

REPORT OF A COUNSELLING INTERNSHIP AT
HOLY CROSS SCHOOL COMPLEX AND A STUDY
ON ADOLESCENT DEPRESSION

CENTRE FOR NEWFOUNDLAND STUDIES

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**Report of a Counselling Internship
at
Holy Cross School Complex
and
a study on Adolescent Depression**

**Presented to
The Faculty of Graduate Studies
Memorial University of Newfoundland**

**In Partial Fulfilment
of the Requirements for the Degree
Master of Education Psychology
(School Counselling)**

**by
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2001**

Abstract

This report provides a summary of a ten week counselling internship at Holy Cross School Complex, Eastport, that was completed from April 23 to June 22, 2001. The report is divided into four major chapters. The first describes the proposed internship including the rationale, objectives, proposed site, internship plan and evaluation. Chapter two provides a literature review on adolescent depression over the past 50 years. The common views of depression, the classifications of adolescent depression and the factors associated with adolescent depression are reviewed in depth. Chapter three discusses the process upon which the survey on adolescent depression was conducted, the results of the survey, and the recommendations and suggestions which follow from this study. Finally, chapter four provides a description of the actual internship activities and a review of the objectives.

Acknowledgments

I would like to acknowledge some important people who helped me reach this point in my career and life. Most importantly, I would like to thank my parents, Sarah and Eugene, for their endless amount of support and encouragement, and for their motto, "You can do anything you put your mind to." Many times I have heard this statement ring in my ears. I know this is true.

I would like to thank my husband for his patience and enduring sense of reasoning. When things became hectic, and most of the time they were, John always helped me to positively refocus my energies.

Another person who was integral in this whole journey was Mrs. Lynda Younghusband, my university supervisor. I would like to thank her for her endless guidance and assistance. You have made this whole process enjoyable, thank you.

My internship was such a pleasurable and memorable experience and I would like to thank Denise Penny, my field supervisor, for her giving nature and her kindness.

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CHAPTER ONE

Introduction

An internship is a ten week full-time practical experience which is undertaken to fulfil the requirements of the Masters of Educational Psychology (School Counselling) program at Memorial University. An internship is designed to provide experience in a practical setting and to provide opportunities for:

the development of personal and professional competencies for each intern based on perceived needs, previous experiences, and career plans; practical experiences that serve to highlight the theoretical and pedagogical aspects under study in the program; and, the development of a creative and reflective perspective given the stated goals of the intern, the nature of the setting, the specific placement, and field supervisor's exchanges on knowledge of subject matter, and counselling/instructional/leadership competence. (Memorial University of Newfoundland, 1997, p. 1)

Proposed Site

The proposed internship will be completed at Holy Cross School Complex in Eastport. This is a kindergarten to grade 12 school with approximately 232 students and 18 teaching units. Holy Cross School Complex serves various surrounding rural communities. Due to the limited time of the guidance counsellor, the focus of the counselling program has been on individual and career counselling. I see this as a great opportunity to benefit the students by offering extra guidance services such as group counselling.

I have chosen to complete the final phase of my studies at this school since my future employment will likely be in a rural school and the experience gained from such an internship will be indispensable as I prepare to become a guidance counsellor. In addition, I enjoy working in rural Newfoundland.

The proposed site is particularly appealing because the field supervisor works as a half-time guidance counsellor at Holy Cross School Complex and as an Educational Psychologist with the Lewisporte/Gander School District. As an Educational Psychologist she is responsible for psychological and achievement assessments at Smallwood Academy and Glovertown School Complex. This is an ideal opportunity for me to be exposed to even a greater number of students who have a range of needs and problems.

University Supervisor

Mrs. Lynda Younghusband is the university supervisor for the proposed internship.

Field Supervisor

The field supervisor for the proposed internship is Ms. Denise Penny. She has a Bachelor of Science in Math and a Bachelor of Education (Secondary) from Memorial University, and a Masters of Educational Psychology from Dalhousie University. She is the guidance counsellor for Holy Cross School Complex and an assessment counsellor for Smallwood Academy and Glovertown School Complex.

My activities will be monitored using a variety of approaches. I will meet on a regular basis with the field supervisor to discuss cases and issues which arise during the internship. I will regularly be in phone contact with my university supervisor given the distance. A selection of individual counselling sessions will be either audio or videotaped to monitor my skills and progress. If this is not feasible direct observation may be utilized. I will keep comprehensive case notes. A reflective journal will be kept as a personal learning tool and will be reviewed by the university supervisor.

Rationale

I have chosen to complete the internship at the proposed site because my current aspiration is to work as a guidance counsellor in the school system. The internship site will closely resemble future places of employment. In addition, I believe that I will most likely be settling in a rural area of the province and the experience of counselling in a rural community such as the proposed site will be invaluable.

I completed a Bachelor of Arts in Religious Education and English and a Bachelor of Education (Secondary) at Memorial University of Newfoundland before being accepted to do a Masters of Educational Psychology (School Counselling) programme. Becoming a guidance counsellor has always been a career goal, however this desire became stronger when I began teaching. I not only wanted to contribute to the academic growth of children but rather to the total well-being of children. During my six years as a teacher, I have had the opportunity to work in many schools and work with children who come from a variety of backgrounds with different needs. This has allowed me to experience first hand the need for guidance counsellors, and thus my calling in this field.

The School Counselling programme at Memorial University has provided me with the basic skills and theoretical framework from which to begin a counselling

career. I view the practical experience of an internship as a vital part of my education whereby I will be able to learn in a supervised and real environment.

Internship Objectives

The objectives of this internship are:

- (1) to further develop individual counselling skills;**
- (2) to develop and co-lead a time-limited, issue-focused group;**
- (3) to become more knowledgeable about the tools used in career counselling;**
- (4) to determine the level of knowledge that teachers have regarding adolescent depression;**
- (5) to develop and conduct an information session for teachers on adolescent depression;**
- (6) to become more familiar with psycho-educational assessment tools and other testing tools;**
- (7) to attend professional development activities within and outside the district;**
- (8) to learn about crisis intervention and emergency services and procedures to follow;**
- (9) to become knowledgeable about the referral process and agencies; and,**

(10) to become more knowledgeable about conducting a survey and assessing the data.

Internship Plan

Individual Counselling

The internship will provide an opportunity for me to conduct individual counselling sessions with a number of clients. The actual number of clients will be determined by the field supervisor. Individual counselling sessions may address personal, academic and career concerns of clients. Since I have proposed to do a study on teachers' knowledge of adolescent depression, it would be beneficial for me to work with some clients who are experiencing depression. I will practice assessing the client's situation, using proper interviewing techniques and skills, and developing a counselling plan to ensure that the client's needs are adequately met.

Group Counselling

It is desirable that I form a group whereby group counselling techniques may be practised and the experience of co-leading a group could be acquired. Since this is a ten week internship, the group will have to be issue-focused and time-limited. A

focus for the group will be determined upon the advice of the field supervisor and after assessing the needs of the school community.

Career Counselling

A proportion of my time will be spent providing career education/counselling services to students. This will involve assessing individual needs, interests, abilities, educational backgrounds and academic achievement and providing career and educational information. I want to become familiar with the various assessment tools used in career counselling and more knowledgeable about university programs and requirements.

Information Session for Teachers

My plan is to develop an information session for teachers on adolescent depression. The aim will be to educate teachers on the signs of adolescent depression, on the referral process for depressed adolescents and to provide resources for teachers on adolescent depression. This will be developed during the internship and will be held towards the end of the internship.

Assessment

There will be opportunities to administer psycho-educational tests and related assessment tools that I feel will be highly beneficial to my internship experience. I would like to learn more about learning disabilities and other areas of exceptionalities guidance counsellors encounter when working with children.

Professional Development

I will attend both on and off site professional development activities deemed appropriate by the field supervisor and of interest to me. Some such workshops are the Suicide Intervention, Manipulation and Self-Mutilation Workshops held by the Health Care Corporation at the Waterford Hospital.

Crisis Intervention and Emergency Services

When working with clients, there will be times when emergency services and crisis intervention is necessary. I want to become aware of the services that are available and the procedures to follow in such cases.

Conducting a Survey

I will develop a questionnaire to determine teachers' knowledge of adolescent depression. The creation and distribution of the questionnaire will be implemented with close consultation and supervision by my university supervisor. The data will be collated using the Statistical Package for Social Sciences 10. Ethics approval will be requested from the Interdisciplinary Committee on the Ethics of Human Research (ICHER) (see appendix A).

Brief Overview of the Internship Features

- ⇒ **Supervision by and consultation with a qualified practitioner in the areas of individual, group and career counselling**
- ⇒ **Supervision by and consultation with a qualified practitioner in the administration of psycho-educational assessment tools and other assessment tools**
- ⇒ **Professional development opportunities**
- ⇒ **Collaboration and team work with members both inside and outside the school**
- ⇒ **Opportunity to work with a variety of clients (K-12)**
- ⇒ **Increase knowledge about the referral agencies and the referral process**
- ⇒ **Improve research skills**

Evaluation

I will be required to submit an internship report after the completion of the internship. The report will be submitted for acceptance to examiners who have completed a graduate degree at the doctoral level. In addition to the internship report, informal evaluation will be on going. This will include feedback and meetings with the field and university supervisors.

CHAPTER TWO

Introduction

Beliefs regarding adolescent depression have undergone many changes over the last fifty years. When adolescent depression first became recognized, many people, including mental health practitioners and medical personnel, believed it was a “normal” stage of adolescence. Relatively little was done to investigate this phenomenon or treat it. Since adolescent depression was perceived as a normal part of growing up it was just accepted.

As the years progressed there evolved a trend of thinking that viewed adolescence as possibly a period of moodiness and intense feelings but saw adolescent depression as something separate from normal development. Currently there is a focus on understanding why adolescents become depressed and to categorize types of depression. To assist in this understanding a number of assessment measures for adolescent depression have been developed. Until recently adolescents were assessed by adult criteria, but since the recognition of adolescent depression as a separate category, a rationale has been laid for specialized assessment tools.

Early Views of Depression

Flynn (1968) in reflecting on the history of depression outlined the earliest reporting of the condition as dating back to 2500 B.C. when the Assyrians and Babylonians attributed it to demon possession that made self-realization and happiness impossible. In Egypt in 1500 B.C. one of the most famous medical documents written, The Papyrus Ebers, provided information regarding the nature of melancholia and treatment measures which are still used today. Hippocrates, who is acknowledged as the first doctor to separate his art from philosophy and magio-religious beliefs, classified and described melancholia as well as other mental disorders. Although Areteus, in 3 B.C., describes a case of a man who suffered melancholia after losing a woman's love and who was freed from this depression upon regaining the love, there was no further exploration into psychogenic factors as causes for depression from this period through the Dark Ages. It was still generally accepted that depression was caused by diabolical possession. According to Flynn in the 13th century, there began a more positive attitude towards the noble person who was in "low spirits". These people were sent to a nunnery to solve this problem and to perpetuate a grief. We see a beginning of respect for people with this type of illness.

Flynn (1968) goes on to report that in 1666, the first psychiatric hospital, the Hotel Dieu, was established and melancholia was classified as one of the three major types of mental disorders. Persons with melancholia were kept alive because it was believed by the religious community that self-destruction was sinful and as a result the person would be excommunicated. A century later, during the time of Pinel, a more humane way of dealing with the depressed was practised. Pinel published a psychiatric book which outlined other reasons for depression besides love problems, namely "heredity, past experience and various deep problems of the patient" (p. 140). It is interesting to note that this commentary is still accepted today.

Many poets of the 20th century such as Byron, Scott, Keats, Gray and Shelley added a touch of romanticism to depression which made it more acceptable for those people from the upper classes.

Depression was recognized even in the earliest of days and people struggled to explain this condition. Even though there were some strange explanations as to the causes of depression, there are many accurate findings that still hold true for today.

Changing Views of Adolescent Depression

Over the last several decades, the views and beliefs concerning depression and adolescent depression in particular have undergone many changes both within the mental health and medical professions and within society in general. There has been a struggle to explain the causes of adolescent depression and classify the types of depression. As the years progress however, there is a clearer and more detailed understanding of this condition which plagues our youth.

Prior to 1960

Although there is much early documentation on depression in adults, there is relatively little information specifically dealing with adolescent depression. Mental health professionals debated whether depression even existed in young people. However, there is an early description of adolescent depression in girls. Burton (1621) stated that adolescent girls who were depressed experienced:

troublesome sleep, horrible dreams, dejection of the mind, much discontent, weary of all, yet will not, cannot tell where or what offends them though they be in great pain, agony and frequently complain, grieving, sighing, weeping still without any manifest cause. (cited by Golombeck, 1983, p.154)

Burton's recorded observations of depression are extremely sharp. It is interesting to note that he has listed every sign and symptom of depression that is associated with today's description. Burton acknowledged the painful, mysterious and pleasurable symptoms of depression.

It was readily accepted that all adolescents experience periods of depression as a normal part of growing up since they have conflicts within themselves and with other people. In 1904, G. Stanley Hall referred to this as "storm and stress" (Mufson, Moreau, Weissman & Klerman, 1993). Hall believed that "normal adolescents experience wide mood swings and variable functioning but that these did not signify psychopathology. Rather, turbulence was part of normal adolescent development, mainly occurring in middle to late adolescence" (Mufson et al, p. 20). Eissler (1958) believed that adolescents were a slave to their impulses and as a result they were susceptible to antisocial behavior, anxiety and depression. Freud (1958) believed that adolescent turmoil was a normal state. Freud stated that "adolescence is by its nature an interruption of peaceful growth and that the upholding of a steady equilibrium during the adolescent process is in itself abnormal" (p. 275).

Poinsard (1967) reports that Bibring (1953) believed that some depression in adolescence is normal and inevitable because it is a period of giving up old objects

and acquiring new ones. A fixation results in a person clinging to old attachments and the person is afraid to form new ones. As a result, the person experiences turmoil. Finally, Greenacre (1953) wrote, "Depression, as a symptom, is as ubiquitous as life itself, and, in a mild degree, appears 'naturally' as a reaction to loss which no life escapes" (p.7).

1960's and 1970's

Common Views of Depression

The belief that adolescents experienced depression as a normal part of growing up continued during this time period. Another common belief which continued from the 1950's was postulated by psychoanalytic doctrine and held that depression could not be experienced by children and could only be experienced when a person reached adolescence and the superego was developed (Rochlin, 1959). Maag and Forness (1991) reported that Lefkowitz and Burton (1978) said that, "depression represents a transitory developmental phenomenon that abates spontaneously without intervention" (p. 2).

A view that was popular among many professionals in the 1960's and 1970's was that depression in adolescents is "masked" (Lamarine, 1995; Maag & Forness, 1991; Shamoo & Patros, 1990; Clarizio, 1989; Emery, 1983; French & Berlin,

1979; Gould, 1965;). Gould (1965) stated that, “depression is more complicated in adolescence because it is seen less frequently in its pure state, but may be presented in masked form” (p. 234). Clarizo (1989) in reflecting on the beliefs surrounding this notion is that depressed adolescents do not exhibit the same signs and symptoms in the ways that depressed adults typically do. According to Easson (1968):

depressive symptoms in the child and adolescent are demonstrated in a fashion less integrated, less static, and less consistent than in the adult. As a child grows to adulthood, the way he experiences and shows depressive feelings will change markedly until it approaches the usual adult pattern. The less mature the child is, the less capable is he of experiencing depression in a mature fashion or of sustaining depressive feelings. (p.1024)

Adolescent depression is hidden by temper tantrums, boredom, restlessness, rebelliousness and defiance, accidental injuries, impulsivity, running away and antisocial acts (Gould, 1965; Hollan, 1970). Clarizo (1989) added a host of characteristics in that time period which included delinquent behavior, school avoidance or failure, psychosomatic or hypochondriacal symptoms to the list of behaviors commonly seen in the adolescent. Difficulty in concentration is a

common complaint made by depressed adolescents (Toolan, 1962). Loneliness, which often goes along with depression, is often masked.

Classifications of Adolescent Depression

Easson (1968) stated that depressive syndromes in young people can be divided into three major groups: the endogenous depressive syndrome, the reactive depressive syndrome and the symptomatic depressive syndrome. He purported that though these syndromes overlap, it is beneficial to treat depressed adolescents according to these divisions.

In the endogenous depressive syndrome, the cause of depression has a physical origin and these young people experience overwhelming sadness. Easson (1968) stated that this type of depression is rare before adulthood. Adolescents are rarely treated for this type of depression because this sadness and moodiness is accepted as a normal part of adolescence that is believed to last for only a short period (cited in Anthony and Scott, 1960).

The reactive depressive syndrome results from an experienced loss, particularly a loss of a significant relationship with family, friends or the environment which provides emotional gratification, external personality integration and stabilization. The adolescent is unable to cope without this person

or thing and experiences a loss of pleasure (Easson, 1968). Toolan (1962) says that this is one of the most common syndromes experienced by adolescents. School counsellors, social workers and physicians with whom I have spoken tend to agree with this statement.

The final category for diagnosis is the symptomatic depressive syndrome which is a more pervasive emotional disorder.

Factors Associated with Adolescent Depression

Brandes (1971) outlines a number of factors which were believed to cause adolescent depression. He argues with Easson (1968) that the death of a significant adult such as a mother can cause depression and depression may result when adolescents are separated from an important adult or a familiar environment because they lose something they love and value. Another reason Brandes outlines is guilt that is caused by rebelliousness. He says that those adolescents who feel guilty because they are rebellious against their parents are very likely to become depressed especially if something were to happen to either of the parents during this time. In essence all that these adolescents are trying to do is gain their identity and independence. Overly strict child raising resulting in angry, critical self-concept is another source of depression among adolescents. Adolescents magnify

mistakes and are very hard on themselves for such mistakes. If they cannot express anger because of the self-control in response to strictness, the feelings build up in an unhealthy way leading to depression.

Brandes' (1971) review of the literature and his own research led him to believe that not being able to get approval from adults may cause depression. It was believed that adolescents experienced depression because they were mourning for the lost days of childhood, their Oedipal origins. It was thought that they were mourning for their carefree, protected and dependant childhood when problems were minimal and love was unconditional. Depression also arises when adults belittle adolescents. Adolescents respect the opinions of adults and thus are negatively impacted when adults belittle them. This interferes with their psychological development. Achievers can become anxiously depressed when they struggle to maintain top performance and feel that they lose approval when they are unable to do so. As a result, these people become obsessed and may resort to cheating. They feel guilty for this behavior and thus the onset of depression begins. Finally, Brandes (1971) identified adolescents in the accompaniment of adults who are depressed stand an increased chance of developing a depression of their own. He goes on to identify that this is particularly important if the adolescent is in a class with a depressed teacher.

French and Berlin (1979) discuss a number of other sources of depression. A sense of aloneness, a lack of counsel and concern from others cause depression. A feeling of failure and not being able to face family as a result often causes depression. Other reasons for adolescent depression include sexual anxieties, especially homosexual feelings, recurrent troubles in school, at home and with peers, poor family relationships and family breakup due to divorce or death. Those adolescents with few friends and poor social and coping skills are at risk for depression. Finally, French and Berlin (1979) discuss depression in students just entering college. Those who are from small towns, are alone and who find the work difficult, experience depression. Those who find college competition overwhelming and experience failure which they are unaccustomed to often become depressed. Krakowski (1970) stated that depression was caused by:

a loss, true or imaginary or even by failure to achieve a desired goal.

It is a result of, but, in a sense, a defense against the loss and it depends upon the severity of the loss as well as the ability of an individual to cope with it and other stresses. (p. 429)

There were a variety of factors believed to cause adolescent depression. Many of these factors continue to be sources of depression for adolescents even

today. Loss, for example, is cited as a cause throughout the literature discussed to this point. Some have been short lived and have died with the dominant theory of the time.

1980 to 2000

Common Views of Depression

During this period we see a move away from the idea that depression in adolescents is “masked”. Instead, the belief commonly accepted is that youth depression is basically the same as adult depression with the exception that youth depression is mediated by developmental differences (Lamarine, 1995).

Another commonly accepted view is that depressed adolescents exhibit many signs and symptoms which are less characteristic of adult depression. Lamarine (1995) states that they show more interpersonal difficulties, over-eat or under-eat and under-sleep more.

Whereas before this period it was commonly accepted that adolescents experience depression as a normal part of growing up, we see a trend diverting away from this belief to one that acknowledges that adolescents undergo changes in mood and feelings. However, we see that depression has not been dismissed as

a part of adolescence. During puberty there are many hormonal changes taking place within the body which result in more intense feelings and mood changes. Thus, there should be focus on the associated symptoms (Lamarine, 1995).

Classifications of Adolescent Depression

There are five subtypes of depression: anaclitic, reactive, acute, chronic and endogenous (Maag and Forness, 1991). Anaclitic depression occurs when there is a loss of the caregiver with no replacement or substitute. The person experiences a period of misery followed by a loss of interest in the environment. Reactive depression is characterized by trauma or loss frequently accompanied by feelings of guilt for past failures. Poor parent-child relations is an important factor in this type of depression. Acute depression happens after a traumatic event such as the loss of a loved one. The person has an excellent chance for recovery. Chronic depression is characterized by repeated separations from the care giver, depression in the mother, periodic recurring emotionally-depriving experiences and no immediate precipitating events. Finally, endogenous depression is genetically and biologically determined. There are no identifiable stressors and it is believed to exist in the person throughout his or her life in some form. This type of depression may reach psychotic or suicidal proportions

Factors Associated with Adolescent Depression

During this time period we begin to see the causes of depression being divided into broader, more encompassing categories such as psychosocial factors, biological factors, neuropsychological/cognitive functioning and comorbidity. Medical problems, environment, television, hurt pride, drugs and alcohol, divorce and changing schools are also factors commonly associated with depression.

Psychosocial factors play an important role in adolescent depression. One of the most common factors of depression in the adolescent is depression in the parent. If a child has a depressed parent it places the child at risk (Clarizio, 1989). The offspring of parents who are depressed have more social and cognitive difficulties such as excessive rivalry with peers and siblings, feel socially isolated, have numerous classroom disturbances, exhibit inattentiveness and withdrawal and have poorer comprehension than children and adolescence of normal parents (Clarizio, 1989). Wilkes, Belsher, Rush and Frank (1994) stated that adolescents with major depressive disorder will have a positive history for mood disorder in 50-80 percent of cases.

Biological factors are also important for determining depression in adolescents. Clarizo (1989) reported that research supports the important role for heredity in adult affective disorders. A study by Smith (1980) found that approximately one fourth of parents who were hospitalized with a primary

depressive disorder had at least one child with at least five of the following eight symptoms: moody, fearful, depressed and sad mood, significant death wishes, difficulties falling asleep or staying asleep, being a loner, apprehensiveness around people, nervous or anxious most of the time (cited by Clarizo 1989). Sixty-one percent of relatives of depressed children had a family history of depression, mania, alcoholism or schizophrenia (Clarizio, 1989). Other areas that have been explored to determine the causes of depression include the role of neurotransmitters such as norepinephrine, dopamine and serotonin in depression, abnormalities in cortisol secretions, sleep characteristics and growth hormones, and age and puberty. Clarizo discusses these biochemical and neuroendocrinal factors in depth.

Cognitive factors are attributed to adolescent depression. Tolon (1982) put forth three reasons as to why gifted youngsters may be more susceptible to depression (Clarizo, 1989). Firstly, they have a very high desire to achieve or they set unrealistically high standards and this makes them prone to depression. Secondly, gifted students feel alienated and shunned by their classmates. Thirdly, they worry about the meaning of life and moral issues such as world peace. Their idealism, lack of understanding and experience obscures their understanding as to why problems cannot be solved the way they foresee it. This causes existential depression (Clarizio, 1989). Wilkes et al. (1994) noted that some depressed

students scored lower on the Wechsler Intelligence Scale for Children-Revised (WISC-R) and indicated general attention and concentration problems and slower speed on timed items.

Comorbidity, which is the presence of two or more disorders at the same time, commonly occurs in adolescents who are depressed (Mufson et al., 1993). Some disorders which are associated with major adolescent depression include attention deficit hyperactivity disorder, learning disabilities, Tourettes, anxiety disorders, conduct disorders, eating disorders, autism and obsessive compulsive disorder.

Other factors that put adolescents at risk and are today readily accepted contributors to depression include age, gender differences, socioeconomic status and family relations. According to Mufson et al. (1993) depression increases with age, especially after puberty, with girls being more prone to depression than boys. Adolescents from low socioeconomic status homes have higher rates of depression. Poor family relationships and a parental death are also associated with increased rates of depression.

Another factor associated with adolescent depression is medical problems. Adolescents who have serious medical problems such as severe asthma, diabetes, epilepsy and other diseases tend to experience depression (Goldberg, 2000).

Goldberg (2000) states that the environment is a powerful indicator of

depression. A variety of things may cause depression - sexual, physical and mental abuse, neglect, a chaotic family, the absence of a consistent parent, school, home and terrible events such as losing a parent, witnessing a death, etc. Adolescents sometimes react to such things with depressive signs. Research shows that depression results when adolescents experience one or more stressful life events.

Interestingly, adolescents who watch over six hours of television a day are thought to experience more problems with depression. This has great implications since we are living in a technological age (Goldberg, 2000).

According to the pamphlet “About Teenage Depression” (1994) adolescent depression is also caused by hurt pride, drugs and alcohol, divorce and changing schools. Adolescents experience hurt pride when they are rejected by their peers, when they fail in school and when they are insulted by others. Teenagers have a strong desire to be accepted by their peers and when they are not accepted, they get upset. Alcohol and drugs often produce greater conflicts, moodiness and irritability for adolescents and in return warrant negative reactions from other people. In addition, the substances in alcohol and drugs cause depressive effects. Parental divorce is confusing and stressful for most teenagers and, unfortunately, they often blame themselves for the break-up. This is a particularly vulnerable time for adolescents since they do not know how to deal with this situation or handle their feelings. Finally, moving from one school to another can cause much anxiety and

sadness. Adolescents usually have little control over such situations and they often feel helpless. They will need to be closely monitored during such a time and given support to deal with this change in their lives.

Theories on the Causes of Depression

Goldberg (2000) discusses various theories regarding the causes of depression. It is believed that there is not one particular thing which causes depression but rather a combination of both physical and environmental triggers. Scientists believe that life events and the way a person has been taught to deal with these events may cause depression. Stress and certain types of medications can also cause depression. Scientists believe that genetics and brain biochemistry may cause people to become depressed. Finally, some adolescents may have biochemical imbalances.

Diagnostic and Statistical Manual of Mental Disorders

One of the most widely used diagnostic manuals for mental disorders is the Diagnostic and Statistical Manual for Mental Disorders. Originally published in 1952 the DSM is currently in its fourth edition. This manual was intended to be a guide that could be used by a variety of people working in the mental health profession. It is written in clear and easy to understand language.

The DSM has been widely used over that last five decades and is of particular interest in the research of adolescent depression, reflecting the position and status that adolescent depression has had in the medical profession over the last fifty years. In DSM I and II, there is no mention of adolescent depression. In neither of DSM III, III-R nor the latest, IV, is there a separate category for adolescents. There is much controversy around whether a separate diagnostic category should be developed and included in the manual for children and adolescents (Mufson et al., 1993). For the most part, the only provisions made for adolescents and children are minor changes in the duration of symptoms.

Conclusion

The views and beliefs surrounding adolescent depression have seen many changes over the last five decades. It is logical to assume that with the advances in the medical field and science this field of research will continue to develop. Hopefully, with the increasing amount of attention that adolescent depression is receiving, our youth will be better served.

CHAPTER THREE

Survey

I was given permission by the Interdisciplinary Committee on the Ethics of Human Research (ICHER) (appendix B) to conduct a survey (see appendix A) to determine the level of knowledge teachers have regarding adolescent depression. The survey was completed before I began my internship with the Lewisporte/Gander School District.

I contacted the director of the Avalon West School District, Dr. Bruce Sheppard, to request permission to carry out this study in one of the schools in the district. He was contacted through telephone followed by a letter for permission to send out questionnaires to teachers (see appendix A). He willingly gave permission as requested (see appendix C).

A junior/senior high school in the Avalon West School District was selected and surveyed using the questionnaire. This school had approximately 800 students who came from one of fourteen communities and 45-50 teachers who came from an even greater geographical location. This school houses students from six pre-existing school complexes.

The participants were informed by a covering letter about the purpose of the questionnaire, that participation was voluntary and that the questionnaire was confidential and anonymous (see appendix A). A completed questionnaire implied

consent. An envelope accompanied each questionnaire to ensure anonymity.

The principal was contacted by telephone followed by a letter requesting his assistance in the study and stating that the director of the school district had given his permission for the study to be undertaken (see appendix A). The principal was asked to distribute questionnaires to all teachers on staff with the exception of guidance counsellors. He called a short staff meeting so that the questionnaires could be completed and returned to him promptly. The questionnaire took approximately 10 minutes to complete.

Survey Results

The Statistical Package for Social Sciences 10 (SPSS) was used to provide summary statistics on the data. Of the 40 questionnaires distributed, 40 teachers responded, a 100 % response.

All teachers who completed the questionnaire reported that they did not have any inservicing on adolescent depression (question #1).

Only 10% of teachers reported that they feel knowledgeable about adolescent depression (question #2). Fifty-two percent reported being somewhat knowledgeable and 37% reported that they did not feel knowledgeable about this topic. No teacher reported that they felt very knowledgeable (figure 1).

How knowledgeable do you feel you are about adolescent depression?

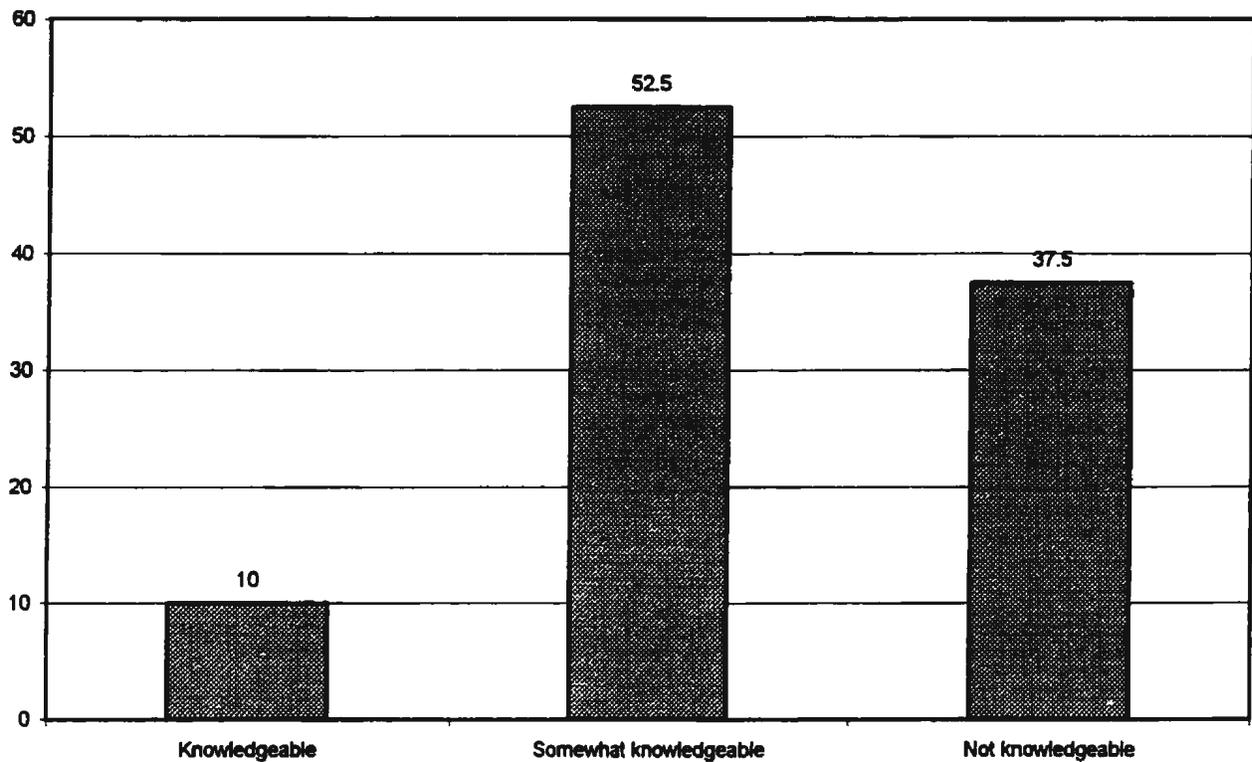


Figure 1

When asked if they thought that they would be able to recognize a depressed adolescent (question #3), 65% either said that they would not or were unsure whether they would be able to do so. Thirty-five percent of teachers responded that they would be able to recognize a depressed adolescent. Since all teachers responded that they did not have inservicing, one could assume that they have acquired their knowledge on the issue through personal education.

Participants were not asked if they knew the differences between adult and adolescent depression characteristics.

When asked if they know the signs of adolescent depression (question #4), 54% of teachers reported that they did not. Forty-six percent listed some signs of adolescent depression and of that percentage, only 20% were able to list four signs.

It is important that those who work with adolescents understand that there are several common mental health problems that are often associated with adolescent depression. If teachers are aware of these health problems associated with adolescent depression, they can be more cognizant of the indicators of depression in these individuals. Twenty-eight percent of teachers reported that they know of mental health problems associated with adolescent depression (question #5) whereas 72% did not know any mental health problems associated with adolescent depression (figure 2).

Do you know of any other mental health problems that may be commonly associated with adolescent depression?

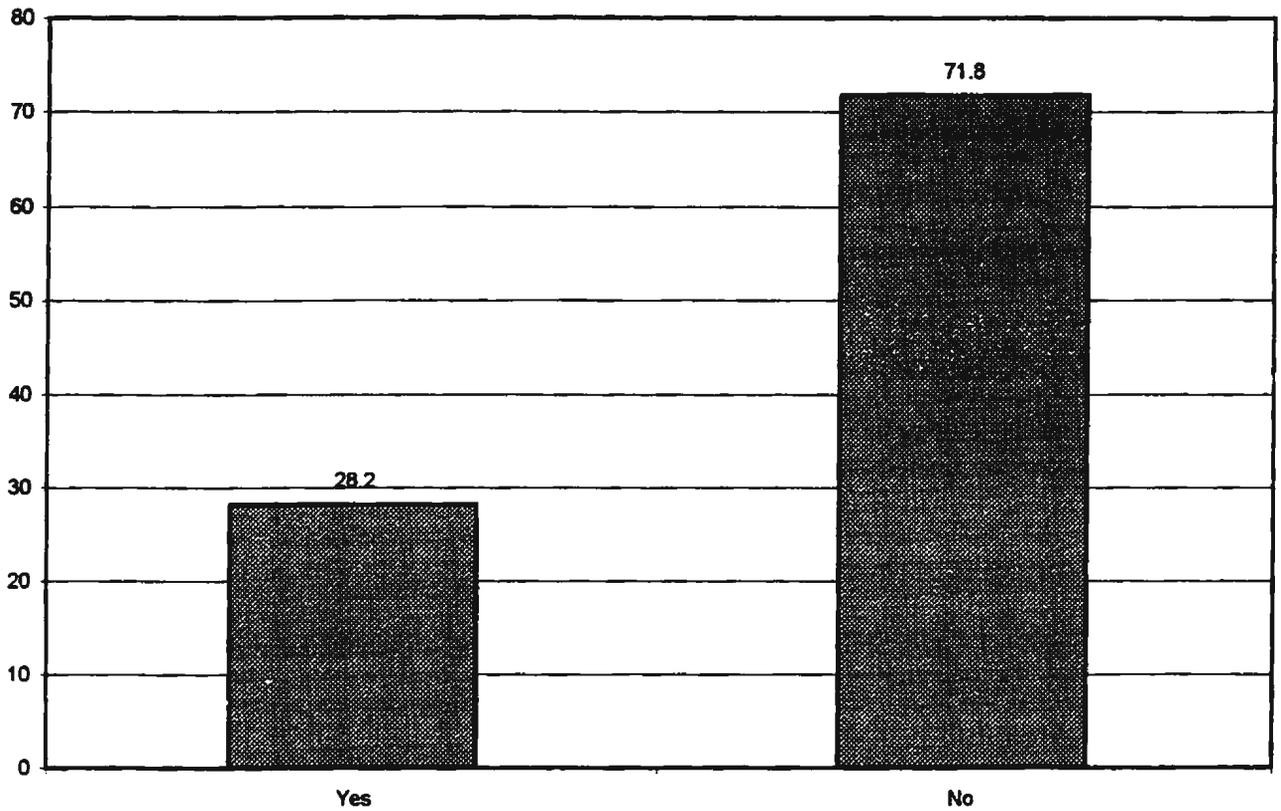


Figure 2

Teachers were asked questions regarding the number of students that were known to have been diagnosed with depression (question #6) and the number of students that they suspected to be depressed (question #7). Sixty-five percent of teachers reported that they did not know of any students who had been diagnosed with depression. Eleven percent knew of one, 16% knew of two, 5% knew of three

and 3% knew of four diagnosed with depression. Thirty-five percent of teachers did not suspect any of their students to have depression whereas 11% suspected one, 24% two, 8% three, 5% four, 3% five, 8% six, 3% ten and 3% twelve to fifteen.

Teachers were asked questions about the referral process in terms of adolescent depression. When asked if they knew who to refer students in the school (question #8), 35% reported that they were knowledgeable, 47% reported somewhat knowledgeable and 18% reported not being knowledgeable. Basically, 65% of teachers either had questions as to whom to refer students or did not know at all. There is a need to understand the counsellor's role. When asked if they knew who to refer students to outside the school (question #9), eighteen percent said that they were knowledgeable, 45% said somewhat knowledgeable and 38% said not knowledgeable.

I questioned teachers about their school's resources on adolescent depression (question #10) and 69% either said that there were no journal articles, recent publications or videos on adolescent depression or that they were unsure whether there were any in their school. Thirty one percent reported that there were resources in the school. This indicates a lack of much needed resources in some schools.

The final question on the survey (question #11) asked teachers about their

opinion of how important this topic was in their school. Twenty-nine percent reported that it was very important, 39% reported important, 24% reported somewhat important and 8% reported not important (figure 3).

In your own opinion, how important is this topic in your school?

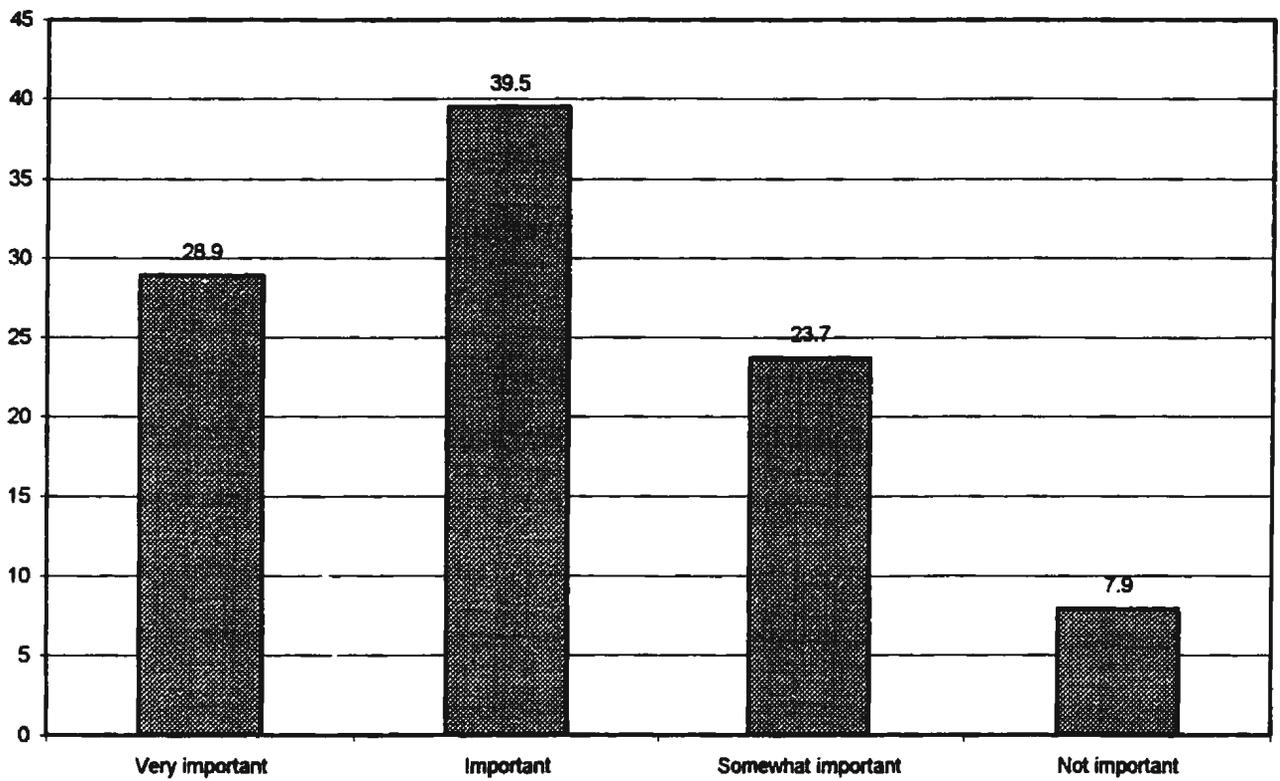


Figure 3

Recommendations and Suggestions

Based on the findings of this study, several suggestions and recommendations can be made. Since adolescent depression is often overlooked because people do not recognize the signs, more inservicing is necessary. Teachers reported that they had not received any inservicing in the last two years. In my opinion, this indicates a need for the Department of Education and individual school boards to make a conscious effort to provide more teacher education in this area. We must remember that it is our teachers who have daily contact with students and they are our front line workers in this regard. Eighty percent were unable to list at least four signs of adolescent depression. These results are disturbing when you consider that they are numerous indicators of depression in an adolescent and only 20% of teachers could identify four. Since teachers spend a significant amount of time with adolescents, it is important that they be able to recognize the signs of depression. Hence, teachers should receive inservicing on this topic. I believe that the individual school should provide this to their teachers with the support of the school boards.

Depression is comorbid with several health problems. Seventy-two percent of teachers reported that they did not know of any health problems associated with adolescent depression. Teachers' awareness of these health problems will likely

help them recognize depression in their students and thus refer them for help. This is another important argument for teacher inservicing on depression.

The Federal Center for Mental Health Services estimates that one in eight adolescents may experience depression (National Mental Health Association, 1999). Peterson, Compas, Brooks-Bunn, Stemmler, Ey and Grant (1993) found that approximately five to seven percent of adolescents experience serious depression and 10 to 40 percent report feeling depressed or unhappy. One of the most detrimental problems associated with adolescent depression is suicide. Statistics Canada (1997) reported that the suicide rate per 100,000 adolescents aged 15 to 19 was 11.5 in 1996, and 12.9 in 1997. This is overwhelming support to offer inservicing to teachers.

Another recommendation which follows from this study is the need for more education on the role of the guidance counsellor. When asked if teachers knew to whom they could refer depressed adolescents, 65% did not know. Teachers are not expected to know how to deal with a depressed adolescent but they need to know where to refer adolescents who are experiencing problems such as depression. Sometimes students do not want a problem such as this dealt with in school because of the attached stigma so if they are to receive help teachers must know who to refer to outside the school. The administration could educate the staff regarding the role of the guidance counsellor early in the school year either by

providing this information to teachers or having the guidance counsellor give a brief presentation on his or her role in the school. This could be especially helpful to new teachers on staff.

Sixty-nine percent of teachers indicated that there were either no resources on adolescent depression in their school or that they were unsure if there were any resources available in the school. This point can be easily addressed by providing resources for teachers. The guidance counsellor often has resources in his or her office which can be made available upon request.

I question the results of question # 11 because they do not coincide with the teachers' reports on inservicing, resource accessibility and overall knowledge of the issue. Sixty-eight percent of teachers feel that this topic is important in their school but they report that they have not received inservicing, do not have access to resources and they lack general knowledge about the issue.

Overall, the results of the survey indicate that there is a lack of knowledge among teachers regarding adolescent depression and they feel a need for more education in this regard.

CHAPTER FOUR

Description of Activities and Review of Objectives

Before I begin describing the internship activities and commenting on the degree to which objectives were met, I must inform the readers that my internship was interrupted as a result of a car accident. I was unable to attend work for two weeks and as a result some of the internship objectives were not completely met and some were altered. My university and field supervisors have been exceptionally understanding in this regard. Mrs. Younghusband, in consultation with the associate dean of education, Dr. R. Hammett, have arranged for me to make up the time I have missed. I participated in a 35 hour institute titled "Adolescent Counselling" which took place in July and August.

(1) To further develop individual counselling skills

A significant proportion of my time was spent providing personal, academic and career counselling to students. My field supervisor suggested a number of students with whom I could work over a number of sessions and I have included some of these case studies. Consent was obtained from the parents/guardians of those students with whom I worked on an ongoing basis. I also did some solution-focused brief counselling. Many students I counselled were not in need of long term counselling so I met with them for one and two sessions only but I always left

the door open for them to return about the present issue or any other issue.

Individual counselling took place in close consultation with my field supervisor. We would discuss the client's situation and counselling plan to ensure the client's needs were met. We also discussed interview techniques.

I did not get the opportunity to work with clients who were experiencing depression since my field supervisor did not know of any identified students. I did however, have the experience of dealing with one of two students who disclosed having attempted suicide. I was exposed to the procedures to follow in such circumstances. Neither my field supervisor nor I did any follow up counselling because the students were referred to an outside agency where they were receiving individual and intensive counselling. Both students were told that they could return at anytime for any reason.

Case #1

Subject number one was a sixteen year old boy who was referred by the school administration because he had been involved in a violent confrontation with another student. This was the second of two such incidents. It was felt that the student could benefit from some anger management skills. I met with the client and we briefly discussed the incident which ultimately led him to counselling. I was not concerned with the details which surrounded the incident but rather the emotions and thought processes behind the client's actions. The client saw that he had a

problem with managing his anger and he agreed to work with me on this issue.

Our second session was spent watching a video titled "Anger, You Can Handle It". We discussed how the characters handled their anger and we compared the way the client handled his anger with the characters in the video. We began working on a series of worksheets which accompanied the video. Basically, the worksheets are intended to help a person identify his or her anger cues and triggers, become aware of anger styles and consequences and, finally, to deal with anger. I selected those worksheets which were pertinent to the client's needs and we spent the following two sessions working through these activities. Much discussion and personal reflection on the client's part accompanied this work.

Our final session involved completing the worksheets and reflecting back on newly acquired skills. I informed the client that he could return at any time to discuss this issue or any other.

A teacher later told me that he could see a positive change in the client's attitude since the anger management sessions.

Case #2

Subject number two was a nine year old boy who was referred to the counsellor by his home room teacher because he exhibited attention-seeking behaviours such as copying another student's reason for going to the teacher's desk,

raising his hand for inconsequential reasons and refusing to do work which he is capable of doing. He figured, was off task much of the time, did not get along well with other people and sometimes lied. This little boy has many issues with which to deal. His mother lives in another province with his half sister and he does not have a relationship with his biological father. He lives with his grandmother and her family. He was primarily referred because of his classroom behaviour. It was believed that his behaviour could be the result of his family situation and unresolved issues.

I spent the first session getting to know this client and we discussed a number of issues. He told me that he did not like school and that he did not have many friends which he refused to elaborate upon. He told me about the things that he liked to do and he talked a little about his family, namely that he had not seen his father since his fourth birthday. There was a loud noise outside the room we were in and he began to tell me how he did not like noises such as classmates talking or whispering and scuffing of shoes on the floor. After about ten minutes of sitting, he began moving around the room fiddling with various objects. He asked many questions about the room. He told me that he could not concentrate in class and was easily distracted. I asked him if he would like to come out to talk with me again and he said he would .

During our second session I decided to explore the issue of family. I asked

the client to draw a picture of his family. It was interesting to see who he included in his family - himself, his grandmother, his uncle and his grandmother's boyfriend. We explored the client's feelings around the members he included in his picture and why he did not include particular other members in his family.

The next session was spent discussing an issue which had arisen the previous night regarding the police.

Since one of the reasons the client was referred concerned classroom behaviour, I decided that we should do some work in this area. I consulted with the classroom teacher regarding the behaviours with which she wanted me to work. These included social appropriateness, raising his hand and asking permission to do things. Due to limited time, I did not have the opportunity to develop a behaviour management plan for the client. This may have helped his behaviour in the classroom.

I gave his teacher a Connor's Rating scale to complete. My supervisor gave the same scale to the client's other teachers and sent one home to be completed by his grandmother. The client will be given a scale to complete in early September.

I was absent for two weeks due to the accident and did not get to do any further counselling with this client. His teacher told him why I was unable to meet with him but I did meet with him when I returned to terminate our sessions. I will be working with him in September as I have gained employment as a counsellor in

that school.

(2) To develop and co-lead a time-limited, issue-focused group

After assessing the needs of the student population, it was determined that a group dealing with the issue of bullying would be most beneficial. Teachers unanimously agreed that the grade seven class would benefit greatly from such a group. I decided to combine two programs on bullying, choosing topics and material that I felt met the needs of the population. I combined portions of the BRAVE (Bully Resistance and Violence Education) program and the "Be Cool" programme which is a series of videos and short lesson plans.

The first session was an introductory session. I introduced myself and the purpose of doing a group on bullying. I then had each person introduce himself or herself. We discussed the rules of the group-confidentiality, trust, respectfulness and the importance of following rules. After I had these housekeeping chores out of the way, I had the group take part in a warm-up activity. I used People Bingo and the group absolutely enjoyed it. We then did a cooperative group activity focusing on the definition of a bully and a victim. We discussed a fact sheet on bullying and the school's policy on bullying. I gave the group an anonymous survey that focused on their perception and views of bullying. Finally, we reflected on the first session.

We started the second session with a warm-up activity and then got into a discussion of what is bullying, why do people bully and what is dangerous bullying? I showed them a video on anti-victim strategies, ways to deal with bullying and then we concentrated on learning the techniques of dealing with a bully. The focus was on hot, cold and cool responses of dealing with bullies which were aggressive, passive and assertive behaviours. The group took on the roles of hot, cold and cool responses to bullying. We ended with a reflection of what took place during the session.

The third session began with a discussion of whether any one had the opportunity to use some of the techniques learned in last session. We then reviewed each of the three responses to ensure the group had a good understanding. I read a scenario and role played for the group the three different responses for the group. I assigned each person to a group and gave a different scenario to each group. They were instructed to practise the three responses, taking turns so that everyone got a turn using the hot, cold and cool responses. We assembled back into a large group and group members volunteered to role play which was then critiqued.

The fourth and fifth sessions followed the same procedures. The group would watch a video which taught an alternate way of dealing with a bully and they would roleplay, using the hot, cold and cool responses, similar situations with

the group critiquing and reflecting back upon it.

Luckily, I did get to finish most of the program but I was not able to have a concluding group session which I realized was so important. When I came back after the car accident, the students were writing exams and it was impossible for me to get them together.

Overall, I felt that this was a good learning experience. The group was challenging due to the nature of the students' personalities and I see things that I would do differently next time such as include a smaller number of people in the group and do more in depth interviewing.

(3) To become more knowledgeable about the tools used in career counselling

My field supervisor had begun to meet individually with the level II students to discuss career interests and to discuss post secondary institution options before I began the internship. I helped her finish this task. I found this very interesting and beneficial because it made me research post secondary institutions and their requirements with which I was unfamiliar.

I spent time perusing and organizing the many post secondary calendars in the guidance office. I also compiled a list of good web sites for career information and exploration.

I had the opportunity to observe another guidance counsellor teaching a

group of grade nine students to use Choices. He had created a scavenger hunt to help familiarize them with the program. I spent time getting used to the program because I know that as a future guidance counsellor I will be using this programme with students.

I held an information session with level II students titled "Saving for School". I began with a warm-up activity and then we brainstormed ways to save for post secondary school. I showed a Street Cents video that discussed ways of saving for post secondary school and the importance of starting to save early. I also went over the student loan application and pointed out important things which are often missed such as the fact that students are expected to contribute a portion of their earnings towards their education. The group seemed to find this information session interesting and helpful.

Finally, I learned about some of the available interest inventories for career counselling.

(4) To determine the level of knowledge that teachers have regarding adolescent depression

One of my main objectives was to determine the level of knowledge teachers have regarding adolescent depression. To do this, I developed a survey that asked teachers specific questions about adolescent depression and asked them

to indicate their level of knowledge. Chapter 3 goes into greater depth about the process and findings of the survey.

(5) To develop and conduct an information session for teachers on adolescent depression

Initially, I began searching for a person who was an expert in the field of adolescent depression, to do a presentation for the teachers of Holy Cross School Complex. I made numerous calls and was unable to get someone to undertake this task for me. People had previous commitments, were understaffed or just did not feel competent enough to do this. I began to get a little discouraged and thought that I may have to abandon the idea, but I decided to develop and conduct the information session myself. I had been researching this topic for quite a while and I had important information that I felt teachers should know. I put together a short presentation that covered pertinent facts about adolescent depression including the result from my survey. I wanted the presentation to be practical and to equip teachers with important information so that they could begin to help identify depressed students. I focused on the signs of adolescent depression and the referral process for depressed adolescents.

I put together an information package for each teacher that included pamphlets on adolescent depression, stress and sources of help for depressed

adolescents. Teachers were given this before the presentation so that they could follow along and highlight important points. I also put together a larger information package on adolescent depression that covered a variety of topics associated with depression and teen issues. This package was left in the school for those who wanted to do further reading.

During the presentation, I showed the video "Out of the Dark" which was produced by the Canadian Mental Health Association and The Rotary Club of St. John's Northwest and East. This is an excellent video for both teachers and students, and it was well received by the teachers who attended the presentation.

I was extremely pleased with the presentation and the teacher's receptiveness of the topic. They commented that they found the session informative and interesting.

(6) To become more familiar with psycho-educational assessment tools and other testing tools

During the internship I had the opportunity to administer a variety of assessments including the Wechsler Intelligence Scale for Children - III (WISC-III), the Test of Visual Perceptual Skills-Revised (TVPS-R), the Test of Visual Motor Integration (VMI), the Boder Test of Reading and Spelling, the Bender Visual Motor Gestalt Test, the Matrix Analysis Test-Revised (MAT-R), the

Wechsler Individual Achievement Test (WIAT), and Conner's Rating Scale. I observed the scoring of the Adaptive Behavior Scale and my field supervisor explained how to interpret scores. I learned how to use the computer scoring program for the WISC-III and the WIAT. I was exposed to a variety of assessment tools and I have a greater knowledge of the tools available and how to use them.

(7) To attend professional development activities within and outside the district

I had the opportunity to participate in several professional development activities. I attended the ASIST (Applied Suicide Intervention Skills Training) workshop which is a two day training workshop offered by the St. John's Healthcare Corporation. This was an invaluable workshop that provided me with essential skills to counsel suicidal persons. I also attended a one day Provincial Symposium on Alcohol Related Birth Defects. Dr. Ted Rosales spoke on ARBD research, diagnosis and assessment as it related to Newfoundland and Dr. Laurie Vitale-Cox gave a presentation titled "Research & Practical Treatment Applications for Children with Fetal Alcohol Syndrome/Effects (FAS/E) and other Alcohol Related Disabilities". I found both presentations interesting and informative.

I attended two special services meetings at the Lewisporte/Gander school board office. All speech-language pathologists, hearing and visually impaired specialists and the educational psychologists employed by the board are part of a special services team. They meet regularly to address issues that relate to their jobs. This gave me an opportunity to meet those specialists within the board, some of whom I will be working in the coming school year.

In July and August I participated in a summer institute titled Counselling Adolescents. The topics addressed included depression, suicide, eating disorders, obsessive compulsive disorder, self-inflicted bodily harm, sexuality, peer pressure and drug use. In addition, assessment and treatment approaches were reviewed.

Unfortunately, I missed two of the workshops for which I was registered - the self mutilation workshop and the crisis prevention and intervention workshop which are offered by the St. John's Healthcare Corporation. I plan on taking these two workshops in the fall.

(8) To learn about crisis intervention and emergency services and procedures to follow

Immediately upon my arrival at Holy Cross School I read the Lewisporte/Gander crisis intervention handbook. I felt that it was necessary to become familiar with this document in case a crisis arose during my internship. I

would then be able to follow proper procedures and have a better understanding of what was happening.

(9) To become knowledgeable about the referral process and agencies

I felt that this objective was very important and I put much energy and effort into acquiring a good knowledge of referral agencies and personnel that I could access if need be. Guidance counsellors deal with a wide array of problems and issues. No counsellor has all the knowledge and skills to deal with every problem that comes his or her way, therefore it is essential that the counsellor know to whom to refer. I made a list of referral personnel who could be contacted when the need arises.

I had direct experience with the referral process in the case of suicide attempts, behavior problems and academic problems.

(10) To become more knowledgeable about conducting a survey and assessing the data

A significant part of my study included creating and conducting a survey. As a result, I have gained a greater understanding of this process and the

preciseness with which you must work when creating and conducting a survey. I have a greater appreciation of the ethical considerations of developing and conducting a survey. I also have a better understanding of the process and importance of acquiring permission from the Interdisciplinary Committee on the Ethics of Human Research (ICHER). I am much more familiar with the Statistical Package for Social Sciences 10 and I now realize the practicalities of using such a research tool.

Salient Learnings

I am so pleased that I chose to complete my Master's program with an internship. It proved to be a very rewarding, memorable and beneficial experience. It was great being able to put into practise the knowledge and skills that I have acquired during my training at Memorial University. I was delighted to have had exposure to educational psychology in addition to guidance counselling. I enjoyed working with the staff at Holy Cross School complex. Overall, this was a wonderful experience.

Although I enjoyed my internship, things were not always easy. I found myself struggling mentally with issues and decisions which needed to be made. I often questioned myself and sometimes agonized over difficult decisions. It was

great to be able to discuss things with Denise and get her opinion. I realize that consulting is extremely important in this profession. I also need to come to the realization that there is only so much that I can do as a counsellor and I must accept that there will be some people who I will not be able to help or do not want my help. This will be a very frustrating part of counselling.

Along the way I made mistakes, of course, but the important thing is that I used this as a learning experience and grew from it. One such example was my experience with group counselling. There was a problem with being able to hold a small group during lunch because all of the students go home for lunch. I decided that I could do a group with the whole class. Big mistake. Groups are meant to be small and members should be interviewed to determine who is suitable for the group. These students had a notorious reputation of giving the teachers a difficult time and I was no different! It was a valuable learning experience, one I will not easily forget.

I also learned that if I ever get a position as a guidance counsellor, I will have guidance slips that students must get signed by the classroom teacher in order to visit me. One time a student was with be without the teacher knowing and there was a small crisis because nobody knew where this student was. A good lesson learned.

I feel that I have some important strengths. I think that the students could

easily relate to me and that I was able to quickly develop a good rapport with them.

I also think that my persistence and dedication will help me better serve the students.

One area where I feel that I need to improve upon is assessment. I have not had a lot of experience interpreting test results and I feel that I need to improve my skills in this domain. I acquired a lot of experience administering assessment tools during my internship but I need more experience interpreting test results.

This internship experience has strengthened my desire to become a guidance counsellor. Before my internship, I questioned whether this was a good career choice for me, but now I feel confident that it is and I plan to actively pursue a career in guidance counselling.

Conclusion

The implications of overlooking adolescent depression are great. Depressed adolescents may experience impairment in academic, social, emotional and behavioral functioning (National Mental Health Association, 1999). If not addressed, these problems often continue into adulthood (Blackman, 1995). Even more serious and detrimental is the possibility of suicide. Some adolescents become so depressed that they attempt, and unfortunately often succeed, in taking their own lives. Statistics Canada (1997) reported that the suicide rate per 100,000 adolescents aged 15 to 19 was 11.5 in 1996, and 12.9 in 1997.

Since adolescents spend approximately half of their waking hours in school, these institutions are in a position to identify depressed adolescents and provide services or referrals to help these young people. Guidance counsellors are available to depressed adolescents, but often times they do not access this service. They may be embarrassed, afraid that their parents or friends will find out, or, in some instances, they do not recognize that they are depressed. It is therefore essential that teachers who work with adolescents on a daily basis be able to recognize the signs of depression so that they can refer these adolescents to guidance counsellors for assessment. Teachers must receive education on this issue so that they can help manage this very serious adolescent mental health problem.

Appendices

Application for Ethics Approval

This is an application for a study to determine the level of knowledge teachers have regarding adolescent depression and to develop a workshop which addresses the needs of teachers in this regard. A junior/senior high school in the Avalon West School District will be surveyed. This school has approximately 800 students who come from one of fourteen communities and 45-50 teachers who come from an even greater geographical location. This school houses students from six pre-existing school complexes. The principal of the school will be asked to distribute questionnaires to all teachers. Participation is voluntary and the questionnaires are confidential and anonymous. A completed questionnaire implies consent. The participants will be informed by a covering letter about the purpose of the questionnaire, that participation is voluntary and that no names will be recorded. The questionnaire will take approximately 10 minutes to complete. The results of this study will be available from Memorial University.

Adolescent depression is a very serious mental health problem (Rice and Leffert, 1997). The Federal Center for Mental Health Services estimates that one in eight adolescents may experience depression (National Mental Health Association, 1999). Statistics Canada (1997) reported that in 1996 to 1997, 27,000 adolescents aged 12 to 14, and 86,000 adolescents aged 15 to 17 experienced depression. More females than males experienced depression.

Often, adolescent depression is mis-diagnosed or underdiagnosed due to the nature of this developmental period. Adolescence is a time of emotional turmoil, moodiness, gloomy introspection, heightened sensitivity and drama (Blackman, 1995). One has to determine whether an adolescent's presenting behavior is a manifestation of depression or typical adolescent behavior. This can be a very difficult task if the signs of depression are unknown. In addition, adolescents do not often display the same depressive symptoms as adults. Adolescents do not always understand and express their feelings clearly (National Mental Health Association, 1999).

Adolescents may exhibit a depressed mood in addition to some of the following symptoms:

increased emotional sensitivity; a noticeable lack of interest or ability to delight in otherwise pleasurable experiences or activities; decreased energy level and increased fatigue; low-self worth or excessive feelings of guilt; recurrent feelings about death or dying (e.g., suicidal ideation with or without a specific plan); withdrawal from friends, sleep and/or appetite disturbances (e.g., restless sleep, weight gain/loss or failure to make expected weight gains); change in school performance and/or change in attitudes toward school and a reduced ability to think clearly or make decisions. (American Psychological Association, 1994; Weinberg, Rutman, Sullivan, Penick, & Dietz, 1973, as cited by Rice and Leffert, 1997, p. 19)

Adolescent depression may not always present itself as depressed mood but rather as academic difficulties, concentration problems, somatic complaints (e.g., headaches or stomachaches), nervousness, peer problems and substance abuse (Rice and Leffert, 1997). If people do not know what signs to look for, they may not recognize a depressed adolescent. Depression is often linked to eating disorders, conduct disorders and substance abuse problems.

The implications of overlooking adolescent depression are great. Depressed adolescents may experience impairment in academic, social, emotional and

behavioral functioning (National Mental Health Association, 1999). If not addressed these problems often continue into adulthood (Blackman, 1995). Even more serious and detrimental is the possibility of suicide. Some adolescents become so depressed that they attempt and unfortunately often succeed in taking their own lives. Statistics Canada (1997) reported that the suicide rate per 100,000 adolescents aged 15 to 19 was 11.5 in 1996, and 12.9 in 1997.

Since adolescents spend approximately half of their waking hours in school, these institutions are in a position to identify depressed adolescents and provide services or referrals to help these young people. Guidance counsellors are available to depressed adolescents, but often times they do not access this service. They may be embarrassed, afraid that their parents or friends will find out, or, in some instances, they themselves do not recognize that they are depressed. It is therefore essential that teachers who work with adolescents on a daily basis be able to recognize the signs of depression so that they can refer these adolescents to guidance counsellors for assessment. Teachers must receive education on this issue so that they can help manage this very serious adolescent mental health problem.

Objectives

The objectives of this study on adolescent depression are:

- ⇒ to determine the degree of teacher knowledge regarding adolescent depression**
- ⇒ to organize an informational workshop to:**
 - educate teachers on the signs of adolescent depression**
 - educate teachers on the referral process for depressed adolescents**
 - provide resources for teachers on adolescent depression**

Research Methodology

Test Measurement: Questionnaire

A junior/senior high school in the Avalon West School District will be surveyed. This school has approximately 800 students who come from one of fourteen communities and 45-50 teachers who come from an even greater geographical location. The director of the school board will be contacted through telephone followed by a letter for permission to send out questionnaires to teachers of this school. The principal of the school will be contacted and asked to distribute the questionnaire to all teachers on staff (preferably during a staff meeting where questionnaires can be completed and returned to the principal promptly). The questionnaires will be delivered with a covering letter describing the study and ensuring confidentiality of participants. An envelope will accompany each questionnaire to ensure anonymity. The questionnaire will be picked up the following week and the principal will be contacted mid week to encourage those who have not filled out their questionnaire to do so. Basic summary statistics on the data will be provided.

Survey on Adolescent Depression

1. In the past two years, have you had any inservicing on adolescent depression?

Yes **No** **Some**

(Explain) _____

2. How knowledgeable do you feel you are about adolescent depression?

Very Knowledgeable **Knowledgeable** **Somewhat Knowledgeable**

Not Knowledgeable

3. Do you think you would be able to recognize a depressed adolescent?

Yes **No**

4. Do you know at least four signs of adolescent depression? If yes, please list them.

Yes **No**

(a) _____

(b) _____

(c) _____

(d) _____

5. Do you know of any other mental health problems that may be commonly associated with adolescent depression? If yes, please list them.

Yes **No**

6. In the last year, how many of your students were known to have been diagnosed with depression? _____

7. In the last year, estimate the number of students you taught that you suspected to be depressed. _____

8. How knowledgeable are you regarding who to refer a depressed adolescent to in your school?

Knowledgeable **Somewhat Knowledgeable** **Not Knowledgeable**

9. How knowledgeable are you regarding who to refer a depressed adolescent to in your community?

Knowledgeable **Somewhat Knowledgeable** **Not Knowledgeable**

10. Does your school have journal articles, recent publications or videos on adolescent depression?

Yes **No**

11. In your opinion, how important is this topic in your school?

Very Important Important Somewhat Important Not Important

Comments:

April 2, 2001

Dear Teacher,

I am completing a Masters of Educational Psychology (School Counselling) at Memorial University of Newfoundland. I am writing to request your assistance with a study I am conducting on adolescent depression. I have the approval of Memorial University Ethics Committee and the Director of the Avalon West School District to carry out this project.

Enclosed is a questionnaire which I ask you to complete and return to your principal in the enclosed envelope at your earliest convenience. Participation is voluntary. Do not put your name on your questionnaire. In published materials, the school will not be named or identified. I will be the sole person who has access to these questionnaires. The data will be collated and released only as aggregate figures to Memorial University. No data can be related to individuals or the school in any way.

This study will take approximately 10 minutes of your time. If you would like to discuss this research with someone other than myself, you can contact Lynda Younghusband, my university supervisor, at 737-7614. I very much appreciate your time and cooperation in assisting me with this study.

Sincerely,

Florence Brown

April 2, 2001

Dear Principal,

I am completing a Masters of Educational Psychology (School Counselling) at Memorial University of Newfoundland. I am writing to request your assistance with a study I am conducting on adolescent depression. I have the approval of Memorial University Ethics Committee and the Director of the Avalon West School District to carry out this project.

Enclosed are questionnaires which I am asking you to distribute to every teacher on your staff with the exception of your guidance counsellors. Participation is voluntary, confidential and anonymous. The questionnaire will require approximately 10 minutes to complete. I will be the sole person who has access to the questionnaires. The data will be collated and released only as aggregate figures to Memorial University. No data can be related to individuals or the school in any way.

If you would like to discuss this research with someone other than myself, you can contact Lynda Younghusband, my university supervisor, at 737-7614. Thank you for your time and cooperation.

Sincerely,

Florence Brown

P.O. Box 676
Blaketown,
Trinity Bay, NF,
AOB 1CO

March 26, 2001

Dr. Bruce Sheppard
Director
Avalon West School District
P.O. Box 500
Bay Roberts, NF
AOA 1GO

Dear Dr. Sheppard,

I am completing a Masters of Educational Psychology (School Counselling) at Memorial University of Newfoundland and I am proposing to conduct a study on the degree of knowledge teachers have regarding adolescent depression. I am writing to request your permission to carry out this study in the Avalon West School District. I have the approval of Memorial University Ethics Committee to carry out this project.

This study will include one junior/senior high school in the district. Enclosed is a copy of the questionnaire I wish to administer. With the exception of the guidance counsellors, all teachers will be asked to complete the questionnaire. Participation is voluntary, confidential and anonymous. The questionnaire will require approximately 10 minutes to complete. I will be the sole person who has access to the questionnaires. The data will be collated and released only as aggregate figures to Memorial University. No data can be related to individuals or the school in any way.

I would greatly appreciate your assistance with this study. If you would like to discuss this research with someone other than myself, you can contact Lynda Younghusband, my university supervisor, at 737-7614. Thank you for your time and consideration.

Sincerely,

Florence Brown



Memorial

University of Newfoundland

Office of Research

March 14, 2001

ICEHR No. 2000/01-048-ED

Ms. Florence Brown
Faculty of Education
Memorial University of Newfoundland

Dear Ms. Brown:

The Interdisciplinary Committee on Ethics in Human Research has examined the proposal for the research project entitled "*Teachers' knowledge of adolescent depression*" in which you are listed as the principal investigator.

The Committee has given its approval for the conduct of this research in accordance with the proposal submitted on the condition that the following minor modifications are incorporated:

1. In the letter to the principal and the director of the school district, the word "approximately" be inserted before "10 minutes" in the sentence giving participants the amount of time required to complete the questionnaire.
2. There should be no way for the researcher or the principal to identify participants who do not fill in questionnaires. Perhaps all teachers could be asked to return the questionnaires in sealed envelopes, whether or not they are filled in. The plan to ask the principal to "encourage" those who do not return the forms promptly should be abandoned - all participation should be completely voluntary.
2. In the covering letter to participants, rather than stating that participation is "confidential and anonymous" it should be stated clearly that questionnaires are to be submitted without names, and that in published materials the school will not be named or otherwise identified. (In all letters, you should provide recipients with the name and contact information of a third party whom they may contact should they wish to discuss the research with someone other than yourself - perhaps your thesis supervisor.

If you have questions regarding the requested modifications, you should contact Dr. Wayne Ludlow, a Faculty of Education representative on the ICEHR.



F. Brown
March 14, 2001
page 2

If you should make any other changes either in the planning or during the conduct of the research that may affect ethical relations with human participants, these should be reported to the ICEHR in writing for further review.

This approval is valid for one year from the date on this letter: if the research should carry on for a longer period, it will be necessary for you to present to the committee annual reports by the anniversaries of this date, describing the progress of the research and any changes that may affect ethical relations with human participants.

Thank you for submitting your proposal. We wish you well with your research.

Yours sincerely,
—

G. Inglis
Chair, Interdisciplinary Committee
on Ethics in Human Research

GI/emb

cc: Dr. W. Ludlow, Faculty of Education



Avalon West School District

OFFICE OF THE DIRECTOR

*Chairperson: Calvin Butt, B.A.; B.A.(Ed.); M.Ed.
Director of Education: Bruce Sheppard, Ph.D.*

March 29, 2001

Ms. Florence Brown
P. O. Box 676
Blaketown, NF
A0B 1C0

Dear Ms. Brown:

In response to your recent request seeking permission to conduct a study on the degree of knowledge teachers have regarding adolescent depression, approval is given to you to seek participation in this research. Please be advised that participation is at the prerogative of the individual teachers and schools. I advise that you contact the principals of the schools you wish to include in your research so that a suitable time can be arranged for your survey.

It is understood, of course, that the normal ethical considerations generally accepted within the academic community for such research will set the parameters for your work.

I wish you success with your research and the continuance of your academic pursuits.

Sincerely,

BRUCE SHEPPARD, Ph.D
Director of Education

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