ADOLESCENT DEPRESSION AND SUICIDE

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ADOLESCENT DEPRESSION AND SUICIDE

A Comprehensive Empirical Intervention for Prevention and Treatment

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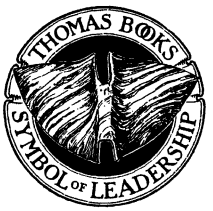

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PREFACE

Within the past decade a considerable effort has been made to assimilate information and explain causes of two of the most difficult problems facing America today–adolescent depression and possible subsequent suicide (Harrington & Clark, 1998). Following accidents while intoxicated and homicides, suicide is the third leading cause of death in the 15- to 24-year-old age group (CDC, 2001; National Center for Health Statistics, 1983). The adolescent population is at greatest risk in regard to suicide, and the risk is increasing (McKeown, Garrison, Cuffe, Walker, Jackson, & Addy,1998). Between 1960-1980, the suicide rate rose from 5.2 to 12.3 per 100,000 for this age segment accounting for a 136% increase. The rate is increasing most rapidly for white males, who account for 73% of all teen suicides (CDC, 2001).

Adolescence is a time of growth, stress, and change. This developmental stage affects not only the adolescent but his or her family as well (Gould, Shaffer, Fisher, & Garfinkel, 1998). Adolescents, while in the natural process of establishing autonomy and identity, begin to separate from parents and experiment with a variety of behaviors and lifestyle patterns (Botvin, 1983). It is during adolescence when the relative importance of family and peers begins to shift. The peer group becomes more central for the adolescent, and the adolescent begins to rely more heavily on peers for support, security, and guidance (Belsky, Lerner, & Spanier, 1984; Kandel & Davies, 1991). Establishing peer relationships and peer acceptance are the hallmarks of adolescence, and the need to gain acceptance, approval, and praise is greater during adolescence than at any other time in life (Morrison, 1985).

Traditionally, adolescence has been portrayed as a carefree period in the life span, when enjoyable times are had by all. In reality, however, the transition from childhood to adulthood is fraught with psychological, sociological, and physical changes (Elkind, 1984a, 1984b; Kaslow, Deering, & Racusin, 1994). The Surgeon General's Report (Satcher, 2000) indicates that an alarming one in five children suffers from mental illness! Included in this statistic are the many children and adolescents who suffer from clinical depression who are not diagnosed as suffering from a mental disorder until a serious event, such as a suicide attempt, occurs (Satcher, 2000). The rela-

tionship between depression, suicide, and drugs must be considered, because drugs play a major role in increasing the risk of suicide and even homicide.

Assessment

To effectively intervene to prevent depression in youth, comprehensive assessment must precede the intervention. Standardized assessment instruments should be used to assess and diagnose the youth and his or her family. A complete assessment must include evaluation of the youth's behavior at home, in school, and in the community. Multiple sources should be used to compile a complete profile of a youth's functioning. It is essential that youth be evaluated for disorders and difficulties that are usually correlated with depressed behaviors. These include mood and anxiety disorders, ADHD, substance abuse, learning difficulties and cognitive deficits, peer rejection, and poor social and coping skills. It is necessary to develop assessment and comprehensive empirically appropriate interventions for youth with comorbid behaviors, because comorbidity increases the probability of suicide and other deviant behaviors.

Communities must look for more effective and efficient ways to identify and help youth who are at risk of becoming depressed. Because many causes exist for youth depression and system deficiencies, support is growing for integrated service delivery systems. Community assessment centers show promise in overcoming the obstacles that contribute to inefficiency and ineffectiveness in assessment and the continuum of care (Oldenettel & Wordes, 2000).

Intervention

The problems encountered with assessment and the heterogeneous characteristics of youth continue to pose difficulties when it comes time to intervene to prevent youth depression. No one intervention can be used for every youth, because youth are so diverse (Thyer & Wodarski, 1998). Assessment knowledge with specific empirical guidelines to assign youth to appropriate interventions is lacking. Empirically based programs have been deemed promising and will require further investigation to determine their effectiveness.

Prevention

The prevention approach to intervention has implications for the traditional role of practitioners and for the timing of the intervention. The prevention approach places major emphasis on the teaching components of the intervention process (Wodarski & Bagarozzi, 1979; Wodarski & Thyer, 1998). Social workers attempt to help clients learn how to exert control over their

own behaviors and over the environments in which they live. Practitioners do not take a passive role in the intervention process. Instead, they use their professional knowledge, expertise, and understanding of human behavior theory and personality development in the conceptualization and implementation of intervention strategies. Since their training equips them to evaluate scientifically any treatment procedure they have instituted, there is continual assessment of the treatment process.

Prevention is especially appropriate in dealing with the problems of the adolescent. It provides an early developmental focus for intervention, which may forestall development of future problems. These problems usually intensify later and become harder to alter. Prevention provides a view of the person that is optimistic. The approach is mass oriented rather than individual oriented, and it seeks to build health from the start rather than to repair.

Schools and Peers

Because young people spend most of their time in a school setting, the school system seems to be a natural forum for imparting knowledge and implementing change (Wodarski & Wodarski, 1995). The school setting is a natural link between parents, youngsters, and the community. Educational and preventive programs can be started early to install positive attitudes regarding conflict resolution and substance abuse. Teachers and staff who teach and exhibit these attitudes and behaviors can be positive role models for the youth with whom they work.

The ideal program should have two foci. First, the information transmission approach to provide basic knowledge and awareness, and second, the responsible decision approach that will teach youngsters the basic coping and decision-making skills (Schinke & Gilchrist, 1984). Programs must take advantage of peer pressure in a positive manner. To be nonjudgmental and to develop self-esteem in these vulnerable youths are goals of utmost importance and urgency. In program planning there is a need for youth to provide input regarding what they feel are their greatest stresses; programs need to directly address these issues.

The evidence suggests that intervention and prevention programs need to begin early, need to intervene on many levels, and need to give youngsters specific skills to learn and to use in their environment. The expansive efforts needed to begin such programs will be worth the almost inconceivable benefits.

This text identifies tools appropriate for assessing adolescent depression and substance abuse. The text also illustrates a short-term research-based group outpatient intervention package for the treatment of adolescent depression and prevention of possible subsequent suicide. The treatment factors are depression intervention and substance abuse intervention. The family factor which supports behaviors adolescents learned in groups is included, because accumulated research supports inclusion of the family.

The Teams-Games-Tournaments (TGT) technique has been presented here as an appropriate, effective educational approach that intervenes with young people, their families, and the community to reduce adolescent depression. This cognitive-behavioral group method focuses on helping youngsters make responsible decisions regarding depressive behaviors and substance abuse. In addition, the TGT program emphasizes education of parents about problem solving and communication. This program is realistic and easy to implement.

The TGT curriculum–which concentrates on peer influence–is particularly effective in teaching adolescents about depression behavior and substance abuse. That is because the data have repeatedly indicated that these social problems are related to peer influence and usually occur within a group context. This curriculum provides young people with feasible techniques for resisting peer pressure and improving social skills.

Timing of the Intervention

Recent research executed on various populations indicated that intervention should occur in the fourth, fifth, and sixth grades to psychologically inoculate children for the risks that they are going to face. All of the interventions discussed within this manuscript should be executed as early as possible. Ideally, booster sessions would occur as children move into junior high and high school. The booster sessions should include procedures for the maintenance and generalization of behaviors that have a high probability of being reinforced in natural environments; varying the conditions of training; gradually removing or fading the contingencies; using different schedules of reinforcement; using delayed reinforcement and self-control procedures (Marcotte, 1997; Wodarski, 1980; Wodarski & Wodarski, 1993).

Curriculum

Updates should occur periodically. Material that is included in the curriculum should be easily comprehended and presented in an attractive manner. All updates should include information that is relevant for the skills that are being acquired. Moreover, role-playing exercises that involve overlearning should be included. Such exercises make up the requisites of relevant curriculums. The social skills training paradigm offers social workers an excellent procedure for preparing adolescents to live successfully in contemporary American society. The curriculums are particularly relevant to social group work, because data indicate that peers play a strong role in the acquisition of either social or dysfunctional behaviors. The small-group learning techniques that are explained within the manuscript capitalize on peers as teachers. Thus, social workers are provided with viable techniques that can

capitalize on peer structures to help adolescents acquire necessary social behaviors to deal competently with the requisites of adolescent development.

CONCLUSION

The solution to the problems of depression and possible subsequent suicide among teens requires an all-out effort by those societal forces capable of effecting change. Families, schools, peers, communities, businesses, and the media all possess powers to eradicate this social problem. The campaign cannot be waged from only one front, however. Combined, cooperative efforts are essential. The responsibility must be shared for creating the conditions that have perpetuated the problems and for working toward mutual goals and solutions (Harrington & Clark, 1998).

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CONTENTS

ADOLESCENT DEPRESSION AND SUICIDE

Chapter 1

THE EPIDEMIC OF CHILD AND ADOLESCENT DEPRESSION AND SUICIDE

INTRODUCTION

Statistics provide evidence that teenage depression and suicide are two of the most pressing problems that afflict adolescents today. Currently, 20% of children and adolescents suffer from a mental disorder such as clinical depression (National Plan for Research on Child and Adolescent Mental Disorder (1990), and often these children are not diagnosed until it is too late. Intervention typically does not take place until the individual begins to lead an aberrant lifestyle. Unfortunately, acts such as drug and alcohol use, poor school performance, and even suicide attempts must take place before it is recognized that there is a problem. The Centers for Disease Control (2001) reports that persons younger than 25 accounted for 15% of all suicides in 1998. From 1952 to 1995, the incidence of suicide among adolescents and young adults nearly tripled, with the rate of suicide among persons aged 15-19 years increasing by 11% and among persons aged 10 to 14 years by 109% between 1980 and 1997.

Research indicates that mental disorders and substance abuse often co-exist (Hilarski & Wodarski, in press). Studies have shown that suffering from depression or anxiety disorders doubles the risk for later drug abuse and dependency (Christie, Burke, Regier, Rae, Boyd, & Locke, 1988; Crowley, Mikulich, MacDonalk, Young, and Zerbel, 1998). Co-morbid psychiatric disorder and substance use problems are as critical in adolescent populations as in adults (Bukstein, 1995). Establishing effective treatments for childhood mental disorder, in addition to research on the impact of the co-occurrence with substance

abuse, will contribute to improved care, especially in public sector agencies. Cognitive behavior treatment modifies dysfunctional behaviors and replaces the behaviors with healthier alternatives. Furthermore, research on reducing subsequent drug abuse by early treatment of depression is critical to prevent possible depression and/or substance abuse problems in adulthood (Harrington & Clark, 1998).

THE DEPRESSION, SUBSTANCE ABUSE, AND SUICIDE TRIAD

Alcohol and drug abuse are recognized as a defense mechanism to combat depression (Wodarski & Feit, 1995). Unfortunately, however, severe alcohol ingestion may lead to a loss of control over suicidal impulses (Dorpat, 1975). Grueling and DeBlassie (1980) studied statistics from several large cities and found that more than 50% of teenagers who had committed suicide had a history of moderate to severe drinking and abusive use of drugs before their deaths. Substance use and abuse by adolescents is a widespread problem. One study notes nearly 100,000 children between 10 and 11 years old report getting drunk at least once a week (Fleish, 1996). Almost 40% of adolescents surveyed have tried alcohol before entering high school. Moreover those adolescents who use substances such as alcohol and drugs have a greater vulnerability to accidents, injuries, and dangerous behaviors (Bukstein, Brent, & Kaminer, 1989). The leading cause of death for 15 to 24 year olds is motor vehicle accidents that involved alcohol.

Presence of an affective disorder in adolescence may serve as a risk factor for later development of a substance use disorder (Christie et al, 1988). Psychiatric symptoms may develop as a consequence of substance use disorder. Although there seems to be an association between substance abuse and depression in adolescence, it is unclear whether depression is primary or whether substance abuse is primary. Researchers have suggested that there may be a causal relationship between use and abuse of alcohol and the development of chronic mental illness (Fleish, 1996). It is unclear whether individuals are attempting to "self-medicate" their mental illness, or if their substance abuse precipitates mental illness in certain individuals. This may be particularly important when determining the proper course of treatment for the individual.

Retrospective studies demonstrate a positive relationship between increased incidence of drug use and suicide attempts among adoles-

cents (Crumley, 1990). Although a causal relationship among depressed mood, substance abuse, and suicide has yet to be established, it seems that increased use of alcohol, particularly the progressive use of alcohol coupled with depression, increases the possibility of a suicide attempt. There also seems to be variance between adolescents with depressive illness, substance abuse problem, or the co-morbidity of both and suicidal plan (Suominen, Isometsa, Henriksson, Osfamo, & Loennquist, 1997). Serious behavioral problems are also associated with adolescents who are abusing substances and trying to function in everyday life while being depressed. Examples of high-risk behaviors such clients may engage in are deviant behavior, sensation-seeking behavior, violence, unprotected sex, and abuse of alcohol with peers. Concurrent complications that may occur with adolescents who abuse alcohol are socially deviant behavior, early initiation of sexual behavior and risk for HIV infection, learning problems, and depression (Meyers, Brown, and Mott, 1995; Wodarski and Feit, 1995).

ASSOCIATED FACTORS IN ADOLESCENT SUICIDE

Suicidal behavior is the result of dysfunctional adjustment by the teenager to psychological and environmental circumstances. Aspects of depression and stress have been cited in research studies as prodromal clues in attempted and completed suicides (Davis, 1983). Evaluation of the role of the family and peer involvement have been examined in the same context.

DEPRESSION. Intense depression has been found to be the most prevalent characteristic of suicidal youth (Calhoun, 1972; Carson, 1981; Friedman, Corn, Hurt, Fibel, Schulick, & Swirsky, 1984; Gibbs, 1981; Holinger & Offer, 1981; Marks & Haller, 1977; Miller, 1975; Tishler & McKenry, 1983). It is estimated that 0.14% to 49% of children and adolescents suffer from a depressive disorder (Angold, 1988). Depression naturally occurs in all adolescents as a part of the maturation process. However, the intensity and severity of this depression are factors in the adolescent's psychological health (Nichtern, 1982; Kaslow, Deering, & Racusin, 1994). Vegetative symptoms of depression include mood variations, sleep disturbances, fatigue and loss of energy, and changes in appetite (Rosenblatt, 1981; Tishler & McKenry, 1983). In the school setting, depression is indicated by a decline in academic performance or a withdrawal from peers and extracurricular activities (DenHouter, 1981; Greuling & DeBlassie,