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Profile of adolescent depression

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Profile of Adolescent Depression

by
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ABSTRACT

Mary E. DelCorio

Profile of Adolescent Depression   :

1995

Dr. Klanderman

Masters in School Psychology

The purpose of this study was to examine specific factors related to adolescents diagnosed with major depression, admitted to an inpatient adolescent mental health unit. The specific factors are birth order, family stability, history of drug and/or alcohol abuse and gender. There were 31 subjects in this study, ages 11 to 17 years. Of these subjects, 18 were female and 13 were male. The data collected was ex post facto. From the subjects' charts, gender, age, birth order, family stability and history of drug and/or alcohol abuse were obtained. This data was analyzed using descriptive statistics, mostly percentages. The results of this study support the hypothesis that female adolescents, oldest in the family, run a greater risk of depression than female adolescents in other birth positions. The second hypothesis which suggested that male adolescents, youngest in the family, are at a greater risk for depression than males in other birth positions was not supported. Additionally, the third hypothesis indicating a higher rate of alcohol and/or drug abuse was not supported. Lastly, a greater percentage of subjects were from unstable families rather than stable families, supporting the fourth hypothesis.

ABSTRACT

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Profile of Adolescent Depression

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The purpose of this study was to examine specific factors related to adolescents diagnosed with major depression, admitted to an inpatient adolescent mental health unit. The results of this study supported the hypothesis that female adolescents, oldest in the family, run a greater risk of depression. Additionally, a greater percentage of subjects were from unstable families.

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Chapter I

Need

"I'm depressed." This is a statement commonly uttered by people – young and old, male and female, black and white. It is usually accepted as a transient emotion with specific reasons ("I'm going through a divorce." or "I got a bad grade.") When the emotion becomes more constant, impairing social, academic or career functioning, a diagnosis of major depression may be warranted. While the emotion or diagnosis of major depression does not differentiate between populations, the factors resulting in depression vary according to population.

Many different theories attempt to answer why depression occurs and thus formulate treatment plans. Unfortunately these theories rarely distinguish between populations, such as adults and adolescents. Most of the research is based on an adult population then generalized and adapted to the adolescent population. As suicide is the leading cause of death of adolescents (Steinburg, 1993, p. 448) and depression is one of the warning signs, it is imperative that research begin to examine adolescent depression more closely and separately from its adult counterpart.

Purpose

The purpose of this study is to examine specific factors related to adolescents diagnosed with major depression admitted on an inpatient adolescent unit. The goal of this study is to obtain a more clear profile of the depressed adolescent in hopes of being able to more accurately correlate which adolescents are at risk for major depression, thus providing more concrete information for prevention and intervention techniques.

The specific factors which were chosen resulted from a trend noticed on an adolescent unit (which will be expounded upon in the next section). In an attempt to

statistically corroborate the hypotheses formulated to explain these trends this study was designed.

Hypotheses

Based on a cognitive theory which indicates low self-esteem leads to depression the following hypotheses were formulated:

1. Female adolescents oldest in the family run a greater risk of depression.

2. Male adolescents youngest in the family run a greater risk of depression.

3. Adolescents from unstable families run a greater risk of depression.

4. Substance or alcohol abuse increases the chances of adolescent depression.

Theory

Rarely does a theory propose that depression is the result of one factor. More common is the idea that depression is an effect of the interaction of environment and predisposition. Specifically, it is the cognitive set which develops during childhood which leads an adolescent to interpret environmental events negatively and thus become depressed (Noelen-Hoeksema, 1990 as cited by Steinburg, 1993, p. 452). Therefore, those adolescents which developed a negative cognitive set are also at risk for low self-esteem and thus depression.

Additionally, Beck (1976) postulated that this set of distorted thoughts is continually reaffirmed by a depressed individual. The depressed individual does this by rejecting positive comments and concentrating on negative comments regarding themselves and their abilities.

Lastly, Abramson, Seligman, and Teasdale (1978) argued that the type of attributions an individual makes about the control he/she has within his/her life affects his/her self-esteem. A depressed individual suffering from low self-esteem believes that he/she lacks the control which others possess. Thus, a learned helplessness results. As the individual generalizes this learned helplessness, an individual may attribute the lack

of control to stable characteristics ("I'm dumb") instead of unstable characteristics ("I had a bad day"). In summary, learned helplessness and attributions of stable characteristics lead to depression.

Definitions

major depression – a mood disorder characterized by disturbances in mood (excessive sadness), behavior (apathy, loss of interest in activities), cognition (hopelessness and low self-esteem), and body function (loss of appetite).

self-esteem – an individual's opinion regarding him/herself and his/her abilities and limitations.

Assumptions

1. The diagnosis of major depression for the patients in this study was based on DSM-IIIR criteria.

2. The stability of families was determined by one of two therapists utilizing the same criteria.

3. Drug or alcohol abuse within the family is based upon the self-report of the adolescent and is accurate.

Limitations

1. Major depression is not only diagnosis which involves depressed mood, therefore diagnostic criteria is not uniform. Many patients with similar symptoms receive different diagnoses.

2. Adolescents admitted on the psychiatric unit have been diagnosed by screeners, crisis workers and/or other therapists. Therefore, it is difficult to guarantee uniformity with which the symptoms must be present before warranting diagnosis.

3. The patients admitted on the psychiatric unit consists of adolescents seeking medical/psychological attention and cannot be generalized beyond that population.

4. A diagnosis of major depression does not denote the severity (mild, moderate, severe). Only a diagnosis of major depression is criteria for the sample of this study. The severity is not considered.

Overview

In the following sections a review of the current literature on the effects of birth order, gender, family stability, drug and alcohol abuse on self-esteem and depression. This will be followed by a section explaining the designs and the results obtained. Lastly, the thesis will be summarized, conclusions will be outlined and the implications for future research will be discussed.

Chapter II

Many studies indicate that depression and adolescence are interrelated. For this study four factors will be examined as they relate to depression. Specifically, the four factors which will be explored are gender, birth order, drug/alcohol abuse and family stability. Research on gender differences among those diagnosed with major depression will be the first area explored. The second section will look at how the position of the adolescent within the family (birth order) affects self-esteem, thus putting the adolescent at risk for depression. The effect of alcohol and drug abuse on the adolescent will then be explored. Finally, the last section will look at how the stability of the family and a chaotic environment affects an adolescent's self-esteem.

<u>Gender</u>

The effect of gender on depression is often debated. On one hand, some research suggests that females are at a greater risk for major depression. On the other hand, less recent research does not indicate a difference in prevalence in depression according to gender.

Deykin, Buka and Zeena (1992) examined the prevalence of depression among adolescents being treated for chemical dependence. The 223 subjects were interviewed and using the National Institute of Mental Health Diagnostic Interview Schedule, 24.7% of the subjects were diagnosed with depression according to DSM-IIIR criteria. The results indicate that female subjects were more likely to experience the depression at an earlier age. Additionally, the male subjects which were diagnosed with depression were twice as likely to experience the depression after the chemical dependence. Conversely, female subjects were more likely to have depression co-occur with chemical dependence

or precede chemical dependence. This study indicates a difference in pattern of depression according to gender.

In a similar study, Worchel, Nolen and Willson (1987) studies 304 students grades 3-12. Using the children's Depression Inventory (CDI), they found females reported more depression than males. These results support other studies which indicate an increase of the experience of depression among females (Nolen-Hoeksema, 1987; Nolen-Hoeksema, Girgus and Seligman, 1991).

The results from these studies is contradicted by Sullivan and Engin (1986) who also studied adolescent depression, but did not find any gender differences. Also in his dissertation thesis for Glassboro State College in 1990, McKenzie studied 40 male and female adolescents aged 12 to 16 years. Using the Structured Pediatric Psychosocial Interview (SPPI Inventory) he found that of the subjects which showed indications of depression, no gender differences could be statistically corroborated.

Birth Order

Little research is available regarding the effect of birth order on depression. Most of the research involving birth order relates to an individual's self-esteem. Most research indicates that low self-esteem may lead to depression (Harter, 1990; Renouf and Harter, 1990). In a study done by Simons and Miller (1987) 400 high school students filled out a questionnaire consisting of items relating to seven scales (depression, self-esteem, hopelessness, powerlessness, parental support, employment difficulties and difficulties at school). The items for the specific scales were adapted from established tests. When correlated to depression, all of the cognitive variables proved to be statistically significant. Self-esteem demonstrated the strongest relationship.

Specifically with respect to birth order, a study was compiled to determine its effect on the rates of depression among adolescents. 404 children ages 7-12 years old were given the Children's Depression Inventory, the State-Trait Inventory for Children

and the Piers-Harris Self-Concept Scale. First-born children showed less depression, less state and trait anxiety then second, third, youngest and only children in the study. Additionally, first-born children received the highest self-concept than any other birth position within the study (Gates, Lineberger, Crockett and Hubbard, 1988). In a similar study which also considered gender, it was found that first-born males and youngest females showed higher self-esteem than first-born females and youngest males (Lester, Eleftheriou and Peterson, 1992).

Alcohol and Drug Abuse

The role of alcohol and/or drug abuse with depression is not clear. One of the main reasons it is difficult to determine alcohol/drug abuse's role is the inability to decipher which came first, the depression or the abuse. Deykin (1987) studied 434 college students and determined major depressive disorder was followed by alcohol and/or drug abuse. Deykin postulated that the abuse was an attempt to self-medicate. In a later study Deykin, Buka and Zeena (1992) postulated that the co-occurance of depression and chemical dependence is varied according to gender. Specifically, in this study males were more likely to experience the depression after the chemical dependence. On the other hand, females were more likely to adhere to Deykin's previous theory that the role of chemical abuse with depression is one of self-medication.

Regardless of the order which drug/alcohol abuse and depression occurs, they often afflict an adolescent at the same time. Therefore, the effects of drug/alcohol abuse must be considered when examining adolescent depression.

Family Stability

The importance of the family in the adolescent's life is not often debated. During adolescence it is important to have a support system to aid in the transition into adulthood. If an adolescent lacks the support from the parent or the parent rejects the adolescent, the system is jeopardized. Burge and Hammen (1991) reported that

dysfunctional family interaction put an adolescent at risk for depression. Additionally, high levels of conflict within the family also are related to higher risks of depression of the adolescent(s) within the family (Carlton-Ford, Paikoff, and Brooks-Gunn, 1991). In a study involving 300 adolescents, perceived parental rejection was the only family factor which related to depression. The researchers postulated that this effect is both direct, via lack of support, and indirect, via lowering of the adolescent's self-esteem (Robertson and Simons, 1989).

In another study which examined the relationship between suicidal behavior and life events (illness, divorce, changing schools, physical abuse, sexual abuse, etc.), it was found that depressed adolescents reported more negative life events than non-depressed adolescents. Additionally, those subjects which had attempted suicide experienced more negative life events both in childhood and in the year prior to the attempt than depressed subjects who had not attempted suicide. These results indicate that the risk of suicide is greatly increased as the number and/or frequency of negative life events increases (de Wilde, E., Kienhorst, I., and Wolters, W., 1992).

In Simons and Miller's (1987) study of 400 high school students used three scales to determine which, if any, socioenvironmental variables were related to depression and low self-esteem. Low parental support and employment problems have statistically significant relationships to both depression and low self-esteem. The authors suggest that these socioenvironmental variables have both a direct and indirect effect on depression. Indirectly, the socioenvironmental variables effect self-esteem which was found to be cognitive variable which the authors found to have a strong, positive relationship with depression.

Overall, the effect of the interaction between the adolescent and the parents/family on adolescent depression is not debated. In and of itself, it rarely can be the lone cause for depression, but research indicates that it can act as a catalyst.
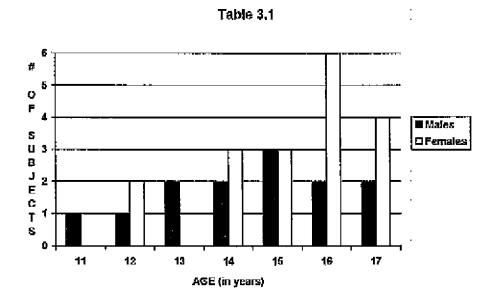
In conclusion, the effect of gender, birth order, drug/alcohol abuse and family stability may not be fully understood, but the potential of an effect exists. It appears that one possible link between these four factors and adolescent depression may be the adolescent's self-esteem. Additionally, since it is difficult to rule out the co-existence of two or more of possible predisposing factors, it is likely that the effects of these factors in combination may be multiplicative.

Chapter III

The purpose of this study is to examine specific factors related to adolescents diagnosed with major depression and admitted on an inpatient child and adolescent mental health unit. The goal is to obtain a profile of the depressed adolescent in order to determine specific risk factors.

Sample

Charts were obtained for 31 adolescents admitted on a mental health unit in 1994 and were diagnosed with major depression. All subjects were diagnosed with major depression by crisis screeners or psychiatrists and the diagnosis was based on DSM-IIIR criteria. The only common symptom of all subjects was suicidal ideation. The ages of the subjects ranged from 134 months to 209 months (approximately 11 years to 17 years). The mental health unit serves southern New Jersey, therefore the subjects were all from this area. Table 3.1 indicates the breakdown of age and gender.

Table 3.1

Procedure

The data collected was ex post facto, from charts after the subjects had left the mental health unit. The length of stay for the subjects ranged from three to twenty-eight days with a mean of ten days. First, a list of patients meeting the criteria for this study (diagnosis of major depression according to DSM-IIIR criteria) was formulated. Second, the charts were retrieved from the medical records department and the four factors (gender, birth order, family stability and drug/alcohol abuse) and age in months were obtained for each subject. Family stability and birth order were obtained through the adolescent's intake interview and were verified by interviews with the family by a family therapist. The measure of drug/alcohol abuse was a combination of self-report and a drug and alcohol screening done upon admission to the mental health unit. The age of the subject was based on the date of admission.

Hypotheses

For the purpose of this study, four hypotheses were developed.

1. Female adolescents oldest in the family run a greater risk of depression.

2. Male adolescents youngest in the family run a greater risk of depression.

3. Adolescents, male or female, from unstable families run a greater risk of depression.

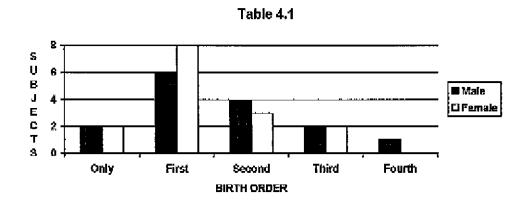4. Substance abuse (drug or alcohol) increases the chances of depression.

Analysis

In Chapter IV, an analysis of data will be addressed. Descriptive statistics will be presented along with a discussion of the findings. Overall, the analysis of the results will be presented according to the three factors: birth order, substance abuse and family stability. Gender will be examined as it relates to each of the three factors.

Chapter IV

As previously stated, the following will be an analysis of the results according to three factors: birth order, substance abuse and family stability. Additionally, gender will be examined as it relates to each factor. Lastly, each section will conclude with an analysis of the results as it relates to specific hypotheses.

<u>Birth Order</u>

Overall 13% of the subjects were only children, 42% were firstborn, 23% were second born, 13% were third born and 3% were fourth born. Two of the subjects' positions in the family could not be obtained. A marked difference was demonstrated when birth order was examined according to gender. 62% of the subjects who were first born were female, as were 100% of the subjects in the fourth position (see table 4.1). Unfortunately, the number of subjects in the fourth born position (1) is small, therefore eliminating the possibility that any conclusions can be reached from this data. On the other hand, the high percentage of female firstborn subjects indicates a possible effect when compared to firstborn males subjects.

Table 4.1

Additionally, 45% of all female subjects were firstborn. This percentage indicates a possibility that birth order may prove to play a significant role in the development of depression. Accordingly, if it is truly the position within the family unit which puts a female adolescent at risk for depression, one might also consider those female subjects who were only children. If these subjects were to be included in the position of firstborn the percentage of female subjects in this position increases from 45% to 56%. This clearly indicates that the majority of the female subjects in this study were firstborn.

It appears from this data that the first hypothesis is supported (female adolescents, oldest in the family, run a greater risk of depression) as the majority of the firstborn subjects were female. Additionally, the large percentage of female subjects who were firstborn further corroborates the theory that adolescents suffering from depression are likely to be firstborn. This may be due to two reasons:

1. The families' likelihood to hospitalize or seek medical attention for depression for adolescents and/or;

2. The fact that adolescents within these families may be more closely examined as he/she reaches adolescence, therefore making the firstborn more likely to be hospitalized sooner than other siblings.

The second hypothesis (male adolescents, youngest in the family, run a greater risk of depression) was not supported, as only 15% of the male subjects were the youngest in the family. Interestingly, the majority of male subjects were firstborn or only children (54%). This effect is similar to the effect previously mentioned pertaining to female subjects. Therefore, the relationship between depression and birth order does not appear to be effected by gender. Overall, the results suggest that adolescents in the first birth position of the family, regardless of the number of siblings, may be at risk for depression.

Substance Abuse

35% of the subjects reported abusing alcohol. This was evenly distributed between male and female subjects. Although this percentage does not support the fourth hypothesis (substance abuse increases the chances of depression), it illustrates a possible co-morbidity which should be further researched. It is important to note that all of the adolescents were under the legal drinking age in the state of New Jersey. Therefore, there may have been some hesitation by subjects to accurately report the amount of alcohol consumed in a given day/week. Additionally, alcohol leaves the system relatively quickly making screening tests done prior to admission unable to verify the amount of alcohol consumed on the days/weeks prior to admission. Considering these possible factors, the percentage of subjects abusing alcohol may be an underestimate.

Family Stability

84% of the subjects came from unstable families. 58% of these subjects were female, while 42% were male. This indicates a slightly higher rate for female, although not a significant difference. These results support the third hypothesis which states that adolescents, male or female, from unstable families run a greater risk of depression.

This may be a result of an attempt by subjects to escape the chaos of the family environment by attempting suicide. It may also indicate that adolescents from unstable families lack appropriate coping skills, emotional supports or suffer from low self-esteem. Unfortunately, this study does not differentiate between the degree of unstableness within the family or whether the unstableness is acute or chronic. On the other hand, hospitalization of the subject may be a solution the families choose in an attempt to stabilize the family unit. This second possibility would indicate that unstable families are more likely to hospitalize depressed adolescents, not that depressed adolescents are more likely to come from unstable families. This would indicate the high percentage of subjects from unstable families, hospitalized for depression, was not a

result of the effect of unstableness on an adolescent's depression as the third hypothesis indicates. Prior to attempting to explain why or how an unstable family effects the likelihood of adolescent depression, these issues must be addressed.

Chapter V

Summary

The purpose of this study is to examine four specific factors (gender, birth order, family stability and drug/alcohol abuse) as they relate to adolescents diagnosed with major depression, admitted to an inpatient adolescent mental health unit. There were 31 subjects aged 11 to 17 years. Of these subjects, 18 were female and 13 were male. The ex post facto data was collected from charts and analyzed using descriptive statistics, mostly percentages. The results of this study support the first hypothesis, that females, oldest in the family, run a greater risk of depression than females in other birth positions. The results do not support the second hypothesis, which suggests that male adolescents, youngest in the family, are at a greater risk for depression than males in other birth positions. The third hypothesis, indicating a higher rate of alcohol and/or drug abuse for adolescents suffering from depression, was not supported. Additionally, a greater number of subjects were from unstable families rather than stable families, supporting the fourth hypothesis.

Conclusions

Overall, the results of this study are not conclusive, but they do indicate the possibility of two factors relating to major depression in adolescents: birth order and family stability. The third factor, drug/alcohol abuse, was not corroborated; therefore no conclusions would be drawn from these results. Lastly, gender as it related to each of the three other factors did not have an effect.

Firstborn adolescents, male or female, was the birth position with the majority of the subjects. This indicates a relationship between birth order and major depression. Specifically, these results indicate that firstborn adolescents are more likely to be

hospitalized for major depression than adolescents in other birth positions. This supports the first hypothesis (female adolescents, oldest in the family, run a greater risk of depression) but not the second hypothesis (male adolescents, youngest in the family, run a greater risk of depression).

Discussion

In this study the conclusions drawn are only able to be generalized to the adolescent population which has been hospitalized for major depression. Without a control group, many of the conclusions cannot be applied to the adolescents suffering from depression who were not hospitalized. Therefore, the goal of this study, to obtain a profile of adolescent depression, must specify the population, adolescents hospitalized for major depression.

Also, the severity of the depression was not considered, but due to the suicidal ideation of all the subjects, the depression could be considered life-threatening. This also must be considered when examining possible relationships between factors and adolescent depression. Specifically, the role of alcohol and/or drug abuse may not be clearly established, but considering the possible repercussions of abuse, a closer examination is warranted.

Lastly, the small number of subjects did not accurately represent all birth positions. Although the results do indicate a relationship between birth order and adolescent depression, additional subjects would strengthen this position.

Implications for future research

Although the results of this study begin to examine some interesting relationships between birth order, family stability and adolescent depression, future research is necessary. Using similar methods, one might try to contact other siblings within the family unit to determine if and to what extent depression exists with other siblings. Additionally, a scale to measure depression may be used to indicate the severity of the

depression with both the subject and his/her siblings. Additionally, since self-esteem may be a link between birth order and depression, a test to measure self-esteem would be beneficial.

As it is not clear whether depression has a genetic component, it would be interesting to note the incidence of depression within step- or foster families or families with adopted children. These results could validate the results of this study which indicate that there may be a relationship between unstable families and adolescent depression. It would also aid in determining the effect and nature and nurture on the development of adolescent depression.

Another direction for future research would be to explore the relationship between alcohol/drug abuse and adolescent depression. The potential for dangerous and life-threatening situations increases as an adolescent loses the ability to think clearly. Since alcohol and drug inhibit clear judgment, the role of alcohol and drugs, whether as self-medication or a precursor to depression, must be examined closely. Although this study attempted to examine this relationship, the data for drug/alcohol abuse was not comprehensive. In the future, a more complete drug/alcohol screening may be helpful.

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