

Indicators

Although the adolescent developmental period is normally a time of emotional change and turmoil, clinical depression in adolescents can be distinguished from the normative state. Adolescent depression affects many areas of functioning including behavioral, emotional, somatic, and social domains, indicating the pervasive nature of this disorder. Aside from some similarities of symptoms to adult depression, depression in adolescents contains features which are unique to adolescents and are often shrewdly translated into teen behavior.

Allen-Meares, (1987) writes that research efforts in the area of child and adolescent depression has revealed evidence that despite some similarities of symptoms with those of adults, clinical depression in adolescents contains features which are unique to the adolescent population. Gjerde, Block and Block (1988) agree that adolescent depression is often expressed differently than adult depression and write, "...adolescents sometimes seem to express their underlying depression through behaviors differing from the traditional manifestations of adult depression" (p. 475). Especially in

the past decade, it has been increasingly recognized and accepted that children and adolescents display features that are unique and different that adult-like symptomatology, (Beckham and Leber, 1995).

Some depressive symptoms specific to children and adolescents (Klein and Wender, 1993) include *poor relationships with parents, siblings, and peers* with ongoing states of *irritability and or insatiability*. Disruptions to normal developmental patterns or developmentally regressive types of behavior may be displayed, (Beckham and Leber, 1995) including behaviors such as *excessive demandingness*, increased *childish and dependent behaviors*, and/or the development of *unusual physical complaints* with no medically sound reason (Klein and Wender, 1993). A depressed adolescent may *drop out of usual activities, refuse to attend school,* or *change peer groups* less acceptable to parents (Wilkes et al., 1994).

Depressed adolescents may be more prone to *catastrophizing minor events* than depressed adults and may express a *preoccupation with death* or morbid subjects through music or art. Pervasive sadness, may be personified by the wearing of black clothing, or the writing of poetry or music with melancholy themes. *Sleep disturbances* may be manifest by changes in sleep schedule, (eg. all-night television watching, difficulty getting up for school, then sleeping during the day), (Blackman, 1995). A loss of ability to concentrate may result in a *drop in grades* (Beckham and Leber, 1995). *Boredom* may be expressed as a synonym for feeling depressed. *Changes in eating habits* may be manifested as anorexia or bulimia with fluctuating weights and erratic eating patterns, (Beckham and Leber, 1995). Blackman (1995) lists other indications of depression in adolescence including *poor peer and/or family relations*, *alcohol and drug abuse*, and *promiscuity*. The depressed adolescent may engage in *risk-taking or antisocial behaviors* such as drug use or vandalism (Beckham and Leber, 1995). Rubin et al., (1992) also address possible antisocial behaviors as indicators of possible adolescent depression and include minor acts of *delinquency*, *assaultive* behavior, increased *school absence* and

lowered school performance to common adolescent manifestations of depression. In a study conducted by Rubin et al., (1992), it was concluded that the higher the level of depressive affect, the more likely it would be that lowered school performance and acting out behavior would be manifested. Finch, Nelson, and Ott (1993) agree with the unique symptoms of depression in children and adolescents and add the indicators of *self-deprecation* and *somatic complaints* to the list of symptoms commonly seen in adolescent depression.

Recognition Difficulties

The literature reviewed for this thesis was in agreement that adolescent depression exhibits its own unique manifestations. Adolescence is normally a time of identity problems, mood swings, rebellion, and behavioral experimentation. It is a challenge to the social work practitioner to identify depressive symptoms amid the normal tumultuous behaviors of adolescence.

Teenagers can be oppositional and negative when depressed. They may display inappropriate social behaviors which mask the underlying depression. Depressive symptoms in adolescents "...may be camouflaged by conduct disorders, hyperactivity, emotional problems, consistent periods of sadness, emergence of separation anxiety, refusal to attend school, and suicidal ideation" (Allen-Meares, 1987, p.512). Thus, the recognition of depression in adolescents is complicated by the tendency of depressed youths to develop behavioral problems which may expand into delinquent activities or the use of alcohol and drugs. Delinquent-type behaviors often demand immediate attention and disguise the underlying problem of depression. The unpleasantness of the adolescent's affect or behavior may misdirect the assessor while covering the actual depression.

Lack of assessment techniques and measurements specific to the adolescent age group increases the challenge of detecting depression in this population. Traditional

methods of assessing depression in adolescents (self-reporting with minimal collateral contacts) and/or the use of diagnostic criteria for adult depression may miss depression in youth by as much as 60% (Allen-Meares, 1987).

Because of the difficulties in detecting adolescent depression, much of this depression may go undiagnosed. Blackman (1995), believes that depression in the adolescent age group is greatly underdiagnosed. Eighty four percent of adults who had experienced a depressive disorder in childhood or adolescence developed similar episodes as adults, according to a study cited by Beckham and Leber (1995). Undiagnosed depression in teens may lead into more serious difficulties (eg. school, work, personal relationships) that extend into and affect adulthood.

Correlates and Antecedents

Correlate and antecedent occurrences connected with adolescent depression were addressed in several of the reviewed studies for this thesis. Such occurrences were related to the prevalence of depression in this age group.

Antecedent circumstances placing an adolescent at risk for developing depression include experiences of emotional, physical, or sexual abuse, frequent separation from or loss of a loved one, a family history of depression (especially parental), unwanted pregnancy, low socioeconomic status, issues with sexuality, attention deficit disorder, and chronic illness (Blackman, 1995).

Correlating conditions with adolescent depression include poor peer relations, alcohol and drug abuse, promiscuity, poor school performance, and teenage pregnancy (Allen-Meares, 1987). Experts agree that the presence of any of these risk factors or correlating conditions should alert a social worker or clinician to the need for more in-depth evaluation of the adolescent and his/her situation.

Life Stressors

Stress levels increase during the period of adolescence believed to be brought about by the normative life changes of puberty, changed expectations in school, and increased responsibilities often confronted simultaneously during this developmental period (Rubin et al., 1992). High school students in a public school setting were studied to determine correlates and antecedents of depressive symptoms (Allgood-Merton, Lewinsohn, and Hops, 1990). This study revealed that recent life stressors must be considered in the assessment of possible depression in adolescents. Particularly stressful events occurring at least one month prior to depressive symptoms should be considered in the assessment process. Other studies have also documented the relationship between negative life events and depression in adolescents (Rubin et al., 1992). Relevant life stressors may include the loss of a family member or peer, family conflict, family suicidality, friend suicidality, family illness, family emotional disorder, economic hardship, sexuality issues, and pressure to achieve. Rubin et al.,(1992) stress the importance of the variables of family cohesion and adolescent friendships as supportive mechanisms which may offset possible depression in adolescents. Conversely, family conflict such as increased marital discord or highly expressed and directed criticism toward a particular child or teen is an identified risk factor for the development of depression in adolescents (Beckham and Leber, 1995).

It is important to stress that an event which may seem insignificant to an adult may be very significant to a teenager. The loss of a boyfriend or girlfriend, drop in grades, or family discord may be precipitant to a depressive episode. Most vulnerable to these types of stressors are adolescents who have had other previous experiences with significant stress in their lives. Significant stressors (Blackman, 1995) include parental divorce, physical or sexual abuse, substance abuse, and the suicide of a relative or friend.

Social Environment

Social workers are urged to gather a social and environmental history from both the adolescent and family and to consider antecedent and correlate events and conditions when suspecting possible depression (Finch, Nelson, and Ott, 1993).

The issues of concurrent diagnosis, family history (genetics), medical concerns (head trauma), biological correlates (chemical imbalances), and neuropsychological functioning (cognitive deficits) are also significant considerations in the assessment of adolescent depression (Wilkes et al., 1994). Coexisting psychiatric disorders are very common in adolescents with depression and include conduct disorders, oppositionality, anxiety, phobias, somatic complaints and alcohol and substance abuse, according to Beckham and Leber (1995).

Learning disabilities may be correlate conditions of depression in teens. Lowered school performance and behavioral acting out are also common correlates of adolescent depression (Rubin et al., 1992). Depressed adolescents often become withdrawn from and unpopular among peers "thus decreasing opportunities for social reinforcement and possibly increasing a sense of loneliness" (Robinson, Jenson, and Yaffe, 1992, p. 337).

Self-Esteem

Lack of self-esteem is often associated with adolescent depression. Allgood-Merton, Lewinsohn and Hops (1990) write that body image concerns and feelings of self-consciousness may be either correlate or antecedent states with depression in adolescents. These authors write that "low self-esteem is a strong correlate of depression in adolescents" (p. 60), and that there seems to be greater female vulnerability for self-image deprecation during adolescence. Depression is correlated positively with low self-esteem (Allen-Meares, 1987).

Delinquent Activities

In addition to the indicators of self-consciousness about physical appearance, and loss of interest in activities, the frequent development of delinquent activities (particularly the abuse of drugs and alcohol) is included as a significant correlate to depression in adolescents (Klein and Wender, 1993). An adolescent's use of illicit drugs (possibly an attempt at self-medication) may misdirect an assessor to determine a need for behavioral or chemical dependency intervention rather than treatment for underlying depression (Rubin et al., 1992). An adolescent's participation in antisocial activities and subsequent diagnosis of conduct disorder may well be a correlating condition with depression, (Beckham and Leber, 1995).

Other Considerations

Heredity

Heredity is an important factor to consider in the assessment of adolescent depression (Klein & Wender, 1993). These authors strongly suggest a review of family members for depression or chemical dependency and write that depressive tendencies may skip generations or be displayed at different levels of severity among family members. Klein and Wender (1993) write that if previous generations in the family have members who have experienced depression or manic depression, the tendency for an adolescent to become depressed is increased.

Gender Differences

Allgood-Merton, Lewinsohn and Hops (1990) noted a preponderance of depression in the female adolescent age group in their study of high school students. Beckham and Leber (1995) also write about the difference of prevalence between male and female adolescents and state that although prepubertal boys and girls are equally at risk for depression, females are twice as likely as males to exhibit depression after puberty.

In addition to an increased frequency of depression in female adolescents, gender differences are also noted in the manifestations of depression between male and female groups. A study addressing gender differences in the manifestations of adolescent depression (Allgood-Merton, Lewinsohn and Hops, 1990) revealed that male adolescents express depression in aggressive, externalized types of behaviors. Female adolescents on the other hand, are more likely to have less visible and more inwardly directed behavioral reactions to depression than males. Depressed female adolescents may express depression through feelings of inadequacy or self-dislike (Gjerde, Block and Block, 1988). These authors report that depressed male participants in their study described themselves as aggressive and alienated from their social environment. Depressed male adolescents are most often characterized by hostile, impulsive, and unrestrained behaviors unconventional to the norm.

Depression may also be manifested at different age levels per gender (Rubin et al., 1992). These authors cite study results showing that males reveal depressive symptoms in earlier childhood, that males and females are equal in depressive symptoms at age twelve, and that females show more depressive symptoms in adolescence than males. In this same study a primary identified stressor for females was sexuality, while suicidality in family or friends was a primary stressor for males (Rubin et al., 1992).

Implications for Social Work Practice

Social workers are urged to expand their knowledge about the risk factors and unique characteristics associated with depression in the adolescent population in order to design effective prevention and treatment interventions (Finch, Nelson, and Ott, 1993). To recognize possible depression in adolescents, social workers must be knowledgeable about the unique symptoms exhibited in such depression.

Wilkes et al. (1994) write that even though professionals may expand their knowledge about the symptoms of depression in adolescents, failure to interview the adolescent and parents in a systematic way may lead to an incomplete or erroneous assessment.

In order to accurately assess the possibility of depression in adolescents, many facets of the adolescent's social environment must be explored. Careful interviewing of the adolescent and parents is needed and must include factors of recent stressors, coping styles, family interactions, and age appropriate developmental issues (Wilkes et al., 1994). Beckham and Leber (1995) agree that an in order to achieve an accurate assessment of possible depression, a social history must be gathered from a number of different sources. These authors stress the significance of obtaining information from the adolescent (internal state), parents, (current symptoms and behavior changes over time) and teachers (academic functioning and peer relationships). Klein and Wender (1993), also stress the importance of parental interviewing as, "...parents are quicker to perceive symptoms that the child may fail to recognize, such as poor social functioning, irritable mood, and lack of interest in normal childhood activities" (p.75).

Information, including life stressors (home, school, peers), daily functioning (eating, sleeping), self and family history and future projections, should be gathered from both the parent and teen to obtain a clear picture of the adolescent's functioning from different perspectives (Carey 1993). Blackman (1995) suggests even a wider perspective through collateral contacts including parents, teachers, and community advisors. Blackman (1995) also advises that a family assessment be undertaken to evaluate what supports and resources are available to the family to both prevent and assist with crisis.

Severe behavior problems exhibited by depressed adolescents may misdirect treatment referrals and address conduct disorders rather than depression. Social workers need to be aware that many of the behavioral characteristics of depression and conduct

disorders are similar and difficult to discern from one another. Beckham and Leber (1995) cite a study which revealed that conduct disorder was concurrently diagnosed in 37% of depressed youth and that such conduct disorder, "...typically develops during the depressive episode and persists after the depressive symptoms remit" (p.475).

A social worker's assessment techniques may be lacking in scope to fully examine adolescent problems and needs. Social workers may place too great an emphasis on only one aspect (self-report) when assessing for possible depression in adolescents. Failure to address other facets in the assessment of adolescent depression may lead to missing and identifying a treatable disorder in favor of addressing a developmental or behavioral problem (Wilkes et al., 1994).

Because of gender differences in the preponderance and expression of depression in adolescents. social workers need to be aware of the possibility of misdirected placements or treatments resulting from gender issues. Depressed male and female adolescents may evoke different reactions for the same disorder (Gjerde, Block and Block, 1988). Westendorp, Brink, Roberson, and Ortiz (1986) address variables that may differentiate placements of adolescents into juvenile justice or mental health systems. This study addresses the complex and sometimes overlapping symptoms of depression and antisocial behaviors. The study found that girls who violated socially normal behavior were more likely to be viewed as mentally ill than boys involved in similar activities and more likely to be viewed as conduct disordered. The study also revealed that there was a tendency for families to prefer mental health treatment for females than for males, who were more often referred to the juvenile justice system.

The Westendorp, Brink, Roberson, & Ortiz (1986) study noted that many youth in the mental health systems had also previously been involved with the court systems. Common to both psychiatric and juvenile justice populations were behavioral traits of poor academic performance, previous involvement with the justice system due to

delinquent behaviors, and a history of community adjustment problems (Westendorp, Brink, Roberson, & Ortiz, 1986).

Summary / Gaps in Research

Criteria for clinical depression are commonly adult based with the more unique expressions of symptoms by adolescents often going unnoticed by helping professionals. The correct recognition and diagnosis of depression in adolescents requires the use of criteria specific to the adolescent population. The reviewed literature was in agreement about the increased prevalence of depression among the adolescent population in the past twenty years. Depression is currently one of the most prevalent and pervasive mental health concerns for the adolescent age group.

Although experts agree that adolescent depression is a prevalent problem in today's society, with a significant percentage of the adolescent population displaying symptoms of depression, lack of research on the causality, symptomatology, and prevention of this disorder in adolescents inhibits accurate and expeditious recognition, diagnosis, and appropriate intervention. Only "... in the last fifteen years has there been a noticeable increase in the interest in and study of child and adolescent depression," (Finch, Nelson, and Ott, 1993, p. 289). According to Siegel and Griffin (1984), research is most lacking in the "essential nature" of adolescent depression. Currently the criteria for the diagnosis of depression in adolescents are highly dependent upon research with adults. More research needs to be completed with "age-specific symptomatology or differing criteria for different developmental stages, in order to create a more accurate diagnostic system for children" (Beckham and Leber, 1995). Because of the unique presentations of adolescent depression, it is difficult to discern which findings resulting from research on adult depression are generalizable to adolescents.

Recent research critiqued for this project agreed that despite some similarities with adult depression, adolescent depression displays symptoms which are unique to this age group. Many of these unique symptoms may appear as negative or oppositional behaviors, often masking the underlying depression. Delinquent-type behaviors may demand immediate attention and sway the intervention toward the juvenile justice or chemical dependency system while missing or delaying the need for treatment of the depression. Many of the reviewed literature sources implied that adolescents with depression may be placed in misdirected treatment situations resulting from socially deviant behaviors which are, in actuality, symptoms of depression. Consequently, much of adolescent depression may go undiagnosed and lead to ongoing or more serious difficulties extending into adulthood.

Experts agree that the correct and early intervention of a depressive disorder is a critical first step in the selection of an appropriate treatment model. They also agree on the need for effective interventions to prevent ongoing, escalating symptoms and risk of suicide. Social workers are urged to consider both correlate conditions and antecedent occurrences to accurately assess the possibility of depression in adolescents. Life stressors, social environment , family history, self-esteem, and gender issues all need to be addressed in order to accurately assess for depressive tendencies in adolescents.

Rubin et al. (1992), identified a number of gaps in current literature on various aspects of depressive affect in adolescence. Rubin et al. (1992), write that more research is needed on the impact and importance of negative life events, family and peer relationships and the supportive aspects of these relationships which may act as a buffer to depression.

County human service social workers in rural Minnesota counties may be the initial contact for assessment, referral, and intervention services to an adolescent and his/her family. These workers therefore, are a critical link in directing effective and early intervention for a depressed adolescent.

None of the literature reviewed for this thesis addressed the skills of direct line social workers in the recognition of adolescent depression. Aside from a study by Westendorp, Brink, Roberson and Ortiz (1986), which compared the behavioral variables for placement of juveniles in a mental health or juvenile justice system, no other studies were located that addressed the possibility of misdirected or delayed interventions based on specific adolescent behaviors.

III. Methodology

Research Design

A cross-sectional survey design was used for this research project to assess the skills of rural Minnesota county social workers in the recognition of adolescent depression indicators. A mailed questionnaire was used as the survey instrument to gather data for the project. Both quantitative and qualitative methods were used to establish demographic information, problem prevalence, identification of symptoms, and common interventions used by individual case workers for certain types of adolescent behaviors. The exploration of intervention processes and placement outcomes was attempted through the use of open-ended questions specific to social workers' case experiences with their adolescent clientele. The resulting research project is both exploratory and descriptive.

Study Population / Sampling Method

A random sampling method was used for this research project, involving the initial random sampling of eight rural Minnesota county Human Service Agencies drawn from a potential pool of all rural county agencies in Minnesota. Seventy eight rural Minnesota counties were identified for the entire sampling pool from a listing published by the Minnesota Department of Human Services.

Rural Minnesota counties defined for this project are all counties not included in the nine county metropolitan Twin City area (the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Sherburne, Washington, and Wright). The remaining 78 counties were used for 8 random selections. These eight selections comprised approximately 10% of the total Minnesota rural county human service agencies. (For reasons of expedience and economy all rural county agencies in the state were not surveyed).

The counties originally selected randomly for this research project were: Carlton, Chippewa, Cook, Crow Wing, Isanti, Lake of the Woods, Rice, and Watowan. Two of these counties (Rice and Watowan) are located in the southern 1/3 of Minnesota. Three (Chippewa, Isanti, and Crow Wing) are located in the central 1/3 of Minnesota. Three of the selected counties (Carlton, Cook, and Lake of the Woods) are located in the northern 1/3 of Minnesota.

In addition to differences in location, the average population of the selected counties for this study was compared to the average population of all rural Minnesota counties. The average population of Minnesota's 78 rural counties (taken from the 1990 census) is 26,440. The average population of the counties selected for this research project (also taken from the 1990 census) is 25,400. Thus, the average population of the counties selected for this research project is somewhat lower than the state average. It is also noted that other differences in the features of the sample counties (e.g., number of social workers involved with adolescent services) as compared with rural county features statewide may have limited the generalizability of the gathered data.

Instrumentation

No existing instrument designed to measure skills in the recognition of symptoms of adolescent depression could be located for this project. A survey instrument (questionnaire) was specifically designed to assess skills and common intervention strategies used by county caseworkers for certain types of adolescent behaviors.

Adolescent depression indicators used for the survey instrument were conceptualized from the literature reviewed for this thesis and data gathered through the use of several multiple choice questions with selections based on symptoms of adolescent depression, (see item #14 in Questionnaire in Appendix for example). Other multiple choice questions were included to explore preferred interventions used by respondents

for certain types of adolescent behaviors or case situations and conditions and issues addressed in the initial assessment process (see questionnaire items #9, #10, and #15).

The questionnaire also included an open-ended question (#17) addressing the possibility of delayed diagnosis resulting in delayed or misdirected placement experiences. This was included to explore a possible correlation between expedient recognition and early, appropriate intervention strategies. Several demographic questions were included to determine the respondent's level of education, area of expertise, and years of experience in the adolescent service area. This demographic information was included to assist in the comprehension and description of the sample population.

Prior to distribution to sampled respondents, the questionnaire was pretested by 6 rural county social workers from a non-selected county in rural Minnesota working with an adolescent service caseload. The purpose of the pretest was to gain feedback from respondents regarding clarity, length, and difficulties in completion of the survey. Changes to the content, organization, and structuring of questions in the survey were made based on resulting suggestions by pretest respondents. A sample copy of the questionnaire used for this research project is included in the Appendix section.

Procedures

Initially, a proposal for this research project was submitted to the Augsburg College Institutional Review Board. Because of the anonymity of the survey process, the project qualified for an exempt review. Some suggestions were received from the Review Board regarding the flow and wording of the questionnaire and an inclusion statement of benefits and risks to respondents (Appendix). Changes were made accordingly and final approval received. The Augsburg IRB approval number for this project is: 96-32-1 (Appendix).

Social service supervisors in each of the selected counties were first contacted by telephone to be made aware of the selection of their county, the upcoming survey, and to gain verbal consent for the researcher to conduct such a survey in their perspective county agencies. Each supervisor was asked for verbal consent to continue with the research process involving their agency. The adolescent caseload population was defined as individuals from the ages of 12-18 receiving assessment, referrals, or services from a county human service social worker. An originally projected number of eighty rural county social workers were identified from these supervisors as applicable respondents for the survey.

Each county supervisor was then mailed a consent statement (Appendix), to gain consent in writing for the questionnaires to be mailed to their individual agencies. The consent forms addressed the survey process, timelines, benefits, and risks to participants, and a statement regarding voluntary participation. Following the mailing of the consent statement to county supervisors, two of the selected counties chose not to participate in the survey due to staffing problems. These two counties (Carlton and Lake of the Woods) were eliminated from the process. This sample reduction changed the percentage of the sample in comparison to the statewide data to 8% of total Minnesota rural counties and possible respondents to $n = 70$.

Following the receipt of written consent, questionnaires were mailed to each supervisor to distribute to each applicable respondent employed by their agency. A cover letter on each questionnaire (Appendix) asked for the completion and return of the survey within a designated time period, and informed each respondent of the voluntary nature of participation, anonymity, and risks or benefits to participants. Self- addressed, stamped envelopes were included with each questionnaire. The envelopes were addressed to the work address of the researcher and when received were opened by the researcher's office manager to preserve the anonymity of the respondents.

IV. Presentation of Findings

The purpose of this survey was to determine if rural county social workers recognize the symptoms of adolescent depression and to gather their perceptions about their own training and skills in this area. Because the study was intended to be exploratory and descriptive, limited statistical procedures were used. Seventy questionnaires were mailed to prospective respondents based on initial estimated numbers of applicable social workers from each county's social service supervisor. Thirty two completed questionnaires were returned, producing a return rate of 46% of all originally estimated respondents. Percentages were rounded to the nearest hundredth percentile to determine data from survey questions. The number of persons answering the question will be represented by *n*.

Most of the respondents (n=15) had been employed as social workers from 5-10 years. The next largest group of respondents (n=8) had been employed as social workers from 1-4 years, (n=6) respondents from 11-20 years, and (n=3) respondents for less than one year.

Although there was some variation in the level and area of education of survey respondents, the mode (n=26) of responding social workers had bachelors level degrees in an area of human services with (n=2) respondents with bachelors degrees in areas other than human services. A few of the respondents (n=4) held masters level degrees in either social work (n=2) or another field (n=2).

The average age of adolescents served on responding social workers' caseloads was age 14-16 (mode) (n=21) for male clients and age 14-16 (mode) (n=24) for female clients. The next largest age group served is age 12-13 (n=9) for male, and (n=6) for female, with the smallest group served being 17-18 year olds, (n=1) for male, and (n=2) for female.

Of the social workers responding to the survey:

(Question # 5)

$n = 21$ or 65%	have noted an increase in adolescents with depression during the past five years.
$n = 0$ or 0%	have noted a decrease in adolescents with depression during the past five years.
$n = 5$ or 16%	have noted no change in the prevalence of adolescents with depression during the past five years.
$n = 6$ or 19%	did not respond to question

(Question # 6)

$n = 11$ or 34%	believe that adolescent symptoms of depression are *similar* to adult symptoms of depression.
$n = 21$ or 66%	believe that adolescent symptoms of depression are *different* than adult symptoms of depression.

(Question # 7)

$n = 4$ or 13%	believe that adolescent depression occurs more frequently in males.
$n = 17$ or 53%	believe that adolescent depression occurs more frequently in females.
$n = 11$ or 34%	believe that adolescent depression occurs equally in both males and females.

(Question # 8)

$n = 11$ or 34%	agreed or generally agreed that adolescents as a group are more depressed than adults as a group.
$n = 13$ or 41%	disagreed or generally disagreed that adolescents as a group are more depressed than adults as a group.
$n = 7$ or 22%	were unsure if adolescents as a group are more depressed than adults as a group.
$n = 1$ or 3%	did not respond to question.

(Question #9)

$n = 25$ or 79%	responded that adolescent males were most often placed out of the home for reasons of aggressive, impulsive, or acting out behaviors.
$n = 0$ or 0%	responded that adolescent males were most often placed out of the home for reasons of withdrawn, isolating types of behaviors.
$n = 2$ or 6%	responded that adolescent males were placed out of the home for equal reasons of aggressive or withdrawn behaviors.
$n = 5$ or 15%	responded that adolescent males are most often placed out of the home for other reasons.

(Question #10)

$n =$ 17	or	53%	responded that adolescent females are placed out of the home most often for aggressive, impulsive, or acting out types of behaviors.
$n =$ 3	or	9%	responded that adolescent females are placed out of the home most often for withdrawn, isolating types of behaviors.
$n =$ 7	or	22%	responded that adolescent females are placed out of the home for equal reasons of aggressive or withdrawn behaviors.
$n =$ 4	or	13%	responded that adolescent females are placed out of the home most often for other reasons.
$n =$ 1	or	3%	did not respond to the question

(Question #11)

$n =$ 14	or	44%	agreed that they had received adequate training in the area of adolescent depression's behaviors and symptoms.
$n =$ 14	or	44%	disagreed that they had received adequate training in the area of adolescent depression's behaviors and symptoms.
$n =$ 4	or	12%	were unsure if they had received adequate training in the area of adolescent depression's behaviors and symptoms.

(Question #12)

$n =$ 14	or	44%	agreed or strongly agreed that they had adequate skills in the recognition of depression as it presents itself in the adolescent population.
$n =$ 13	or	41%	somewhat agreed that they had adequate skills in the recognition of depression as it presents itself in the adolescent population.
$n =$ 5	or	15%	somewhat disagreed that they had adequate skills in the recognition of depression as it presents itself in the adolescent population.

(Question #13)

Respondents identified the following as possible correlate or antecedent conditions of depression in adolescents:

$n = 26$	or	88%	**increased stress**
$n = 19$	or	59%	**changed expectations in school**
$n = 16$	or	50%	**increased responsibilities**
$n = 20$	or	63%	**learning disabilities**
$n = 23$	or	72%	**behavioral (delinquent) acting out**
$n = 30$	or	94%	**problematic peer relationships**
$n = 15$	or	48%	**other** (family conflict, chemical abuse, sexuality, ADHD)

(Question # 14)

Respondents identified the following behaviors as possible indicators of depression in adolescents:

$n = 32$	or	100%	**suicidal ideation**
$n = 31$	or	97%	**use of alcohol or drugs**
$n = 30$	or	94%	**feelings of worthlessness**
$n = 30$	or	94%	**self consciousness about physical appearance**
$n = 29$	or	91%	**emotional problems**
$n = 29$	or	91%	**ongoing periods of sadness**
$n = 29$	or	91%	**insomnia / trouble awakening in a.m.**
$n = 28$	or	88%	**lack of interest in normal activities**
$n = 28$	or	88%	**decrease in school performance**
$n = 28$	or	88%	**poor self esteem**
$n = 27$	or	84%	**truancy issues**
$n = 27$	or	84%	**poor social functioning**
$n = 27$	or	84%	**unexplained physical complaints**
$n = 27$	or	84%	**change in eating habits**
$n = 26$	or	81%	**preoccupation with morbidity**
$n = 25$	or	78%	**decreased ability to concentrate**
$n = 24$	or	75%	**feelings of boredom**
$n = 22$	or	69%	**exuberant moods prone to sudden change**
$n = 22$	or	69%	**irritable mood**
$n = 21$	or	66%	**involvement in delinquent activities**
$n = 21$	or	66%	**overreaction to frustrations**
$n = 21$	or	66%	**change to less acceptable peer group**
$n = 21$	or	66%	**separation anxiety**
$n = 19$	or	59%	**increased childish / dependent behaviors**
$n = 18$	or	56%	**conduct disorders**
$n = 13$	or	41%	**hyperactivity / feelings of restlessness**
$n = 12$	or	38%	**excessive demandingness**

(Question # 15)

Respondents address the following issues/areas when initially interviewing and assessing an adolescent and family:

$n = 32$	or	100%	**recent stressors / negative life events**
$n = 24$	or	75%	**coping styles / strategies**
$n = 22$	or	69%	**age appropriate / developmental issues**
$n = 30$	or	94%	**family interaction / communication**
$n = 25$	or	78%	**family history (genetics)**
$n = 29$	or	91%	**peer relationships**
$n = 24$	or	75%	**recent losses (family, peers)**
$n = 19$	or	59%	**economic hardship**
$n = 16$	or	50%	**sexuality issues (not specific to abuse)**
$n = 7$	or	22%	**other** (education, medical, community activity, chemical dep.)

(Question # 16)

Respondents rated the most frequently used interventions (**#1**) to the least frequently used interventions (**#4**) as strategies used in the provision of services to adolescents:

Referral for further diagnostic services:

#1. $n = 20$ or 63%
#2. $n = 11$ or 34%
#3. $n = 0$
#4. $n = 0$

Out of home placements: (mental health treatment emphasis)

#1. $n = 0$
#2. $n = 0$
#3. $n = 8$ or 25%
#4. $n = 18$ or 56%

Out of home placement: (behavioral treatment emphasis)

#1. $n = 1$ or 3%
#2. $n = 1$ or 3%
#3. $n = 6$ or 19%
#4. $n = 18$ or 56%

Support services to the family of origin:

#1. $n = 23$ or 72%
#2. $n = 5$ or 16%
#3. $n = 1$ or 3%
#4. $n = 0$

(Question #16 cont.)

Foster care with support services as needed:

#1. $n = 0$
#2. $n = 7$ or 22%
#3. $n = 17$ or 53%
#4. $n = 6$ or 19%

(Question #17)

$n = 18$ or 56% of responding social workers stated that an adolescent on their caseload had been placed in a correctional / behavioral type of placement, and after residing in that placement for a period of time, had received a diagnosis of depression.

$n = 3$ or 9% responding social workers added that behavioral placement/treatment prior to a diagnosis of depression was a frequent or common occurrence in their experience with adolescents.

** Length of placement prior to diagnosis of depression ranged in case experiences from 1 week to 5 months.

The average (mean) length of placement in such cases from this survey was 28 days.

The results of this survey seemed to produce some common themes most of which are positively comparable to the reviewed literature. To explore these themes more closely, questions will be grouped into categories in the following chapter, each category's properties explored in more depth and connections made with relevant theories.

V. Discussion

Social workers employed by rural county human service agencies are often the first contact for rural families seeking assistance with their teen. These workers may first complete an initial assessment and then develop a plan to implement support or intervening services to aid the family. Because of the complexities and sometimes unique nature of the symptoms and behaviors of adolescent depression, assessing social workers may be misled in their assessment of the problem. In cases of inappropriate or delinquent displays of behavior, attempts may be made to decrease or eliminate the behavior and miss the potential underlying cause of depression.

The survey for this research project was completed as an attempt to assess whether rural county social workers recognize the behaviors and symptoms of adolescent depression and to get their perceptions of the prevalence of adolescent depression in their caseload populations. Responding social workers were also asked to self-assess their professional training and skills relating to the recognition of depression in teens.

The majority of responding social workers employed by the agencies sampled had been employed as county social workers from 5-10 years and held bachelor level degrees in the area of human services. These social workers also responded that the majority of adolescents served on their caseloads for both males and females were in the 14-16 yr. old age group.

Awareness / Prevalence

Several questions on the survey addressed the perceptions of social workers regarding the increase, stability, or decrease of identified cases of adolescents with depression during the past five years. These questions also addressed the respondent's awareness of the prevalence of depression in the adolescent age group as compared with the adult population, and females in comparison with males. Past research has shown that the propensity for the development of depression increases as an individual passes

through adolescence (Gjerde, Block & Block, 1988), and that the adolescent age group, as a whole, is more depressed than the adult age group (Allgood-Merton, Lewinsohn, and Hops, 1990). Also noted in past research is a preponderance of depression in the female gender as compared to males (Beckham & Leber, 1995)

Over half, (65%) of the survey respondents noted that they had perceived an increase of adolescents with depression during the past five years. This response may be an indicator that social workers have become more sensitized to the prevalence of depression in adolescents. In responding to comparison of depression prevalence with the adult population, the majority of respondents (41%) disagreed that adolescents as a group are more depressed than adults as a group. Another (22%) responded as being unsure about this factor. A slight majority of participants (53%) correctly identified that depression occurs more frequently in adolescent females rather than males. It appears, therefore, that although respondents are aware of the increase of adolescents with depression on their service caseloads, they are not particularly aware of the propensity of possible depression in age or gender groups.

Familiarity with Indicators

Two questions included in the survey addressed the unique symptoms and specific behaviors possible in adolescents with depression. Research is in agreement that adolescents with depression exhibit many unique behaviors that differ from adults with depression (Wilkes et al., 1994). A majority of responding social workers (66%) believe that adolescent symptoms of depression are different than adult symptoms of depression. This response indicates that most of the survey's participants are aware of the differences in the display of depressive behaviors between these two age groups. It should also be noted, however, that respondents selected the more conventional indicators most frequently on a choice of possible depressive behaviors listed on the survey. These more commonly recognized indicators; emotional problems, sadness, suicidal ideation, insomnia, self-doubt, and use of alcohol or drugs all received over a 90% response as an

indication of possible depression. The more unconventional indicators of depression specific to adolescents; conduct disorders, hyperactivity/restlessness, and demandingness were not as widely recognized. This may indicate that some of these inappropriate social behaviors may indeed misdirect or distract attention from underlying depression.

Correlate and Antecedent Conditions

One question in the survey asked respondents to identify possible antecedent or correlating conditions with adolescent depression. The intent of this question was to determine if such conditions would alert social workers to risk factors leading to depressive tendencies during the assessment process. Several antecedent occurrences (abuse, loss, family stress, etc.) are believed to place adolescents at a greater risk for the development of depression, (Blackman ,1995), and correlating conditions (substance abuse, truancy, peer problems, etc.) should alert a social worker to the need for more in depth evaluation of the possibility of depression (Allen-Meares, 1987). Most participants identified problematic peer relationships (94%) as a condition which would alert them to the possibility of depression in teens. Increased stress was another correlating or antecedent condition largely recognized by respondents (88%). Least recognized by respondents as correlating or antecedent conditions of depression were changed expectations in school (59%) and increased responsibilities (50%). Participants responding to the open-ended portion of this question also identified the conditions of family conflict, chemical abuse, sexuality issues, and attention deficit disorder as possible corresponding or preceding events in relation to adolescent depression. The overall response to this survey question indicates that responding social workers are generally knowledgeable about the risk factors and correlating circumstances for adolescents with depression.

Issues addressed during Assessment

Social workers were asked to identify the issues they most often addressed during the initial assessment of an adolescent and his/her family. Such an assessment is the

beginning process toward acquiring an understanding of a problem, determining the nature and cause of a problem, and developing a plan to minimize or resolve a problem. Experts advise social workers to explore many different facets of the adolescent's social environment in the assessment for possible depression, Wilkes et al. (1994). All of the survey's responding social workers (100%), identified a need to address recent stressors and negative life events as important to the initial assessment process. Other largely agreed upon areas for inclusion in initial assessment were family communication (94%) and peer relationships (91%). Least identified by respondents as issues covered during an initial assessment were the areas of economic hardship (59%) and sexuality issues not specific to abuse (50%). According to this the survey, therefore, it seems that participating social workers generally conduct assessments addressing a holistic view of the adolescent and family in a larger, systems type of context as recommended by previously discussed research.

Common Interventions

Several survey questions asked respondents to identity their most frequently used interventions when working with an adolescent and family. They were also asked to identify what type of behavior displayed by adolescents (both male and female) resulted in an out of home placement intervention. These questions were designed to determine if socially inappropriate types of behaviors (e.g., aggressive, impulsive) resulted in *behavioral* treatment plans with a possible misunderstanding of the behavior's base (depression). The questions were also designed to determine if similar types of inappropriate behavior may result in different placement situations or interventions influenced by the client's gender (Westendorp, Brink, Roberson, & Ortiz, 1986). Respondents identified support services to the family of origin (72%) as their most commonly used intervention in the provision of social services to adolescents. The next most commonly identified intervention was a referral for further diagnostic services (63%). Least identified as frequently used interventions were out of home

placements for either *mental health* or *behavioral* treatment emphasis. Only 6% of respondents chose an out of home placement with a behavioral emphasis as their first or second intervention choice and none of the respondents chose an out of home placement with a mental health treatment emphasis as either their first or second choice for social service intervention. It is encouraging to note from these survey results that responding social workers tend to seek further diagnostic opinion prior to any type of out of home placement.

In regard to interventions applied to like behaviors displayed by both male and female groups, a large majority of the respondents (79%) identified that adolescent males were most often placed out of the home for reasons of aggressive, impulsive, or acting out behaviors. None of the respondents reported that males were most often placed out of the home for withdrawn, isolating types of behaviors. It should be noted that 15% of the respondents identified other reasons for the out of home placements of males (e.g., chemical dependency, truancy, delinquency) and that these behaviors, previously discussed in the reviewed literature section, may also be linked to adolescent depressive tendencies, (Klein and Wender,(1993), and Rubin et al., (1992). In responding to female adolescents, social workers also identified aggressive, impulsive behaviors as the primary reason for out of home placements (53%). Nine percent of the respondents stated that females were placed out of the home primarily for reasons of withdrawn, isolating types of behaviors and 22% responded that females were placed out of the home for equal reasons of aggressive and withdrawn behaviors. Again, other reasons listed by responding social workers (13%) for out of home placement (running, chemical use, family conflict) may also be compared with reviewed literature as internal types of behavioral expression of depression in female adolescents.

Possible Misdirected Services

One question on the survey asked respondents if an adolescent on their caseload had ever been placed in a correctional / behavioral type of placement, and , after residing

in that placement for a period of time, had received a diagnosis of depression. Over half (56%) of the participating social workers responded positively to this question. Nine percent of responding social workers added that this experience was common and frequent in their caseloads.

Social workers were also asked to comment on the length of time of the behavioral placement prior to the diagnosis of depression with an adolescent client. Length of such placements, as reported by respondent's experiences, ranged from 1 week to 5 months with the average length of stay of all reported cases being 28 days. This two part question was a beginning attempt to determine a possible correlation between undiagnosed depression in adolescents and misdirected and/or delayed treatment services. Although this correlation was not adequately addressed in this research project to imply any significance, it certainly warrants further study.

Training and Skills in the Recognition of Adolescent Depression

Finally, two questions on the survey were designed to gauge participant's perceptions of their own training and skills in the recognition of adolescents with depression. Responding social workers were split in their response to both of these questions. Less than half (44%) of the participants *agreed* that they had received adequate training the area of adolescent depression's behaviors and symptoms with (57%) of the respondents being either *unsure* or *disagreeing* that they had received adequate training. In comparison, 44% of respondents *agreed or strongly agreed* that they possessed adequate skills toward the recognition of depression as it presents itself in the adolescent population. An additional 41% *somewhat agreed* that they had such adequate skills with 16% only *somewhat disagreeing* that they possessed such skills. Based on the response to this question, it appears that of the surveyed respondents, additional training in the recognition of adolescent depression would be beneficial. There is some confusing discrepancy between the response to adequate training and adequate skills. Possibly,

many of the respondents have gained their skills in the recognition of adolescents with depression through job experience rather than training. It is noted that social desirability may be a limitation to the question regarding the self assessment of skills.

Limitations

This research project examined only a small percentage (less than 10%) of rural county human service agencies in Minnesota making the external validity and generalizability of gained data quite low. The study is also limited by the return rate of the questionnaire (less than 50%). The percentage of unpolled social workers could have changed the results significantly. It is also recognized that the design and administration of the questionnaire itself may have limited this study. Because the questionnaire was designed by the researcher for this specific project, there are no data or tested validity on the measurement used.

Other limitations are noted by the use of a self-administered measurement instrument which may be swayed by social desirability factors and lack of more qualitative insight into actual assessment processes and/or direct service provision of social workers in their perspectives. This study did not address variables which may affect interventions or service provision such as case load size, varied job duties and responsibilities other than services to adolescents, or available community support and resources in each county agency. It is recognized, therefore, that the results of this research project are very limited, not statistically significant, and would benefit from further and more in depth research in order to be generalizable to the larger population of rural county human service agencies.

VI. Summary

The findings from this study, though not generalizable to all rural counties in Minnesota, have provided myself, and hopefully other social workers who may read this thesis with a greater awareness and understanding of depression as it presents itself in the adolescent age group. As a former rural county human service social worker, I believe that I have personal insight into the dilemma of expectations of service provision to a wide variety of clientele, problems, and issues with general social work knowledge, limited resources, and little specialization in any particular area. Nevertheless, rural county social workers are a critical part of the social service process to rural families, often completing initial assessments and planning and directing future services and interventions to an adolescent and his/her family.

Perhaps the completion of the questionnaire through the survey process evoked thought, produced discussion, or sensitized participating social workers to adolescents with depression.

It is my hope that future research and attention will be given to the subject of depression in adolescents and that such continued study will result in more accurate assessment tools and techniques, earlier recognition, and subsequently more expedient and effective methods of intervention and treatment.

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Questionnaire

A Study of the Difficulties in the Recognition of Adolescent Depression

Do not put your name or any other identifying information on this survey. Please return it in the enclosed self-addressed, stamped envelope as soon as possible, and no later than **March 14, 1997**.

1. I have been employed as a social worker for:

___ less than one year
___ 1-4 years
___ 5-10 years
___ 11-20 years
___ more than 20 years

2. My level of education is:

___ Bachelors level (human service field)
___ Bachelors level (other field)
please specify _____
___ Masters level
please specify _____
___ other
please specify _____

3. The average age of adolescent males on my present caseload is:

___ 12-13
___ 14-16
___ 17-18

4. The average age of adolescent females on my present caseload is:

___ 12-13
___ 14-16
___ 17-18

5. During the past five years, (please choose one)

___ I have noticed an increase in the diagnosis of adolescents with depression in my caseload.
___ I have noticed a decrease in the diagnosis of adolescents with depression in my caseload.
___ I have noticed no change in the prevalence of adolescents with depression in my caseload.
___ I have not worked with the adolescent service caseload for five years.

6. **Please choose one:**

___ Adolescent symptoms of depression are *similar* to adult symptoms of depression.
___ Adolescent symptoms of depression are *different* than adult symptoms of depression.

7. **In my opinion / observation, adolescent depression occurs more frequently:**

___ in males
___ in females
___ equally in both males and females

8. **Adolescents, as a group, are more depressed than adults as a group.**

___ agree
___ generally agree
___ generally disagree
___ disagree
___ unsure

9. **Adolescent males in my caseload are most often placed out of the home for reasons of: (please choose one)**

___ aggressive, impulsive, or hostile acting out behaviors
___ withdrawn, isolating types of behaviors
___ equal placement for both types of behaviors
___ other (please specify) _____

10. **Adolescent females in my caseload are most often placed out of the home for reasons of: (please choose one)**

___ aggressive, impulsive or hostile acting out behaviors
___ withdrawn, isolating types of behaviors
___ equal placement for both types of behaviors
___ other (please specify) _____

11. **I have had adequate training in the area of adolescent depression behaviors and symptomatology.**

___ agree
___ unsure
___ disagree

12. I feel that I have adequate skills in the recognition of depression as it presents itself in the adolescent population.

___ strongly agree
___ agree
___ somewhat agree
___ somewhat disagree
___ disagree
___ strongly disagree

13. Please choose which of the following you believe may be preceding or related conditions of depression in adolescents: (check all that apply)

___ increased stress
___ changed expectations in school
___ increased responsibilities
___ learning disabilities
___ behavioral (delinquent) acting out
___ problematic friendships / peer relationships
___ other (please specify) _____

14. Please choose which behavior/s would alert you (as the primary social worker) as possible depressive tendencies in adolescents: (check all that apply)

___ hyperactivity/ feeling of restlessness
___ emotional problems
___ ongoing periods of sadness
___ conduct disorders
___ separation anxiety
___ truancy issues
___ suicidal ideation
___ irritable mood
___ poor social functioning
___ lack of interest in normal activities
___ change in eating habits
___ change to less acceptable peer group
___ insomnia / trouble awakening in the a.m.
___ feelings of boredom
___ other (please specify) _____

___ feelings of worthlessness
___ decreased ability to concentrate
___ decrease in school performance
___ excessive demandingness
___ increased childish/dependent behaviors
___ unexplained physical complaints
___ preoccupation with morbidity
___ overreaction to frustrations
___ involvement in delinquent activities
___ exuberant moods prone to sudden change
___ poor self-esteem
___ self-consciousness about physical appearance
___ use of alcohol or drugs

_____

15. **When initially interviewing and assessing an adolescent and family, issues/areas which are always addressed are:** (check all that apply)

___ recent stressors / negative life events
___ coping styles / strategies
___ age appropriate / developmental issues
___ family interaction / communication
___ family history (genetics)
___ peer relationships
___ recent losses (family, peers)
___ economic hardship
___ sexuality issues (not specific to abuse)
___ other (please specify) _____
___ other (please specify) _____

16. **On a scale of 1-4 with 1 as the most frequently occurring intervention and 4 as the least frequently occurring intervention, please rate the following intervention strategies used in your service provision to adolescents in your caseload:**

___ referral for further diagnostic services
___ out of home placements (mental health treatment emphasis)
___ out of home placements (behavioral treatment emphasis)
___ support services to the family or origin
___ foster care with support services as needed
___ other (please specify) _____

17. **Has an adolescent on your service caseload ever been placed in a group home or other correctional/behavioral type of placement, and after residing in that placement for a period of time, received a diagnosis of depression?** ***(please feel free to elaborate)***

_____
_____
_____

If so, approximately how long (days, weeks, months) was the adolescent/s placement in the above described setting prior to the diagnosis of depression?

_____

Thank you!!

(Please return this survey in the attached self-addressed, stamped, envelope by March 14th!)

AUGSBURG

C•O•L•L•E•G•E

DATE: January 14, 1997

TO: Laurel L. Klawitter
Rt. 1, Box 56B
Hector MN 55342

FROM: Rita R. Weisbrod, Ph.D.
Chair
Institutional Review Board
(612) 330-1227 or FAX 330-1649.

RE: Your IRB application: "Difficulties in the Recognition of Adolescent Depression"

Your application qualifies for exempt review under category 2 because it is an anonymous survey. Therefore, I have reviewed it as chair and approve it with the following conditions:

1. You need to revise your letter to the social workers who respond to your survey using the format that you used in the letter to agency supervisors. Your letter **to respondents** should also include a statement of benefits and risks; confidentiality assurances (no one at your agency will know whether you participated or not) and data handling/destruction procedures. See the sample letter in the application packet (p. vii). A statement of consent is not relevant here except your last sentence may be included in your letter (..."By completing and mailing.....").

2. Do you really intend to send a full copy of your thesis to any respondent or agency supervisor who requests one? The cost could be prohibitive to you! I suggest you promise a summary of results instead. Please clarify this point.

3. You need to specify procedures/directions on your survey itself: "Do not put your name or any identifying information on this survey. Please return it in the enclosed self addressed envelope."

4. You do not indicate whether or not you are paying postage for return of surveys. To what address will surveys be returned? I recommend against use of your home address because of privacy issues; also, it appears more professional to have an organizational/non-personal address. If you wish to use an Augsburg College Box, please let me know and I will assign you a box number.

I have the following suggestions and questions about your project:

1. The flow in your survey seems hard to follow: some questions relate to caseload characteristics in general and other questions to depression. Perhaps you need to reorganize so that these two areas are not inter-mixed.

2. Question 15 appears to me to difficult to answer in general. Perhaps you want to change the format or wording. For example, you might asks which of these areas the caseworker always/sometimes/rarely addresses. Also, I don't understand question 14. "Our caseload...?"

Please reply to me in writing with your changes so that final approval of your project can be given. I will make every effort to respond in time for you to meet your deadlines!

Copy: Edward Skarnulis, Thesis Advisor

AUGSBURG

C • O • L • L • E • G • E

January 31, 1997

TO: Laurel Klawitter
Rt. 1, Box 56B
Hector MN 55342

FROM: Rita R. Weisbrod, Ph.D.
Chair, Institutional Review Board
Augsburg College
2211 Riverside Avenue
Minneapolis MN 55454
(612) 330-1227 OR fax (612) 330-1649

RE: Your IRB application: "Difficulties in the Recognition of Adolescent Depression"

I have received your changes on January 28 and am pleased to report that your application is now approved. Your Augsburg IRB approval number is:

96 - 32 - 1.

This number should appear on all participant-related material.

If there are substantive changes to your project which change your procedures regarding the use of human subjects, you should report them to me in writing so that they may be reviewed for possible increased risk.

Good luck to you on your project!

Copy: Edward Skarnulis, Thesis Adviser

Transitions Learning Center
800 Grove St. So.
Hutchinson, MN 55350

_____, Social Service Supervisor
_____County Human Services
_____
_____

Re: Survey Participation

Dear _____,

As discussed in our earlier phone conversation, your agency is invited to participate in a *research study on the difficulties in the recognition of depression in adolescents.* Your agency was randomly chosen for this cross-sectional survey from a listing of all Minnesota rural county Human Service agencies published by the Minnesota Department of Human Services.

This study is being conducted by myself, Laurel Klawitter, a graduate student in the Department of Social Work at Augsburg College. This study is being conducted in partial fulfillment of the requirements for a master's degree in social work as part of my master's thesis.

The purpose of this study is to determine if rural county social workers note an increase in depression in adolescents, feel they have the skills to recognize the symptoms of such depression, and if delayed diagnosis of depression has resulted in delayed or misdirected service interventions.

Procedures

If you agree that your agency's adolescent service social workers may participate in the study, I would ask you to do the following:

** Read, sign, and return to me the following consent statement. (A self-addressed, stamped envelope is enclosed).
** Distribute the questionnaires (which will be sent to you upon receipt of your consent statement) to all social workers at your agency that work with adolescents. A cover letter will be attached to each questionnaire explaining the survey and asking for the return of completed questionnaires by **March 14, 1997.**

Risks and Benefits regarding Study Participation

There are no identified risks or direct benefits or compensation for participating in this study. Upon your (or any participant's) request, a summary of the completed study's findings will be made available.

Confidentiality

All data received from this study will be kept private. Research raw data (completed questionnaires) will be accessible only to the researcher, will be kept in a locked file, and will be destroyed 12-31-97.

Voluntary Participation

Your agency's decision whether or not to participate will not affect current or future relationships with Augsburg College or any other cooperating organizations. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contacts / Questions

The researcher conducting this study is Laurel L. Klawitter, L.S.W. Questions before or after consenting to participation may be directed to the researcher at # (320) 587-1157.

Ms. Klawitter's thesis advisor is Edward Skarnulis, PhD. He is also available for questions and may be reached at the Dept. of Social Work, Augsburg College, #(612) 330-1759.

Statement of Consent

I have read the preceding information, asked questions, and received answers. As an administrator / supervisor of _____, I give my permission for agency staff to participate in the described study. I also agree to distribute forthcoming questionnaires to all adolescent services social workers employed by our agency.

(name of county agency)

_____

Supervisor's signature

(Please feel free to keep a copy of this form for your records)

Thank you!
Your cooperation is greatly appreciated.
Laurel L. Klawitter, L.S.W.

February 1997

Dear Colleague,

As a portion of my graduate studies at Augsburg College in Minneapolis, MN, I have chosen to complete a limited study and analysis on the difficulties in the recognition of adolescent depression. Your county was randomly chosen as one of eight rural counties in Minnesota to participate in this cross-sectional survey.

I am interested in your opinion and experience as a social worker providing services to adolescents and their families in rural areas of Minnesota. Your participation in and contributions to this survey is completely anonymous and has been pre-approved by your agency's supervisor.

Procedures

If you agree to participate in this study, we would ask you to do the following:

** Complete the attached questionnaire
** Return the completed questionnaire in the self-addressed, stamped envelope by **March 14, 1997.**

Risks and Benefits regarding Study Participation

There are no identified risks or direct benefits or compensation for participating in this study. Upon your request, a summary of the completed study's results will be made available. (Anticipated completion date: May 1997)

Confidentiality

All data received from respondents will be kept private. Completed questionnaires will be available only to the researcher, kept in a locked file cabinet, and destroyed by 12-31-97. No one at your agency will know if you participated in the survey or not.

Voluntary nature of the study

Your decision whether to participate or not will not affect your current or future relationships with Augsburg College or with any other cooperating organizations.

Contacts and Questions

If you have any questions prior to or during the completion of the survey, please feel free to call the researcher (Laurel Klawitter) at # (320) 587-1157 (daytime) or (320) 848-2511 (evening) (callers are asked not to identify themselves).

Ms. Klawitter's thesis advisor is Edward Skarnulis, Ph.D.., Professor in the Dept. of Social Work, Augsburg College. He is also available for questions and can be contacted at (612) 330-1759.

In the interest of contributing to the knowledge base of the social work field, and the success of this survey, please take about **20 minutes** from your already busy schedule to complete the attached questionnaire.

By completing and mailing the questionnaire, you will have given your consent to participate in this study.

Thank you for your willingness to complete the survey.

Laurel L. Klawitter
MSW Student
Augsburg College