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ADOLESCENT DEPRESSION AND

THE ROLE OF THE SCHOOL COUNSELLOR

LOIS GADD

JOHANNESBURG 1987

ADOLESCENT DEPRESSION AND THE ROLE OF THE SCHOOL COUNSELLOR

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JOHANNESBURG, 1987

DECLARATION

I declare that this research is my own work and that I have not submitted it, nor any part of it, for a degree at any other university.

LOIS MERLE GADD

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ABSTRACT

The purpose of this study was to examine the phenomenon of adolescent depression in an exploratory manner. Although recent literature has attempted to address the nature and prevalence of childhood and adolescent depression, there is a considerable lack of research within the school context. This study attempted to redress this imbalance.

A sample of 20 school counsellors/guidance teachers, who are members of the Transvaal Education Department Association for Counselling and Guidance participated in the study. Their role in terms of recognition and management of depression was recorded in the form of a questionnaire designed specifically for this study.

A further section included individual case studies which aimed at enhancing our understanding of some of the inner conflicts experienced by adolescents who encounter depression in various forms.

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1.1 INTRODUCTION

Prior to the 1970's, conventional wisdom held that depression was rarely experienced or evident in children. As such, there was no need to officially recognise the diagnosis of Childhood Affective Disorder. Up till the present time, the area remains characterised by definitional problems, diagnostic difficulties and methodological contradictions. Furthermore, the American Psychiatric Association has still to accept the distinction between Adult and Childhood Depression formally in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition, Washington D.C.; A.P.A, 1980). However, despite these obstacles, the growing acceptance that depressive disorders can and do occur in childhood and adolescence has been followed by an increase in clinical and theoretical research.

Chartier and Ranieri (1984), state that there is no question that depression occurs in adolescents, but that the clarification of certain conceptual issues depends on knowledge of the prevalence of adolescent depression in normal as well as clinical samples.

Certain issues emerge when dealing with adolescent depression and the first distinction that has to be made is between depressive feelings as an affective phenomenon and depressive disorders as psychopathological conditions.

As Achenbach (1978) notes, the issues are :

i) whether some of the phenomena indicative of depression are in fact manifestations of "adolescent turmoil";

ii) whether some depression is a normal reaction to stressful life events or crisis situations, with a course that is fully understandable in these terms; and

iii) the extent to which adolescent depression may be the result of consequences associated with other behavioural problems, such as aggression or drug abuse

Given the above distinctions, it is often a most difficult task when dealing with adolescents to distinguish what is a normal disturbance due to the developmental upheaval of the age and what constitutes a diagnosable disorder. It becomes crucial when discussing the diagnosis of depression to differentiate between symptoms and syndromes. Depressive syndromes fall under the general classification of affective disorders in DSM III. These syndromes include major depressive episode (single episode or recurrent, possibly with psychotic features or with or without melancholia), bipolar disorder, cyclothymic disorder and dysthymic disorder. These syndromes are differentiated by specific clusters of symptoms, age of onset, and duration of disturbance. (Diagnostic and statistical Manual for Mental Disorders - 3rd Edition, American Psychiatric Association, 1980).

In terms of Erik Erikson's Stage Theory (1951), the adolescent would be vulnerable to certain feelings at a stage where the major life task is that of arriving at a sense of self and identity (Bootzin, 1980). Eriksor uses phrases such as 'normative crisis' and the 'psychopathology of everyday adolescence', (Conger, 1977) implying that depressive feelings among others might well be part of the adolescent's reaction to the psychosocial crisis of identity formation.

Epidemiological data on depression in children and adolescents is important toward establishing some insight into the scope and impact of the disorder. From an examination of the literature it would appear that although research has been conducted in both normal and clinical populations, a huge gap is evident in school psychology research. According to Sullivan & Engin (1986) prior to 1984, only one study on depression had appeared in school psychology - related journals. In spite of this unfortunate situation, it is however necessary to acknowledge the progress that has been achieved.

An index of the prevalence of depressed affect is provided by Rutter et al (1976), as a result of the Isle of Wight study which involved assessing children at 10 years old and then again at age 15. Links between puberty and depressive feelings were indicated, with evidence that girls experienced a higher frequency of depressive disorders than boys. Although criticised for not being entirely representative, the study is one of the first to explore issues of age and gender in relation to depression. Interest in the area of adolescent depression appears to lag behind that of childhood depression and to-date one of the few measures which has been developed specifically for adolescents, is the Reynolds Adolescent Depression Scale (R.A.D.S.) (1984). However, the Beck Depression Inventory (BDI) is the most frequently used measure in both adult and adolescent studies on depression. Three studies offering data on the prevalence of adolescent depression in the general population using the Beck Depression Inventory include those of Albert and Beck (1975), Teri (1982), and Kaplan, S.L., Hong, G.K, and Weinhold, et al (1984). These studies give some indication of the prevalence of depression, efficacy of classification systems used in both adolescent and adult situations, as well as the effect of age and gender when measuring depression. Another recent investigation was that of Reynolds (1983a), of over 2,800 adolescents in high school settings. He reported a prevalence rate of 18%, using criteria for moderate and severe levels of depression formulated by Beck (Reynolds, 1984). Furthermore, a repeated assessment of 126 adolescents in a longitudinal study (Reynolds, 1983b) suggests that in severely depressed adolescents, depression is a relatively long term affective disorder consistent with diagnostic criteria for dysthymic depression. These findings along with recent research investigations of major depressive disorders suggest that this disorder is extensive in adolescents (Cantwell & Carlson, 1983). This conclusion contradicts the Rutter (1976) study, which suggests that while depressive symptomatology may be rather common in adolescents, it is rarely of clinical significance.

Sullivan and Engin's (1986) study presents evidence pertaining to the prevalence of depression in high school students. They state that in spite of an increasing concern with adolescent depression, prevalence figures are not clearly established. This is understood to be a result of problems rooted in differences in conceptualization and measurement of this affective disorder. Sullivan and Engin are highly critical of the current state of confusion in the field. They state that no one has systematically addressed the etiology of childhood and adolescent depression and that our understanding has been severely hampered by the use of different instrumentation and sample characteristics across the "relatively few empirical studies". The above-mentioned study is supported by the findings of Albert and Beck (1975) and Teri (1982), all of which suggest that about 6% of the adolescents in regular schools report severe levels of depression.

Considering the magnitude of the problem, it is fairly evident that research in the area of adolescent depression has yielded only tentative conclusions. Future research on the prevalence of adolescent depression in both normal and clinical populations would be more useful if a number of issues could be resolved. This would involve agreement on diagnostic systems and criteria, symptomatology and intervention procedures.

Furthermore, although there has been a rapid expansion of research in childhood and adolescent depression, the school psychologist has rarely been involved in this area. (Reynolds, 1984). As providers of psychological services to children and adolescents, it is evident that professional workers can and should play an important role in the assessment, diagnosis and treatment of this disorder.

It is however important to acknowledge that the first step in helping depressed children and adolescents is gaining awareness of this disorder and this step has been taken.

1.2 THE CONCEPT OF ADOLESCENCE

The concept of adolescence as we know it today, has a relatively short history. G. Stanley-Hall is regarded as the first theorist to have recognised adolescence as a distinct stage in his influential work, 'Adolescence', published in 1904. The word adolescence comes from the Latin verb 'adolescere' which means 'to grow' or 'to grow to maturity' (Hurlock, 1967). However, detailed definitions provided by theorists are dependent on the theoretical orientation taken in that emphasis may be placed on the biological, psychological or sociological criteria of development.

For the purpose of this study, adolescence is defined as a transition period between childhood and adulthood characterized by rapid physical, physiological, psychological and social change which ends when maturity has been obtained in these areas.

Therefore the period is one in which an individual progresses from dependency to self sufficiency by confronting and consolidating a number of different psycho-social-sexual tasks.

We have become accustomed to thinking about adolescents in terms of turmoil and emotional upheaval. This orientation was originally established by the psychoanalysts, and in particular Anna Freud, who regarded this turmoil as being a necessary part of the resolution of age appropriate developmental conflicts (Esman, 1975). However, more recent evidence strongly suggests that the 'storm and stress' theory, originated by G. Stanley-Hall has been exaggerated, and that the majority adjust quite normally to this phase of life.

Nevertheless, our focus needs to be on those adolescents who fail to meet the psychological challenges of a process which is essentially about loss and mourning (Noonan, 1983).

Depressive reactions are a common way of trying to integrate loss, whether this be object loss, loss of childhood, loss of esteem, etc.

Adolescence is also about cumulative gain in that new physiological processes develop and sexuality begins to emerge. This can be both exciting and disorientating in that the adolescent might become overwhelmed by an influx of confusing and contradictory feelings.

1.2.1 The development tasks of adolescence

The Work of Erik Erikson

One of the most influential ego psychologists is Erik Erikson whose theories emphasize the importance and power of the ego and the social context of the personality. Erikson's psychosocial stage theory postulates development through a series of chronological stages. Each stage represents a "normative crisis", which the individual is required to resolve by integrating new adaptive tasks. Each crisis represents a challenge to the ego which becomes progressively more consolidated through the process of conflict resolution.

AGE	PSYCHOSOCIAL STAGE	HEALTHY RESOLUTION
Infancy (1st Year)	Trust vs. Mistrust	Trust, optimism, warmth
Early Childhood (2nd Year)	Autonomy vs. Shame, Doubt	Pride of accomplishment
Play Age (3-5 Years)	Initiative vs. Guilt	Development of conscience, self worth, goal definition
School Age (6 Years - Puberty)	Industry vs. Inferiority	Competence, self confidence mastery of skills
Adolescence	Identity vs. Identity diffusion	Sense of continuity with one's past, present and future, healthy sense of identity
Young Adulthood	Intimacy vs. Isolation	Ability to form close, stable relationships and commitments
Middle Adulthood	Generativity vs. Self Absorption	Productivity, creative concern for the world
Mature Age	Integrity vs. Disgust, despair	Acceptance of mortality, sense of peace

(Diagram adapted from Bootzin, 1980)

It is important to point out that the psychosocial stages represent processes the individual has to negotiate, the resolutions of which determine basic personality traits. Each phase is prefaced by the term "a sense of" to denote the importance of the subjective reality - for example, crisis leads to trust, optimism and warmth being established within the individual.

The focal point of adolescence is a 'crisis' of identity, and the failure to achieve a coherent sense of identity, Erikson termed the syndrome of 'identity diffusion' (Conger, 1977). With reference to the DSM III, the inability to reconcile aspects of the self into a relatively coherent and acceptable sense of self can cause the adolescent severe anguish and result in an Identity Disorder. Mild anxiety and depression are symptoms often associated with adolescents who experience uncertainty with regard to issues relating to identity, long term goals and career choices, friendship patterns, sexual orientation and behaviour, religious identification, moral value systems and group loyalties (DSM III 1980).

According to Erikson, the adolescent already has a nucleur sense of identity that develops from earlier stages, provided these were successfully negotiated. A sense of identity is formed by the integration of all earlier stages into a whole, via a process called 'ego synthesis'. Erikson describes identity as the adolescent's knowledge of who and what he/she is and what he/she can become. It is a sense of self confidence and sameness and a sense of continuity.

Thus the principal tasks of adolescence can be summarized as the development of a sense of independence from the family, successful integration into the dominant society, and the acquisition of a sense of self confidence and purposefulness that leads into tertiary education, career develo; nents and a constructive adult life.

The Work of Peter Blos

Blos, like Erikson, is regarded as a theorist whose primary emphasis is on the developmental tasks the adolescent has to negotiate in order to achieve a consolidated sense of identity.

For Blos, the developmental work of the adolescent represents a recapitulation of separation - individuation tasks. This process makes the adolescent vulnerable not only to normal everyday losses, but also to unresolved conflicts from infancy and childhood, the first individuation process having been completed toward the end of the third year of life with the attainment of object constancy . What is in childhood, the individuated toddler, becomes in adolescence the shedding of family dependencies to become a member of society. Blos defines the individuation process as the ego aspects of the regressive tasks in adolescence to loosen ties to both infantile objects as well as the shredding of family dependencies (Blos, cited in Esman, 1975). This corresponds with Erikson's view of the adolescent's attainment of a sense of identity. Ego disturbances apparent in acting out learning disorders, depression, negativism and moodiness are frequently the symptomatic signs of a failure to individuate.

Individuation implies that the adolescent takes increasing responsibility for his/her actions in society and achieves a sense of purpose and commitment in relation to work and relationships. As such, Blos and Erikson both arrive at a similar end point in their conceptualizations of the healthy outcome of adolescent conflicts.

Differentiating between normative and clinical depression is not an easy task in practice. However, both theorists would consider depressions of adolescence to evolve out of the developmental phases of childhood, rather than adolescence itself. Adolescent depression in its clinical form has precursors in childhood which can be related to both pre-oedipal and post oedipal stages. Of particular note are significant mood disturbances during childhood e.g. temper tantrums, crying and head banging (Anthony, 1976).

Anthony, (1975) confirms that a well defined clinical depression is evident in adolescents who are already highly sensitized to depressive reactions because of pre-oedipal and post oedipal experiences.

Blos (1962) further suggests that adolescent depression is indicative of conflicts in object relationships and that object loss makes a deep impact on psychic development.

Depressive reaction is viewed as the usual method for integrating the cognitive and affective recognition of loss. What distinguishes normal from clinical depression, according to Blos, is the way mourning is handled. Adequate mourning results in the rapid restoration of equilibrium. When the mourning mechanisms are deficient, various states of incomplete mourning and clinically manifested depressions develop.

In conclusion, both theorists conceptualize development in terms of progressive milestones each marked by a phase specific conflict whose resolution is a pre-condition to higher levels of differentiation. (Blos, 1962). Both Blos and Erikson regard adolescent depression as originating in childhood. The individual has to struggle with regressive phenomena in order to re-negotiate conflicts that have as a result depressive reactions.

1.3 DEPRESSION

Depression is an umbrella term, referring to a variety of painful emotional states which have been recognised and written about since ancient Greek times (Bootzin, 1980).

Depending on one's perspective, the value and meaning of depression can be understood and defined in numerous ways.

Esther Harding, in a paper read before the New York Analytical Psychology Club in 1970, forwarded the 'idea of a wilderness' to symbolize depression. "It symbolizes a psychological condition or experience when one has the feeling of being in a desert place, or in a wilderness - a feeling of being lost, lost in an inhospitable region, so lost that one is in a state of despair". In this approach, she is essentially describing depression in its archetypal dimensions. While valuable in itself, this approach needs to be further extended as the term depression may have at least three clinical meanings that overlap, but do not necessarily coincide.

1.3.1 Depression as an affective state

Depression as an affective phenomenon is characterised by feelings of dejection, dysphoria or melancholy that vary in intensity and duration. Often this state is a response to actual life events, but can also occur for no apparent reason. Individuals who experience these feelings might be described as depressed, but are not necessarily suffering from depression as a clinical syndrome (Clayton, 1982).

1.3.2 Depression as a clinical syndrome

A clinical syndrome is a distinct recognisable cluster of symptoms associated with a specific 'illness'. Depression as a clinical syndrome is characterised by loss of interest, ability, competence, etc.

Beck (1967), described depression in terms of the following affective, cognitive, motivational, vegetative and motor disturbances, respectively.

i) Mood change with sadness, apathy and loneliness.
ii) Negative self concept with self reproach and blame.
iii) Regressive and self punitive wishes.
iv) Vegetative change with anorexia, insomnia and loss of libido.
v) Activity level change, with retardation and agitation. These changes range in pathological intensity from mild to severe.

According to DSM III, the essential feature of Affective disorders is a disturbance of mood, accompanied by a full or partial manic or depressive syndrome, that is not due to any other mental of physical disorder. Affective disorders are considered in terms of well defined onset, essential and associated features, diagnostic criteria as well as expected course of the syndrome. This syndrome may exist as a primary or secondary disorder.

The manifestations of depressive disorder has lead clinicians to attempt to sub-classify it in terms of different dichotomies i.e. Manic-Depressive - Psychogenic, Neurotic - Psychotic, Endogenous - Reactive and Unipolar - Bipolar. These dimensions attempt to distinguish mild from severe depressions within the clinical framework. The duration and intensity of certain symptoms e.g. loss of libido, decreased appetite and feeling of despair are meant to distinguish mild from severe depression.

It remains unclear whether the differences between these clinical categories and so called normal depression are qualitative or quantitative.

The continuity hypothesis proposed clinical depression to be an exaggeration of normal low mood. This idea was based on the observation that clinically depressed individuals resembled normal people who had suffered a major setback or bereavement. (Mudie, 1978). This view has been criticised for being simplistic and the dichotomies which have been formulated would suggest that important differences do exist although these still remain uncertain.

However, despite uncertainty clinical depression is generally considered to result from an interaction of predisposing and precipitating factors, be they genetic, biological, developmental, personality or psychosocial.

1.3.3 Normal vs Clinical Depression

The clinician's task of distinguishing between depression as a manifestation of health in relation to developmental tasks and depression as being indicative of pathology is a difficult one.

However, for practical purposes in terms of intervention in the school context, some guidelines are necessary.

Evidence of depression as a reaction to disappointment, frustration or loss e.g. exam failure, relationship breakdown or feelings of rejection is considered appropriate if it occurs within certain limits of time and depth. In most cases, the individual is responding to a real life situation or event and has the capacity to understand and work with the feelings that are evoked. The acknowledgement and working through of these feelings are preconditions to dealing with loss and sadness in later life.

When attempting to understand depression as a pathological response it is advisable that the clinician explore the adolescent's developmental and family history. According to Erikson and Blos, adolescent depression in it's clinical form has precursors in childhood, (refer to 1.2.1). Disturbances in childhood are often re-enacted, albeit in different form in adolescence. It is well known that adolescents in whom depression plays a central role, manifestly or covertly, often display self damaging behaviour which may be seen as a direct expression of their feelings of hopelessness and despair. (Baker 1978). Actual suicide is at the extreme end of the continuum which covers a wide range of activities including sexual promiscuity and delinquency. Factors which predispose adolescents to clinical depression, resulting in these behaviours often include severe deprivations in childhood e.g. loss of a parent. This finding further underlines the necessity of examining the individual's past.

A noticeable lack of depression or ability to mourn in response to loss is equally worrisome and the clinician needs to consider the maladaptive use of primitive defense mechanisms e.g. splitting and denial which are preventing the individual from obtaining a healthy resolution.

Thus, the ability to experience certain levels of depression needs to be closely assessed in order to ascertain the difference between a normative and a pathological reaction.

1.4 DEPRESSION IN CHILDHOOD AND ADOLESCENCE

The area of childhood and adolescent depression shows a marked absence of generally agreed upon and objective criteria for classifying the disorder. Nevertheless, the burgeoning interest in the area over the past decade has ensured continued efforts towards understanding these disorders.

1.4.1 Depression in childhood

Researchers who have carried out extensive studies of depression in latency age children vary in their descriptions of symptomatology, and they remain divided over what constitutes a reliable clinical picture of the disorder (Toolan, 1962; Poznanski and Zrull, 1970; Ling, Oftedal and Weinberg, 1970). Infant depression often manifests with signs of withdrawal, feeding and sleeping disturbances, weight loss and developmental retardation. In latency age children, depression is associated with somatic complaints, social withdrawal and school problems. A major problem in diagnosing depression concerns the measurement of certain complex emotions and cognitive features. Young children are not able to report or to experience certain aspects which have been regarded as indicative of depression. Clinicians have often relied on symptoms comparable to the Adult syndromes, but now realise the necessity of creating a totally separate system of diagnosis (Rutter, M; Izard, C.E & Read, P.B; 1986). In a relatively short period of time, childhood depression has gone from being essentially overlooked (Kanner, 1957) to being accepted as a distinct clinical phenomenon. Issues concerning behavioural, emotional and somatic dimensions of depression do however require continued assessment.

1.4.2 Depression in adolescence

Depression as it appears during adolescence, cannot be separated from the context of this developmental period, which represents a recapitulation of issues of separation - individuation, oedipal struggles and autonomy conflicts. The enormous increase in the intensity of sexual and aggressive impulses, fuelled by the revival of infantile urges and fantasies, cannot be dismissed as a passing phase. General population surveys suggest that depressive feelings are more prevalent in adolescence than in earlier childhood, and that the rise may be a function of puberty (Rutter, 1979 cited in Rutter, Izard and Read, 1986).

Blos and Erikson view adolescence as a developmental stage which renders the individual susceptible to crisis points when he/she confronts the psychological challenges of identity formation and individuation. The psychoanalysts have continually emphasized the internal emotional upheaval of the adolescent and regard a period of stress as normal. Erikson's normative crisis refers to a "normal phase of increased conflict characterised by a seeming fluctuation in ego strength . . . what under prejudiced scrutiny may appear to be the onset of a neurosis, often is but an aggravated crisis which might prove to be self-liquidating, and in fact contributive to the process of identity formation" (cited in Rutter, Graham, Chadwick and Yule, 1976).

Recent empirical evidence (Guardo, 1975) shows that the storm and stress theory is exaggerated and the majority of adolescents undergo transition with very little upset. Baker (1978), together with Blos and Erikson would challenge this view. Baker's basic premise is that adolescence is a time when the individual has to negotiate difficult developmental tasks. Separating from parents, acceptance of the sexual self and healthy relating to peers all present with some stress. He believes that the adolescent who emerges more or less emotionally intact is dependent at one level on his/her capacity to experience certain degrees of depression.

The question as to degrees of depression which go beyond what could be considered appropriate, needs careful consideration. These depressive states are characterised by their persistence and the failure of the adolescent to come through it. Symptomatology is known to be varied and unpredictable. Different clinicians associate a variety of behavioural, attitudinal, motivational emotional and somatic symptoms with depression. It remains unclear whether there is a progressive shift toward adult symptomatology or whether age specific criteria apply. However certain symptoms are more frequently associated with depression than others.

These include social withdrawal, psychosomatic complaints and hypochondriasis Other fairly common symptoms include guilt, low self esteem, school problems, drug abuse, suicidal ideation, appetite loss and acting out (Mastropaola, 1972; Nissen 1973; Toolan, 1974; Lesse and Rutter, 1975). Baker (1978), highlights feelings of emptiness, worthlessness and self hatred. Pre-occupations with death and dying may also be present.

An important point to bear in mind is that symptcms are likely to manifest in the contexts that adolescents are most involved. This has particular significance in terms of school where depression may be associated with school underachievement and school refusal (Rutter et al, 1976). It is however important to distinguish whether these symptoms are a normal response or constitute a Clinical disorder. (refer 1.3.3 and 1.5.2).

1.5 MANIFESTATION OF DEPRESSION IN THE SCHOOL CONTEXT

Although the prevalence of depression in schools has not been clearly established, certain studies report a high rate of depressive symptoms among adolescents (Sullivan and Engin, 1986). There appears to be correlations between depressive symptoms and school related problems, e.g. academic deficits (Reynolds, 1984).

The role of both teachers and school counsellors is crucial as children spend most of their academic and social time in this context and adjustment levels can usually be assessed quite accurately. Evidence exists that teachers are able to assess a child's current adjustment with considerable reliability and validity. For example, Weintraub, Neale and Liebert, (1975), found that teachers were able to identify vulnerable children at risk for psychopathology.

1.5.1 <u>The younger adolescent</u>

The manifestations of depression have been defined in various ways, with recent literature focusing on the overt expressions of depression. These would involve a child looking miserable, feeling weepy, guilty, exhibiting social problems, expressing concern about death and being withdrawn (Kovacs, 1980 in Cantwell and Carlson, 1983).

Depression in the school context is often expressed in poor school performance, failure and school refusal. These factors form part of the clinical picture of many depressed children resulting in theorists suggesting a relationship between depression and intellectual disturbances. (Malmquist, 1977). The relationship has not been clearly established in terms of whether depression is secondary to learning disabilities or a primary condition.

Tisher's 1984 Australian study is particularly informative in giving recognition to the presence of depression in school refusal. The study provides contextual data about the broader social systems of the children to which both their school refusal and depression are related. School refusers tend to differ from regular attenders in that they came from lower socio-economic larger families who had received little education. In terms of Systems Theory, children refusing to go to school were exhibiting not only an individual sign of depression, but also a symptom of the family dysfunction - helping other members to remain symptom free.

Other writers (Cytryn and McKnew, 1974) have described school refusal as one of the many behaviours which are depressive equivalents - channels which the child uses to express depression which is otherwise generally masked.

1.5.2 The older adolescent

In older adolescence, there is the capacity for the understanding and communication of depression. However what happens during the course of depression depends on a number of factors. If the depression can be worked through the opportunity of emotional growth presents itself and an integrative process, reflecting mental health can occur (Hyatt-Williams, 1978). If the feelings of depression are not tolerated and the adolescent resorts to conscious or unconscious defensive avoidances of those feelings the outcome can be maladaptive. Avoidances may take the form of escape into drug and alcohol abuse, sexual promiscuity and delinquency. Pleasure and excitement often provide the adolescent with a 'magic' solution to stresses which would seem to alleviate uncomfortable feelings.

Acting out in particular, has been cited as a strong adolescent phenomenon (Blos in Eisman, 1975). It can be seen as defensive action against feelings of helplessness, depression, fears of separation and conflicts about object loss. Rather than working with these feelings the individual short circuits the painful situation by action. Usually this action, which might take the form of substance abuse or sexual promiscuity can be seen to be destructive or at least disadvantageous to the adolescent. Lesse (1980), suggests that acting out serves as a behavioural equivalent for underlying feelings of depression. It is important to point out that depression is only one of the causes of acting out. This could also suggest the existence of a conduct or oppositional disorder. Therefore acting out seen in isolation does not justify a diagnosis of adolescent depression and the presence of other behaviours such as mood change, loss of ability, energy, precipitating events and personality factors would have to be explored.

Depression demonstrated through school problems is quite common. Such problems are likely to fall into four categories (McCoy, 1982).

i) Lack of motivation - loss of involvement and falling marks. This problem is compounded in the case of individuals with learning disabilities or who are academically slow. A cyclical relationship emerges between the inability to keep up with peers and low self esteem and depression.

ii) School phobia - a tendency to avoid school via a myriad of symptoms and crises ranging from a constant array of physical complaints to fears of teachers and peers, to stubborn refusal to attend school regularly.

iii) Truancy - failure to attend school for days or weeks or dropping out altogether.

iv) Serious problems with teachers, peers and school authorities. These may manifest in direct confrontations and rebelliousness or withdrawal. Drug and alcohol abuse may also occur. It is unfortunate that adolescents who fall into this category most often evoke retaliatory and punitive reactions from the environment, as they then have great difficulty in believing in the possibility of empathy from school personnel. Winnicott (1971), emphasized the importance of confrontation in a containing non-retaliatory way. Baker (1978), emphasizes the importance of understanding the destructive nature of the counter-transference evoked by these depressed adolescents. The display of self damaging behaviour through sexual promiscuity, delinquency, substance abuse and suicidal ideation is often a direct expression of feelings of despair, worthlessness and hopelessness which can be worked with, given the basic premise that ultimately the adolescent seeks and longs for understanding.

1.5.4 Conclusions

The problem as has been stated previously is that depressive behaviour is both normal and adaptive at specific developmental stages and in response to situational crises and must be distinguished from the disorder itself. However, the problem is further complicated as diagnostic criteria for adolescent depression have not been formally established . Studies in adolescence have however confirmed that certain descriptive criteria are common and provide an indication that the individual is in distress.

Depression considered to be a normal response is usually a reaction to certain life events, disappointment, frustration or loss. In contrast, pathological depression is understood to be present when the individual exhibits behaviours such as social maladjustment, loss of self esteem, isolation, suicidal thoughts, self damaging behaviour and feelings of guilt and inadequacy. Depression manifested in the school context can appear directly through a combination of symptoms usually considered significant when several occur in one individual. In addition to these symptoms other signs of distress at school may include lack of motivation, school phobia and truancy. These are not considered normal responses to a situation and would necessitate further enquiry into family and personal history on the part of the school counsellor.

The role of the school counsellor becomes especially important when distinguishing between depressive responses which are essentially reflections of mental health and those which may foster development in the direction of pathology. However this role remains unexplored in the literature, which is unfortunate considering that depression may impinge upon important aspects of the adolescent's functioning at shool. (Reynolds, 1984). (See 5 for futher discussion on counsellor's role).

The view that depression in adolescence is a 'passing phase' is a dangerous one in that it fosters complacency and loses the adolescent the opportunity to re-negotiate psychic conflicts. Depressive reaction as an appropriate way of integrating loss can provide the individual with insight and understanding, but left untreated and especially in the case of clinical depression can be potentially life threatening.

CHAPTER TWO : METHOD

RATIONALE AND AIMS

2. Rationale

A review of the literature clearly indicates that adolescent depression is an affective disorder which warrants the attention of people involved in providing psychological services to children and adolescents.

Despite the relative expansion in research relating to adolescent depression, lacunae exist in the literature regarding depression in the school context, which is a significant life - context of the adolescent.

Furthermore, school psychologists and counsellors have rarely been involved in assessment, diagnosis or treatment of the disorder. Given that these individuals are responsible for the mental health of children at school, it behooves them to be aware of various symptom patterns that may be indicative of depression. Actual treatment would depend on the counsellors' qualifications and expertise, but involvement can take place at many different levels which might include educating teachers, assessment and referral procedures.

According to Sullivan and Engin (1986), the only study dealing with depression to appear in school psychology - related journals was that conducted by Reynolds in 1984. The purpose of the study was to provide school psychologists with information as to the current status of depression in children and adolescents. Epidemiological data, phenomenology, diagnostic criteria, assessment measures and intervention strategies were discussed. In addition the role of the school psychologist was described in terms of primary prevention. Sullivan and Engin's 1986 study, presented evidence pertaining to

the prevalence of depression in high school students. The high rate of reported depressive symptoms among adolescents was discussed in relation to school psychology practice.

Although there is increasing concern with adolescent depression, the above studies appear to be the only two which attempt to explore the problem in relation to the school psychologist. The present study attempts to redress the imbalance in the literature by researching in an exploratory manner the nature and prevalence of depression in some South African schools.

2.1 Aims

These were two fold:

Part One: To investigate the perceptions and role of school counsellors/guidance teachers in relation to adolescent depression in South African Schools.

Part Two: To use individual case studies to highlight common areas of conflict and depression among school-going adolescents.

Part One - Study of Counsellors role and perceptions

2.2 Method

2.2.1 Subjects

The high schools surveyed included Government and Private co-educational and single sex schools in the Pretoria and Witwatersrand areas. The subjects were chosen from a membership list of 40 people belonging to the Transvaal Education Department, Association for Guidance and Counselling Education. Of the 20 who replied, 11 were from Government co-educational schools, 4 from Private co-educational schools, 3 from all girls Government schools, 1 from an all girls Private school and 1 from an all boys Private school. Although this is a fairly limited sample, it was considered to be adequate in terms of an exploratory study of this nature.

2.3 Measures

Because of the exploratory nature of this study no objective or validated questionnaires were available. Therefore the researcher developed a questionnaire which attempted to tap the major parameters of school counsellors perceptions. (See appendix 1)

2.3.1 A detailed description of the questionnaire follows below:

The first section of the questionnaire aimed at establishing the academic qualifications and type of experience which each subject in the role of school counsellor had (see page 65).

The second section of the questionnaire required the counsellors to comment on the prevalence and management of depression as well as treatment procedures most often exercised when dealing with depression. (See page 66).

The third section included a table of symptoms of depression. Counsellors were required to mark off those symptoms they considered to be frequent indicators of depression (see page 68).

The results of the questionnaire were interpreted quantitatively and qualitatively

2.4. Procedure

Questionnaires were posted to school counsellors and guidance teachers presently employed in both private and government high schools in the Pretoria and Witwatersrand areas. Only 20 of the 40 questionnaires sent out were returned and after a follow up phone call was made to each subject further introducing and explaining the nature of the study it was decided not to pursue the matter further.

It is important to note that those people who agreed to reply when spoken to on the phone, were people who attended guidance and counselling education meetings regularly. As such they felt there was value in research and knowledge in this area.

3. Results

3.1 Summary of subjects' qualifications

Table 1 shows a summary of the academic qualifications of the 20 subjects who participated in the study.

TABLE 1.

SUBJECTS QUALIFICATIONS

QUALIFICATIONS	NO OF SUBJECTS
M.A. Clinical Psychology	3
M. Educational Psychology	4
B.A. Social Work	5
B.A. H.E.D. or T.T.H.D.	8

Qualifications held by individuals working as school counsellors (whether this was regarded as a primary role or secondary to teaching) covered a fairly broad spectrum, ranging from fully qualified clinical psychologists to teachers with little or no formal training in psychological practices.

To understand the discrepancy, one has to consider the nature of counselling in South African schools, which remains largely underdeveloped compared to that in Britain and the U.S.A., where roles are more clearly defined and demarcated (Sandoval, 1985). Counselling is also accepted as an integral part of education.

Guidance and counselling are terms which have been used synonymously in the South African situation, but actually imply fundamentally different orientations both theoretically and in practice.

Guidance in government schools is linked to broader educational policy insofar as it aims to promote the values and ideals of Christian National Education. The main thrust of this philosophy is the moral preparedness and vocational guidance of White youth (Dovey, 1980). Personnel who implement guidance in schools under the supervision of inspectors, are essentially teachers, who might have taken psychology courses during their training, but whose roles are prescribed for them in terms of a defined syllabus. Guidance teachers who follow British and American theories and practices of guidance, which derive from humanistic psychology and focus on the needs of the individual, are often in direct conflict with the official definitions of guidance.

It is only in the private schools that a fair amount of autonomy is given to counsellors to practice in terms of models that are psychological. These individuals are not necessarily required to have a formal teaching qualification, as are their counterparts in government schools. Although private schools have taken the initiative in this regard, the idea of a full time counsellor is rare, and school counselling still remains a comparatively unheard of phenomenon.

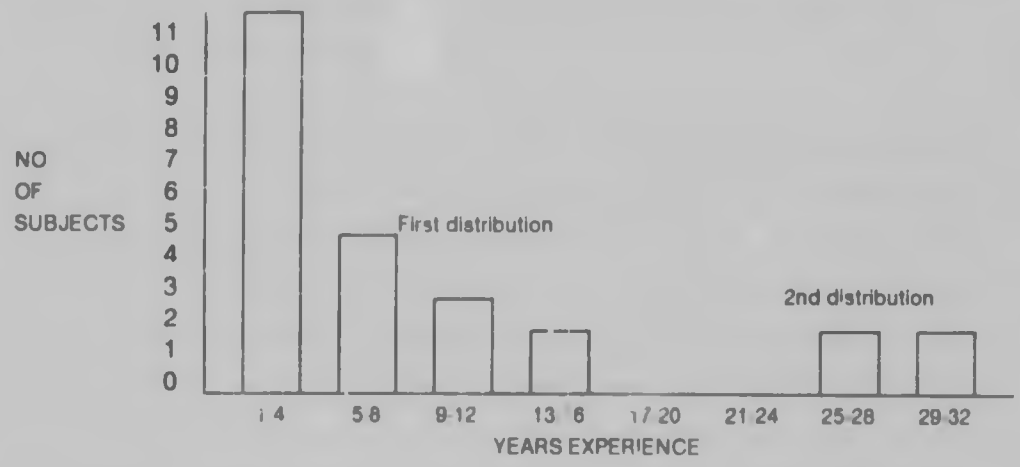
3.2 Number of years experience

Table 2 reflects the number of years experience the subjects have had in the school context. The distributions were introduced to highlight the distinctions between the individuals dealing with counselling issues.

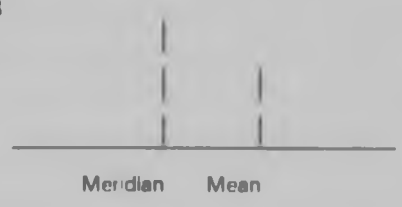
TABLE 2 NUMBER OF YEARS EXPERIENCE

NUMBER OF YEARS EXPERIENCE	NUMBER OF SUBJECTS
1 - 4	11
5 - 8	4
9 - 12	2
13 - 16	1
17 - 20	0
21 - 24	0
25 - 28	1
29 - 32	1
	20

FIGURE 2 DISTRIBUTIONS OF NUMBER OF YEARS EXPERIENCE



Mean = 6.85
Median = 4
Quartile Range = 2-8



25%	25%	25%	25%
1	2-4	4-8	9-32

Median

The range of experience in schools varied dramatically with the majority of the subjects having had less than four years counselling experience. Interestingly enough, those subjects with appropriate psychological qualifications had been in the school context for noticeably fewer years than had teachers who were involved in guidance and counselling. (Refer Table 2). This trend is assumed to be due to the very recent recognition of the importance of affective education in the schools, and the establishment of suitable posts for counselling personnel.

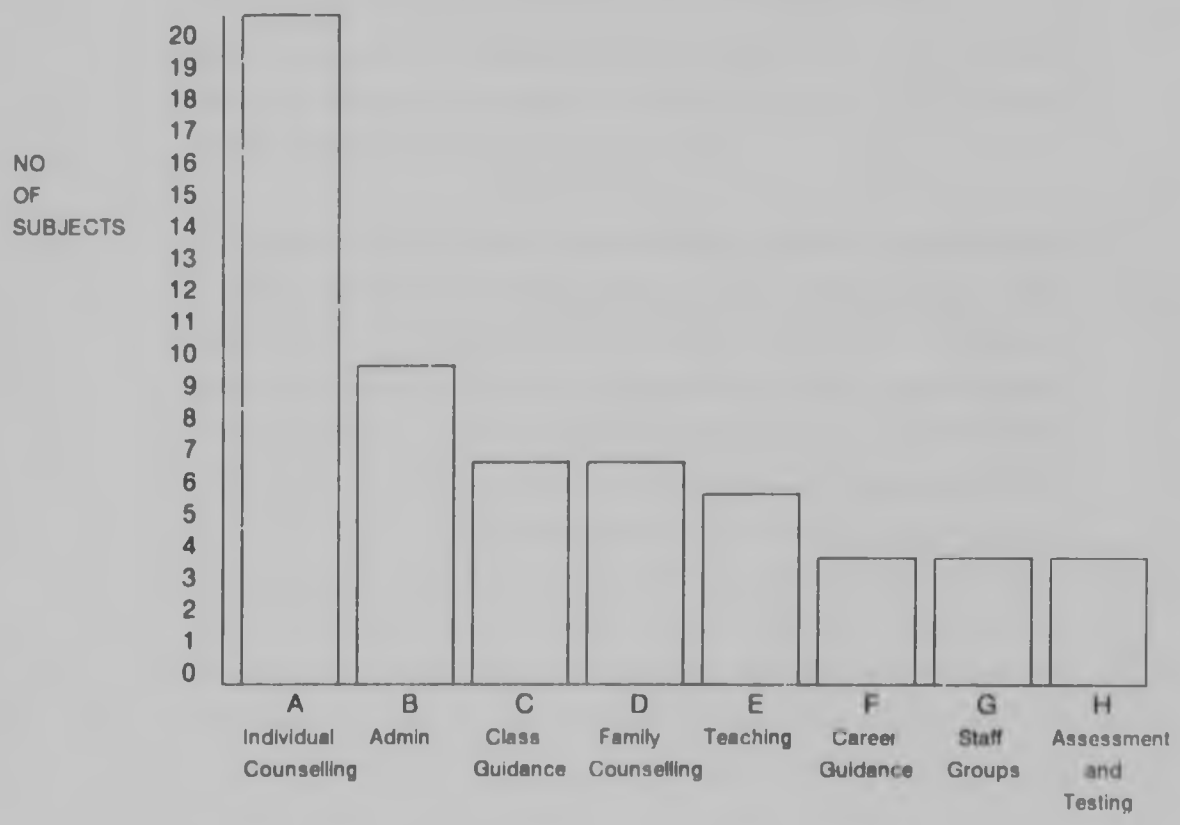
Full time counsellors appropriately qualified are still a relatively rare phenomenon as guidance teachers have been responsible for psychological intervention.

Two distinct distributions appeared from the surveys, and the conclusion was reached that counselling was being handled by two groups who differ in a number of ways. The majority of subjects falls into the first group, and are more qualified in psychological techniques, possibly younger graduates, but with little actual experience in the field. It would be difficult to determine their commitment to long term service at this stage. On the other hand, the second group comprised older teachers who had little formal psychological training, but had been involved and committed to the school for many years. Their job portfolios seem to have been only recently expanded, to include counselling. It is difficult to draw any conclusions from the above results as school counselling is still so largely under-developed. However, it is important to point out that these discrepancies in qualifications and experience will remain until counselling practice is more clearly structured and defined in all educational spheres.

3.3 Frequency of functions

Figure 3 reflects the aspects of the counselling role in which most counsellors are involved, and those rarely dealt with.

FIGURE 3 FREQUENCY OF FUNCTIONS



In spite of discrepancies noted in terms of qualifications and experience in the previous section, a fair amount of consensus was evident in terms of how counsellors viewed the main functions of their role.

The histogram (Figure 3) gives an overall indication of which aspects of the counselling role were considered priority by the school counsellors. It is interesting to note that individual counselling was the only function carried out by all the respondents. Fine (1982), emphasizes that individual counselling with adolescents seems to hold much appeal for those people working at the secondary school level. Sandoval (1985), states that although school counsellors / psychologists list counselling with children and families as important duties they perform, surveys into how their time is actually spent reveals that most of the day is spent on assessment and administrative related activities. This would be borne out by the second most important function identified on the histogram, namely administration, but not the first function.

The remaining results showed involvement in a number of spheres such as guidance classes and career guidance. Only 20% of the respondents were involved in assessment and running of staff groups. This is a conservative number when one considers the emphasis in the literature on the importance of techniques for diagnosing depression in the school context and the need for teacher education in recognising symptoms (Reynolds, 1984). Practically speaking, assessment procedures are usually lengthy and when one looks at the range of activities counsellors are involved in, it is not surprising that very little assessment is undertaken. It is important to note that one of the treatment modalities most often employed by counsellors was referral to an outside agency - which would imply that assessment is conducted in cases which warrant in-depth investigation.

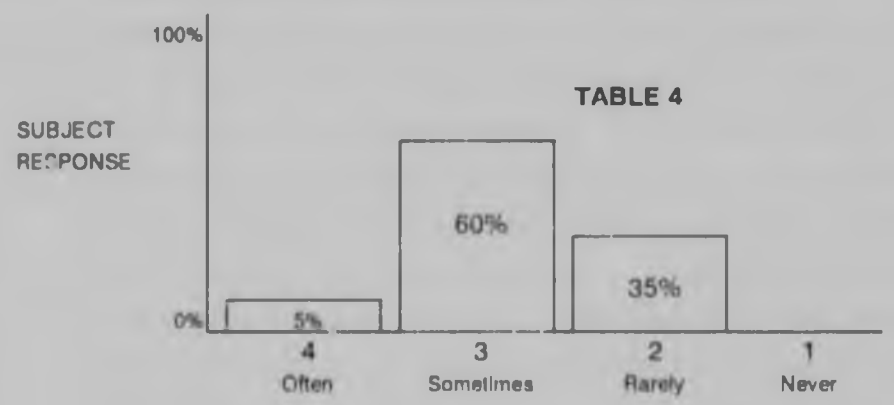
It is important to distinguish counselling from psychotherapy as it applies to a working model in the school situation. Counselling has been seen as a less intense, more supportive process which often related to a narrowly defined problem, with the goals of assisting the client to work through that problem usually within a relatively short time frame (Fine, 1982). Psychotherapy is usually viewed as a long term process, where change happens on deeper personality levels. Debates have centred around whether in fact there are essential differences, considering that the techniques, goals and outcomes are in many cases similar. Nevertheless, the short term counselling approach would appear to be more acceptable and appropriate to a school situation.

When the subjects were asked whether the treatment they implement is carried out on a short or long term basis, 80% worked with a short term or crisis model. Only 10% elected to carry out in-depth work and the remaining 10% stated that it would depend on the nature of the problem. Sandoval (1985), puts forward the view that the most legitimate counselling role in the school situation is that of crisis counsellor working within a short term model. He highlights the fact that demands of other duties restrict the time available for counselling and notes that there is some question as to whether counsellors are trained adequately to do long term psychotherapy. Considering the range of crises an adolescent might be confronted with, e.g. failure, sexuality and parental problems, the school counsellor has an important role in helping restore equilibrium after the onslaught of a crisis situation. Immediate intervention can often aid in equipping children with coping skills without becoming involved in personality re-organization on a deeper level. Thus, the counsellor should be equipped with both crisis skills and assessment and diagnostic tools for distinguishing between crises which can be dealt with immediately and those which need an alternative approach.

3.4 Prevalence of Depression

Table 4 shows a frequency distribution of perceived depression in the school.

Table 4 **PREVALENCE OF DEPRESSION**



In spite of increasing concern with adolescent depression, it remains a difficult task to clearly establish prevalence figures. Counsellors were required to comment on prevalence of depression in their schools, and the problem was perceived as significant by only one counsellor. The term depression and its meaning was not made explicit, as the study relied on the subjective interpretation of the disorder by the counsellors. However. the table (see Appendix 1, question 10) served to highlight certain symptoms indicative of depression. 60% of the respondents encountered depression on an infrequent basis and 35% of the respondents regarded it as a problem which rarely emerges among the school-going adolescent. It must be emphasized that results were obtained from the subjective opinions of counsellors, and given the high rate of reported depressive symptoms among adolescents in certain studies (Sullivan and Engin, 1986; Albert and Beck, 1975 and Teri, 1982) no definite conclusions can be reached. However, it would seem that counsellors need a clearer definition of the term 'depression', as this can have several meanings, ranging from 'typical' adolescent crises to more severe manifestations of a clinical disorder.

An additional problem in identifying the extent of the disorder is that depressions may be disguised as various types of 'acting out' or behavioural disturbances (Lesse, 1980). The behavioural mask may take the form of anti-social acts, impulsiveness, sexual acting out, destructiveness or histrionic dramatizations. The depressive masking may also take the form of substance abuse or eating disorders. Psychosomatic disorders and hypochondriacal symptoms may also indicate a depressive core from which an overt depressive affect may evolve. The above behavioural patterns may be considered either as being masks of depression or depressive equivalents (Lesse, 1980). Furthermore, a relationship between acting out and the avoidance of working through the depressive position has been established (Hyatt-Williams, 1978). The impact of acting out phenomena, is such that people in helping professions tend to get caught in the management of these crises, and in their efforts at containing the behaviour often lose sight of underlying affective states. In a school situation, there would be particular urgency in reducing 'unacceptable' behaviours, rather than providing an extensive investigation into whether a depressive core exists.

It is interesting to note that the symptoms least associated with depression, as noted by the counsellors in the study, included anti-social acts, promiscuity, delinquency and violence. Suicide ideation and attempts were not manifested among adolescents in the schools that counsellors were working in. Considering the link which has been established between suicide and depression (Emery, 1983) it is interesting that this is not a feature which emerges in the study. Statistics attest to the increasing severity and tragic escalation of adolescent suicidal behaviour as a means of resolving difficulties, yet this remains largely untapped in the present study's school-going population.

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3.5 Frequent indicators of depression

Table 5 represents the results of a frequency count of those symptoms identified by school counsellors, as being the most frequent indicators of depression, that manifest among adolescents. A cut off point of 40% was introduced in order to differentiate those symptoms which are regarded as significant indicators of depression, from those which are not regarded as significant, and have therefore been omitted from this table. (See appendix 1).

TABLE 5 FREQUENT INDICATORS OF DEPRESSION

Symptom	Number of Subjects	%
Loneliness	14	70%
Study problems	14	70%
Insecurity	14	70%
Inferiority feelings	13	65%
Communication problems	11	55%
Poor concentration	11	55%
Helplessness	9	45%
Restlessness	8	40%
Fatigue	8	40%

These symptoms would correlate with previous studies conducted into adolescent depression (Mastropaola, 1972 and Lesse, 1974). It must be stressed that these symptoms cannot be used as the basis for diagnosis alone and if they do occur, need to be considered in conjunction with other evidence associated with depressive syndromes. For a diagnosis to be made, a full assessment into underlying psychodynamic and psychopathological mechanisms is necessary, together with an understanding of the impact of social and cultural contexts.

3.6 Summary of results

The overall result of the present study suggests that there is not as high an incidence of depression among adolescents as the reviewed literature has suggested. Only one counsellor perceived the problem as significant. Sixty percent of the respondents encountered depression on an infrequent basis and the remaining 35% regarded depression as a problem which rarely emerges among the school going adolescent.

It is important to reiterate the point that the adolescents themselves were not assessed on measures of depression, and that the results relied on the perceptions of the counsellors. As such, these perceptions which were to a large extent subjective, cannot be regarded as reflecting the actual rate of depression. Further research to determine this rate is needed before stating conclusively how prevalent depression is in some South African schools.

This highlights an additional issue which is the ability of counsellors to identify psychological disorders such as depression, considering the variations in academic qualifications and training. Given that 40% of the subjects were qualified as high school teachers with little formal training in psychological practices, the assumption could be made that these individuals would not be adequately skilled in recognising and working with affective or clinical disorders. The role expectations of the counsellors in this position would be qualitatively different to those counsellors specifically trained in clinical techniques. Teachers functioning in this role could however be involved at different levels which might include being equipped with knowledge of specific behavioural symptoms and referral procedures.

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All 20 subjects saw individual counselling as the primary function of their job and although levels of clinical sophistication might vary it is important to note that certain therapeutic models e.g. the Client-centred-non-directive approach and Crisis intervention can be practiced successfully with a minimum of academic training (Belkin, 1981). The more clinically trained counsellor treating depressed adolescents in the school setting should however be more familiar with and knowledgeable of the specific underlying theoretical rationale and model of depression upon which the chosen therapy is based. (Reynolds, 1984). Certain symptoms were recognised by the majority of subjects as being frequent indicators of depression (See table 5).

In view of previous statements concerning the problem of evidence based on perceptions, these syptoms cannot be regared as a completely accurate reflection of adolescent depression. However, studies conducted, confirm that symptoms such as study problems, fatigue, poor concentration, loneliness and insecurity are prevalent among depressed adolescents. (Mastropaola, 1972; Toolan, 1974; and Rutter, 1975). Other symptoms which include substance abuse, acting out, psychosomatic problems and guilt are also regarded as important indicators of depression, but were not identified as significant in the present study.

In conclusion it would appear that the prevalence of depression among adolescents needs to be more clearly established as should the role of the counsellor in relation to this and other psychological disorders. The role would have to be assessed and developed depending on the level of expertise. Awareness that counsellors have an important role to play in schools needs to be reinforced, and school counselling acknowledged as an important field in the area of mental health.

4. Part Two - Case Studies

This section involved a fairly in-depth consideration of case studies taken from the writer's own school counselling experience. The case studies were drawn from a predominantly White, all girls, private high school and as such can not be regarded as representative of a total adolescent population. Case study investigation refers to the relatively uncontrolled and subjectively described study of a single case (Kratochwill, 1985). Although this is not the prominent methodology employed in psychological research due to its lack of scientific rigour and objectivity, it does provide insight into individual dynamics which cannot be readily obtained through other methods. Case studies can also have a very important role in linking theoretical research to clinical assessment and treatment procedures (Barlow, et al; 1984). The case studies were considered in terms of family background, symptomatology, treatment and outcome. These individual situations were intended to provide some insight into the manifestation of depression as seen through the conflicts and dynamics experienced by the individual.

4.2. CASE 1 - LINDA. AGE 16

Presenting Symptoms

Perio ic absence from school, muscle spasm, feelings of depression, apathy, rejection and helplessness.

In addition to her emotional and physical state, her school record had shown a steady decline over a six month period. Prior to this crisis, Linda had been regarded as a conscientious, although average student who contributed in most classes.

Family background

Linda is the elder daughter in a sibship of two. Her sister, Mary, is eight and seems to be protected from any family crisis. Linda in particular takes on a maternal role in relation to her sister. The parents were recently divorced and Linda lived with both parents, alternating on a weekly basis. Linda adjusted to this unsettling situation because it was important for her to have equal access to both parents. Mother's news that she was to remarry put an end to Linda's hopes that her parents would seek a reconcilation.

Treatment

Linda sought help at this point, opting for individual couns ling at school in preference to involving the family on any level.

The client-centred model provides the essential framework in which the counselling process takes place in most school contexts. Depressed, vulnerable adolescents usually respond positively to genuineness, empathy and unconditional positive regard. In Linda's case, this provided the structure, but due to her highly charged emotional state, crisis intervention techniques were used. These included active emotional involvement of the counsellor, immediate assessment of the total situation and the mobilization of her own inner resources to aid in coping with the crisis of the 'remarriage'. Unresolved feelings about the divorce were evident and Linda needed to confront and deal with her feelings of anger, denial, rejection and loss, which would enable her to gain insight as well as acceptance of the current situation.

Linda responded well to the first few sessions. She needed to work with her feelings of hatred and anger toward the 'other' man, the intruder and her contrasting feelings of protectiveness towards her father. Linda needed to move away from 'mothering' her father in order to deal with her own needs. She struggled with the idea of being present at her mother's wedding, but with persuasion eventually attended. The physical witnessing of the marriage prevented her escape through denial, which might have become firmly established as a dominant mode of defense. Working with the experience in counselling, she used metaphors applicable to funerals, e.g. my grandparents had to support me by holding me up, and the last time we were all together was at my aunt's funeral. The re-marriage was symbolic of the death of her parents' marriage and Linda struggled with coming to terms with the loss. A couple of weeks later, she elected to terminate counselling stating she was able to accept the situation.

Conclusions and follow-up

The precipitating factor leading to Linda's feelings of depression was news of her mother's re-marriage. Although symptoms of depression were evident, her case represented a reactive depression, as there has been no previous record of childhood disturbance or upheaval and no family history. The present crisis did however reactivate unresolved feelings of loss caused by the divorce. Having worked with this, she was able to reach a new level of adjustment and her progress seemed to follow the stages of grief working as outlined by Elizabeth Kubler Ross. (1978).

4.2 CASE 2 - ELLEN, AGE 15

Presenting symptoms

Ill defined symptoms, feelings of depression and isolation were expressed in a vague fashion.

School performance was consistently good and goals set were high. Work represented a retreat from everything social and familial.

Family background

Ellen is the youngest child in a sibship of three. Sam is 21 and Farouk is 18. Her family are traditionally conservative Hindus who place emphasis on academic achievement. As a young girl, her role is to work hard and achieve at school. Leisure time is to be spent with the family and contact with the opposite sex is forbidden.

A number of issues became apparent after the first few sessions:

i) Acceptability in a predominantly White school, where her peers were 'dating' and establishing independence by loosening family ties. This was especially important to her as she had been ostracised in her own community. More importantly was her need for self acceptance and the consolidation of an identity she felt congruent with.

ii) Pressure to achieve placed on her by the family had become incorporated as her own 'ego' ideal. As a result, she was becoming obsessively involved with school work to the exclusion of everything else. It also provided a way of avoiding difficult feelings. Exam anxiety, sleeplessness and appetite disturbances were becoming regular symptoms

iii) The reality of being caught in the middle of two very separate 'cultural' realities. She was living a dual existence - conservative at home and wanting to be part of the contemporary scene at school. She was also beginning to explore her growing sexuality. These two worlds never coincided.

Thus, the shift towards independence from her parents, the establishment of an identity and acceptance by her peers had to happen almost as an internal reality as well as externally - but this was difficult as she had no access to social life outside the home.

Treatment

The counselling process started at the beginning of the term as it seemed Ellen needed to secure a support system immediately. The counsellor represented a mediator between the two worlds and counselling continued over an 18 month period until Ellen was placed in another school. Ellen responded well to a supportive, listening approach whereby reflective techniques helped her gain an understanding of her situation. Ellen experienced many depressive moods during the process, often losing hope of achieving an appropriate relationship with either her parents or peers. Ideas of photographic modelling and cosmetic operations were frequent in an attempt to establish a new identity.

Conclusions and follow-up

Ellen worked hard at establishing a sense of self she felt congruent with. An identity which was neither rebellious or conservative. She rejected the images others wanted her to project, becoming increasingly able to emerge as an individual. In the process, she had become more independent, exhibiting a more balanced perspective with regard to her school work and family life. She accepted that she would have to tolerate certain frustrations due to restrictions at home and would probably never feel totally accepted by her peers.

Ellen's case represents a typical adolescent crisis of attempting to solidify an acceptable identity. Lamb (1978) highlights symptoms of depression which accompany this struggle, such as isolation and feelings of inadequacy. Accompanying Ellen's depressive moods were feelings of vagueness and a lack of definition which became more consolidated as she gained insight and understanding. Thus, Ellen's primary struggle was that of finding an identity and depressed feelings were seen as secondary although significant to this process.

4.3 CASE 3 - SANDY, AGE 16 ½

Presenting symptoms

Severe upset, crying and helplessness. Overwhelmed by her feelings, it took a while for her to begin verbalising some of the events and feelings that had precipitated this crisis.

Family background

Sandy was the youngest in the family. She had an older brother (21) and a sister (20) who both lived overseas.

Sandy's parents were divorced and her mother had a history of chronic alcohol abuse. Both older siblings were fairly regular substance abusers. Sandy lived alone with her father and periodically visited her mother. Weekends with her mother often turned into a nightmare, with Sandy having to nurse her during her drunken episodes.

As counselling proceeded, it became clear that Sandy was suffering from a depression underneath which were conflicting feelings of anger. hate and love toward her mother. Pre-occupied with her family situation, here school work suffered and this reinforced her feelings of inadequacy and fear of failure. Exam time was particularly stressful and anxiety manifested in the form of severe asthma attacks. She was being treated medically for the asthma, although this was clearly psychosomatic in origin.

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As counselling proceeded, it became clear that Sandy was suffering from a depression underneath which were conflicting feelings of anger, hate and love toward her mother. Pre-occupied with her family situation, here school work suffered and this reinforced her feelings of inadequacy and fear of failure. Exam time was particularly stressful and anxiety manifested in the form of severe asthma attacks. She was being treated medically for the asthma, although this was clearly psychosomatic in origin.

Treatment

Sandy was in crisis during the first session and had to be worked with accordingly. The situation demanded the active involvement of the counsellor with the aim of restoring some equilibrium, so as to enable receptivity to working with feelings that were experienced as overwhelming.

In terms of Crisis Intervention Theory, Sandy was in a state of psychological disequilibrium and immobilization (Belkin, 1981). Previous problem solving techniques were thus redundant at this point. As such the counsellor needed to actively focus on the immediate problem with the aim of establishing equilibrium, prior to understanding the precipitating events and dynamics of the situation.

Given the family circumstances, it was clear that the crisis was a result of many years of family dynamics and pathology which had a disturbing impact on Sandy's personality and development. Her father suffered from bouts of depression, and relied on Sandy's support. She 'mothered' both her parents, and as a result was rarely the recipient of any real support she needed.

Psychotherapy and referral to an outside agency was recommended either on an individual level or with her father. The counsellor felt it was necessary for Sandy's father to be aware of her emotional conflicts, and suggested Sandy discuss options with him. She reluctantly agreed. Feedback the next day suggested a total lack of interest in his participating in a psychotherapy programme. However, he agreed to her beginning psychotherapy.

Conclusions and follow-up

Sandy was reluctant to relinquish her relationship with the school counsellor even though she was to enter psychotherapy. An agreement was reached between the school counsellor and psychotherapist that the former would remain in a supportive, but more informal relationship with Sandy.

Sandy's emotional progress over the next few months was noticeable in terms of her ability to work with things that happened to her, rather than being overwhelmed. Depressive symptoms noted in the beginning, would however, re-emerge periodically causing feelings of despair, hopelessness and helplessness. Sandy's tendency was initially to block these and inevitable crises would erupt. With time and continual reinforcement of her strengths and resources, she gained insight and the understanding that there would be difficult times, but that they would diminish and she showed an ability to be more contained and responsible. Her school work improved giving her added strengths and belief that she could establish an identity and goals separate to her family who represented confusion and failure.

Sandy's father remained resolute about his non-involvement in any form of psychotherapy. However he did attend one interview which aimed at providing him with insight into his daughter's feelings. Hopefully this enabled him to better understand her inner experience.

4.4 Overview of the Case Studies

The above three case studies represented areas of adolescent crises which were accompanied by varying degrees of depression. None of them constituted a fully diagnosable clinical disorder. Out of the three, Sandy's case was the most severe in terms of depressive symptoms and considering her father's depression and family circumstances, she would have to be carefully monitored in the event of a full blown disorder occurring.

Although treatment strategies varied to some degree, the therapeutic models employed in the school context included the Client Centred approach, Crisis Intervention and Psychodynamic therapy.

Client Centred Approach

School counselling is fairly well established in terms of this approach, which has as its central feature the development of a facilitative relationship with the client. Three concepts namely genuineness, empathy and unconditional positive regard, form the foundation from which the counsellor enters the subjective, personal world of the client, thereby experiencing and understanding his/her feelings and perceptions. After trust and rapport has been established the goal is to help the client attain congruence i.e. the concordance between his/her perceptions of experiences and the reality of those experiences. (Belkin, 1981).

Crisis Intervention

Often the client is in a state of distress which demands that the counsellor actively focus on the immediate problem. The primary goal is to re-establish psychic equilibrium by working consciously with the presenting problem and feelings around what is happening. Allowing the client full expression of fears and conflicts by encouraging dialogue and a willingness to share in the experience facilitates the restoration of balance.

Psychodynamic therapy

Psychodynamic techniques aim at understanding some of the underlying feelings and resistances the client may have in relation to problems they are experiencing. Usually applied in more clinical settings these techniques do have value in short term counselling. Reflective and mirroring techniques are used in addition to interpretation of defenses which are preventing the individual from confronting painful feelings and conflicts. (Belkin, 1981). The aim is to help the client deal with these hidden feelings thereby facilitating insight and understanding.

The ability of the school counsellor to interpret the individual's dynamics would depend on the level of psychological and psychotherapeutic expertise. The Client Centred approach and Crisis Intervention can be successfully employed by counsellors who do not have extensive clinical training. A more dynamic approach does however rely on specific training and knowledge relating to this way of working. The above case studies relied on a combination of all three models and was found to be valuable and functional when attempting to understand some of the dynamics and feelings experienced by adolescents who are confronted with emotional upheavals.

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5. Conclusions

The study has attempted to examine the phenomenon of adolescent depression in an exploratory manner. The role of the school psychologist/counsellor in the recognition and management of depression in some South African schools was considered as a means of fulfilling this aim.

Studies of depression in children and adolescents, and evidence suggesting it is an affective disorder, amenable to early intervention, supports the need for school counsellors to acknowledge the importance of assuming some role in its assessment, diagnosis and treatment. Evidence also suggests that depression may impinge upon important aspects of functioning at school and as such necessitates the involvement of counsellors at some level.

The role of the counsellors as it emerged in the present study was one in which depression was recognised, although not as a problem of crucial importance, and managed primarily by two treatment interventions. The first was short term individual counselling and the second most frequently used option was referral outside the school context. There was no investigation into the possibility of implementing primary intervention or early intervention techniques with adolescents considered at risk for psychopathology, although this has become a growing area of interest in the development of school counselling programmes. The rate of adolescent depression in South African schools needs to be established first, before the importance of prevention and early intervention efforts can be emphasized. Some researchers have suggested that entire schools be screened as certain measures such as the Reynolds Adolescent Depression Scale can be implemented without any practical difficulties. (Reynolds, 1984). Currently, efforts are underway by Reynolds and several colleagues to develop a school-based multi-component affective curriculum for the treatment and prevention of depression in adolescents.

Whether these developments can be applied to the South African school system given the discrepancy in qualifications, experience and most importantly, acknowledgement of the impact of depression on young people, remains to be seen.

The role of the counsellor in initiating short term individual counselling and referral as the primary treatment options, would indicate an awareness of the limitations of both the role and of certain skills. This cautionary choice is preferable in that supportive short term counselling which helps the child cope more effectively with identifiable sources of conflict is appropriate to cases of acute and reactive depression which occur at school. However, frequently this mode of intervention is insufficient to bring about any significant changes if the child is suffering from chronic or masked depression. In these situations, referral to outside agencies is preferable and it would seem that the majority of counsellors in the sample saw intensive, long term work as being inappropriate to the school context.

However, there does appear to be room for the expansion of the counsellors' role in relation to depression and involvement can be conducted at many different levels.

This would include educating teachers to look for specific behavioural symptoms, screening and assessing suspected depressed adolescents and the inclusion of awareness activities in the prevention programmes at class level. As such, work can be started at the preventative mental health level.

Counsellors in the present study acknowledged the existence of depression among school-going adolescents, although the problem was not perceived as one of great magnitude. This response might possibly have been due to the limitations of the method employed, as it relied on the subjective opinions of the counsellors, who are perhaps not equipped fully with the wide range of definitions and meanings the term 'depression' can have.

Although this study was exploratory in nature and attempted to describe the manner in which depression was handled, future research needs are clear. Adolescents themselves need to be assessed on measures such as the Beck Depression Inventory (BDI) or the Reynolds Adolescent Depression Scale (RADS). Clinical use of these measures has not been widespread, and reliability and validity is yet to be established (Reynolds, 1984). Nevertheless, considering the high rate of reported depressive symptoms in some studies (Albert and Beck, 1975 and Teri, 1982), research needs to be continually conducted at the school level in order to investigate the prevalence of depression at various ages and developmental stages. Data should be compiled from regular and special populations to determine the relationship between depression and other conditions.

An example of the need for exploring certain relationships between depression and other conditions is as follows: The relationship between acting out and depression has been established, and is regarded as being crucial to understanding the psychodynamics of adolescent depression (Hyatt-Williams, 1978). The present study, however, revealed that behaviours associated with acting out such as substance abuse and delinquency, were not linked to depression. This emerged following a frequency count of symptoms considered to be indicative of depression. This contradicts the findings of some studies into adolescent depression which have established this relationship. (Meyerson, 1981; Mastropaola, 1972; Toolan, 1974; Lesse and Rutter, 1975). It is important to point out that substance abuse and deliquency are activities which manifest principally outside the school context and are not initially observable by the counsellor. Thus, although these symptoms were not regarded as significant, and remained untapped, does not imply they do not exist in relation to depression, but would have to be further investigated.

Future research on the prevalence of depression among adolescents also depends on recognising a number of methodological issues. Most prominent is the lack of agreement on diagnostic systems and criteria. Although most of the more recent studies have used DSMIII criteria for adults, applicability to adolescents still needs validation. Furthermore, numerous studies have examined symptoms of depression, and yet researchers' data are inconclusive in that various symptom clusters regarded as important in some research is dismissed in other studies. Nevertheless, knowledge of possible symptoms relating to depression has generated an awareness among personnel working in the helping profession.

Although the case studies included in this study were not in-depth, they were considered valuable insofar as they provided a synopsis of a therapy situation. They further contributed by providing insight into the psychodynamics of individual adolescents. Certain factors that limit this method need to be outlined and recommendations suggested if case studies are to be employed in future school psychology research. Traditionally, case studies have involved a subjective description of progress including reported impressions or self report data from the client. Perhaps direct measures of progress should be developed to supplement more subjective data so that reliance is not restricted to the investigators' descriptions. The number of case studies used in the present study was limited to three. Cases are commonly limited to one subject, although this need not necessarily remain the norm. When the researcher is able to implement treatment across a number of subjects, a greater degree of inference for the treatment effect is possible (Kratochwill, 1985). It is desirable to know how persuasive the treatment effects are in improving client functioning over a long period of time and therefore continuous assessment is advisable.

Once, efficacy of certain treatment interventions can be established by assessing a series of single case studies, models which can be employed in similar circumstances in the school context can be generated and developed further.

In conclusion then, it is important to acknowledge the progress that has been achieved in the area of childhood and adolescent depression. Considering the non-acceptance of this disorder prior to the 1970's in most psychiatric quarters, the amount of research and awareness that has been generated in a relatively short time span is marked. The present study has focused more specifically on the South African school situation and the role of counsellors within this context. It is abundantly clear that an exploratory study of this nature only begins to broaden the field for further educational input and research which will aid us in our attempts to understand the impact of depression on the adolescent population.

APPENDIX I

I am conducting research into the area of Adolescent Depression with particular emphasis on the adolescent in the school context.

I have two broad aims in this project :

i) To understand how depression manifests in the school-going adolescent

ii) To gauge the role of the school counsellor / guidance teacher in the intervention and management of depression.

Please tick or fill in where appropriate :

Are you employed at a

i) Government school

ii) Private school

Do you work

i) Full time

ii) Part time

Position held at school

i) Guidance teacher

ii) School counsellor

iii) Social worker

iv) Educational Psychologist

v) Clinical Psychologist

vi) If other please state . . .

State exact University or College qualifications you hold (e.g. BA HDE)

How many years training as a guidance teacher / counsellor did you receive ?

Number of years in present job

What would you say are the main functions of your job, e.g. counselling, administration, etc

1. How often is depression the reason for the adolescent seeking help in your school?

Often	Sometimes	Rarely	Never

2. How often can you identify depression as underlying study problems and other school related issues?

Often	Sometimes	Rarely	Never

3. Approximately what percentage of your clients come primarily because of depressed feelings?

4. Is the depressed adolescent who is referred usually

   a) self-referred

   b) sent by a parent

   c) sent by a teacher

   d) sent by the Head

   e) requested by yourself to make an appointment

   Is any one of these referrals sources obviously more frequent than the other?

5. To what extent do you experience a willingness among adolescents to discuss their personal / emotional problems ? (Please elaborate)

6. In your experience, do adolescents feel more comfortable expressing their feelings in a classroom situation with their peers, OR on a one-to-one basis in the counselling situation. If there are other situations you have encountered, please elaborate.

7. What do you see as your role in the management of depression in the school context?

8. Which options do you most often exercise when dealing with adolescent depression?

   a) individual counselling at school.

   b) family counselling at school

   c) peer group work in the classroom

   d) referral to another agency

   d) other . . .

   (comment if necessary)

9. Is the treatment you choose usually on a short term or long term basis, i.e. crisis or in-depth counselling?

10. Which of the following symptoms would you consider the most frequent indicators of depression you encounter? Please rank by placing a number to indicate their relative position.

SYMPTOM	OFTEN/3	SOMETIMES/2	RARELY/1	NEVER/0
Changing interests				
Restlessness				
Fatigue				
Poor concentration				
Insecurity				
Inferiority feelings				
Communication problems				
Psychosomatic symptoms				
Psychomotor retardation				
Crying				
Appetite disturbance/loss				
Obedience and conformity				
Tantrums				
Flight				
Social withdrawal				
Study problems				
School refusal				
Apathy				
Inhibition				
Inadequacy				
Lack of initiative				
Anti-social acts				
Cynicism				
Suicidal ideation				
Suicide attempts				
Guilt				
Loneliness				
Drug abuse				
Alcohol abuse				
Boredom				
Sexual promiscuity				
Illegitimate pregnancies				
Acting out				
Delinquency				
Hopelessness				
Fluctuating moods				
Overactivity				
Impulsiveness				
Ambivalence				
Behavioural problems				
Theft				
Violence				
Irritability				
Risk taking				

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