WISCONSIN YOUTH FUTURES

Technical Report #9

An Ecological, Risk-Focused Approach To Preventing Youth Depression

University of Wisconsin-Madison/Extension
Cooperative Extension

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In its mild form, depression is probably the most common psychological disturbance during adolescence; all adolescents suffer at least mild depression at one time or another (Weiner, 1980). Even though depression is widespread among contemporary youth, less is known about the predictors of depression than such other youth problems as drinking, early sexuality, and school failure; consequently, few prevention efforts and formal programs exist to prevent the sadness, worthlessness, and pessimism that many young people experience.

The focus of this paper is three-fold. First, the meaning of depression during adolescence will be explored with distinctions made between depression as a normal part of the developmental changes of adolescence, depression as a response to adverse life circumstances, and depression as a clinical disorder.

Second, the paper builds on a growing body of research evidence indicating that depression like other youth problems is influenced not by a single factor, but by many. Furthermore, the factors are not confined to any one part of the adolescent's world, but occur in individuals, their family and peer groups, school and work settings, and the communities in which they reside. Risk factors are identified that increase a youngster's vulnerability to depression in both normal and clinical populations followed by protective factors that enhance a youngster's ability to resist depression and promote adaptation and competence.

Finally, this paper concludes by drawing implications of this risk-focused, ecological approach for designing effective community prevention programs. Identifying the life circumstances that magnify adolescent depression and how resilient youth are able to cope is important for parents, educators, and professionals interested in preventing youth depression.

ADOLESCENT DEPRESSION--WHAT IS IT?

Without question, depression occurs during adolescence (Chartier & Ranieri, 1984); the questions that arise, however, are whether depression is a normal but temporary reaction to the storm and stress of adolescence, whether depression is a reaction to changes in life circumstances during the teen years, or whether depression during this time is severe enough to be classified as a clinical condition.

Beck, well-known for his work on adult depression, categorized adult depression into the following four categories: (1) emotional, (2) cognitive, (3) motivational, and (4) physical and vegetative (cited in Chartier and Ranieri, 1984). Using this four-category schema, Chartier and Ranieri (1984) identify the most common features of adolescent depression:

1. Among depressed adolescents, the two emotional symptoms that are most frequently observed and that are required for a DMS-IIIR diagnosis of depression are sadness and loss of enjoyment of activities that were once pleasurable.
2. Cognitively, adolescents tend to view themselves, their world, and their future in a negative light (Rutter, 1986a; Chartier & Ranieri, 1984); some researchers also include low self-esteem as a cognitive feature of adolescent depression.
3. Motivational features of depression include apathy, boredom, a loss of ability to concentrate (evidenced primarily in poor school performance), and a tendency to withdraw from others. Depressed adolescents are also more apt to engage in suicidal thoughts and acts.
4. Physical and vegetative symptoms include involvement in aggressive, impulsive, and antisocial behaviors, changes in sleeping and eating habits, and participation in feminine-stereotyped activities. Biological factors, such as abnormal EEG patterns, and situational factors, such as recent stressful life events may also play a role.

To understand depression, it is useful to distinguish between depression as a symptom (i.e. sadness), as a syndrome (a collection of depressive symptoms), and as a disorder of clinical importance (Chartier & Ranieri, 1984). According to Steinberg (1989), many more individuals have occasional depressive symptoms than suffer from the clinical disorder professionals would call depression. Among adults, three main criteria are used to distinguish a depressive syndrome from a depressive symptom:

1. other symptoms also exist,
2. social relations are impaired, and
3. the symptoms persist (Rutter, 1986a).

As a rule of thumb, an adolescent who shows three or more of the above signs of depression for two or more weeks, should raise concern (Small, Herlache, & Doll-Yogerst, 1990).

These symptoms of depression are easy to overlook in adolescent populations, however, because they are mistaken as normal manifestations of the changes that occur during the transition from childhood into adulthood. For example, fatigue can be viewed as a natural effect of growing rapidly and leading an active life, rather than a symptom of adolescent depression (Weiner, 1980).

Adolescent depression may be especially difficult to identify during early adolescence, a developmental stage when adolescents are more inclined toward doing things than thinking about them (Weiner, 1980). Early adolescents are more apt to exhibit the following triad of symptoms: fatigue, hypochondria, and concentration difficulty (Weiner, 1980). In general, early adolescents may be expected to exhibit more motivational, physical, and vegetative symptoms than cognitive or emotional symptoms.

PREVALENCE

Problems in measuring and defining depression make it difficult to say exactly how prevalent the disorder is. When asked if they have feelings of sadness, worthlessness, or pessimism about the future, about 35 to 40 percent of nonpatient samples respond affirmatively. Prevalence rates of actual depression are estimated to range from 15 to 25 percent (Horn, 1991), although estimates were as high as a third of 7th and 8th graders in a suburban parochial school sample. In studies that employ psychiatric diagnoses as the criteria for depression, estimates vary widely from 2 to 16 percent among outpatient samples and from 2 to 30 percent in inpatient and mixed samples (Chartier & Ranieri, 1984).

Chartier and Ranieri (1984) conclude that a substantial number of adolescents report feeling unhappy accompanied by other symptoms characteristic of adult depression. Psychiatrists conclude, however, that depression may be common among adolescents, but it is rarely of clinical significance.

Evidence suggests depression increases from childhood to adolescence; a variety of explanations for this age difference have been offered (Rutter, 1986a):

- Age differences may be genetically determined and these genes may not be triggered until late childhood or adolescence.
- Sex hormones may increase susceptibility to depression, and these hormones may not be present until puberty.

- Life stresses may increase during this time which, in turn, may be associated with higher levels of depression.
- Protective factors, such as family support, may be reduced or less available during this time of independence-seeking.
- The cognitive advances of adolescence may lead to thoughts and feelings associated with increased risk of depression. For example, younger children are more apt to attribute failure to a specific situation, while adolescents are more apt to generalize that failure implies a stable and lasting limitation on their performance. Similarly, only during later childhood and early adolescence are children able to imagine the future, consider various future life alternatives, and conclude that none are satisfactory.

The transition to adolescence has more pronounced effects on girls than boys (Gjerde, 1991). Before puberty, boys are twice as likely to be depressed as girls; beginning in late adolescence, girls and women are about twice as likely to be depressed as boys and men (Rutter, 1986b). Adolescent boys who are depressed exhibit antisocial tendencies, while adolescent girls who are depressed appear to be relatively more intelligent, mature, introspective, insightful, and concerned with important issues in life than girls who are not depressed (Gjerde, 1991).

In summary, depression doesn't affect a majority of adolescents, so it can hardly be considered solely a normal reaction to the developmental changes of the adolescent years. Depression among adolescents appears to be a reaction to adverse circumstances in their lives which some experience, but not all; among those who experience these adverse life circumstances, some are better able to cope than others.

INDIVIDUAL RISK FACTORS

Emotional Factors

Anxiety - For both junior and senior high students, strong correlations were found between self-reported depression and general anxiety (Chartier & Ranieri, 1984).

Loss of gratification from pleasurable experiences - About two-thirds of depressed children and adolescents, both inpatients and outpatients, report less enjoyment of formerly pleasurable activities (Chartier & Ranieri, 1984).

Sadness - Between 35 and 40 percent of normal young people report having some feelings of sadness (Weiner, 1980). Not surprisingly, sadness has consistently been associated with depression (Chartier & Ranieri, 1984). Among affectively disordered 7 to 17-year-olds, some who were inpatients and some

who were not, about 70 percent report sadness while 95 to 100 percent of clinically depressed adolescents say they feel sad. Even though the majority of depressed adolescents are sad, sadness is not a universal feature of adolescent depression (Chartier & Ranieri, 1984).

Cognitive Factors

Dissatisfaction with personal appearance - Dissatisfaction with physical appearance is associated with depression among adolescents (Harter, 1987). In one study, the best predictor of depression in high school students is poor body image, as evidenced by feeling ugly, unattractive, weak, unhealthy, not proud of one's body, and dissatisfied with recent body changes (Chartier & Ranieri, 1984). Dissatisfaction with recent body changes appears to be more prevalent among girls than boys. At age 11, both boys and girls like their body shape. At age 15, however, girls become more dissatisfied with their body shapes than boys, and increasingly wish they were thinner than they are (Girgus, Nolen-Hoeksema, & Seligman, 1989). Among those adolescent girls who express dissatisfaction with their body image, negative life events are much more likely to be associated with depression (Girgus et al., 1989); negative life events are linked to depression among adolescent boys regardless of their body satisfaction.

Fear of death (in early adolescence) - One symptom of adolescent depression, not found in adult populations, is fear of death. One study found a moderate association (r=.49) between death anxiety and depression among junior high, but not senior high school students (Chartier & Ranieri, 1984).

Guilt - Depression usually involves feelings of guilt which may result from violations of one's own standards of conduct or failure to reach one's own goals. This may explain, in part, why depression is more common among adolescents than younger children who may not possess the capacity for this complex thinking (Rutter, 1986a).

Helplessness - When one fails at an undertaking, depression is associated with feelings of helplessness and the associated belief that there is nothing that can be done to change the situation (Rutter, 1986a); other researchers contend that this theory, while appealing, is still largely untested among adolescent populations. During the transition to adulthood, adolescents may feel an increased need to exert control over their environment as well as external pressure to do so. Failures may, therefore, assume greater importance; if the individual reacts with helplessness, depression may be more likely to occur (Chartier & Ranieri, 1984). Feelings of self-efficacy, the belief that adolescents have a large measure of control over their lives, could hypothetically counteract these feelings of helplessness and hopelessness (Munoz, Glish, Soo-Hoo, & Robertson, 1982).

Hopelessness - Evidence suggests that hopelessness is a characteristic of depression among adolescents as it is in adults (Chartier & Ranieri, 1984; Rutter, 1986a). According to Rutter (1986a), the negative thinking that characterizes depression tends to be threefold—a negative view of oneself, of the present situation, and of the future. About 35 to 40 percent of normal samples of young people report having some feelings of pessimism about the future. In a mixed sample of affectively-disordered inpatient and outpatient 7 to 17-year-olds, however, about 89 percent reported hopelessness (Chartier & Ranieri, 1984). Among normal adolescents, hopelessness is often associated with an external locus of control.

Low self-esteem - In normal populations, about 35 to 40 percent of young people report low self-esteem (Kandel & Davies, 1982; National Institute of Mental Health, n.d.; Weiner, 1980), but, as one might expect, the prevalence is even higher among depressed populations. Low self-esteem is reported for almost three-fourths of depressed inpatients and outpatients between the ages of 7 and 17 (Chartier & Ranieri, 1984; Harter, 1987; Weiner, 1980). The frequency of depression among normal adolescent samples have led some to contend that low self-esteem is a cardinal feature of adolescent depression, even though it is not presently required for a DMS-IIIR diagnosis for depression. Even though the link between self-worth and depression is quite strong (correlations between .75 and .83), a small subgroup of children with high self-esteem report feelings of depression (Harter, 1987); this group, however, reports relatively low levels of social support.

Motivational Factors

Apathy - Depression may be marked by a pronounced apathy, a cynical, "what's the use of it all" view of the world (Weiner, 1980). Due to their fear of failure and disappointment, depressed adolescents avoid special efforts and set aside long-term goals (Weiner, 1980).

Need for Excitement, Stimulation, and Activity - Adolescent depression is sometimes marked by restlessness or a high activity level. An incessant search for new activities and a boredom with anything familiar or routine may seem at first blush to be an enthusiasm for living; instead it may be a "desperate effort to keep one step ahead of having time to think" (Weiner, 1980).

Suicidal Thoughts/Acts - Depressed adolescents are more apt to engage in suicidal thoughts, gestures, and behaviors (Chartier & Ranieri, 1984; Weiner, 1980). Fully one-third of normal adolescents engage in self-destructive thoughts with proportions as high as 89 percent in a sample of 7 to 17 year-old inpatients and outpatients (Chartier & Ranieri, 1984).

Physical and Vegetative Factors

Abnormal EEG Patterns - For both adolescents and adults, depressed individuals exhibit significantly higher right-to-left hemisphere variance ratios in EEG amplitude patterns (Chartier & Ranieri, 1984).

Assertive Behavior - Surprisingly, depressed adolescents, but not adults, reported higher levels of assertiveness than those who were not depressed (Chartier & Ranieri, 1984).

Complaints of tiredness or fatigue - One-half to two-thirds of depressed adolescents, both inpatients and outpatients, complain of fatigue and lack of energy. These complaints are reflected less frequently in actual behavior among adolescents than in adults (Chartier & Ranieri, 1984).

Increases or decreases in appetite and accompanying bodily changes - For adults, loss of appetite appears characteristic, while for adolescents changes in appetite and the accompanying weight changes appear to be more characteristic (Chartier & Ranieri, 1984; Weiner, 1980).

Involvement in aggressive, impulsive, and antisocial behaviors - Adolescent depression is associated with involvement in aggressive, impulsive, and antisocial behaviors such as use of drugs, sexuality, temper tantrums, running away, stealing, truancy, and other defiant and rebellious conduct (Chartier & Ranieri, 1984; Rutter, 1986a; 1986b; Weiner, 1980). Involvement in these potentially problematic behaviors appears to be both a cause and a consequence of adolescent depression.

Some evidence suggests that depression may cause these problem behaviors as young people turn to drugs, sex, or some other risky behavior in an attempt to combat depression; the element of danger associated with many of these activities appears to provide immediate stimulation, conveys a certain degree of notoriety, and provides a basis for establishing and maintaining companionship. Among marijuana users, for example, depressive mood was associated with both the initiation and continued use of other illicit drugs; continued use of these drugs appears to be associated with a decrease in depressive moods. Other evidence suggests, however, that adolescent depression occurs simultaneously with involvement in these problem behaviors or that depression results from involvement in youth problems.

Problem behaviors in depressed adolescents differ from those observed in sociopathic individuals in three important ways (Weiner, 1980). First, among depressed adolescents, these behaviors are uncharacteristic of the young person and represent a departure from an earlier history of exemplary behavior. Second, the behaviors are triggered by a major life stress such as divorce or death of a parent. Finally, the behaviors appear to represent an attempt at communication since they are carried out in ways that guarantee the young person is caught or observed.

Participation in Feminine-Stereotyped Activities - Depression rates were higher among adolescents when they spent more time on such feminine-stereotyped activities as shopping; hairstyling; make-up; cooking; sewing; and doing music, theater, or dance; conversely, depression rates were lower when adolescents spent more time on such masculine-stereotyped activities as participating in sports; playing games; watching TV, movies or sports events; and playing with rock, stamp or baseball card collections (Girgus et al., 1989). Feminine activities are hypothesized to be more closely linked to depression because they do not encourage autonomy and mastery.

Recent Stressful Life Events - The greater the amount of recent life stress, the more likely an adolescent will be depressed (Friedrich, Reams, & Jacobs, 1982). A stressful life event increases the risk of depression two to five times (Paykel cited in Williams, 1987), accounting for more than two-thirds of the differences in rates of depression among adolescents (Friedrich et al., 1982). Among early adolescents, depression is more strongly related to recent stress, which suggests a more transitory nature of depression in this age group.

Despite this strong relation between depression and recent stressful life events, it would be a serious oversimplification to portray depression as simply a direct consequence of stressful life events; this overlooks the fact that most adolescents do not respond to stressful life events with depression. Thus, other factors must also lie at the root of adolescent depression (Chartier & Ranieri, 1984).

Sleep Disturbances - Sleep disturbances are common among adolescents with nearly half of adolescents estimated to have difficulty sleeping; among depressed inpatients and outpatients, however, estimates range from one-half to three-fourths of adolescents (Chartier & Ranieri, 1984).

FAMILY RISK FACTORS

Family Conflict - More conflicted family relationships have been associated with depression in eight and ninth-graders (Friedrich et al., 1982).

Loss of a Parent through Death or Separation - Evidence suggests that the loss of a mother in childhood (Rutter, 1986a; Weiner, 1980) is associated with later depression, although this relationship does not always exist. The fact that early loss is not always associated with later depression illustrates how risk factors in different parts of the adolescent's world may interact. Hence, the relation between early loss and later depression may occur only if there are accompanying changes in thinking such as low self-esteem and a negative view of the world and the future. This type of thinking makes it more likely that the individual will develop depressive feelings in later life, but only if stressful negative life events occur (Rutter, 1986a).

Parental History of Psychiatric Depression - Depressed adolescents are more likely to have a parental history of depression (Kandel & Davies, 1982); fifty-five percent of those individuals considered depressed had at least one biological parent with a history of psychiatric disorder, compared to 22 percent of normal adolescents (Chartier & Ranieri, 1984). The combination of a parental history of psychiatric disorder and a severe medical prognosis doubles the likelihood of depression as compared to the presence of either factor alone (Chartier & Ranieri, 1984).

Poor Parent/Child Relations - Depression among adolescents appears to be associated with poor parent/child relationships, especially early relationships that are less close and supportive (Chartier & Ranieri, 1984). The specific parenting practices associated with adolescent depression are not clear cut and may vary depending upon the specific youth behavior under consideration.

Kandel and Davies (1982) report that adolescents reared in a democratically-oriented family are less likely to be depressed than those reared in either a permissive or autocratic home; autocratic control, especially during preschool, predicts later depression, especially for girls (Gjerde, Block & Block, 1991). In another study of depressed adolescents, parents were more apt to attempt to control offspring through rejection, withdrawal, ridicule, criticism, anxiety, and guilt (Chartier & Ranieri, 1984).

In the Oregon youth study, distinctions are drawn depending upon whether depression occurs alone or in combination with conduct problems. Boys who display only depressed mood had parents who were less involved in parenting, showed poorer supervision, and participated in fewer activities with their sons. In contrast, boys who exhibited only conduct problems or both conduct problems and depression, had parents who exhibited inconsistent and coercive discipline (Capaldi, 1991). Other studies report, however, no differences in depression as a result of such parental behaviors as permissiveness, discipline or limit-setting (Chartier & Ranieri, 1984).

As an estimate of the strength of this risk factor, family support in combination with life stress accounted for 71 percent of the difference in depression in a sample of 8th and 9th graders; life stress accounted for 60 percent of the variation and family support an additional 17 percent (Friedrich et al., 1982). This study of normal adolescents suggests that depression, at least among early adolescents, may be more situational and stress-related; suicidal thinking, on the other hand, may be more closely related to family support. Even though depression is highly related to recent life experience, which suggests a more immediate and transitory aspect to depression in early adolescence, the importance of family support and paternal income suggests longer-term aspects as well.

PEER RISK FACTORS

Association With Others Who Hold Unconventional, Anti-Establishment Ideas - Depression is more likely when adolescents associate with others who are unconventional or anti-establishment in their ideas and actions. Youth can be attracted to others who hold unconventional ideas or attitudes on the basis of principle or deep conviction; for the depressed adolescent, however, their main motivation may be escaping from feelings of being alone, unimportant, or inadequate (Weiner, 1980).

Flight to People - One adolescent scholar contends that depression can be associated with a flight away from people, as is consistently mentioned in the literature, but also in a flight toward people (Weiner, 1980). Depressed young people may exhibit a constant need for companionship and ever more interesting friends, in an attempt to keep occupied and ward off thoughts of depression (Weiner, 1980).

Social Isolation and Withdrawal - Poor peer relations, low social support and alienation is frequently associated with depression among adolescents (Chartier & Ranieri, 1984; Friedrich et al., 1982; Girgus et al., 1989; Harter, 1987; Renouf & Harter, 1991; Weiner, 1980). Social withdrawal was reported for between 63 and 78 percent of adolescents hospitalized for depression (Chartier & Ranieri, 1984). Feelings of social abandonment or lack of understanding from others was found to be even more important to depressed adolescents than for adolescent psychiatric patients, with over 95 percent of the depressed adolescents reporting a lack of understanding from others (Chartier & Ranieri, 1984).

Social support has been shown to account for over 50 percent of the variation in depression (Renouf & Harter, 1991); the support of father and peers contributed primarily to depression, whereas mother support is perceived as being low only in adolescents who are both depressed and suicidal.

Strong Peer Orientation and Low Attachment to Parents - Depression in adolescence is often characterized by a strong orientation to peers in the context of a low attachment to parents (Kandel & Davies, 1982). In fact, when strong orientation to peers occurs in the context of a high level of attachment to parents, adolescents are least likely to be depressed. The most beneficial pattern for adolescent mental health appears to be involvement with peers that occurs simultaneously with close ties to parents.

SCHOOL RISK FACTORS

Diminished Concentration - Poor concentration is reported for 70 percent of depressed inpatients and 63 percent of depressed nonpsychiatric medical patients (Chartier & Ranieri, 1984).

Low Academic Achievement - For inpatient samples, the relation between depression and poor school performance has varied from 13 to 73 percent. In studies with depressed inpatients and outpatients, almost half reported poor school performance. In studies of normal 7th and 8th graders, depression was linked to diminished school performance (Chartier & Ranieri, 1984; Friedrich et al., 1982).

School Transitions - While studies have not directly assessed the relation between school transitions and depression, evidence does suggest an increase in factors associated with higher rates of adolescent depression. When adolescents move from an elementary school into a middle school or junior high, and again when they move into senior high, feelings of being anonymous increase, self-esteem goes down, and extracurricular participation goes down.

COMMUNITY RISK FACTORS

Low Socioeconomic Status - Lower levels of paternal occupation and maternal education and occupation were associated with elevated depression (Friedrich et al, 1982). Three variables—life stress, family closeness, and paternal occupation—accounted for 78 percent of the total variation in depression. Paternal occupation accounted for 7 percent of the variation over and above that accounted for by the other two variables; a lower level of employment and presumably family income is associated with elevated risk of adolescent depression. In addition, living under conditions of low socioeconomic status is linked to slightly more negative life events, a potent predictor of depression among early adolescents (Friedrich et al, 1982).

PROTECTIVE FACTORS

Why is it that one person develops symptoms of depression or depressive disorder when confronted with the adverse life circumstances cited above, while others remain psychologically healthy? What's right with these children? What protects them? What are some of the factors that serve as safeguards from stressful life events and enhance a youngster's ability to adapt and grow into a competent, responsible adult? This is the central question addressed in a study of 483 5th to 9th grade boys and girls from four schools in two Chicago communities (Horn, 1991).

Based on the findings, the researcher drew the following conclusion. On a daily hourly basis, resilient kids do not seem much different than normal youth:

> *"The seemingly pervasive myth that resilience is a `trait' possessed only by a few charmed `invulnerable' children, and that these super-kids' manifest strength in all areas of their lives is not supported by the data" (Horn, 1991, p. 18).*

Normal, depressed and resilient youth appear outwardly to be doing much the same thing. What is significantly different, however, is how they spend their time, their perceptions of themselves and their daily lives, and their relationships with family and friends. The following factors appear to protect adolescents from depression and contribute to their resiliency; these factors are identified in Horn's study (1991), the only study to the author's knowledge that deals with protective factors for adolescent depression. Other factors in the family and community may also serve as safeguards, as implied by this review, although studies have not yet examined whether these factors actually protect youth from depression.

Involvement in Physical Activities and Homework - Adolescents in the resilient and normal group reported spending significantly more time playing sports than did those at either low or high risk of depression. Resilient youth appear to spend more time in physically active as opposed to passive activities, but the findings are more robust for girls than boys; resilient girls are much more likely to be engaged in sports. Youth at high risk for depression also spend significantly less time on homework.

Well-Developed Social and Interpersonal Skills - Resilient youth, when faced with conflict in their family, spend less time with parents and more time with friends; these youth possess a social network outside the family that they can turn to and rely on. Similarly, high risk youth also spend more time with friends; the difference, however, is that high risk youth report that this time with friends is less enjoyable. The findings imply that resilient youth have the wherewithal and social skills to attract and keep supportive relationships around them, and these relationships, in turn, buffer them against depression.

Avoiding Over-Generalization of Negative Experiences - One of the strengths of resilient youth is their ability to avoid generalizing negative interpersonal experiences from one domain of their life to another. While resilient youth may be experiencing an interpersonal problem in one aspect of their life, they are less apt than high-risk youth to perceive all social situations as similarly harmful.

Social Contact - Resilient boys spend more time socializing than less resilient boys; resilient boys may more effectively use their social support networks to provide needed support. Resilient girls, on the other hand, are less likely than other girls to spend their time socializing; evidently the high-risk girls attempt to cope with depression, albeit unsuccessfully, through increased use of peer support.

In summary, these data suggest that resilient children, like other children, are affected by negative life events and family circumstances. Unlike children who are overcome by these risks, however, resilient children maintain a positive view of themselves and others. Even though they are having trouble in one domain, they do not generalize to all aspects of their lives. Resilient youth are able to concentrate on school work and other activities, despite chaos and uncertainty in their lives. Finally, they deal with negative life events by turning to family and friends for help and support.

IMPLICATIONS FOR PREVENTION

According to a risk-focused, ecological approach, the more risk factors and the fewer protective factors, the greater the danger of youth involvement in potentially problematic behaviors. In one study by Rutter (1979), the presence of one risk factor (i.e. low social status) was no more likely to create dysfunction than when no risk factors were present; with two risk factors (i.e. low social status and severe marital discord), there was four times the chance of problem behaviors, and with four risk factors, the risk increased as much as 20 times.

This ecological approach assumes that just as the causes of depression are complex, so are the solutions. Yet prevention programmers often search for single factors and simple solutions to complex problems like adolescent depression. Unfortunately, there are no magic bullets; if prevention efforts are to have any hope of success, they need to be comprehensive and multi-dimensional, reducing risk factors and promoting protective factors in diverse parts of the child's world.

While studies have not yet examined the effectiveness of comprehensive community approaches for preventing youth depression, this review suggests the importance of addressing those factors that either place adolescents at risk of depression or protect them from it. Consistent with the ecological framework, the strategies are organized by different levels of the human ecology, even though some of these strategies may fall into more than one level.

Individual Level

- Parents and other adults can help youth learn how to cope with failure and avoid the over-generalization that can occur (National Institute of Mental Health, n.d).
- Youth can be guided toward experiences they can master to develop self-efficacy that can serve as a buffer from feelings of hopelessness and despair.
- Communities can provide opportunities for youth to be involved in meaningful ways and to recognize youth for their accomplishments (National Institute of Mental Health, n.d.).

Family Level

- Parent education programs can be aimed at promoting family activities, building closeness, and reducing conflict among family members (Horn, 1991).
- Parents can learn the importance of monitoring children closely to reduce the likelihood that teens will find themselves in situations where potentially problematic behaviors can occur, especially those behaviors linked with depression such as drug use, early sexuality, or delinquent activities.
- Parents can take steps to shield adolescents from stressful life events such as parental divorce or unnecessary changes in school or residence. On the other hand, parents may consider changes in school or residence to provide opportunities for a more supportive peer, school, and community environment.

Peer Level

- Parents, other adults, churches, youth-serving organizations, and the community can provide opportunities for youth to interact with peers and develop the necessary social and interpersonal skills to develop and maintain a supportive social network.
- Adults can provide opportunities for teens to learn the skills to resist negative peer pressure.

School Level

- Efforts can be made to enhance and promote academic achievement.
- Efforts can be made to increase student attention and concentration through cognitive training or manipulating the environment (Horn, 1991).
- Decisions about changes in school structure can acknowledge the negative effect middle schools or junior highs may have on adolescent mental health; for those communities with middle schools or junior high schools in place, programs can be developed to alleviate the negative consequences and provide a supportive environment (Felner & Adan, 1988).

Community Level

- Support can be provided to help youth and adults deal with such stressful life transitions as school transitions, marriage, divorce, job loss, and death (Williams, 1987).
- Communities can provide employment opportunities and advanced job training for parents.
- Community residents can promote social values and norms that are supportive of programs and policies related to prevention (Williams, 1987).
- When policies are developed, communities can consider the potential impact policies or programs may have on youth mental health.

This listing is not intended to identify all the prevention strategies a community may undertake, but rather to illustrate the breadth and diversity a comprehensive community approach may entail. In any given community, some of these factors may be more important than others (Bogenschneider, Small, & Riley, 1990). Thus, communities need to assess which of these supports for averting youth depression are in place and which are missing so programming can be directed toward local needs (Bogenschneider et al., 1990).

As important as identifying the prevention strategies most needed in the community is targeting the most appropriate developmental age. Intervening early before negative behaviors begin to crystallize increases the chances that efforts will be successful (Williams, 1987). Finally, the potential consequences of any prevention effort should be considered carefully. No matter how well-

intentioned, any intervention that is powerful enough to change behavior to produce a beneficial outcome could also have an unwanted (and usually unforeseen) adverse side effect (Shaffer, Philips, Garland, & Bacon, 1989).

CONCLUSION

The phenomenon of adolescent depression remains an understudied field (Chartier & Ranieri, 1984), so the conclusions of this paper must be interpreted with caution. These findings do suggest, however, that preventing youth depression requires a comprehensive, multi-dimensional approach that focuses on family dynamics, school performance, and the development of social skills and coping strategies that will reduce levels of anxiety and promote feelings of competence. Preventing youth depression and promoting healthy emotional development requires enhancing the many conditions that nurture and support youth (Bogenschneider et al., 1990).

REFERENCES

Bogenschneider, K., Small, S., & Riley, D. (1990, September). *An ecological risk-focused approach for addressing youth-at-risk issues.* Chevy Chase, MD: National 4-H Center.

Capaldi, D. M. (1991, April). *Antisocial behavior and depression in young adolescent boys: Longitudinal analyses of family and adjustment variables.* Paper presented at the Biennial Conference for the Society for Research on Child Development, Seattle, WA.

Chartier, G. M., & Ranieri, D. J. (1984). Adolescent depression: Concepts, treatments, prevention. In P. Karoly & J. J. Steffen (Eds.), *Adolescent behavior disorders: Foundations and contemporary concerns* (pp. 153-193). Advances in Child Behavioral Analysis and Therapy, 3. Lexington, MA: Lexington Books.

Felner, R. D., & Adan, A. M. (1988). The school transitional environment project: An ecological intervention and evaluation. In R. H. Price, E. L. Cowen, R. P. Lorion, & J. Ramos-McKay (Eds.), *14 Ounces of Prevention: A casebook for practitioners.* Washington, DC: American Psychological Association.

Friedrich, W., Reams, R., & Jacobs, J. (1982). Depression and suicidal ideation in early adolescents. *Journal of Youth and Adolescence, 11*, 403-407.

Girgus, J. S., Nolen-Hoeksema, S., & Seligman, M. E. P. (1989, August). *Why do sex differences in depression emerge during adolescence?* Paper delivered at the meetings of the American Psychological Association, New Orleans, LA.

Gjerde, P. F. (1991, April). *Depressive symptoms during the transition from adolescence to young adulthood: A longitudinal perspective.* Paper presented at the Symposium "From Adolescence to Young Adulthood: Continuity and Change" (J. Block and S. Hauser, chairs), Society for Research in Child Development (SRCD), Seattle, WA.

Gjerde, P. F., Block, J., & Block, J. H. (1991). The preschool family context of 18 year olds with depressive symptoms: A prospective study. *Journal of Research on Adolescence, 1*, 63-91.

Harter, S. (1987). Causes, correlates and the functional role of global self-worth: A life-span perspective. In J. Kolligan & R. Sternberg (Eds.), *Perceptions of competence and incompetence across the life span* (pp. 67-98). New Haven, CT: Yale University Press.

Horn, M. P. (1991, April). *Competence in daily living: A study of children and adolescents at risk for depression.* Paper presented at the Biennial Conference for the Society for Research on Child Development, Seattle, WA.

Kandel, D., & Davies, M. (1982). Epidemiology of depressive mood in adolescents. *Archives of General Psychiatry, 39*, 1205-1212.

Munoz, R. F., Glish, M., Soo-Hoo, T., & Robertson, J. (1982). The San Francisco mood survey project: Preliminary work toward the prevention of depression. *American Journal of Community Psychology, 10*, 317-329.

National Institute of Mental Health (n.d.). *Adolescence and depression.* Produced by the National Institute of Mental Health; revised and reprinted by the Wisconsin Clearinghouse. Madison, WI: Wisconsin Clearinghouse.

Renouf, A. G., & Harter, S. (1991, April). *Levels of social support for adolescents with depressed affect and suicidal ideation.* Paper presented at the Biennial Conference for the Society for Research on Child Development, Seattle, WA.

Rutter, M. (1979). Protective factors in children's responses to stress and disadvantage. In M. W. Kent & J. E. Rolf (Eds.), *Primary prevention of psychopathology: Social competence in children, 3* (pp.49-74). Hanover, NH: University Press of New England.

Rutter, M. (1986a). Depressive feelings, cognitions, and disorders: A research postscript. In M. Rutter, C. E. Izard, & P. B. Read (Eds.), *Depression in young people: Developmental and clinical perspectives* (pp. 491-519). New York: Gilford Press.

Rutter, M. (1986b). The developmental psychopathology of depression: Issues and perspectives. In M. Rutter, C. E. Izard, & P. B. Read (Eds.), *Depression in young people: Developmental and clinical perspectives* (pp. 3-30). New York: Gilford Press.

Shaffer, D., Philips, I., Garland, A., & Bacon, K. (1989). Prevention issues in youth suicide. In D. Shaffer, I. Philips, N. B. Enzer, & M. M. Silverman (Eds.), *Prevention of mental disorders, alcohol and other drug use in children and adolescents. OSAP Prevention Monograph-2* (pp. 443-456). Rockville, MD: Office for Substance Abuse Prevention.

Small, S., Herlache, S., & Doll-Yogerst, D. (1990). Whose kids? ... our kids. *Newsletter of the Teen Assessment Project (TAP),* January 1990.

Steinberg, L. (1989). *Adolescence*. New York: Knopf.

Weiner, I. B. (1980). Psychopathology in adolescence. In J. Adelson (Ed.), *Handbook of adolescent psychology* (pp. 447-471). New York: John Wiley & Sons.

Williams, R. T. (1987). *Prevention in the mental health arena.* Madison, WI: Wisconsin Clearinghouse.

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