Depression in Adolescents

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Abstract

This paper describes in detail about depression amongst adolescents. Depression is a serious mental health disorder and should not be taken lightly. Treatments for depression include medication and psychotherapy. School achievement has a strong correlation with stress that causes depression in teenagers. Facebook use, substance abuse, and anxiety have also shown strong correlations between depression and adolescents. This study focused on comparing Cognitive Behavioral Therapy to Behavioral Activation to see which is more effective. Therapists who work with clients with depression need to be culturally competent while working with different groups of people. Depression is the number one cause of suicide. Those with depression often experience suicidal ideation which can be helped with the use of treatment. Depression is a common disorder that can result in fatality if not treated or recognized in time.

 *Keywords:* depression, adolescents, Cognitive Behavioral Therapy, Behavioral Activation

Depression in Adolescents

 Major Depressive Disorder (MDD), is a mental health mood disorder that ranges from mild to severe symptoms in which feelings of sadness, loss, and/or anger impairs daily life functioning for weeks at a time. In accordance to the Diagnostic Statistical Manual 5th edition, to be diagnosed with Major Depressive Disorder, one has to qualify for five out of the nine diagnostic criteria that is as follows: depressed mood or irritable most of the day, decreased interest/pleasure in activities, significant weight change (5%) or change in appetite, change in sleep, change in activity, fatigue/loss of energy, guilt/worthlessness, diminished concentration, and suicidality (American Psychiatric Association, 2013). A depressive episode can signify major depressive disorder or it could be an isolated event. Depressive disorders have a 5.7 percent frequency rate among adolescents. Those who are considered to be adolescents are between the ages of thirteen and nineteen (PaixÃO, 2013). Depression is a mental health disorder that affects people at all stages of life.

Depression causes a disruption in family relationships, peer relationships, and academic/work life among all who experience the disorder regardless of age or gender (PaixÃO, 2013). Among adolescents, depression is often caused by stress related to school and academic achievement. The frequency and intensity of depressive episodes rise considerably between the ages of fifteen and eighteen years old. In fact, fourteen to twenty-five percent of teenagers will experience a major depressive episode at least once before adulthood (Jacob, 2013). Despite the percentage of teenagers experiencing depression, there is a strong likelihood that an adolescent diagnosed with Major Depressive Disorder will also experience MDD in adulthood (PaixÃO, 2013). Severe depression can lead to suicide ideation which is not an uncommon problem among adolescents experiencing depression. Suicide is the third leading cause of death among people between the ages of fifteen to twenty-four years old (King, Strunk, & Sorter, 2011). Even though suicide may not always be possible to prevent, there can always be preventative measures taken. Education and awareness of depression can help those battling with the disorder reach out for help.

 The focus and purpose of this paper is to bring awareness of depression in adolescents. Adolescents experience an extreme amount of pressure to succeed from their environment which includes their parents and the school system. A typical high school teenager is expected to achieve high grades, do well in sports, and partake in other extracurricular activities such as clubs, musical instruments, or work. Not to mention, the social pressure the teenagers face from fellow peers and society. Social networks such as Facebook are supposed to connect people to one another, yet users of Facebook have reported feelings of depression, anxiety, and stress (Labrague, 2014). The high levels of stress placed on teenagers are causing high rates of depression among them. Many teenagers do not know how to handle the consistent negative emotion caused by depression; therefore, they internalize it until it becomes a very serious issue.

 The most extreme severity of depression may result in suicide. According to a study conducted by King, Strunk, and Sorter, results show that one in five teenagers diagnosed with Major Depressive Disorder have seriously considered attempting suicide in the past (King, Strunk, & Sorter, 2011). Along with awareness of the disorder, comes the knowledge of potential treatments for depression. The two most common types of treatment for depression are medications and psychotherapy. Both treatments have proven to be effective, although, there is a strong possibility of increased suicidal ideation in teenagers who use medications such as fluoxetine and selective serotonin reuptake inhibitors (Maughan, Collishaw, & Stringaris, 2013). Preventative programs can educate students about where to seek help if they are experiencing symptoms of depression. These programs can help improve and create healthy coping abilities for students.

 Depression is often comorbid with other mental health disorders. The most common comorbid disorder with depression is anxiety and substance abuse. There are many links between drug involvement, aggression, suicidal behaviors, and depression (Thompson, Connelly, Thomas-Jones, & Eggert, 2013). Adolescents are in need of a supportive school environment to promote positive interactions among students. Positive interaction among students is an important school health issue that should be addressed within all school districts to help prevent depressive symptoms (Garmy & Clausson, 2014). If schools provide preventative programs teaching students about suicide prevention, depression awareness, and appropriate intervention steps for seeking help, then there would be less suicides or attempts (King, Struck, & Sorter, 2011). Depressed students will know how to receive help for their condition.

**Literature Review**

Major Depressive Disorder has many risk factors that may catalyze a depressive episode. A family history of depression is the main predisposition for the disorder. However, antisocial behavior, conduct problems, poverty, sexual abuse, stress, and neglect also contribute to a depressive episode. Some environmental risk factors for depression, especially within adolescents, include but are not limited to: separation, mourning, conflict, abuse, and bullying. It is been noted that recurrent stressors are more likely to trigger depression in comparison to a single occasion. This is especially true for females who happen to be twice as likely to develop Major Depressive Disorder. Ten to seventeen percent of teenagers will be affected by depression during adolescence. Depression is relentless because of the high relapse rate. Fifty to seventy percent of those diagnosed with depression will have another episode within five years, although, the severity of the episode may or may not be worse than the previous (Maughan, Collishaw, & Stringaris, 2013).

Early forms of depression can be very challenging for adolescents due to the lack of knowledge of what is happening to them and the stigma that follows it. Some cultures, especially Asian cultures, find it shameful to be depressed which causes teenagers to internalize and worsen their condition (Hsieh & Bean, 2014). Many students who have Major Depressive Disorder are unable to focus or complete daily activities because of their feelings of sadness, inadequacy, and hopelessness. These feelings interact with teenager’s personal lives, which reach all aspects such as: physical health, social interaction, and academic performance. If the condition is severe enough, teenagers with a suicidal ideation will show warning signs. Some warning signs may be talking about death, comments of hopelessness, and saying goodbyes to people. These indicators can be identified with training in suicide prevention (King, Strunk, & Sorter, 2011).

Depression is very common within adolescents; in fact, nearly twenty-five percent of adolescents will experience at least one depressive episode by the age of nineteen years old (Garmy, Berg, & Clausson, 2014). Adolescents who are diagnosed with Major Depressive Disorder experience it differently than adults, which is important for therapists to keep in mind. Teenagers exhibit a few different symptoms than adults, while still displaying adult-like symptoms. Some of the symptoms that are specific to teenagers are: irritability, loss of energy; sensitivity to criticism, apathy, unexplained aches, and withdrawal from people (Hsieh & Bean, 2014). Often times, adolescents somaticize their symptoms, which are commonly represented by headaches, dizziness, and abdominal pains (Garmy, Berg, & Clausson, 2014). Somatic symptoms occur when a person has internalized their symptoms to the point that they become a physical ailment.

Major Depressive Disorder has high rates of comorbidity usually associated within adolescents. Two-thirds of adolescents diagnosed with depression have a comorbid disorder and from that number, ten percent of adolescents with depression have more than two comorbid disorders (Maughan, Collishaw, & Stringaris, 2013). Treatment for comorbid disorders can become extremely difficult, especially if medications are involved. The best form of treatment for comorbid disorders would be a mixture of psychotherapy and medications—depending on the severity. Depressed adolescents who do not receive any form of treatment are at a higher risk to have low income, to not receive a college degree, to have a baby before marriage, and to have a substance abuse problem as an adult (Jacob, 2013).

School is where teenagers spend a majority of their time. It is the place where most socialization occurs. School also happens to be a main cause of depression amongst adolescents. School places an insurmountable level of stress on students. Academic, social, and financial stress accumulates and overwhelms students. Many parents expect high academic achievement from their child, which increases stress that may result in depressive symptoms. When a student is experiencing a depressive episode, it becomes difficult to maintain academic achievement. Once students start having difficulty in school, they are at a higher risk for dropping out, truancy, fighting, drug usage, and suicide. School-related problems make a student lose interest in extracurricular activities and feel less connected to the school. When students are less connected to school then they are more likely to be doing illegal activities (Thompson, Connelly, Thomas-Jones, & Eggert, 2013). Illegal activities such as drug usage and consumption of alcohol increases depression in adolescents and may influence them to partake in high-risk activities.

When an adolescent is depressed, aspects of everyday life including academics, social relationships, and health are negatively affected. When one of these aspects beings to go downhill, then usually the rest of the aspects follow, thus continuing the downward spiral of depression (Garmy, Berg, & Clausson, 2014). Adolescents with Major Depressive Disorder and difficulty in schools have a higher risk for self-harm (Thompson, Connelly, Thomas-Jones, & Eggert, 2013). The pressure to academically succeed causes an increase in stress and depressive symptoms for adolescents. Asian cultures greatly value achievement and expertise; in fact, academic failure brings shame to the family. The feeling of shame in collectivistic cultures causes depressive symptoms to worsen because it represents the whole family, not just the individual. Because of the extreme pressure placed on the teenager, Asian cultures tend to have higher rates of suicide compared to Americans. The pressure to succeed brings about enormous levels of stress, depressed mood, anxiety, aggression, and somaticized symptoms for male and female students (Hsieh & Bean, 2014). Social pressure among students is very serious. There is the pressure to fit in, make friends, and establish healthy relationships. Students in high school face social adversities such as bullying and exclusion. The Internet has become inherently known as a place for bullying, which causes stress and depression among teenagers. The Internet allows teenagers to anonymously post mean and negative comments about others. Internet also has the ability to make a post go viral for all to see and experience.

Facebook is a social media website that has over one billion members. The website allows members to share photographs, post statuses, and chat with friends. Members of Facebook often use the website as a replacement for face-to-face social interaction. This trend is becoming increasingly popular among adolescents because it removes the potential for awkward social interaction. High-usage of Facebook has been linked to lower levels of self-esteem, along with higher levels of depression, anxiety, and stress. Facebook itself does not create feelings of depression, but enhances the feelings when there is a significant amount of time spent on the website. By spending more time on Facebook, adolescents are exposed to negative updates and comments that may influence their emotions. Rates of loneliness, stress, shyness, anxiety, and “friend sickness” increase with the amount of time spent on Facebook. “Friend sickness” is defined as, “the distress one experiences at the loss of old friends” (Labrague, 2014). Many members of Facebook post their emotions through the use of statuses. Roughly twenty-five percent of members on Facebook have had at least one depressive symptom shown through a status update. Ironically, Facebook can raise awareness for depression by people sharing articles, personal information, and creating a sense of community. Just to clarify, it is not Facebook that triggers depression, but it is the amount time spent on Facebook that could trigger depression (Labrague, 2014).

In January of 2012, Facebook tampered with the number of positive and negative posts that show up on the news feeds of over six hundred thousand members. The researchers found that the alterations did have an effect on posts created by those viewing the experimental variables. Viewing negative posts influenced others to also create negative posts and vice versa for positive posts. The researchers who conducted this experiment argue that the experiment was ethical while others do not perceive the experiment in this way (Goel, 2014). As for the reason of this experiment, one of the researchers stated, “We felt that it was important to investigate the common worry that seeing friends post positive content leads to people feeling negative or left out. At the same time, we were concerned that exposure to friend’s negativity might lead people to avoid visiting Facebook.” The researchers stated the results had a small effect and that the experiment was not worth the anxiety (Goel, 2014).

Major Depressive Disorder should not go untreated because it can be fatal. Less than thirty percent of people with depression seek treatment from a professional (King, Strunk, & Sorter, 2011). There are many forms of treatment for depression some of which include medication and psychotherapy. Medications for depression are generally antidepressants. The four major types of antidepressants are selective serotonin reuptake inhibitors, monoamine oxidase inhibitors, tricyclic antidepressants, and serotonin and norepinephrine reuptake inhibitors. Psychotherapy (also known as “talk therapy”) is most effective when a client is willing to overcome their problems and engage with the therapist. Psychotherapy results present significantly lower suicidal ideation in adolescents (PaixÃO, 2013). The therapist should be culturally competent and know many strategies and interventions appropriate for the client (Hsieh & Bean, 2014). For teenagers with depression, psychotherapy should be the first line of treatment during the healing process. If a teenager’s symptoms are severe enough, then medication can be used to assist psychotherapy—not replace it. However, suicidal ideation is a common side effect of antidepressants when taken by adolescents and children. Studies have been conducted with the use of antidepressant medication, psychotherapy, and a placebo pill. The studies found no significant difference between the antidepressant medication and the psychotherapy (PaixÃO, 2013). There are two popular forms of psychotherapy that have been effective when dealing with depressed adolescents. Those practices are Cognitive Behavioral Therapy and Behavioral Activation. Cognitive Behavioral Therapy (CBT) uses techniques to change negative thoughts and behaviors into more positive ones. The goal of Behavioral Activation is to keep clients from becoming isolated by getting involved in activities that improve mood (Jacob, 2013).

Cognitive behavior therapy trains adolescents to have better coping strategies with the use of positive thought training and time management skills. CBT has shown to be effective and have lasting benefits for depressed teenagers because it teaches them skills that can be used throughout life. It is also helpful for depression that is triggered by academic pressure because it improves time management skills which helps to reduce stress (Hsieh & Bean, 2014). Cognitive Behavioral Therapy is generally the initial treatment for those with mild to severe depression. Behavioral Activation has demonstrated to be just as effective as Cognitive Behavioral Therapy with lower depression scores and better psychological welfare. Teenagers who have used Behavioral Activation tend to be happier and fight less. Also, the results show that those teenagers have a rekindled interest in school activities. Behavioral Activation has been helpful in treating depressed clients with different cultural backgrounds. It helps MDD clients in low socioeconomic statuses to attain goals. Similar to all treatments, Behavioral Activation is not as effective if the parents are not involved or do not care about the treatment that their child is receiving (Jacob, 2013). A lack of support within a household hinders the healing process.

If the healing process goes awry, the result could be suicide. Teenagers with Major Depressive Disorder are seven times more likely to commit suicide than adults (PaixÃO, 2013). This could be a result of teenage impulsivity and lack of coping skills. Also, suicide rates have tripled in the United States of America since the 1950s. To be more specific, every two hours and three minutes an adolescent commits suicide and fifty percent of those adolescents have Major Depressive Disorder. There are roughly one hundred and fifty suicide attempts made for every one suicide completed (King, Strunk, & Sorter, 2013). For more perspective of the situation, in a typical American high school classroom, at least two female and one male student had attempted suicide in the past year. Substance abuse, depression, anxiety, and impulsive behavior put teenagers at a greater risk for committing suicide. Substance abuse and depression are closely linked to suicidal behavior in both males and females. Suicidal behavior is defined as, “a constellation of self-destructive cognitions and behaviors measured using frequency of suicide thoughts, direct, and indirect threats of suicide, and prior suicide attempts” (Thompson, Connelly, Thomas-Jones, & Eggert, 2013). Suicidal behavior is increased with the use of drugs and alcohol, which may escalate to suicide attempts and completion. Females and males tend to have different patterns of suicidal behavior. Females report more direct threats and attempts than males who were more likely to report indirect threats of suicide (Thompson, Connelly, Thomas-Jones, & Eggert, 2013).

Many schools have suicide prevention programs. School-based suicide prevention programs teach the students coping skills and how to participate in less risky behaviors. All schools should have policies and preventative measures for suicidal behavior within the student population. If a school is planning to host a suicide prevention program, then the program needs to be informational and straightforward. A main protective factor within the school system is school connectedness. This can be achieved with the use of a school-wide prevention program teaching students how to recognize symptoms of depression and suicidal ideation amongst the student body (King, Strunk, & Sorter, 2013). Programs designed for at-risk teenagers have found that twenty-five to forty percent of the students had elevated levels of depression and/or suicidal ideation before intervention (Thompson, Connelly, Thomas-Jones, & Eggert, 2013). Goals for the prevention programs should include knowledge of: depressive symptoms, depression and suicidal risk factors, and warning signs for suicide and depression. After the intervention program, students reported that they would seek help from a friend or a trusted adult if they were contemplating suicide. Post-test results indicate that students who were previously experiencing suicidal behaviors were much less likely to continue doing so and many have stopped (King, Strunk, & Sorter, 2013).

Major Depressive Disorder affects everybody who frequently and directly interacts with the person who has the diagnosis. If a parent has depression and is experiencing an episode, then the family life has been disturbed. Therapy for the family along with the individual can create cohesiveness within the home (Maughan, Collishaw, & Stringaris, 2013). All schools should get involved with their student body to promote mental well-being and to enforce preventative measures. For example, students should be aware of the services that the school provides for the students who are in need of help. Regardless of being shameful, a teenager should seek help if they know they are in need. If a family were to reject the healing process, then the process will be ineffective (Hsieh & Bean, 2014).

**Method**

A quantitative study was performed to compare the effectiveness of Cognitive Behavioral Therapy (CBT) and Behavioral Activation (BA) interventions in adolescents diagnosed with Major Depressive Disorder over the time period of eight weeks.

**Participants**

 Three hundred clients diagnosed with Major Depressive Disorder of various therapists participated in the study. The participants were aged thirteen through nineteen and lived in the area of Hampton Roads located in southern Virginia. Participants were a mixture of White (*n*=187), Black (*n*=67), Hispanic (*n*=9), Asian (*n*=13), and biracial (*n*=24) descent. One-hundred and fifty of the participants were male and one-hundred and fifty of the participants were female. There were seventy-five males and seventy-five females assigned to each condition. Both conditions had twenty-five participants from each age group. Participant demographics were distributed as equally as possible throughout the conditions; however, there was no controlling for the number of males and females in the age groups and ethnic distribution between the conditions.

**Procedure**

After gaining permission from the Institutional Review Board, a letter with information regarding the study’s purpose, design, and methods was sent out to a number of reputable therapist’s offices throughout the Hampton Roads area of Virginia (*n*=30). The therapists who wanted to participate were required to be trained in Cognitive Behavioral Therapy and Behavioral Activation therapy. Of those initial letters, twenty therapists agreed to participate in the study. Once the therapists consented to performing the treatment conditions, they chose clients who would benefit from the treatment by reducing their depression scores. The criteria for the clients were restricted to those diagnosed with Major Depressive Disorder, aged thirteen to nineteen, live in the Hampton Roads area, and were receptive to receiving therapy for their depression. After all of the participating therapists gained the client’s consent, the researchers randomly assigned seventy-five males to each condition and seventy-five females to each condition. The researchers instructed the therapist as to which treatment to give the participant.

Participants completed a self-report survey titled 6-ITEM Kutcher Adolescent Depression Scale: KADS-6 (see Appendix A) in the therapist’s office before treatment began. The survey being distributed has a designated spot for the participant’s name, but the participants were instructed to not fill out that piece of information, but to instead write the chart number assigned by the therapist. Participant’s scores were recorded and computed using SPSS database. Therapists conducted the assigned treatment to the participant. Participants received the treatment condition for a one-hour therapy session two times a week at their normal session time. After eight weeks of treatment, the participants completed the survey again. The scores were computed and recorded. When treatment was over, therapists gave the researchers the participant’s scores to the survey. The researchers compared the pre-treatment and post-treatment scores to create an average score for the males and females of the treatment conditions. An in-depth analysis of the scores determines how effective each treatment was for different sex and age of the participants. The data was analyzed to find differences between the two treatment conditions; and more specifically, according to gender and treatment conditions and age and treatment conditions. To analyze age, participants aged thirteen to fourteen, fifteen to sixteen and, seventeen to nineteen were grouped together.

To ensure confidentiality, researchers do not know the names of the participants, only the chart number assigned to the participant. The chart number does, however, identify sex and age of the participant. Only the therapists know both the name and chart number of the participants. The therapists were instructed to lock away the surveys until treatment had been completed and the data was ready to be computed by the researchers. The researchers locked the surveys in a file cabinet and placed the key in a safe location that only the researchers knew about. The researchers destroyed the surveys with a paper shredder after keeping the records for six months.

As previously mentioned, this is a quantitative, quasi-experimental, survey study. The quantitative research method emphasizes numerical and statistical data to answer the research question and hypothesis. A quasi-experiment is similar to a regular experiment, except participants are not randomly assigned to a treatment. A survey is compiled of close-ended questions that gather data that is computed to make a general assumption about a population (Rubin & Babbie, 2014, p. 79). More specifically, this study uses a one-group pretest-posttest design for Cognitive Behavioral Therapy and Behavioral Activation. A one-group pretest-posttest design measures the dependent variable (depression score) before and after the treatment. The major problem with the one group pretest-posttest design is the threat to internal validity that may be caused by maturation and history (Rubin & Babbie, 2014, p. 278). A quantitative method is appropriate for this study because the researchers want to see the means of effectiveness for two types of therapy. This study combines randomization with matching which groups the participants based on certain similarities which were sex and age but the participants were randomly assigned to the treatment (Rubin & Babbie, 2014, p.287).

There are no evident ethical issues with this study because everybody in the study is receiving a form of treatment for their disorder and information is kept confidential. The goal of this study is to compare the effectiveness between Cognitive Behavioral Therapy and Behavioral Activation which is why there was no control group. Perhaps an ethical issue that could happen would be the treatment obviously worsening the condition of a participant, but that did not occur within this study. A major weakness of the study is intervention fidelity. Intervention fidelity is defined as the degree to which the intervention actually delivered to clients was delivered as intended (Rubin & Babbie, 2014, p 313). That is the biggest problem with having multiple therapists delivering the treatment. This weakness had the preventative measure of requiring therapists to be trained in Cognitive Behavioral Therapy to Behavioral Activation. A major strength of this study is that it evaluates the outcomes on multiple levels. The researchers not only compared overall scores of Cognitive Behavioral Therapy to Behavioral Activation but also the scores to find the effectiveness for males and females and different age groups for the treatment. This will give other researchers and therapists other information as to what may be the best form of intervention for the adolescent.

**Discussion**

Major Depressive Disorder is treated most effectively when there is a strong support system involved in helping to treat the client. A strong support system will give the adolescent security and trust that is needed for a full recovery. A support system will also help those with depression to be able to overcome the stigma that is associated with the disorder. If the stigma of depression is removed, then people who are experiencing depressive symptoms will be more likely to receive help and treatment which will lead to a positive increase in mental health and a decrease in suicidal behaviors. By getting treatment, teenagers learn coping skills which will help them immediately and in the future. Coping skills that may be learned include sharing emotions, asking for help, accepting the help, and using the strength’s perspective (King, Strunk, & Sorter, 2011). The strength’s perspective is defined as “a set of ideas and practices seeking to recognize and utilize the inherent personal strengths to promote change and lifelong resilience” (Ward, 2013). The strength’s perspective is a form of positive psychology that encourages clients to “look on the bright side” of a situation. By doing so, clients will be able to develop a more positive outlook on life which helps to counteract depression.

Regardless of the form of treatment--whether it is therapy or medication-- any treatment is better than no treatment for depression. Depressed individuals have low self-esteem, so anybody who initiates care for the person will be able to help. By simply talking out problems with a friend, family member, or therapist, depression severity can be reduced or eliminated. Schools should implement a proactive, preventative program teaching students how to identify depressive and suicidal behaviors in themselves and others. The program should go into detail about warning signs and risk factors for depression and suicide, while also debunking myths about the disorder and pairing it with factual information (King, Strunk, & Sorter, 2011). The program can help students learn proper coping skills that will help build resiliency. With schools putting this program into effect, they may increase positive changes to the school environment which will help all students by creating a closer environment. Although the program may create awareness, it may not be the primary form of decreasing suicidal behavior; yet, it may be a secondary form by educating those who come into daily contact with somebody who is depressed.

This study can be modified to achieve more detailed and accurate results. A major modification could be to gather the therapists who have agreed to participate in the study and train them in Cognitive Behavioral Therapy and Behavioral Activation. This would create more control over the experiment because the therapists would all have the same training. The researcher could create a rigorous plan to give to the therapists to conduct the treatment. Also, to ensure the most accurate results, both treatments would have to be used on each participant to evaluate which is more effective. However, that process would be extremely lengthy, expensive, and would require a participant to have another depressive episode. To trigger an episode would be unethical. The study could also benefit from the use of multiple depression scale tests. This would ensure an average score from more than one credible source. Another control for the experiment would be to use adolescents who have the same score on the depression test. The experiment does not account for comorbid disorders which may have a significant impact on the adolescent’s treatment. The study eliminates those who have Major Depressive Disorder that are a part of the low socioeconomic social class because they cannot afford therapy. Therefore, there are no results about the effectiveness for the treatment of either condition.

Overall, Major Depressive Disorder can be treated effectively if the adolescent is willing to receive help and has a strong support system. By creating coping skills, adolescents become resilient to life stressors and obstacles. Cognitive Behavioral Therapy and Behavioral Activation are both effective in treating depression in males and females regardless of their race. School prevention programs will help students identify and help others experiencing depression which will help schools to not be a main trigger for depression. Also, limiting a teenager’s time on Facebook and other forms of social media may help reduce depression by getting them more engaged in life and by not experiencing friend-sickness. Suicidal behaviors can be dramatically reduced with the use of treatment and support from friends and family. As previously stated, medications should only be used for severe depression while being paired with a form of talk therapy. This will ensure teenagers to face and work out their problem instead of just masking it with medication.

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Appendix A

The Kutcher Adolescent Depression Scale is a self-report scale of measurement designed to analyze and evaluate the severity of adolescent depression. A score of 0-5 identifies that the participant is probably not depressed, but a six and above identifies possible depression and a need for further assessment (Kutcher, 2006).

