

# Depression:

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A major youth health issue

## BACKGROUND

Feeling sad or down occasionally because of negative life experiences, or even for no obvious reason, is common for a lot of people at some point in their life. A range of self-help, and formal or informal support is normally enough for most people to deal with such feelings. Clinical depression, however, is different. Clinical depression refers to problems of low mood that have become chronic (lasting for two weeks or more), are distressing, significantly impact on the person's daily functioning, and are not just a reflection of drug use, a physical problem, or a natural grief response (American Psychiatric Association, 2000).

When young people are depressed they may lose interest in the activities they used to find pleasure in. They also often become critical of themselves and may feel that others criticise them. They can feel unloved, pessimistic or hopeless about the future. They might think that life is not worth living and could have thoughts of suicide. Depressed children and adolescents are likely to be irritable, which may lead to aggressive behaviour. They are often indecisive, have trouble concentrating and may lack energy and motivation. They may also neglect their appearance and hygiene and their normal sleeping patterns could become disrupted (American Psychiatric Association, 2000).

Depression is a commonly diagnosed mood disorder and a majority of young people experiencing depression may also be facing other difficulties such as anxiety, substance abuse or conduct problems (Angold & Costello, 1993; Anderson & McGee, 1994). A depressive disorder may arise as a response to another disorder or precede the development of an associated condition, for example, substance abuse (Kessler & Walters, 1998).

The Christchurch Health and Development Study (CHDS) – a longitudinal study following a cohort of New Zealand children from birth – found a strong link between depression at ages 17 and 18 and later mental health issues at age 25 (Fergusson, Horwood, Ridder, & Beautrais, 2005). More than a quarter of the participants in the study reported one or more core DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) symptoms of major depression, and 18% met criteria for major depression. Hankin and colleagues (1998) also reported a similar rate (17%) of major depression in 18-year-olds from Otago.

Depression is consistently identified as a major contributor to youth suicide (Beautrais, 2003). However, it is important to note that many people with depression will not be suicidal. Further, the risks associated with depression are increased by the attitudes many young people have about seeking help for mental health problems. Young people with the most suicidal ideation are often the least likely to seek help (Carlton & Deane, 2000).

The prevalence of depression among young people, its association with other difficulties, and its role in increasing the likelihood that a young person may end their life prematurely, makes depression a *major youth health issue*.

## RISK FACTORS FOR DEPRESSION

Depression has no single cause; often it results from a combination of biological, psychological, and socio-environmental factors, and the causes of depression are likely to be different for different people.

### *Biological risk factors*

Although the causes of major depression are complex and varied, a family history of depressive disorders has been associated with an increased risk of developing depression. Such patterns within families (as demonstrated by twin and adoption studies) have led researchers to conclude that there are genetic vulnerabilities to depression (Morley, Hall, & Carter, 2004). People with a family member suffering from depression are reported to be up to three times more likely to suffer from depression themselves than a member of the general population (Williamson, Birmaher, Axelson, Ryan, & Dahl, 2004).

Additional research indicates that depression may be a result of an imbalance in neurotransmitters. Neurotransmitters are chemical substances used by brain cells to communicate with one another. The three neurotransmitters believed to play a role in depression are dopamine, serotonin and norepinephrine. Decreased dopamine levels in the brain have been shown to relate to attention, pleasure and interest in life; a serotonin deficit has been associated with obsessions and compulsions, irritability, and anxiety; while a norepinephrine deficit may cause fatigue and a low mood (Nutt, 2008).

A range of studies also suggest that, overall, females are more likely to experience depression than males (see Kuehner, 2003). It is possible that this difference is genetic; however, the determinants of gender differences in depressive disorders are far from being established and are likely to be the result of a combination of bio-psycho-social factors, such as puberty, and social roles and cultural norms (Piccinelli & Wilkinson, 2000).

### *Psychological risk factors*

Several psychological factors may put people at risk for depression. People with a negative or pessimistic cognitive style, or who are readily overwhelmed by stress, are more prone to experiencing an episode of depression (Mathews & MacLeod, 2005). Similarly, children and adolescents with low self-esteem and a tendency to attribute positive outcomes to external non-controllable causes are at higher risk of experiencing depressive symptoms than are youth with a higher level of self-confidence (Birmaher et al., 1996). Furthermore, longitudinal studies have shown that following a depressive episode, depressed youth often have lower self-esteem, which in turn predicts future episodes of depression (Birmaher et al., 1996).

Issues surrounding weight and body dissatisfaction have also been shown to be predictive of future increases in depressive symptoms in several studies, particularly among young females (Franko & Striegel-Moore, 2002; Stice, Hayward, Cameron, Killen, & Taylor, 2000). Bearman and Stice (2008) suggest that, as boys are less likely to experience bulimic symptoms and body image issues this may be a unique risk factor for girls.

### *Socio-environmental risk factors*

The environment in which young people grow up shapes their lives and development. The risk and protective factors for depression include both individual and environmental factors. However, if we consider the 'ecology' of a young person, individual factors are largely inseparable from environmental factors (Bronfenbrenner, 1979). As Berk (2000) states, personal difficulties are developed as a result of a young person's environment.

There is a large group of socio-environmental risk factors that have been implicated in the development of depression. Specifically, negative and stressful life events (Hammen, 2005), problematic peer relationships (bullying) (Saluja, Iachan, Scheidt, Overpeck, Sun, & Giedd, 2004), negative parental rearing/neglect or feeling alienated from parents (Muris, Schmidt, Lambrichs, & Meesters, 2001), and low socioeconomic status (Lorant, Deliege, Eaton, Robert, Philippot, & Ansseau, 2003) are among the factors most consistently associated with depression.

Such socio-environmental factors can affect the way we think, feel, and behave. How we react to the events and circumstances of our environment may influence the development of depression.

## YOUTH DEVELOPMENT AND DEPRESSION

Youth development occurs through the reciprocal and dynamic interactions between young people and the various aspects of their environment. Positive youth development and issues such as depression can be seen as existing along a 'development continuum'. All young people experience 'risk' and 'protective' factors – positive developmental pathways can be fostered when a young person is exposed to opportunities and experiences that shape: (U.S. Department of Health and Human Services, 1997)

- A sense of industry and *competency*
- A feeling of *connection* to others and society
- A belief in their *control* over their life
- A stable *identity*

The above promote protection against depression (ref). In addition, these 'competencies' increase the likelihood that young people will take positive life journeys. This is important, given that depression is associated with destructive lifestyles, and risk-taking behaviours (U.S. Department of Health and Human Services, 1997).

Youth development programmes foster the above competencies in young people. Youthline follows the six key principles of the Youth Development Strategy Aotearoa (Ministry of Youth Development, 2002) to guide its youth services and to reduce the *risk* factors and increase the *protective* factors acquired throughout a young person's development.

1. *Youth development is shaped by the 'big picture'*

Young people are shaped by society's political, social, economic and cultural systems. It is important for young people to understand the forces which emanate from these systems and how they shape their lives. Such an understanding promotes self-direction and provides a platform for young people to effect change within themselves and their community.

2. *Youth development is about young people being connected*

Young people need healthy connections with community, family, friends, school, and workplaces. Strong, positive connections with many social environments combine to protect and foster development. Moreover, negative life experiences in one environment can be reduced by the quality connections experienced in others.

3. *Youth development is based on a consistent strengths-based approach*

Youth development is strengthened by the identification and development of each person's strengths. The development of various social, emotional, physical, and autonomy skills mitigates the risk of young people experiencing low self-confidence or exhibiting anti-social behaviour, and strengthens the likelihood that they will realise their potential.

4. *Youth development happens through quality relationships*

Young people need community support and positive relationships throughout their lives. These relationships provide essential support to young people and increase the opportunities youth have to develop the social skills and other competencies that facilitate the development of self-confidence and a sense of wellbeing.

5. *Youth development is triggered when young people fully participate*

Young people need to be given the opportunity to take control over the lives they lead and the direction they choose. Positive development is supported when young people are invited to actively participate in the work and development of their communities and organisations that have an impact on youth.

6. *Youth development needs good information*

Youth development is fostered by evidence-based practice. Young people need clear, unbiased information in order to help them make informed choices about how they plan, live and direct their lives. Such information includes providing links to numerous community youth-focused services.

If these six principles are upheld, they will contribute to the desired result of positive youth development – and young people will develop a sense of themselves and their value to society, a connection to others and the community, and the belief that they are autonomous, self-directed individuals who can achieve the goals they set for themselves.

## INTERVENTIONS AND EVIDENCE-BASED PRACTICE

In order to provide appropriate services for young people with depression, Youthline supports evidence-based practice and the use of empirically supported psychological interventions.

Interventions need to address the systems that impact on the young person and increase the protective factors, while also decreasing the risk factors for depression. Ecological interventions that take family, school and peers into account are seen as appropriate. Such interventions are able to address the risk factors both directly and indirectly. For example, family therapy can work towards developing positive family relationships, and parents can then work with their child's school to deal with stress and/or issues present in that system. Interventions which target individuals experiencing depression complement an ecologically focused approach.

This holistic health approach is embraced and driven by Youthline's philosophy, values and principles. Consistent with this, Youthline applies an individual assessment and plan for each client, using the following approaches:

- Assessment and monitoring of safety, self-harm, severity of mood, substance use, strengths and difficulties
- Make available information about depression and recovery, and discuss the possible options for support
- Typically recommend a consultation with a doctor. Some symptoms of depression are exacerbated by physical illness or substance use. For some clients, medication or referral to a specialist mental health service is appropriate
- If considered helpful and appropriate, the client's partner, family or friends may be involved. The client's personal wishes, privacy and safety are always considered
- Therapies are based on client needs and wishes, best practice and evidence, and can include:
  - Cognitive behavioural therapy
  - Family therapy
  - Problem-solving therapy
  - Social skills, stress management, relaxation training, or lifestyle approaches
  - Supportive counselling
  - Interpersonal therapy

- Therapy is reviewed regularly, and alternative approaches are developed where positive progress has not been achieved.

*Cognitive behavioural therapy (CBT)* focuses on the thoughts and behaviours that may be influencing the experience of depressive symptoms. CBT typically includes: psychoeducation (information regarding symptoms and treatments for depression), mood monitoring, stress management, cognitive training (learning to recognise and replace unhelpful ways of thinking), and behavioural and problem solving interventions. Lifestyle modification and relaxation training are also often components used in CBT. Psychoeducation and self-help can be used as an intervention on its own. This may be helpful for young people, especially as an initial approach.

*Family therapy* takes an organic view of the family, emphasising the interconnectedness of family members as parts of a whole family system, rather than focusing on individuals. The most common approach to family therapy is based on family systems theory. Treatment involves considering the systems unique to the family and the internal rules and patterns of functioning by which their system operates. Difficulties faced by one family member (the identified patient) may be an outcome of an unproductive function within the system. Introducing change into the system is theorised to bring change to the individual by making healthy the whole family system.

*Problem solving therapy (PST)* involves two processes – problem orientation and problem-solving style. During the initial phase, PST involves the evaluation of the extent to which the client recognizes, denies, or ignores the problem, and whether the client views the problem as a personal and stable defect. The second process involves the identification of the client’s problem-solving style, reappraisal of the problem, and developing appropriate goals based on the client’s strengths. Together the client and therapist brainstorm different problem-solving strategies that will increase the client’s capacity to cope and decrease or alleviate the adverse effects of the problem.

*Supportive counselling* may be provided by mental health specialists, general practitioners in the primary care setting, or paraprofessional (trained but unqualified) counsellors. Supportive counselling draws on the supportive aspects of the therapist-client relationship. In this form of counselling, the client is encouraged to talk about what is troubling them and is taught strategies to restore and maintain quality of life. Empathy, sympathetic listening, encouragement, and education are vital components in supportive therapy.

*Interpersonal therapies* assist clients with difficulties in relationships with families, partners and social situations. Interpersonal therapy teaches skills to enable clients to reintegrate into their social circles, strengthen their support networks and engage with the support that’s available to them to facilitate recovery.

Furthermore, research shows that therapy outcomes are related to the development of a positive therapeutic alliance (Leach, 2005).

Youthline's phone volunteers are young people who are enthusiastic about helping others, and although trained by Youthline do not hold a professional qualification in counselling or psychology. Recently, den Boer et al. (2005) found that counselling for anxiety and depression by paraprofessionals (i.e. individuals trained in counselling techniques without being qualified counsellors) gives effective outcomes comparable to that of professionals such as psychiatrists and psychologists. This is an important finding for helpline counselling, and indicates the importance of empathy in the delivery of telephone counselling alongside clinical skills. Positive outcomes from telephone counselling are associated with Rogerian active listening skills in combination with more directive techniques (Mishara & Daigle, 1997). Together, these studies provide a rationale for Youthline's helpline as a key tool in addressing issues for young people.

## CONCLUSION

Depression is a major youth health issue that can be linked to other difficulties faced by youth, such as substance abuse. Depression is also a significant risk factor for suicide. The relationship between environmental influences and depression is significant and holistic interventions need to be put in place in order to increase the protective factors present in a young person's life. Youth development programmes increase the factors which provide protection against depression and equip young people to undertake positive life journeys.

## RANDO:

For young people experiencing mild to moderate depression, low intensity psychosocial interventions, following a stepped care approach (where the intensity of treatment is adjusted according to the response to treatment) are recommended (Fraser & Tilyard; National Institute of Health and Clinical Excellence, 2005).

An emerging area of interest is early preventative measures for young people displaying signs of depression but who have not crossed a clinical threshold for diagnosis. Currently, there is not consistent evidence to suggest that preventative treatments are successful for depression (Merry & Spence, 2007). However, as the costs associated with depression are high and some studies indicate positive outcomes; further research is therefore warranted.

It is anticipated that the future of preventative measures lies in broad-based prevention approaches. Catalano et al. (2004) state that successful approaches to youth issues utilise diverse strategies to strengthen:

- social, emotional, behavioural, cognitive, and moral competencies
- build self-efficacy
- increase healthy bonding with adults, peers, and younger children
- provide structure and consistency in program delivery

Youthline delivers a number of clinical services to the community in the following areas: education, counselling, family therapy, email and text message counselling, pregnancy counselling and crisis support via a helpline. In order to provide young people with the highest quality services, Youthline delivers empirically-supported interventions to young people faced with depression, and their families.

A Youthline *Assessment and Treatment Guidelines Manual* has been developed which outlines effective treatment methods for psychological issues. The manual is comprehensive and the treatment template is flexible enough to adapt according to a diversity of client needs. The approach outlined in the manual mitigates risk (e.g. suicide), emphasises service integration, and maintains a movement towards health with a youth development focus



## YOUTHLINE'S POSITION

Youthline takes the position that:

1. Youth-focused services need to encourage help-seeking behaviour by providing health information through a youth friendly media, for example, internet and email services.
2. Depression is a serious problem and evidence-based practices should be employed to treat it.
3. Depression cannot be isolated from other issues, and treatment should embrace a holistic health approach that is developmental.
4. Integrated service delivery ensures the needs of the whole individual are taken into account, and enhances the likelihood that a young person will be protected from depression.
5. Youth-focused services need to be adequately funded to provide a holistic health service to young people experiencing depression, and their families.
6. Youthline's youth helpline is an effective way of providing help to young people, and is supported by current research.

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