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DEPRESSION AND SELF-CONCEPT: THE ROLE OF SELF PERCEPTIONS IN UNDERSTANDING, ASSESSING, AND INTERVENING WITH DEPRESSED ADOLESCENTS

A thesis submitted in partial fulfilment of the

requirements for the degree of Doctor of Philosophy in

Psychology at Waikato University

by

JOHN MATTHEW FITZGERALD

University of Waikato

Te Whare Wananga O Waikato

2002

Abstract

In 1994 the World Health Organization published statistics which identified New Zealand youth, and males in particular, as being the most likely to die by suicide compared to young people in 22 other economically developed countries (WHO 1993). A review of the literature suggests that depression in adolescents is a highly significant precursor to suicidal behaviour. For the most part, models of depression that have been applied to adolescents fail to acknowledge the unique social context within which adolescents function, and tend not to be sensitive to developmental considerations.

This thesis explores key aspects of the adolescent depression literature, focussing particular attention on the core adolescent task of the development of a sense of self. The literature review prompted two research studies.

The first study examined qualitative data from clinical interviews with depressed youth. Three major themes were drawn out of these interviews, the importance of *relationships*, perceptions of power and *agency*, and the sense that the young people had of themselves, their *self-concept*. These themes were present when the participants talked about their lives in general, and depression in particular. Depression impacted on their relationships with families and peers, rendered them less able to manage their lives, and negatively effected their self conceptions.

The second study was a survey of a community sample of non-referred adolescents. The focus here was to explore the correlates of teenage depression, again

with particular reference to variables that were likely to be related to self-conceptions. As well as a measure of self-concept, I also explored attributions for everyday events and depression on the basis that the way a person thinks about themselves (self-concept) is likely to influence their reasoning about the world and depression, and vice versa. The data reflected a statistically significant relationship between depression and self-concept, as well as supporting the associations with attributions and the importance of life experiences. The process of interpreting the various associations highlighted the importance of adopting an adolescent frame of reference when thinking about factors influencing the development of depression in adolescents.

These first two studies were completed to complement each other, focussing on similar variables, but using different methodologies. The third study utilised the data from the first two to generate a clinical intervention based on the enhancement of self-concept as a route to achieving symptomatic and clinically relevant change in a small number of depressed adolescents. The psychometric data suggested that depressive symptoms reduced as self-concept became more positive, this was confirmed by the clinical presentation of the young people. Despite the small sample size, both the quantitative and qualitative data suggest that an intervention aimed at promoting positive self-conceptions may be a useful adjunct to mainstream cognitive-behavioural intervention programmes.

Acknowledgements

I would like to start by acknowledging the support of my wife, Claire, and my sons (Joe, Tom, and Mike). I always thought that it was a little 'precious' when authors acknowledged their family members "without whom...". However, having now conducted such a substantial piece of work I know how much family are asked to compromise. I can state categorically that without their tolerance and continued support this thesis would never have been completed. Thank you.

The three research studies reported were conducted while I was Senior Clinical Psychologist with the Child & Adolescent Mental Health Team at Taranaki Base Hospital, New Plymouth. I acknowledge the support of Taranaki Health, especially the management and clinical staff of the Child & Adolescent Community Centre.

I am greatly indebted to Prof. Ian Evans for his supervisory support and ongoing friendship. Enjoying Ian's company has been one of the major personal benefits that I have experienced over the years it has taken me to complete this thesis. I would also like to record my thanks to Dr Bernard Guerin, my second supervisor. His thoughtfulness and challenge have been vital ingredients. Also, thanks to the members of the Clinical Psychology Research Laboratory at Waikato University.

Finally, I want to acknowledge the young people who agreed to participate in these studies with such enthusiasm, despite it being a record of their difficulties. It is my hope that through their willingness to share a part of their lives I have been able to contribute something of value.

I have assured all the participants anonymity, therefore details which would enable identification of an individual participant have been altered.

Author's Biographical Notes

Few things are impossible to diligence and skill... Great works are performed not by strength, but perseverance.
-- Samuel Johnson

Completion of this doctorate has been a significant personal journey for me. I consider the undertaking of three research studies, and the compilation of this thesis document to have been a major achievement, no matter what the outcome. I have been privileged to be able to focus on a clinical area which has brought me into contact with young clients who have shared their lives and troubles in the hope that they can obtain some assistance. However, they have gone further by allowing their experiences to be subjected to more detailed analysis in anticipation that this may be of assistance to others. I have certainly benefited from their generosity. In reciprocation, and so that the biases that I have undoubtedly introduced can be acknowledged (Elliot, Fischer, & Rennie, 1999), I provide the following autobiographical notes.

I was born in St. Albans in Hertfordshire, England in 1960, and moved with my family to Enfield in North London when I was two years old. My mother worked as a homemaker and secretary, and my father as a policemen. Both are still alive and well, and living happily in a sleepy little Essex village near Haverhill. I have an older brother whose pragmatism and focus have been a source of confusion and inspiration to me. I admire his loyalty and adherence to the Protestant work ethic. He always has been a 'solid' older brother. My younger sister now lives New Zealand. She has an almost feline ability to land on her feet, to make a the best of any situation, and is generous to a fault. We grew up together in a happy home.

I attended a Catholic primary and secondary school. I achieved adequate grades in my school work, made many good friends, never had a fight, only received corporal punishment on one occasion, and played 1st XV rugby for two years. My Catholic faith has remained important to me since it was nurtured in my adolescent years by some charismatic priests, brothers, and other assorted 'very holy people'.

After school I went on to further study of the social sciences, and psychology in particular. I meandered through a first degree, and a subsequent Masters degree in the Psychology of Mental Handicap (Keele University).

I had been acquainted with Claire, my wife, at primary school. Our mothers would chat at the school gates. Over my late teenage years I got to know Claire better until we became 'an item' half way through my first degree. We married when I graduated, at the tender age of 21.

After completing my studies at Keele I went on to work as a research assistant for three years on a project examining the development of "higher cognitive functioning" and cognitive representations in children with Downs Syndrome. It was at this time that I was introduced to the work of Lev Vygotsky, Alex Luria, and George Herbert Mead, and was re-introduced to the writings of Jean Piaget. I was fascinated then, and still am, by the area of social cognition and the construction of meaning through social interaction.

I returned to my studies having been accepted onto the clinical programme at Birmingham University. My first preference was to work with people who have intellectual disabilities, but I was influenced and inspired during my clinical training by practitioners working with adults, and then families. I enjoyed my clinical training immensely. It was hard work but, in retrospect, marks the point at which I finally decided what I wanted to do with my life. This was cemented into place by the birth of our first son (Joe) in 1987.

After qualifying as a Clinical Psychologist in 1988 I worked in a community adult mental health team for 18 months before moving to Stoke-on-Trent where I was employed for 2½ years as Senior Clinical Psychologist working on a project evaluating Family Therapy as an intervention with injecting drug users. I also had the opportunity to work with a range of other substance use related problems, e.g., alcohol, solvents, marijuana use in adolescents as well as adults. During this time I undertook further training in Family Therapy both at the Institute of Family Therapy (London) and at Manchester University. Tom (son #2) was born in 1990 amid the chaos of a house move (terrible timing). As pay-back he seemed to cry for much of the first two years of his life, which was very taxing after the easy time that we had with the angelic Joe.

In 1992 we decided that we wanted an adventure, so we moved to New Zealand. We knew very little about the country or health system although we were told that, in many ways, it reflected aspects of rural England. We settled in New Plymouth, and five months later welcomed our own 'kiwi kid' (Michael).

I was able to indulge my growing passion for working with younger people and families in my role as Senior Clinical Psychologist at the Child & Adolescent Centre, Taranaki Base Hospital. I also took on the roles of team leader (0.2 FTE), and Professional Advisor for Psychology (0.3 FTE) in additional to a reduced clinical role (0.5 FTE).

So, with family complete and settled in a new home on the 'other side' of the world, in a new job with new responsibilities... I was looking for a new challenge ... why not start a doctorate?

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CHAPTER 1

Depression and Self-Concept in New Zealand Adolescents.

In 1994 the World Health Organization released statistics in which New Zealand topped the international table for male youth suicide, and were positioned fifth for youth suicide amongst females (World Health Organization, 1994). These data were obtained from the 23 OECD nations, countries that boast high levels of economic and social development. At that time the data showed that approximately 38.5 per 100,000 New Zealand males, and 4.7 per 100,000 females between the ages of 15 – 24 years were dying by suicide each year. These figures were high by international standards. Finland, traditionally a country with high suicide rates, recorded male and female rates of 35.2 and 8.3 respectively for the same age groups. The New Zealand data that caused most concern was related to Pakeha (non-Maori) youth showing males at 39.0 per 100,000, and females at 6.3 per 100,000. However, because the New Zealand government also collected separate data referring to Maori, these were also reported. Maori youth suicide rates were given as being 37.9 per 100,000 for males and 3.0 per 100,000 for females over the same period.

The release of these figures by the World Health Organization resulted in a flurry of media activity, with experts, novices, adults and adolescents all being asked to comment on the mental health status of New Zealand youth. It was clear that something needed to be done both to understand youth suicide better and to intervene

to prevent suicide. While the acts of suicide in themselves are difficult to predict and prevent, the precursors and conditions for suicide attempts could be challenged.

This thesis will focus on the major precursor for suicide and attempted suicide in youth—depression, to develop interventions based on the most current thinking about the link between the two.

Youth Suicide and the Link to Depression

Much of the research linking depression and suicide at the time of the WHO report, had been done in New Zealand by the Canterbury Suicide Project based at the School of Psychological Medicine in Christchurch, New Zealand (Beautrais, Joyce, & Mulder, 1994, 1996, 1998, 1999; Beautrais, Joyce, Mulder, Fergusson, Deavoll, & Nightingale, 1996).

The primary work of the Canterbury project team has been focussed on the completion of "psychological autopsies" (Robins, Murphy, Wilkinson, Gassner, & Kayes, 1959; Rich, Young, & Fowler, 1986) following a confirmed death by suicide of adults within their geographical catchment area. This has involved the collection of a wide range of data regarding the last days in the life of the individual before their death, obtained from spouses, partners, parents, friends, work colleagues, and so on. The information collected has been related to personal, family, employment, health and other significant aspects of the person's life, and has provided the raw materials in an attempt to understand how the individuals were functioning during the period before their death, and hopefully gain some insight into their psychological state.

The Canterbury team have also collected a large amount of data relating to serious suicide attempts made by young people aged under 24 years. The first two analyses reported by these researchers focussed on the role of family and childhood experiences (Nightingale, Beautrais, Joyce, & Mulder, 1994; Beautrais et al., 1994), and the contribution of a range of mental disorders (Beautrais, Joyce, Mulder, Fergusson et al., 1996) as risks factors for serious suicide attempts. These studies reported a high incidence of social and demographic disadvantage, experiences of childhood adversity, such as, sexual abuse and poor parental care, and psychiatric illness, among those who made serious suicide attempts before the age of 24 years. In their study of co-morbid mental disorders they reviewed 302 'serious suicide attempters' and found that 187 (61.9%) had experienced a Major Depressive Episode within the month prior to their suicide attempt. A total of 232 (76.8%) had experienced some form of Mood Disorder. Ninety four (31.1%) reached criteria for the diagnosis of a Substance Use Disorder, and 93 (30.8%) would have attracted a diagnosis of Disruptive Behaviour Disorder (excluding Attention Deficit/ Hyperactivity Disorder specifically) at some time in their life. In total, they found that 272 (90.1%) of those making a serious suicide attempt had a mental health difficulty at the time of their death. These findings have been supported by subsequent research both within New Zealand (Beautrais, Joyce, & Mulder, 1997; Horwood & Fergusson, 1998) and overseas.

Brent, Baugher, Bridge, Chen, and Chiappetta (1999) conducted a study using a standard psychological autopsy protocol to compare 140 suicide victims (13-19 years old) in Western Pennsylvania, USA. They explored risk factors for those above

and below the age of 16 years and found that mood disorders, parental psychopathology, lifetime history of abuse, availability of a gun, and past suicide attempts contributed significantly as risk factors. Substance abuse was also a major factor, either with or without a mood disorder.

Kingsbury, Hawton, Steinhardt, and James (1999) measured problem solving, depression, anger, impulsivity and self-esteem in 33 adolescents after they had overdosed. They also had data from a group of matched control participants. They found that there were significant differences on these measures until they controlled for the effect of depression as measured by the Beck Depression Inventory. When this was done, the differences disappeared with the exception of the impulsivity dimension. This was interpreted as support for the growing belief that depression is a significant vulnerability factor for suicidal activity among young people.

Brent et al. (1986) suggested that there may be two groups of suicide attempters: a dysphoric, hopeless group who plan attempts and, according to McKeown et al. (1998), exhibit more seriously suicidal behaviour; and an impulsive group who make attempts without plans or serious intent. This would certainly be consistent with Beautrais et al. (1999) who found that impulsivity was significantly associated with suicide attempt risk, and conclusions of Wichstrøm (2000) that depressed mood was not a simple linear predictor of suicidal behaviour in a community sample of 9,679 non-referred adolescents.

In the conclusion to their summary of the current knowledge-base regarding suicidal behaviour in adolescents, de Wilde, Kienhorst, and Diekstra (2001) state that;

> *The burden of suicidal behaviour – emotionally, socially and financially – is (therefore) too big not to explore everything to prevent it. Understanding adolescent suicidal depression better should be a major target in this respect.* (p. 285)

It was these data, and specifically data which correlated youth suicide with depression, that provided the impetus for the research programme reported here. That is, if a positive impact is to be made on the high youth suicide in New Zealand then addressing issues of adolescent depression may be the most effective ways of achieving this.

Adolescent Depression

Earlier this century there was a belief that children and young people did not experience depression; child and adolescent depression was a 'silent' disorder. This view has gradually changed through a period when younger people were thought to experience an attenuated form of the adult disorder, to a current realisation that adolescent depression differs significantly from its adult counterpart.

The differences between adolescent and adult depression (e.g., physiological markers, differential responses to anti-depressant medication, presence of irritability, prevalence rates) are only now starting to be examined more systematically (Hoberman, Clarke, & Saunders, 1996; Mueller & Orvaschel, 1997). In addition to focussing on the epidemiological data, researchers have drawn attention to a wide range of developmental and social factors that influence the aetiology and course of adolescent depression. These include consideration of physical, social and cognitive

development, family and peer group relationships, as well as intrapsychic factors. Despite the complexity and speed of the physical changes that occur during the adolescent years, it is difficult to attribute adolescent depression wholly to physiology. This view is supported by a wide range of treatment studies that have found the physiological correlates of depression are somewhat more difficult to detect in teenagers. For example, EEG sleep studies and studies of hormone secretion have either failed to demonstrate the same associations with depressed mood in adolescents as in adults (Yaylayan, Weller, & Weller, 1992), or have yielded inconclusive results (Brooks-Gunn, Auth, Petersen, & Compas, 2001; Cytryn & McKnew, 1996; Goodyer, Herbert, Tamplin, & Altham, 2000). Medication studies have also been far less conclusive regarding the efficacy of drug therapies with child and adolescent depression than with adults (Conners, 1992; Emslie, Walkup, Pliszka, & Ernest, 1999; Geller, Reising, Leonard, Riddle, & Walsh, 1999; Greenberg, Bornstein, Greenberg, & Fisher, 1992; Hazell, O'Connell, Heathcote, Robertson, & Henry, 1995; Jensen et al., 1999).

Studies have shown that between 10-15% of children and young people will experience symptoms of depression at any one time (Garrison et al., 1997; Oldehinkel, Wittchen, & Schuster, 1999; Smucker, Craighead, Craighead, & Green, 1986). The prevalence of a diagnosable Major Depressive Disorder (MDD) among all children and young people between the ages of 9 - 17 years is estimated at about five percent (Cantwell, 1996; Petersen et al., 1993; Shaffer et al., 1996). There seems to be a watershed around the time of puberty with pre-pubertal one-year prevalence rates between 0.4% and 2.5%, and equal rates for females and males; and a rate for

post-pubertal adolescents as high as three percent (Garrison et al., 1997), with rates displaying the traditional adult gender bias in favour of females (2:1). Hammen (1997) suggests that not only are the rates of onset and current depression highest amongst young people, but that these rates are increasing. It is of note that while the rates of depression in young people are highest among females, the rate of completed suicides is highest among males. This is due to differences in the lethality of the suicidal action, with males more likely to attempt to take their lives with firearms, by hanging, or by carbon monoxide poisoning. Females are more likely to act in non-lethal ways, that is, taking overdoses (Beautrais, 1998). Females are far more likely than males to exhibit para-suicidal behaviour, that is, behaviours which have the possibility of causing significant self-harm or death, but without the intention of dying being present.

Similar rates to those reported above have been confirmed in New Zealand (Feehan & McGee, 1993; Horwood & Fergusson, 1998). These data have been collected as part of the large scale longitudinal cohort studies in Dunedin and Christchurch respectively. Both these studies have been based largely on a non-Maori sample and have adhered strictly to the formal psychiatric diagnosis of affective disorders. Little work has been conducted in New Zealand on subjective experiences of depression, self-diagnosis of affective disorders or the exploration of the social factors which may promote the experience of depressive symptomatology, such as sadness, helplessness, hopelessness.

There are a number of excellent texts and journal articles which detail the epidemiology and phenomenology of adolescent depression. In a review paper by

Hoberman, Clarke, and Saunders (1996) the authors outline the nature of depressive disorders in adolescents attending to issues of aetiology and epidemiology, as well as exploring vulnerability, risk, co-morbidity, prognosis, recurrence, and psychosocial and residual functioning. They also review the efficacy of psychological and pharmacological treatments. The picture which emerges confirms the pervasiveness of the negative impact of depression upon youth, impinging on every area of their functioning - intrapsychic, peer, family, social, school, work. The authors concluded that despite growing knowledge and understanding of the experience of adolescent depression, further research is required, especially in the identification of the important active elements of psychosocial therapies.

Birmaher et al. (1996) have also conducted a large literature review on the topic of depression in children and young people. Their review of published research over the period 1986-1996 has a reference list containing 199 entries, covering the areas of epidemiology, clinical characteristics, natural history/course, and several correlates of early onset depression (e.g., family environment, stressful life events, negative cognitive style, and various biological markers). In a second paper Birmaher and Ryan (1997) covered assessment, treatment and prevention. From their reviews they concluded that much progress has been made in supporting the validity of childhood MDD and Dysthymic Disorder (DD). They identified a need for further research, especially in the area of the "biological underpinnings and the interrelationships amongst psychosocial and psychobiological factors in the early onset of depression" (Birmaher et al., 1996, p. 1435).

Lewinsohn, Rohde, Seeley, Klein, and Gotlib (2000) present research data taken from the Oregon Adolescent Depression Project which has followed 1,709 adolescents since 1987, when the participants were 14-18 years old. This project has produced a great deal of useful data relating to adolescent depression. Lewinsohn et al. have focused on the natural course of adolescent MDD. Their results, based on interviews with 940 of the original participants, found a number of factors related to the recurrence of MDD during young adult hood (19-23 years of age). In particular, factors related to an absence of future pathology included low levels of emotional reliance, only a single episode of adolescent depression, low numbers of family members experiencing recurrent MDD, low levels of antisocial and borderline personality disorder symptoms, and a positive attributional style. High levels of depression in young adults were associated with female gender, repeated episodes of adolescent depression, high levels of family depression, the presence of features associated with borderline personality disorder, and conflict with parents.

Hammen, Rudolph, Weisz, Rao, and Burge (1999) report data from a study of 43 depressed youths who were reviewed in a mental health outpatient treatment clinic. Using a wide range of psychometric measures of depression, parental mental health status, family history, social functioning, life stress, and marital functioning, Hammen and her colleagues concluded that treatment based on a downward extension of adult procedures generally neglected key characteristics of depression in adolescents. Indeed, they suggested that it is primarily for this reason that the results of outcome studies involving treatment of adolescent depression have been poor (Mueller & Orvaschel, 1997).

When reading the burgeoning literature relating to depression in adolescents one becomes aware of an impersonal quality, a sense in which understanding the illness of depression takes primacy over an understanding of the person living with depression. Mainstream research in this area, whether psychiatric (medical) or psychological in focus, has tended to be informed by a Cartesian approach and adopt reductionist methods to the exclusion of other complementary perspectives. It is Cartesian in the sense that it accepts as fundamental the distinction between the mental and the physical, the mind and the body, the subject and the object. What is missing from much of the literature is a 'self as subject' approach where young people are asked to share their personal thoughts and experiences of depression from the perspective of 'personal experts'. Research paradigms which could encompass such an approach are not always easily integrated into mainstream psychological models of depression, which tend to be *instrumental* in their view of depression - doing-to rather than doing-with (Greenwood, 1994; Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995; Pilgrim & Bentall, 1999). One of the primary foci of this thesis is the integration of data from both these research paradigms, quantitative and qualitative.

Models of Depression in Adolescence

As suggested above, depression in adolescence has generally been conceptualised in the same way as for adults. The predominant psychological models focus on cognitions and behaviour, although other models exist.

Psychoanalytic models: The earliest psychological formulations of depression were based primarily on psychoanalytical theory, postulating disturbances in early childhood as contributing to problems of self-determination, separation and loss, such as depression. In particular, it was suggested that conflict, and specifically the aggressive feelings which result, was turned against the self to be experienced as depression or suicidal thoughts. A key component of Freudian and post-Freudian thought was that the conflicts and defences operate at an unconscious or pre-conscious level. Thus, any 'neuroses' (including depression) were interpreted as signs/symptoms of inner conflict and past trauma which were outside conscious awareness, and required long and complex therapeutic 'uncovering'. (Bemporad, 1988; Karasu, 1992).

Behavioural models: Early behavioural formulations of depression attributed symptoms to inadequate or insufficient reinforcement (Lazarus, 1968), that is, either a reduced frequency or quality of reinforcement. This focus on reinforcement was expanded to include the apparent reduction of reinforceable behaviour in the repertoire of a depressed individual, leading to a downward spiral of reduced reinforcement and reduced activity (Ferster, 1973). Another explanation was based on aversion control (Lazarus, 1968), which emphasised the fear that anything a person did may be punished. In addition it was suggested that for depressed individuals there was a loss of reinforcement effectiveness or "potency" (Costello, 1972). This could perhaps occur through the loss of a single reinforcer in a chain, thus disrupting a chain of behavioural stimulus-response relationships.

Until the mid-70's there was little research evidence for the validity of any of these behavioural models. This was partly because of the difficulty in generating testable experimental hypotheses based on the models that addressed depression in an ecologically valid way. Although developed in parallel, these early theories were amalgamated to lend support to the view that depressed people experience deficits in the area of social skills, such as reduced reinforceable behaviours, and reduction in potency of social interaction as a reinforcer and subsequent withdrawal.

This integrated view was proposed in the 1970s and 1980s by Lewinsohn and his colleagues (Lewinsohn, Weinstein, & Alper, 1970; Libet & Lewinsohn, 1973; Youngren & Lewinsohn, 1980). Lewinsohn emphasised deficits in - non-verbal behaviour, frequency of initiation of interaction, focus of interaction, latency in responding to the behaviour of others, and the rate of positive and negative reinforcement. Debate continues regarding the causal primacy of depressed mood and "non-assertive" behaviour. However, Lewinsohn's behavioural/social skills approach has been developed into two group programmes, one for adults (Lewinsohn, Antonuccio, Steinmetz, & Teri, 1984), and another for depressed youth called the "Adolescent Coping with Depression Course" (Clarke, Lewinsohn, & Hops, 1990) which have been extensively researched and have proved to be highly efficacious. It should be noted that both of the group programmes also contain substantial emphasis on cognitions, especially the controlling of negative automatic thoughts. For this reason they are generally referred to as Integrative Cognitive Behavioural programmes.

Another development from the early behavioural formulations of depression was Self-Control Theory (Rehm, 1977). This model emphasised problems that depressed people have in giving themselves sufficient reward. It was suggested that there are three processes which allow an individual to have control over their own behaviour: self-monitoring, self-evaluation and self-reinforcement. Research data from studies examining Rehm's formulation showed that depressed and non-depressed individuals differentially reward and punish themselves as predicted by the theory. It is important to note that Self-Control Theory marks a movement from simple behavioural formulations of depressions to greater emphasis on cognitions and cognitive style.

Learned Helplessness Theory, proposed by Seligman and his colleagues, emphasised the contingencies between actions and reinforcement, rather than the more simplistic view of the basic adequacy or inadequacy of rewards provided by other people or by oneself (Maier & Seligman, 1976; Seligman, 1975). A major component of this model was the view that not only does an individual learn the relationship between response and outcome, but can also learn to assess the probability of their behaviour resulting in a particular outcome.

Cognitive models: A major refinement of Seligman's theory took place later when the theory of Learned Helplessness was re-formulated in terms of attributional style (Abramson, Seligman, & Teasdale, 1978; Metalsky, Halbertstadt, & Abramson, 1987; Needles & Abramson, 1990). This revised model has four basic premises, the co-occurrence of which was hypothesised to be sufficient for depression to occur. These premises include the individual's expectation of aversive stimuli, the

individual's expectation of powerlessness, the individual's maladaptive attributional style so that negative events were attributed to internal, stable and global causes, and the direct impact of expected aversive states on motivational and cognitive deficiencies. A large number of studies have been devoted to examining attributional style and depression. This has included evaluation of a range of intervention techniques such as re-attribution training.

Unlike the Learned Helplessness theory, Beck's cognitive theory of depression arose out of clinical observations rather than animal or human laboratory work (Beck, 1976). Beck's original formulation outlined three main components of depression. These are *negative automatic thoughts* (self, world, future) which are often prompted by activating events and have a disruptive effect on mood, via *systematic cognitive errors* such as dichotomous thinking, magnification and minimisation, personalisation. Both of these elements are placed within the context of *depressogenic schemas*. This latter component refers to general and long lasting attitudes, assumptions and beliefs about the world which impact on monitoring, evaluations and actions (Figure 1.1). One of the key features of this theory is the wholly cognitive focus of its primary components.

Beck's model has been criticized for failing to take into account the findings that negative thinking may be a *consequence* of depression rather than an *antecedent*. There is also some evidence that dysfunctional attitudes, assumptions and beliefs, identified by Beck as being enduring characteristics, actually have a more transient

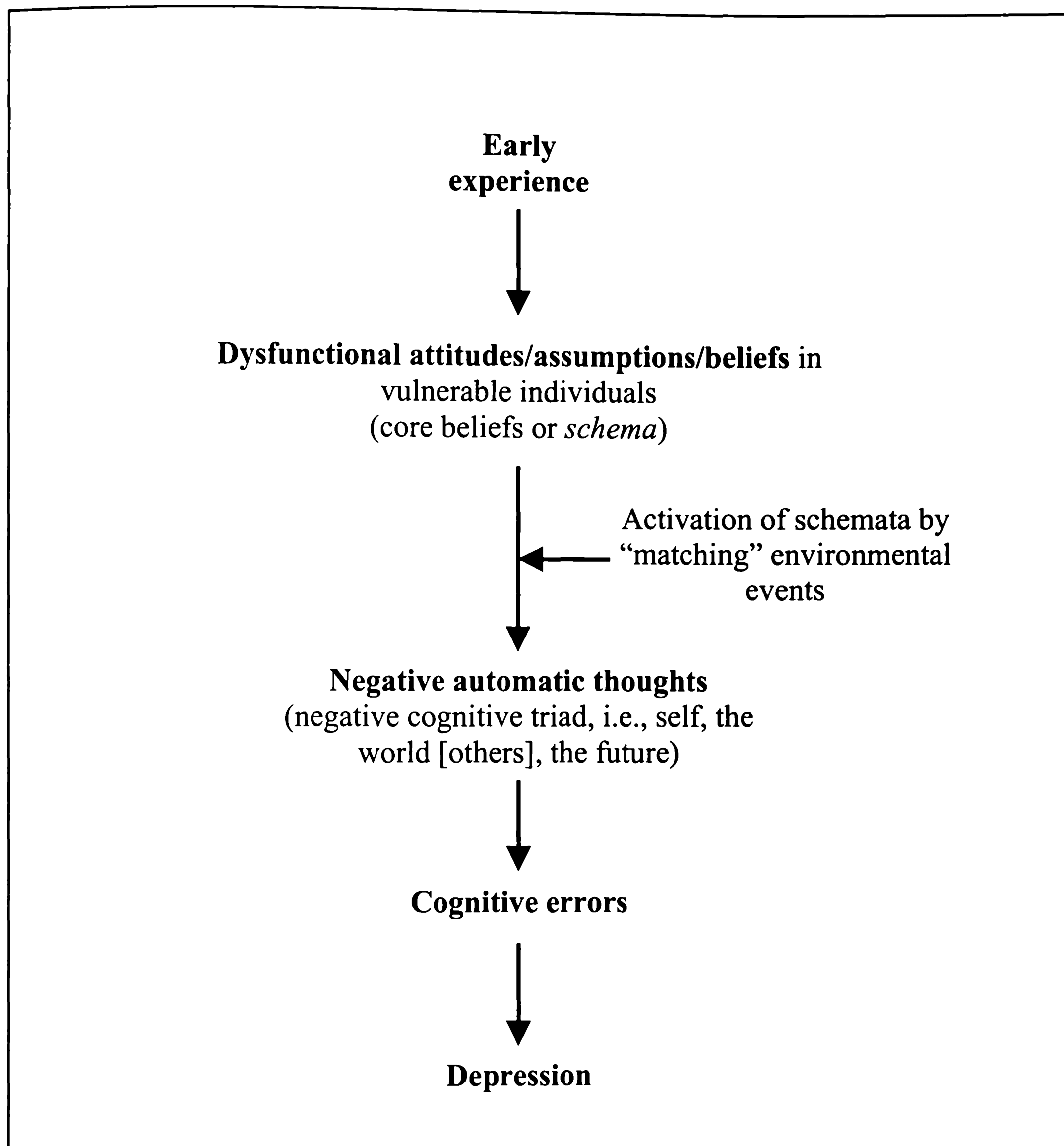

Figure 1.1 Key features of Beck's cognitive model of depression.

quality, returning to normal levels following intervention (Teasdale, 1988). Beck's model also casts environmental events as mere triggers of pre-existing dysfunctional cognitive structures, whereas there is substantial research regarding the importance of negative life events, and other social and environmental factors that are left unaccounted for by his model (Barnett & Gotlib, 1988; Brown, 1996; Brown, Bifulco, & Andrews, 1990; Goodyer, 1996). Finally, and perhaps most important in terms of the research programme reported in this thesis, is the criticism that Beck's cognitive model recognises only one level of meaning, that of *intellectual* or *objective* meaning. As Teasdale and Barnard (1993) observe, if a client were to say "I *know* I am not worthless, but I still *feel* as if I am", Beck would suggest that this is simply a variation in the degree to which the client believes they have worth, rather than the knowing (belief) and the feeling being qualitatively different levels of meaning, both of which have validity.

This suggests that an effort needs to be made to augment cognitive models of depression to include not only the self as subject, but also to incorporate multiple levels of meaning that are both objective (other-referenced) and subjective (self-referenced) in nature.

Wilkes, Belsher, Rush, and Frank (1994) have edited one of the few books exclusively on the topic of cognitive therapy with depressed adolescents. Although there is a chapter in their book entitled 'Developmental Considerations' (Wilkes, 1994), it contains little specific advice apart from statements of the obvious;

> *The presentation of a depressed adolescent on a shifting bed of biopsychosocial issues is the essence of the difference between the*

two populations (adult and adolescents). When assessing a depressed adolescent, the therapist must try to identify the relative contributions of the major depression, the adolescent phase itself, and the adolescent's personality and temperament to the total clinical picture. (Wilkes, 1994, pp. 77-78).

Elsewhere in the book Belsher and Wilkes (1994) identify 10 key principles underlying adolescent cognitive therapy. Again, these tend to emphasise ways to engage adolescents in cognitive therapy designed for adults rather than exploring specific theoretical or treatment implications of conducting cognitive therapy with adolescents. The only clear exception is a suggestion to "acknowledge the adolescent's narcissism", meaning their developmentally appropriate tendency to have a greater focus on 'self' relative to "many adult patients".

Post-modernist models: The post-modern approach to clinical problems and therapeutic interventions has its origins in sociology, cultural studies and a range of other social science disciplines which are far less influenced by the scientific rigours of formal experimental methodology than traditional experimental and clinical psychology. The philosophical underpinnings of this approach can be traced to Mead (1934), Foucault (1980, 1982) and Wittgenstein (1953) with notable contributions to psychological theory and practice being made by Gergen (1991) and Shotter and Gergen (1989).

The basic tenet of the post-modern approach is that 'schema', understanding, even reality itself are subjective experiences that are constructed and reconstructed through the interactions which take place between an individual and their

environment, primarily their interactions with other individuals. When applied to a phenomenon such a depression, it would be consistent with this approach to view the experience of depression as being, at least in part, an internal and subjective construction which is unique to the individual. This is not to deny either the objective reality of depression, or the efforts made to understand its more consistent and enduring characteristics. Rather it is a simple acknowledgement that clients are not passive *recipients* of depression, but active *participants* in both the development and over-coming of depression. Also, this process is lived within a social context that both impinges on the individual ("this is what depression is and this is how you behave when you are depressed"), and within which the individual can act.

Post-modern approaches (social constructionism, Narrative Therapy) have developed quickly within the general mental health field. They appear to address some of the concerns raised in relation to cognitive conceptions of depression. However, despite their heuristic appeal and anecdotal clinical effectiveness there is limited empirical evidence to support their use. This is partly due to the paradigmatic inconsistencies which are present when using generally *reductionist* (objectifying) research methodologies to evaluate *constructionist* (subjectifying) therapies.

Post-modernism suggests an active and generative role for the individual, not only in responding to their environment, but actively constructing it through their attributions and behaviour. In the case of individuals who are experiencing difficulties with their mood it seems reasonable to conclude that working to understand the individual (self) is as important as understanding the depression they

are experiencing. Indeed, this approach would imply that the latter *cannot* be understood without the former.

The models outlined above all contribute to our overall understanding of depression, and those who live with depression. However, the latter focus is less well attended to, with very few accounts of the experience of depression finding their way into the academic literature, although they are abundant in the self-help literature. No single model or approach has proved to be universally or consistently effective in either facilitating accurate assessments of depression, or yielding completely predictable therapeutic outcomes. Indeed, it would be surprising if they could be given their general failure to address issues of individual difference and development.

The Adolescent 'Self'

Adolescence is not unique in being a time of extraordinary stress. However, each phase of life tends to have a specific set of stressors and challenges (Erikson, 1959, 1968). Erikson proposed a model of development that highlights eight psychosocial stages through which an individual progresses. While these are represented as discrete stages, it is acknowledged that at every point in one's life, elements of each of the stages are present. However, Erikson suggests that for developmental and social reasons the resolution of particular stage conflicts are more suited to specific periods of one's life. The psychosocial stage associated with the adolescent period is labelled *Identity* vs. *Role Confusion*, and relates to the means by which individuals come to experience a sense of being "at home" with themselves.

Marcia (1980, 1983) developed the generally more theoretical work of Erikson by suggesting that individuals move towards a state of *identity attainment*, via a period which he referred to as *moratorium* during which the principles, values, and roles learned from significant others are subjected to intense scrutiny prior to being fully internalised. Therefore, adolescence can be characterised by experimentation and rebellion against established norms and values. If social norms are accepted without critical examination then identity attainment is achieved through a process of *foreclosure* which, according to Marcia, can lead to rigidity and lack of creativity in responding to challenges as an adult. So, for Erikson and the many researchers who have followed him, adolescence is seen as a time of experimentation and change prior to the resolution (albeit incomplete) of identity issues in a way that leaves the individual with a clear sense of who they are and how they fit into society. The process as described is not an easy one; Grotevant, Bosma, de Levita, and Graafsma (1994) concede that at times it can be difficult to discriminate between issues related to identity development and depression in adolescents.

The task for an adolescent is to achieve a sense of identity and the independence, and mature inter-dependence, necessary to meet the adult demands of relationships (marriage), responsibility (family), and work (employment). A self-concept frame of reference is useful because of its focus on each individual's unique perceptions of self as a starting point for understanding one's own or another person's behaviour. A distinction can been made between two major components of the self, both of which were first introduced by James (1890); the self-as-doer (non-verbal 'I-Self') and the self-as-object (verbal 'Me-Self'). It was proposed that the I-Self,

functioning through perceptions, thinking and remembering. comes to 'know' the Me-Self which possesses various physical, social, emotional and intellectual attributes. This act of coming to *know* the *self* was thought to occur primarily within a social context through processes of *social comparison* (Gilbert, Giesler, & Morris, 1995), comparing oneself to similar others, and *social assimilation*, the tendency to identify perceived similarities between oneself and others (Martin, Seta, & Crelia, 1990; Pelham & Wachsmuth, 1995). These messages and images come from family and peers, but particularly from the media (television, advertising). Media images of young people can be powerful moderators of what is 'cool' and what is not, guiding aspirations and fuelling frustration. This places a social emphasis on the development of self-concept (an idea of personal identity), one that is consistent with the views of Mead (1934) and the newer post-modernist school of thought.

However, the term 'self-concept' has been defined in a number of alternative ways. Beane and Lipka (1984), writing from a educational perspective, refer to it as being the perception(s) that a person has of themselves in terms of personal attributes, and the various roles that are played or fulfilled by the person. Hormuth (1990) suggests that self-concept is a cognitive structure that organizes experiences and guides actions. He presents self-concept development as a dynamic process which is fuelled by exposure to 'new' cognitions, these being introduced through social interaction and experience. This places self-concept firmly within the social domain, reinforcing that self-concept related processes require a social context.

Osborne (1996) takes a more eclectic approach, suggesting that self-concept arises as part of a developmental process that incorporates five factors,

a. Immutable characteristics	-	Unchanging characteristics that influence the way that others perceive us, e.g., race, gender, body build.
b. Genetic tendencies	-	'Inherited' attributes such as intelligence, aggressiveness, temperament.
c. Environmental determinants	-	Contextual factors that can impinge on the individual, e.g., parental socio-economic status, intellectual stimulation, growing up in a rural versus an urban environment.
d. Identity negotiation	-	The way that the individual goes about negotiating 'who they are' in relation to others. This is made more complex by others, e.g., parents, peers, teachers, also wanting a 'say'.
e. Self-understanding	-	The ability to integrate feedback about the self from others, and the ability to convey ones sense of who one is to others.

Self-concept itself is seen as consisting of integrated and flexible self-images ("Good Me", "Bad Me", "Not Me", etc.) which have emotional and social components. These disparate self-images coalesce to form a single global self-image which, in turn, impacts on and informs behavioural decisions. Osborne hypothesises that behaviour, and the associated cognitions and attributions, feed back into one's self-image via specific self-esteem (feelings of personal worth). However, it would be consistent with the everyday experience that changes to the basic components of self-concept can also impact on self-image.

Osborne's (1996) model would appear to be consistent with the view that self-concept is unidimensional (Coopersmith, 1967; Marx & Winne, 1978), where self-concept is seen as possessing only one general factor, or where a general factor dominates more specific and subordinate factors. However, there are other models of

self-concept which emphasise a multidimensional perspective with specific factors being independent, correlated, multifaceted, or hierarchically organised (Marsh & Hattie, 1996).

The literature cited above gives an indication of the difficulty in finding a single definition of self-concept which would be widely accepted. Bracken (1996) goes as far as suggesting that agreement over the definition of self-concept is a priority within the field. In the absence of a generally accepted definition of self-concept, and following the earlier work of Shavelson, Hubner, and Stanton (1976), the following definition of self-concept was developed and adopted in this thesis. Self-concept is a stable, structured and multi-faceted internal representation of the individual which develops through introspection and social interaction. It includes behavioural, cognitive and affective elements which are hierarchically organised.

Irrespective of how self-concept is defined there is growing interest in the paradigm, and growing evidence that various components of an individual's sense of self (self-concept, self-worth, self-esteem, self-discrepant representations) are associated with both depressive symptomatology and suicidal ideation in adolescents (Battle, 1987; Gonnerman, Parker, Huff, & Lavine, 2000; Harter, 1986; Harter & Marold, 1991; Higgins, 1987, 1989; Kaslow, Rehm, & Siegel, 1984; Moretti & Wiebe, 1999; Scott & O'Hara, 1993; Strauman, 1989). A strong association has been found between depression severity and low reported self-esteem in adolescent psychiatric populations, with improvements in depression coinciding with increases in global self-esteem (King, Naylor, Segal, Evans, & Shain, 1993). In general, depressed adolescents have been found to display high levels of self-reproachment

(Strober, 1985), poor self-image (Inamder, Siomopoulos, Osborn, & Bianchi, 1979), negative self-concept (Marton, Connolly, Kutcher, & Korenblum, 1993), and low self-esteem (Fine, Haley, Gilbert, & Forth, 1993; Overholser, Adams, Lehnert, & Brinkman, 1995). Harter (1999) concludes that while research in this area started from the premise that self-evaluations (self-concept) generally preceded negative affective reactions, the research has since shown that a model placing negative affective reactions as occurring prior to negative self-evaluations fits the research data just as well.

A Model of Depression and Self-Concept

Given the varied models of self-concept, and the lack of integration of these with models of depression, I thought it would be useful to propose an overall synthesis of the two (Figure 1.2). This integration should be seen as a simplified first draft. One strength of this approach is that an emphasis on self-concept development allows us to consider a model of depression that is more exclusively focussed on adolescence, something that none of the adult-orientated models can offer.

Given the general currency of the Cognitive-Behavioural model of depression it was thought appropriate to use this as the basis of such a synthesis. Further, because of the possible complexity of what is proposed it was necessary to utilise a basic cognitive model for illustrative purposes. For this reason Beck's model, as presented earlier in this chapter, was used (Beck, 1976), albeit amended to include an acknowledgement of the role of attributional styles. The diagrammatic view of the proposed model encapsulates a dual role for depressogenic attributional style as

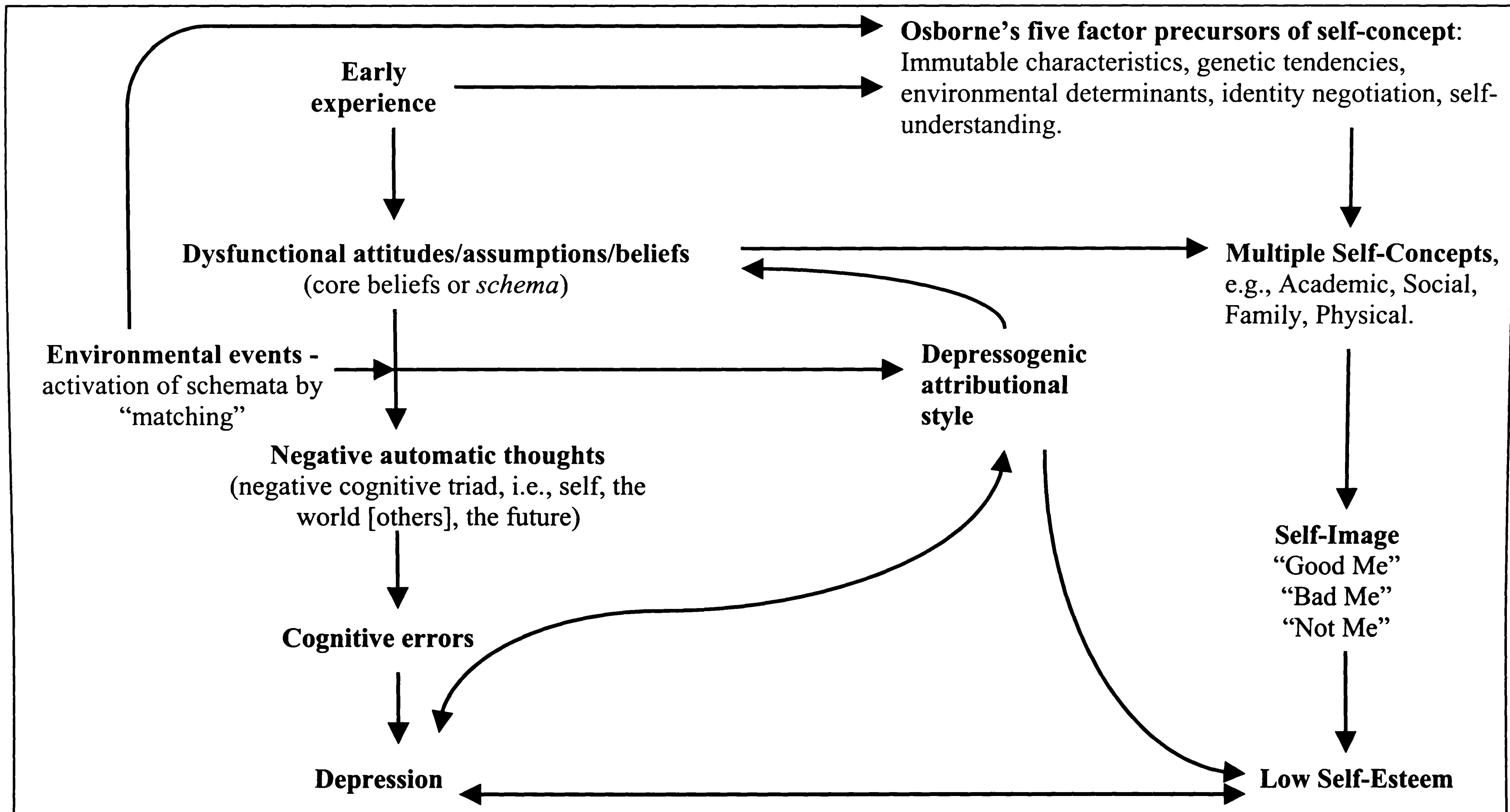

Figure 1.2 Model of depression and self-concept.

constituting a consequence of depression, and as a risk factor ("Scar hypothesis", Rohde, Lewinsohn, & Seeley, 1990). This is mediated via both cognitive structures such as attitudes, assumptions and beliefs, but also through one's sense of self-esteem, that is, how an individual feels about themselves.

The associated 'self' components are adapted from Osborne's process model of self-concept development (Osborne, 1996). His five precursors of self-concept are presented with a static rather than dynamic bias, particularly the first three elements. However, even these factors are far from being fixed. While gender and race may be considered 'immutable' if considered as objective constructs which are externally defined, there may be some variation in the subjective experience of these. Within New Zealand, cultural affiliations which were challenged, even prohibited in the past as inappropriate components of self-definition, are undergoing revision. If such apparently immutable factors are open to reinterpretation and change, then certainly factors such as aggressiveness, socio-economic status, and attentiveness of parents must also be considered flexible in response to environmental events.

The model incorporates a multiple focus for self-concept as this is more consistent with the literature which has shown that different aspects of a child's self-concept develop at different stages (Harter, 1999; Marsh & Hattie, 1996). As suggested by Osborne (1996), self-concept is linked to self-image. It is suggested here that where self-concept is poorly or inadequately defined or reinforced, this can result in poor self-image ("Bad Me") and lowered self-esteem. This constitutes a vulnerability factor for depression, or a specific risk factor in cases where self-esteem is very low. This may be the case when combined with an attributional style which is

more negatively orientated. The link from depression directly back to low self-esteem, and via negative attributional style, dysfunctional cognitions, and self-concept is an acknowledgement of Harter's (1999) conclusion that negative self-evaluations both result in and result from the experience of depression (p. 219).

Prout and Prout (1996) distinguish between self-concept problems which precede (*primary)* the development of a clinical disorder, such as depression, those that are reactive to a disorder (*secondary*), and those that are initially reactive, or secondary, but where the self-concept problem assumes a central and pervasive role in the individual's functioning (*secondary/primary*). They conclude that where the person is experiencing a primary or secondary/primary type of self-concept problem there should be some element of their treatment which focuses on self-concept/esteem enhancement, although they do not go as far as outlining specifically what this means, or how it is to be done.

The research presented in this thesis draws on the various themes identified above, and represented in Figure 1.2. That is, growing evidence of a link between depression and aspects of self-concept and self-esteem, an understanding of the developmental tasks of the adolescent years, and interest in the intensely personal aspects of depression as experienced by young people, who are more at risk of depression than any other age group, and at higher risk of experiencing its more lethal consequences.

I thought that two main study topics followed directly from the above review (Figure 1.3). First, a more thorough evaluation of the parameters of the depression

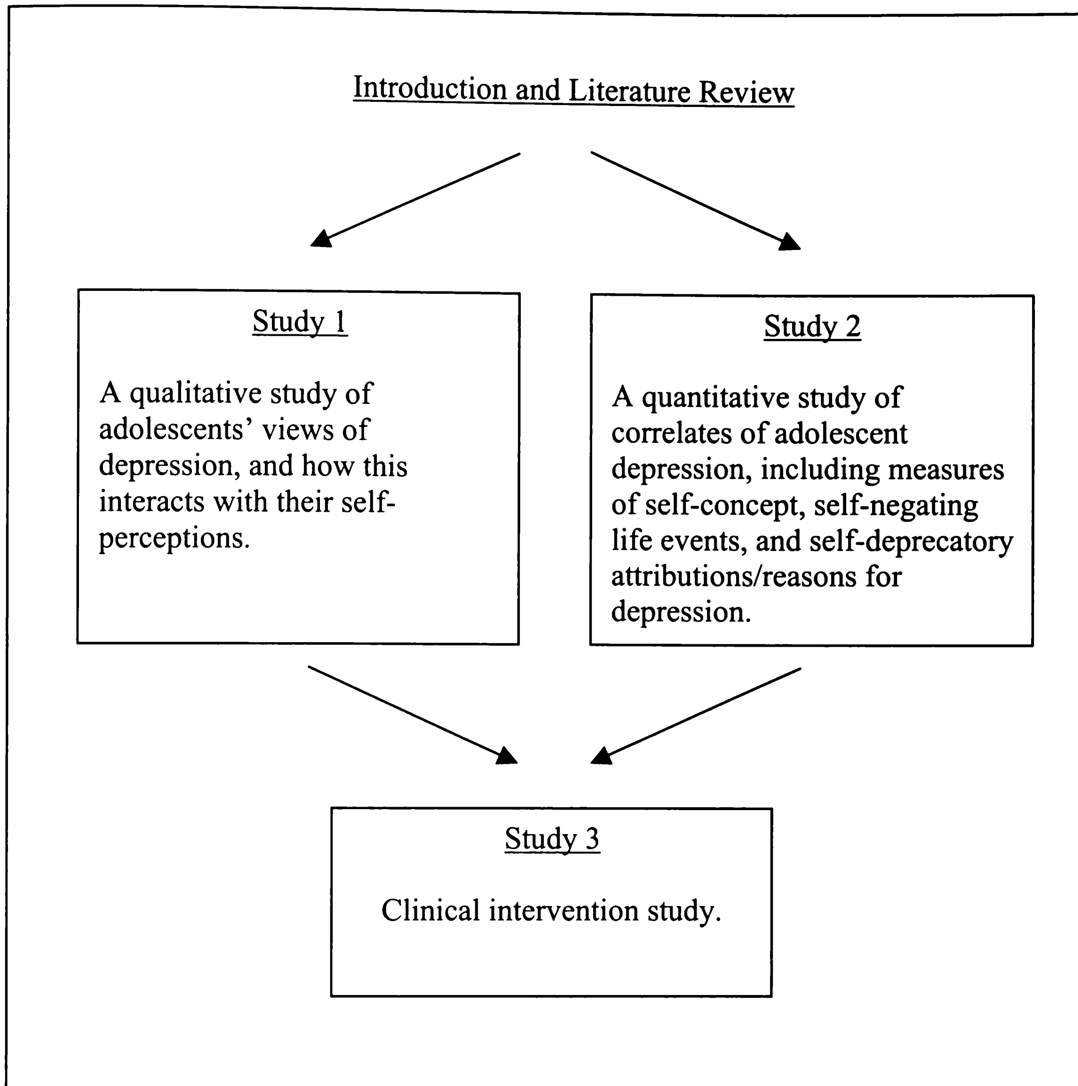

Figure 1.3 Proposed research plan for this thesis.

experience for adolescent in New Zealand. This would not only address the question of how common depression is among New Zealand youth, but also consider various correlates such as life events and attributional style. In order to gain information about the subjective experience of lowered mood I thought it would be interesting to access the reasons that young people gave for their depression. And, of course, explore the relationship of these various measures to ratings of self-concept. Reasons

for depression and attributional style were thought to be interesting mediating variables as the way one interprets events in the world, and depression itself, may have a direct impact on an individual's experience of depression, the ease with which they are about to initiate change, and their vulnerability to low mood. This study was designed to use quantitative methods so that the resulting data could be more easily compared with data already available from other researchers both in New Zealand and overseas.

However, before conducting the above study I decided to conduct a clinical study using a qualitative design. This was partly to provide a context within which to consider the data from a second planned study outlined above, and partly because its relatively unique focus made it appear more interesting. The first study was designed to give a group of depressed young people an opportunity to talk about their experience of depression, and its impact on their life. It is this study that is reported in the next chapter.

A final study was envisaged which would be focussed on using the data from the first two studies to develop a clinical intervention programme for use with depressed youth. It was anticipated that this would involve an emphasis on self-concept in some way.

CHAPTER 2

Adolescent Depression and Self-Concept: What Adolescent Females Say About Their Own Experience of Depression. [1]

There already exists a substantial and growing literature reporting the quantitative evaluation of adolescents who present with signs and symptoms of depression. Data reported in these studies are generally associated with diagnosis, intervention, and symptomatic recovery. However, there is little information that reflects the views and experience of young people themselves regarding their mood difficulties, in particular, their own understanding of what 'depression' is and how it effects their lives. Karp (1994) notes that despite the existence of a large number of detailed quantitative studies reporting attempts to understand depression, there has been little written about the subjective experience of depression.

Karp's research included two studies that provide a 'window' on the experience of depression among an adult population. The first study (Karp, 1992) reports on the author's participation in, and observation of, a self–help group for adults with unipolar and bipolar depression. The author made detailed notes during his attendance at this group over a two year period. As a theoretical base for his work, Karp adopted a symbolic interactional perspective which proposes that a person's feelings and behaviours arise from their definition of the situation/context, and that to understand a person's thoughts, feelings and actions, one needs to understand how

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[1] A version of this chapter was presented at the 1st Child & Adolescent Mental Health Services Conference, Christchurch, New Zealand in 1998 under the title "Adolescent Depression Stories".

they arrive at the definitions of their social interactions. The analysis presented in Karp's fascinating research report focussed on the development, within the self-help group, of a 'language' that provided plausible explanations for the difficulties that the group members were experiencing in relation to their mood, while also protecting their sense of personal competency and self-esteem.

The second study developed the themes of the first with Karp conducting detailed interviews with 20 adults who had been diagnosed with, and treated for, unipolar depression (Karp, 1994). Analysis focussed on establishing and illustrating the key points in what Karp presented as the dynamic process of evolution, experience and resolution of depression; a 'career' process. In particular, Karp presented five significant waypoints along the journey (a) having tentative feeling of distress, (b) the development of these feeling into something more robust, (c) crisis, (d) coming to grips with an "illness identity", and (e) seeing depression as something in the past. Of particular relevance to the thesis presented here is Karp's observation that each of these stages corresponded to transformations in the participants' self-conceptions, e.g., as "damaged and in need of repair by psychiatric experts", or as an individual who was confident in moving beyond depression through their own efforts. He suggested that such transformations hinge on a number of factors, for example, on the way individuals reinterpret their past in the face of the diagnosis of depression, their understanding of the meaning of medication, or their experience of hospitalisation.

A study conducted by Lewis (1995) adopted similar research procedures to Karp (1994) by undertaking in-depth interviews with research participants who were

diagnosed as depressed, or who described themselves as being depressed. From a theoretical position informed by symbolic interactionism and social constructionism, Lewis undertook a thematic analysis of her interview transcripts with the aim of exploring the subjective experience and understanding of the participants. Four dominant themes emerged in her study; (a) the identification of a problem of depression through diagnosis, (b) the need to explain depression, (c) the search for meaning, and (d) the individuals' explanations for their experience of depression. Lewis concluded that there was some support for the notion that the experience of depression and the meaning of the diagnosis of depression vary between individuals;

> *More fundamentally, the notion of depression is itself problematic. Mainstream approaches within psychology and psychiatry have neglected to look at the meanings of depression for the individual experiencing it. Depression is a different experience for everybody, and individuals are actively engaged in interpreting and making sense of their own experiences of depression.* (Lewis, 1995, p. 381)

Although these studies were conducted with adult participants, they provide us with powerful themes and stories about the subjective experiences of depression that are missing from most mainstream research reports on the subject. However, such qualitative studies of this type are uncommon, or at least largely unpublished, and only have adult participants; they are non-existent with younger participants.

AIMS OF THE STUDY

We have seen so far in reviewing the literature that research and intervention with adolescents has primarily been about adding extensions to research methods and interventions used with adults. One aim of this thesis was to develop research and interventions unique to adolescents. A second theme of our review has been to give voice to the adolescents themselves, and have them speak about their experiences and understandings of depression. Finally, from almost all the perspectives and models has come the idea that a consideration of self-concept is needed to understand and treat adolescent depression, and that this might be one of the uniquely adolescent facets of depression.

This first study was designed to give a small group of referred adolescents an opportunity to talk about their mood, and record this conversation for review and detailed analysis. In particular it was intended to give special attention to the presence (or absence) of two main themes. First, I wanted to attend to those themes that were more consistently presented by the depressed adolescents as being pertinent to their experience of depression, both in terms of aetiology and change (the attainment of symptom free status, or adjustment to a more positive lifestyle while remaining symptomatic to some degree). That is, how do young people see depression, and how does the experience of depression impact on their lives? The second, and related theme, concerns self-concept. Specifically, how does the experience of depression impact on them as individuals, on the way they perceive themselves personally and in relation to others? This latter theme seems important as it reflects one of the core

developmental tasks of adolescence, and coincides with one of the areas of psychological impact of mood disorders which was highlighted in the qualitative research cited above (Karp, 1992, 1994; Lewis, 1995).

It was anticipated that the results of this study would be useful in extending standard psychological interventions for depression in adolescents by introducing a more considered response to the developing sense of self among this group.

METHOD

Participants

The participants in this study were a small number of consecutively referred adolescent clients from a provincial Child and Adolescent Mental Health Service in New Zealand. Each of the participants was referred because of concerns related to their mood. While twelve participants were originally recruited technical difficulties with recording and transcribing the audiotaped interviews reduced the amount of usable data to that obtained from ten participants. The ten participants for whom data are reported were all female and aged between 15 – 18 years. They were all non-Maori New Zealanders. Six participants were living at home with both their parents, two were living with one parent after a marital separation, and the remaining two were in boarding arrangements (one at a school hostel, the other in private lodgings).

They were all referred by their family doctors. There were varying degrees of specificity in the referrals with some mentioning “depression” explicitly. Six participants were taking anti-depressant medication by the time they were interviewed.

Measures

Psychometric measures

Psychometric data were collected using two measures. These were employed to provide baseline data for subsequent therapeutic intervention as required, and to support the diagnosis of clinical levels of depression as presented by the participants. Details and copies of the psychometric instruments used are included in Appendix A, although a brief summary is provided below.

Beck Depression Inventory - 2nd Edition (Beck, Steer, & Brown, 1996). The Beck Depression Inventory – 2nd edition (BDI-II) rating scale is amongst the most frequently used self-report methods of assessing the severity of depression. It consists of a 21-item questionnaire, with the respondent being asked to rate the way they have been feeling during the previous two weeks on a four-point scale (0-3) for each item. The BDI-II yields a full scale score in the range 0-63, with established thresholds for non-depressed, mild, moderate and severe levels of depressive symptomatology. The scale was constructed for use with respondents aged 13 years and over. This instrument has been used in a number of studies of depression in adolescents, for example, studies involving adolescent sexual offending (Bonner, Marx, Thompson, & Michaelson, 1998), the impact of sight loss (Koenes & Karshmer, 2000), persistence of psychiatric deviance (Kumpulainen, Rasanen, Henttonen, Hamalainen, & Roine, 2000), and social and family networks (Olsson, Nordström, Arinell, & von Knorring, 1999).

General Health Questionnaire (Goldberg, 1978). The General Health Questionnaire (GHQ) is a self-administered screening questionnaire designed to detect psychiatric disorders among respondents in a community setting. The 60-item version used here (GHQ-60) has been well researched over two decades, and its psychometric properties are well understood (Goldberg & Williams, 1988). While the GHQ is not recommended for use with children there is research which supports its use with adolescents (Banks, 1983; Sales & Hunter, 1990).

Respondents are asked to indicate how their health has been over the previous few weeks in relation to 60 probe items on a 4-point scale where the responses are indicated by phrases appropriate to the probe item, e.g., "much more than usual", "less often".

There are a number of different strategies for scoring the GHQ. The option used for this study is referred to as the Simple Likert method (Goldberg, 1978). This method was used because it has been found to be associated with the lowest percentage of misclassified 'cases' – false positives (12.6%), and the lowest percentage of 'missed cases' – false negatives (8.5%). Using this method scores are assigned to each column (0-1-2-3), with '0' being allocated for the response category indicating better health status, and '3' being scored if health status is reported as being worse than usual. The 60 item scores are then summed and compared to predefined threshold scores provided by the instrument's author. When using the Simple Likert scoring method the threshold score suggested is 40.

Procedure

The study proposal was reviewed and approved by my local Regional Ethics Committee, and the Human Subjects Review Committee, School of Psychology, University of Waikato.

Participants were selected on the basis of a referral for assistance with a mood difficulty. Participants were only considered for inclusion in the study if they were between the ages of 13 – 18 years. No other exclusion criteria were specified for this study since the intention was to obtain data from as wide a range of adolescents as possible.

On receipt of a referral the client was sent an appointment letter, information sheet about the project, and audiotape consent form. The information sheet and consent form were entitled *Feeling Low?* and contained no direct mention of depression. This was done to avoid a situation where participants, especially those who did not already see themselves as depressed, were being led into adopting this self-description. Clients were asked to sign and return the audiotape consent form prior to their appointment if they were willing to participate in the study. All clients who were sent the study documentation agreed to participate. Copies of the client information sheet and audiotape consent form used in this study are included in Appendix A.

When the client attended their initial interview they were given the opportunity to obtain further information about the study, and to withdraw their consent if they wished to do so. All participants elected to continue in the study. At

the end of the audiotaped interview, participants were asked to complete both the BDI-II and the GHQ-60. In most cases these were completed at the time. However, in some cases the participant took the rating scales away with them, and two of these were not returned, explaining the fact that psychometric data are only available for eight of the ten participants.

While the interviews were conducted within the framework of an adolescent mental health outpatient clinic, scope was given for discussion of a wider range of issues. As the participants had been referred for a clinical service the general parameters of the interview were those of a clinical intake assessment of the type outlined by New Zealand's Mental Health Commission (Mental Health Commission, 2000). This involves discussion of the client's concerns, general history taking (clinical, family, educational, social, health), and an evaluation of current mental health status. Additional scope was allowed for the participants to present information on their attitudes and beliefs relating to their adolescent experience in general (their search for identity and role), as well as their experience of depression. Where concerns were raised which indicated that the young person's mood was so low as to cause doubts about safety, this was addressed more directly. However, when specific issues of this type were not present the limits of the interview were generally less restrictive and more exploratory. Greater scope was allowed for discussion of the clients' experiences, explanations, and activity in relation to depression. This was prompted by questions such as "Why do you think you got depressed?", "In what ways, if any, has your experience of depression changed you?", "What advice would you give to other young people who are experiencing

depression?", and "What has been the most difficult part of this whole experience for you, and why?" All interviews were conducted within the context of an initial assessment for ongoing therapy and lasted approximately one hour. This context meant that a proportion of the data was collected in response to either direct questions, or as part of a series of open and closed questions exploring a particular theme. While these can appear to be leading the participants' focus, and on a few occasions they were, I made a concerted effort not to introduce new language or concepts that were not initiated by the young person.

Interviews were audiotaped with the consent of the participants and transcribed for later analysis. While some of the clients were unsure about the audiotaping process, all gave their consent. As often seems to be the case in such situations, the taping of the session was quickly forgotten once the interview had started, and all clients were happy for the tape to be retained at the end of the session. Two administrative assistants transcribed the audiotapes to text and then I checked them for accuracy against the original audiotape. Inconsistencies were resolved by consensus where possible, or by inserting the word or phrase that was considered to be most consistent with the perceived meaning of the episode.

Analysis of content and theme was based on two general schemes. The first stage of data analysis was based on a procedure outlined by Herth (1998). Herth utilised a process in her qualitative study of hearing loss which was based on the earlier work of Colaizzi (1978). The steps consist of (a) detailed reading of the transcripts, (b) extracting 'significant' statements, (c) determining the 'meaning' of these statements, (d) organising the statements and meanings into thematic

categories, (e) developing descriptors for the themes, (f) developing fully inclusive identification statements for the analytic structure. This process was used to generate a generic template or taxonomy around which the interview data were organised. The taxonomy assisted in the grouping of information 'bits' from the interviews into categories and sub-categories, and eventually themes which were presented at various times within individual interviews and within the data obtained across the participants.

The second scheme used to structure subsequent investigation of the data was based on the thematic analysis conducted by Lewis (1995), who identified four dominant themes in the way young people in her sample talked about their experiences of depression, viz, diagnosis, the need to explain depression, search for meaning, and individual explanations of depression.

RESULTS

Psychometric Measures

As already mentioned, only eight of the ten adolescents returned completed BDI-II and GHQ-60 rating scales. The mean score on the completed BDI-II for the group was 35, with a range of 10 - 54. This indicates that each of the respondents reported some signs and symptoms of depression, and that overall these were in the *moderate/severe* range.

The authors of the BDI-II suggest that respondents scoring two or three (the highest scores) on Item 2 (hopelessness/ pessimism) and Item 9 (suicide ideation) should be carefully scrutinized for suicidal potential. It is of interest that only one of

the participants (Olivia) met this criteria, and that she went on to require hospital admission because of concerns over suicidal risk.

GHQ-60 scores indicated the pervasiveness of difficulties experienced by the adolescents with all eight who completed the rating scale reaching the level of "caseness" (*M* = 115, range 58 - 165), most well exceeding the threshold criteria (see Table 2.1).

Goldberg and Williams (1988) cite research regarding the factor structure of the GHQ-60 which identifies seven items that form a 'severe depression' factor. If one can assume that each of the 60 items contribute equally to the establishment of the instrument's threshold score of 40, then a total rating of 4.7 (i.e., 40/60 x 7) on the seven severe depression items could be considered to indicate the threshold score on this factor. The average total score on the severe depression items on the GHQ-60 for the eight respondents was 15.3 (*SD* = 7, range 0 – 21). The zero score reported by one participant (Cathy) was unusual with all other respondents returning scores of 13 or above. However it is of interest that Cathy also returned the lowest BDI-II score of the eight participants, scoring in the *mild* depression range.

Interview Data

Before considering the interview data it is important to be clear on what we are attending 'hearing'. As already outlined, the data for this study are drawn from the transcripts of clinical interviews. These are interviews where distressed and depressed young people have been invited to talk about their difficulties. These data are clearly different from those that would result if I had asked young people to talk

Table 2.1

Sample Demographic and Psychometric Data

Name	Age (yrs)	Living arrangements	anti-depressant medication	BDI-II	GHQ-60 [b]	GHQ-60 [c] 'depression' factor
Angela	17	Parents separated. Living with father. Frequent contact with mother and step-father.	yes	54	165	21
Carol	18	Parents separated. Living with mother. Very limited contact with father.	yes	21	93	13
Jean	15	Private boarding by choice. Parents still together.	no	n/a [a]	n/a	n/a
Monica	17	At home with family.	no	31	106	15
Rachel	17	At home with family.	yes	n/a	n/a	n/a
Susan	17	At home with family.	yes	39	119	20
Olivia	16	At home with family. Parents in marital conflict.	no	44	157	21
Cathy	17	At home with family. Step-mother present since soon after birth, mother deceased.	no	10	58	0
Anne	18	At home with family.	yes	35	110	19
Louise	17	Private boarding by choice. Parents still together.	no	45	113	13

Notes. [a] n/a indicates that rating scales were not returned by the participant.
[b] The Simple Likert (0-1-2-3) scoring method was used yielding a clinical cut-off threshold score of 40 for 'caseness'.
[c] A derived score suggesting severity of depression. The proposed threshold is 4.7.

about previous experiences of depression, or about non-clinical low mood. It is likely that, in addition to the voice of the young person, we are also hearing depression 'speak'. That is, the themes and issues presented as pertinent by the participants may be different from the issues which they would present if they were not depressed. It seems important to be aware of this distinction so that we are not lured into an erroneous belief that all young people would hold the views expressed here.

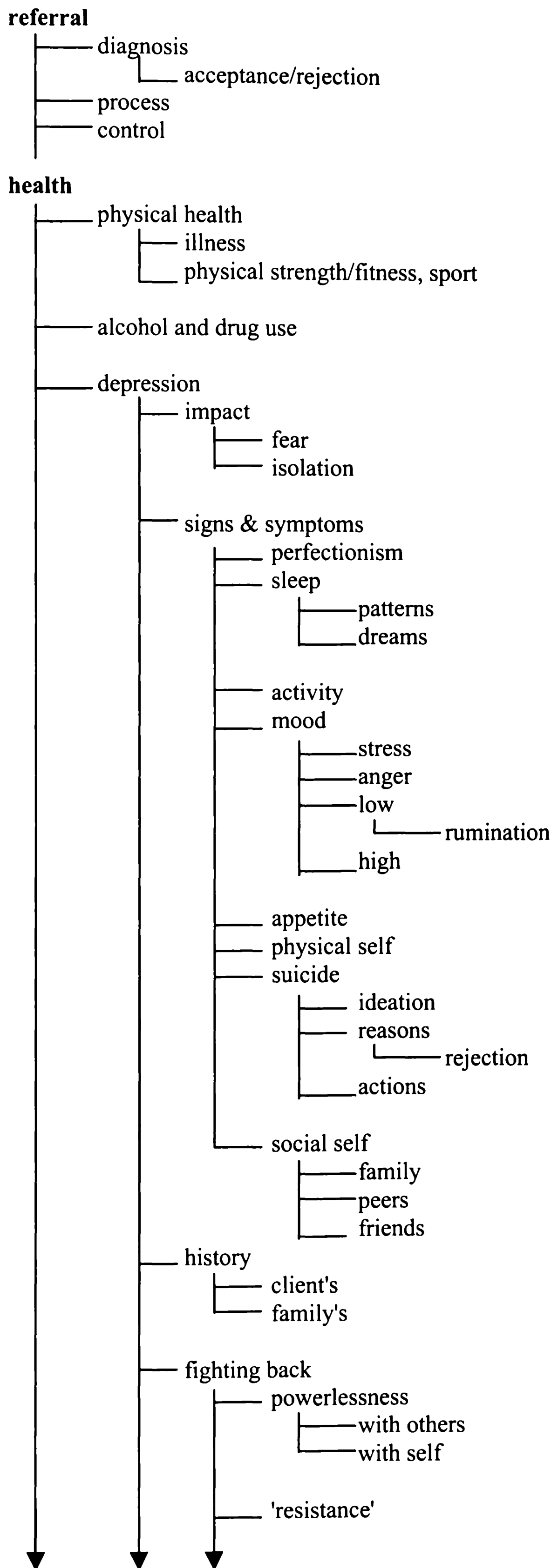
For ease of reference all transcripts were broken down into *participant speech episodes*. An episode was an utterance no matter how long: a word, phrase, sentence, or longer statement. A participant speech episode continued until the interviewer spoke. Participant speech episodes were numbered sequentially through each transcript. Where sections of transcript are included in the text for illustrative purposes they are referenced with the name of the participant and the number of the participant speech episode(s) in question.

When the audiotapes were transcribed and coded there was a high degree of *prima facia* uniformity in the way that respondents presented their experiences of depression, their views of themselves, and aspects of their lives. This is not surprising given that the respondents were females of a similar age and developmental stage. Discussion of depression was not limited to physical symptomatology, but also covered aspects of affect/mood, cognitions and behaviour as defining characteristics of the participant's experience of depression. A number of participants were also keen to explore the reasons for their depression, and ideas about how to 'fight back' against depression. Some of the young people were more able to think and talk about

taking an active stance against depression, feeling that they should and could be doing more to resist the negative consequences of depression.

The topic areas discussed were categorised and assigned a descriptive label. They were then arranged diagrammatically in an attempt to show the general areas of discourse (see Figure 2.1). Not all issues were discussed by each participant, and more than one participant may have contributed to any one 'branch' on the diagram.

It should be noted that the diagrammatic structure developed is my own interpretation of the interview content. Validation of main topic areas was found in the internal consistency of individual transcripts, and also by comparison across transcripts. General qualitative research methodology suggests that it is desirable to seek validation of the themes from the participants. However, the speed with which the participants were recruited to the project and the work context within which this study was conducted meant that the transcripts were not available until quite some time after the interviews had been completed, and the development of the session taxonomy was generally retrospective rather than simultaneous with the interviews. As this study was conducted within the context of a standard clinical environment rather than a research laboratory setting it was also thought to be an unreasonable demand on participants to make special arrangements to review these documents. Some support for various components of the taxonomy as a summary of issues relevant to the adolescent experience, including their experience of depression, can be found from other sources (Adamson & Lyxell, 1996; Gonnerman et al., 2000; Habermas & Bluck, 2000; Higgins, 1987; Laidlaw & Davidson, 2001; Lewis, 1995).



referral
diagnosis
acceptance/rejection
process
control
health
physical health
illness
physical strength/fitness, sport
alcohol and drug use
depression
impact
fear
isolation
signs & symptoms
perfectionism
sleep
patterns
dreams
activity
mood
stress
anger
low
rumination
high
appetite
physical self
suicide
ideation
reasons
rejection
actions
social self
family
peers
friends
history
client's
family's
fighting back
powerlessness
with others
with self
'resistance'

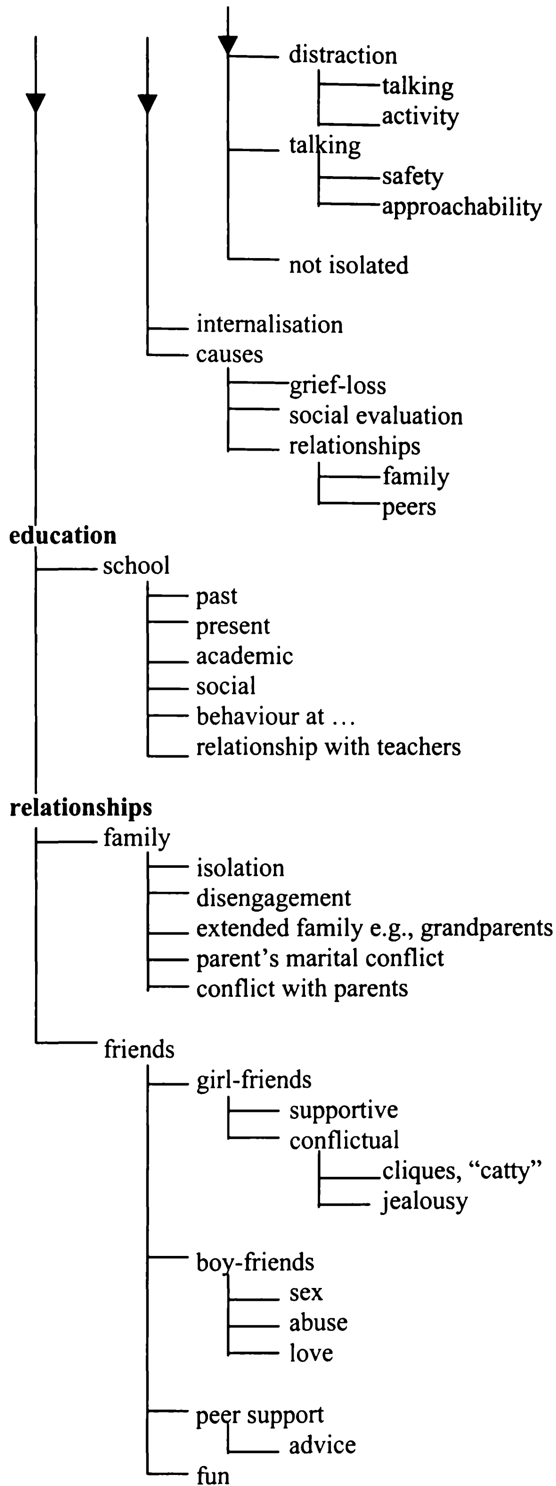


Figure 2.1 Taxonomy outlining the range of topics discussed as part of the initial clinical interviews with study participants.

Referral. In general, the level of self-acceptance of the participants as being depressed was high. This may have been related to the route of referral, i.e., via a general practitioner, and the fact that half of the participants were taking anti-depressant medication when they arrived for the initial interview. For some, having a medical practitioner confirm a diagnosis of depression was a relief;

> *SUSAN 28:*
> *... I was quite upset when I went to the doctor and we talked about everything. I was quite upset. And she put me on anti-depressants, but I was also really relieved that I found out what it was. I was still worried because there are still people who want to understand it when you don't understand it yourself.*

and;

> *INTERVIEWER:*
> *So the doctor said that this is clinical depression, this explains all the things...*
>
> *CATHY 82:*
> *Yeah, it was sort of like, yes, and so I think that's why I didn't do so well in my exams, I was thinking .... yeah, I'm depressed um... (laughing) I have a reason, sort of thing, I was quite relieved.*

In these cases it appeared that a diagnosis of depression provided the participants with a framework within which they could place emotions and events which they had previously struggled to make sense of. For others, the implications of accepting the label 'depression' were not so positive;

> *INTERVIEWER:*
> *When you think about depression, what thoughts go through your mind?*
>
> *ANNE 80:*
> *Loopy people in Ward 17.*
>
> *INTERVIEWER:*
> *So Ward 17's just over there (pointing). So, depression equals loopy people in Ward 17? You're taking an antidepressant, so what does that mean?*

ANNE 81:
A loopy person who needs to be in Ward 17?

INTERVIEWER:
Is that where you see yourself?

ANNE 82:
Some days (crying).

INTERVIEWER:
What are those days like?

ANNE 83:
Bad. That's when I think about not wanting to be in the world anymore.

Those taking anti-depressant medication presented as being more accepting of the diagnosis of depression, as well as the necessity and utility of the medication. Reports of parental support for the use of anti-depressants were far from unanimous.

Most of the participants were keen to have an opportunity to talk about their history and experiences of depression via therapy. Some had received counselling from their school guidance service or similar, but most reported varying degrees of satisfaction with this. It became apparent that a willingness to engage in therapy was associated with the perceptions held by the individual participants about their level of depression rather than the degree of objective depressive symptomatology. For example, Cathy, who was relieved to be given a diagnosis of depression despite returning the lowest BDI-II score, was very keen to engage in therapy. Conversely, Louise, who returned a BDI-II score of 44 (*severe* symptomatology), was not. This suggests that even in cases of significant objective mental health distress, one's self-perceptions can be a powerful moderator of help-seeking behaviour.

<u>Depression.</u> Discussion of the impact of depression on the adolescents' daily lives was expressed primarily within the context of depressive symptomatology. For example, the effect that lowered concentration and degraded short-term memory had been having on their ability to function at school, the impact of lower energy and loss of motivation on their interest in sport and other social activities, the difficulty in maintaining good relationships with family and friends in the face of their increased irritability and tearfulness, and so on. As can be seen from the taxonomy, a wide range of depressive symptomatology was presented including cognitive, behavioural, affective, and social aspects of the depressive experience. Generally it was the impact of specific physical symptoms (e.g., tearfulness, difficulty in concentrating) that were seen to be the most troubling aspects of depression.

There was only a limited focus on school and education as a major issue except where school was providing the context for conflict in relation to teachers or peers.

> *OLIVIA 38:*
> *My drama teacher, he's just, he's got something against me. Just because I happen to be the only person in the class who has a sense of humour and when I make the rest of the class laugh he gets really angry with me because I'm such a distraction, and he'll be telling me to be quiet, and* (crying) *he gave me a one out of five for my general because I'm not the kind of person who writes personal feelings about things down on paper, because I've just never been able to do that, and yet .... I mean I can't do it in English, I can't I just can't do it, so he gave me a bad mark.*

The participants did not generally raise the topic of familial mental health problems without being prompted. Some other aspects of physical health and illness were raised as being implicated in their depressed mood, particularly episodes of

glandular fever and concerns over weight and eating which pre-dated the individual's experience of depression.

Most of the young people admitted to a degree of current suicidal ideation. For some this had developed to the stage of having a plan, albeit rudimentary and relatively unlikely to succeed. Rachel spoke about her suicidal thoughts within the context of an experience of depressed mood that had, in retrospect, been present for at least 12 months;

> *INTERVIEWER:*
> *You said you thought about ending it. What did you mean by that?*
>
> *RACHEL 38:*
> *Um, I was trying to think and I'd be lying in bed crying and I'd just think oh maybe if I just left and just um, basically jumping off rocks, like cliffs and stuff pretty stupid, but yeah, I just sort of think that it would be just really easy, just to end it. I didn't want him ... it was just really hard.*
>
> *INTERVIEWER:*
> *So dying actually seemed like an option at some point?*
>
> *RACHEL 39:*
> *Yep.*
>
> *INTERVIEWER:*
> *Did you actually get very far with planning how it would all happen?*
>
> *RACHEL 40:*
> *Yeah, the Coastal Track. 'Cos I used to think how nice it would be just to fall off it, just to..... I used to close my eyes, I could see it, I could see. When I was little Dad used to take us, and just sort of falling off it .... I'd be really upset and I'd just be lying there .... and I'd just, 'cos I couldn't sleep and I'd just close my eyes and imagine it.*

Many of the young people who expressed suicidal plans stated that they would not put these into action because of the effect that it would have on their parents.

There were a small number of participants who did not have current plans but had previously exhibited suicidal behaviour and presented other characteristics which are associated with increased suicidal risk, such as a lack of future orientation, a high degree of impulsivity and intentionality, being acquainted with someone who had died by suicide, or having a family history of depression and suicide attempts. Olivia, who was eventually hospitalised because of concerns for her safety, was one participant who expressed suicidal ideation during the interview to a degree that caused significant concern. In particular, she expressed a view that seems to be more frequently related to actioned suicidal plans, the desire to become invisible or just 'not be', an 'invisible-self'.

> *INTERVIEWER:*
> *You said that this morning when you got up you just wanted it all to stop.*
>
> *OLIVIA 43:*
> *I just wanna stop feeling like I'm a bad person, and I just want it to go away... (sniff/crying) I just want all these feelings to go away.*
>
> *INTERVIEWER:*
> *Sometimes when people feel that way they can think about doing things themself to make themself go away, even taking their own life... have you thought of that?*
>
> *OLIVIA 44:*
> *About two months ago, or a month and a half ago, when I was in school and they were all talking to me and I just sat there after lunch and I was crying and Elaine sat there and didn't say anything to me, (sniff/crying) and the whole time I was sitting there I was thinking, is there somewhere I can go and lie down and die .... where no-one would ever find me. Then everything would be alright. (pause) I was gonna leave school. (sniff/crying) I was going to walk out of school and see where I ended up. But my friend saw me and she stopped me. I had been thinking of lots of ways to die, I was just gonna see what happens...*
>
> *INTERVIEWER:*
> *So that's a month and a half ago... how about it more recently?*

OLIVIA 45:
Yeah, I think that somebody better do something before I do it myself. (sniff/crying)

INTERVIEWER:
Do what?

OLIVIA 46:
I don't know. (sniff/crying) I just feel like, if I die then everyone .... my problems would go away and nobody else would have to worry about that, and I wouldn't have to go through this (sniff/crying).

Several clients admitted to previous suicidal/self-harming behaviour, this taking the form of overdoses of prescribed and non-prescribed medications belonging to the participant and/or other family members, cutting of their arms with a knife, inflicting a non-cutting injury to themselves with a sharp objects such as a geometry compass, and self-injury through hitting and biting. None of the reported incidents had resulted in medical attention or hospital admission, although at least two of the overdoses would have been likely to result in medical supervision if they had been brought to the attention of an adult.

The young people were generally keen to talk about other aspects of their lives: school, activities, and relationships. It is of interest that despite referral by their family doctors with diagnosed or suspected depression, generally high BDI-II scores, and some very high ratings on the GHQ-60 (both overall and on the seven severe depression items), many of the participants talked about aspects of their lives in an animated and enthusiastic fashion. They spoke about relatively active lives that still included participation in sport, socialising, and some degree of continuing success at school. However, there were three notable exceptions (Olivia, Angela, and Anne)

who had a more depressed presentations with respect to mood, cognition, and behaviour.

While an active presentation is somewhat inconsistent with the stereotypical view of depressed adults as lacking in energy and enthusiasm, it is consistent with the clinical presentation of many depressed adolescents. Certainly, some severely depressed adolescents are overwhelmed by the cognitive and somatic aspects of depression. However, many are able to experience periods during which energy levels are higher, and the symptoms of depression are less in evidence. This experience had caused some confusion for the parents of the current participants who found it difficult to understand how, for example, their daughter could return home from school very morose and low, but become rapidly re-animated when answering a telephone call from a friend. This difference in presentation may be partly due to the way that depression is manifest in younger people, with irritability also being identified as meeting the criteria for mood disturbance in children and adolescents (American Psychiatric Association, 2000). It is also possible that the social context within which depression in adolescents is located holds greater significance for this group because of their developmental stage, i.e., self-concept development within a highly charged social milieu. Thus, when social interactions are supportive of a positive self-concept then depression is kept at bay, or is at least manageable. Conversely, when poor self-concept is reinforced by negative social interactions, or at least the absence of positive interactions, then depression exerts a greater influence. Thus, there may appear to be a greater degree of variability in adolescent depression compared to its adult counterpart.

Some of the participants presented theories as to why they were depressed, although most did not know. The theories were generally couched in terms of 'significant' precipitating events which occurred within the context of a relationship. That is, most reasons given were about arguments with friends, conflict with siblings, enforced separation from peer group/boyfriend. None of the participants cited the sort of major environmental stressors or life events which have been identified in the research literature as precipitating low mood, e.g., moving home/school, trouble with the law, death of a family member (Adams & Adams, 1991; Daley, Hammen, Davila, & Burge, 1998; McGee & Stanton, 1992; Paykel & Cooper, 1992).

It was interesting to note that fear of social isolation was consistently raised by the participants in response to questions about their perceptions of the future. Most experienced themselves as lacking in social supports, and felt that they were isolated from their peers and family. Their fear was that this situation would continue.

Finally, most participants reported feeling a degree of impotence in relation to their depression. Apart from starting/continuing with anti-depressant medication, or finding some way to 'undo' the events of the past, they were generally unable to generate strategies that would assist them in managing the negative experiences of depression. On a limited number of occasions participants were able to contemplate 'resistance' in the face of depression, such as making statements that they were not willing to let depression "get the upper hand". However, the making of such statements was not linked to any clear plan of action. The more usual perception was that the participants were being dominated by their experience of depression, did not know what to do about it themselves, and wanted someone else to take the depression

away. This suggests that enhancing self-efficacy may well constitute a useful focus for a treatment programme with young people, a challenge to learned helplessness.

Relationships. There appeared to be one particular category of speech episodes which permeated all the interviews, that of social relationships. Relationships in various guises were mentioned as both a perceived cause of depression, and as a primary component in its resolution. Some participants focussed on difficult relationships within their families;

> *INTERVIEWER:*
> *How about your dad. You said your dad has problems with his health, do you think your dad might have ever felt the way you do?*
>
> *MONICA 42:*
> *Probably because he's always stressed out at work. I don't talk to him about it 'cos he's like a stranger. He has been for all my life. Huh.*
>
> *INTERVIEWER:*
> *Why's he a stranger?*
>
> *MONICA 43:*
> *I dunno know. He's just like, 'cos he just works and he gets stressed out and then he'll sort of like take it out on us, and I dunno know, I don't think he sees me as what I am. I ....think he sees me as what he wants me to be and that's not what I wanna be. And so, I don't know, I just never talk to him about it. Not about anything, if I got a ride home with him I can't even like talk to him, like about anything...*
>
> *INTERVIEWER:*
> *How do you think he feels towards you?*
>
> *MONICA 44:*
> *Like not a failure, but like that he can't see me succeeding in what I wanna do.*

However, it was the nature and experience of peer group relationships that seemed to be most crucial for these young people;

INTERVIEWER:
Is this a new way of thinking for you Olivia?

OLIVIA 4:
Oh, it wasn't like this, it all started in March really .... me and my best friend fell out... we didn't talk for like a couple of months and ... I hardly ever saw her, I just started feeling really bad about myself, like, she didn't want to be my friend anymore because I was bad person, (sniff/crying) and things like that. And that's just when it all started, from then everything I thought about myself was always bad (sniff) and just, just everything was bad (sniff/crying) there was nothing good about me.

INTERVIEWER:
So it started off over a falling out with a friend... do you remember what that was about?

OLIVIA 5:
I'd started work and she just felt like that... (sniff/crying) like I didn't want to be friends with her anymore because I was working so I didn't have the same time as I used to and I couldn't spend that time with her and she just stopped talking to me and was always angry with me because (sniff) because I didn't have time to for her because I was working so that made me feel like it was my fault because I was the one who wasn't making time to spend with her. They were planning everything, or they just not include me in anything they did (sniff), they wouldn't ask me to go out with them and ask me to do stuff with them, and then when I asked them about that she just turned around and said to me, well we just thought you'd wanna spend that time Simon (sniff)...

and;

INTERVIEWER:
At this time why did you end up going to John, Dr Smith?

ANGELA 7:
Well, I couldn't stand it anymore. I'd just been sad for too long. I had a party recently, me and my best .... I hadn't been really involved with my friends because I kind of you know, wasn't the same person that I was, and um, they probably thought that I was snubbing them or something, and they didn't turn up. And it really, it really caught my attention to the fact that what's the point now... you know. Friends that I trusted didn't come through for me. It was my birthday party and my best friends... yeh... they didn't turn up. They had excuses but I just didn't listen to them.

INTERVIEWER:
And that for you was like the final straw...

> *ANGELA 8:*
> *Yeh, (laughs) that was the final straw and I thought "right", and then I'd go to school every day because at the start of the year I'd taken too many days off school and if I take any more days off now I won't pass 6th form certificate, which means I have to redo 6th form and I really don't want to do that. So I'd go to school every day but I just wouldn't talk or anything, just do the work and go home, and sleep.*

Among the common topics presented when discussing relationships was a sense of abandonment experienced by the participants. Not only was this seen as being an immediate precipitating event, for example, loss of a boyfriends, 'defection' of a best friend and confidante, or separation of parents, but it was also interpreted as confirmation of the participants' own doubts regarding their self-worth.

The way that the participants presented their difficulties suggested that they were heavily influenced by the values they perceived to be expressed by their peers, in particular, those expressed within intimate relationships. This may well have been a function of the degree to which the participants were 'lost' within these relationships, struggling to maintain a sense of individual identity which was separate from their identity within the relationship, being a 'couple'. This was exemplified by Olivia who expressed great difficulty in maintaining a treasured sense of her social-self within her female peer group while also maintaining an intimate relationship with her boyfriend. It is of interest that she felt this was not due to her own actions, but to the views of her close friends who she felt had assumed that she 'should' be spending more time with her boyfriend than with them.

More than any other area of current functioning, the relationship domain was characterised by a high degree of rumination, a behaviour that has been shown to be inconsistent with the effective management of depressed mood (Nolen-Hoeksema,

2000; Nolen-Hoeksema & Morrow, 1993). Given the rapidity and significance of changes in personal and social identity at this stage of development it is understandable that even small negative changes in self-representations may have an impact on mood (Kinderman & Bentall, 2000), changes which were compounded by continual re-exposure to negative affect via rumination.

Themes

Exploring the categories further helped to elucidate three substantive organising themes that were present throughout the interviews. These themes were present across the main conversational areas (depression, their lives, and their relationships). The first of these themes related to **positioning** and refers to the sense the participants had of the way they related to their environments, be this to people, objects or events. The second theme was that of **agency**, the sense of personal power that participants felt both in relation to their place within the world, but also in the context of their developing **self-concept**, which was the third theme. While it is not surprising that issues of personal and social positioning, agency and self-concept arose for the adolescent participants in this study, it is of interest that these same themes can be applied to the understanding they had of depression, i.e., the meanings that they attribute to depression, the relative personal power they were able to exert in managing or influencing depression, and the way that depression impacted on their sense of personal identity, efficacy and self-esteem.

Positioning. This theme refers to the way in which the adolescents both perceived themselves to be positioned ('dominated') and positioned themselves ('located') in relation to others, including in relation to depression. Harré suggest that individuals develop a sense of how the world is to be interpreted and how they fit into it through a number of processes (Davies & Harré, 1990; Harré & van Langenhove, 1999). These processes inform perceptions of the individual him/herself, relationships with others, and the relationship that a person has to events. First, the individual is required to learn the categories which partition the world, e.g., male/female, grandparent/parent/child, depressed/non-depressed. Second, they have to participate in interactions which associate meaning with the various categories. Next the individual positions them self and/or is positioned by others in relation to these categories and meanings, for example, 'dutiful daughter', more or less depressed. Finally, as a result of this positioning via discourse the individual comes to identify as a member of the allocated categories as long as the discourse remains unchanged and unchallenged, and the meanings remain constant. Within the context of the data reported here there were several examples of discursive processes being reported which were applying pressure on the participants to adopt particular roles, relationships, positions, etc. These were within the domains of social and intrapersonal relationships, and within the context of the participants' relationship with depression.

Positioning by virtue of developmental stage and life experience was a significant feature of the data. Several of the participants were endeavouring to lead lives which were characterised by increasing independence and responsibility, with

the associated freedoms that this can bring. In two cases (Jean and Louise), this was within the context of a boarding arrangement. This was working well in one case, but had been associated with marked disinhibition in the other. However, perhaps the most striking example was Anne (18 years old) who presented with low mood that was clearly associated with a thwarted 'positional' change. She was making steady progress towards university entrance when marginal failure in one exam brought her plans to a grinding halt. Despite her efforts to find an alternate course she could not find one that suited her. Her tentative self-perception as a successful student ready for university life came under intense scrutiny from herself, and others;

> *INTERVIEWER:*
> *Maybe you could start by saying what your concerns are at this time.*
>
> *ANNE 1:*
> *Living at the school hostel (crying).*
>
> *INTERVIEWER:*
> *Living in the hostel. The school hostel at the girls high school. What are the problems with being there?*
>
> *ANNE 2:*
> *This year I wanted to be free and easy, 'cos I should have gone to university this year and I sort of built up the expectations that um I was gonna go to university and I could do what I like without answering to mum and dad and then I went down to Teachers College 'cos I didn't get into university. I missed out by one mark, one C, and um I got into Teachers College, and decided I didn't want to be a teacher and I've got to wait three years to do what I really wanted to do. So um, I decided to come up here 'cos I'd really had a look around the high school about the week before I went down to college, and I never wanted to go to the Hostel but um, I decided to come up to the Hostel and just bear with it, but, the um this little what, when the Principal showed me around it was um, like we had sort of bit more freedom than what you get, but it's worse than home.*

Anne's expectation was that life would be "free and easy", and characterised by independence, setting her own rules, self-direction. Her experience of the school

hostel was quite the opposite, with rules designed to provide structure for adolescents up to five years younger than herself. From a position where she was expecting to move on to a new stage in her development she was forced into a major re-assessment of her position. Her self-concept was challenged through loss of independence, and loss (perhaps temporarily) of a view of herself as 'academically able'. It was this latter loss that proved more telling over the course of the therapy as Anne worked harder and harder to convince herself that she was worthy of a university place. Within Marcia's (1966, 1980) framework it would be possible to place Anne's sense of herself as 'successful', 'academic' and 'adult' within the bounds of *identity attainment* if it were not for the intensity and duration of her reaction to the challenge that her exam failure precipitated. Aspects of family history, and competition with a sibling may have driven Anne to *foreclosure* concerning this facet of her sense of self, making it difficult for her to respond flexibly when the challenge came.

Positioning also occurred within the context of relationships, with powerful relational structures operating in such a way that a number of the participants found themselves to be restricted in their opportunity or capacity to move the relationship on to a new footing. This is akin to the description of *complementary* relationships within the family therapy literature (Watzlawick, Beavin, & Jackson, 1967). This style of relating follows a sequential exchange based on hierarchical differences. These authors referred to the relative positions as 'one-up' and 'one-down' positions denoting superiority and inferiority respectively. Problems occur when two people

become entrenched in their relative positions, or where positioning is challenged by one party only to be met by intransigence from the other ('rigid complementary').

A good example of social positioning which justifies such a description is of Monica (42-44, cited on p. 55) and her distant relationship with her father, and to a lesser extent her mother. Developing perceptions of self-esteem and efficacy were challenged by the expectations and values of her parents. In other cases this challenge came from different powerful agents such as teachers, or even favoured and influential siblings and peers. Such powerful influences seemed able to change the developmental trajectory of the young person by introducing either negative elements such as self-doubt, guilt, shame or positive elements like pride, self-assurance, excitement, etc. Unfortunately, the participants reported mainly on the deleterious effects of negative evaluations rather than the converse. In some cases such evaluations appeared to have played a part in impelling them towards negative outcomes, for others the challenge was met directly and 'irresistible force met with an immoveable object", with the resulting confrontation.

Another example can be seen in the way that Rachel attempted to position herself in such a way that she did not annoy either her parents or her boyfriend. Eventually the only way out of the situation was to end her relationship with her boyfriend;

> *INTERVIEWER:*
> *You said that during the first part of this year you had a boyfriend and that that relationship...*
>
> *RACHEL 29:*
> *It didn't work out .... it was really hard.*

INTERVIEWER:
That came to an end?

RACHEL 30:
He tried to um, my parents didn't like him, so I was trying to like not go with him to annoy them but not to go with them to annoy him, and sort of thing (mmm huh) and it ended up being really hard and he was just like always there... and he was... (laughing) but I just flicked him off in the end 'cos it was just too much.

INTERVIEWER:
You felt caught between him and your parents?

RACHEL 31:
Yeah, yeah and he was just, he wasn't like because I was sick he didn't understand that I was sick for so long, he just thought, he was not very supportive and then when I broke up with him it was really hard because he threatened to kill himself and he... his mum rang up my mum and abused my mum on the phone, and then she wrote my mum a real horrible letter and he wrote me a letter but I never saw them because mum just chucked them. And... yeah...

As stated above it seemed that it was not only people and situations that were dominating the participants, but also depression itself. While there were examples of resistance against depression, low mood was also clearly oppressive in its positioning of the participants. In the following example Angela, 17 years old, reported how aversive physical and cognitive symptoms of depression and anxiety led her to avoid social contact, and how her desire not to worry her best friend led her to defer obtaining social support, this compounding her social isolation;

ANGELA 11:
I just didn't talk. I just used to sit there... They'd talk to me and I'd say yes or no, but no in-depth conversation. I just used to read, just read lots of books, decided what I wanted to be and everything, and made plans so I could get out, you know. But, in terms of actually keeping the friendships going .... I couldn't be bothered.

(Pause)

I've got a really best friend who, I've been best friends with since I was 11, and she lives in town here and I still kept my friendship with her because she's just had a baby and I'm the god-mother and stuff.... and she was the only one I really talked to. But I never told her how I was feeling because I knew that she had worries of her own, and she didn't need mine to add to her problems.

INTERVIEWER:
Do you still feel the same?

ANGELA 12:
Yeh. I still feel the same. I don't trust them again... I don't go out anymore. I used to go out all the time, I haven't been out for months. I don't like really like being around other people. Just... I don't know. I just can't stand lots of voices at the same time. They just overloaded my mind and I can't grab a hold of them. I can go to town but I can't stay in like big areas for very long, because I get real claustrophobic and I just think everyone is staring at me and I can't stand it anymore. I just have to get out.

INTERVIEWER:
Do you get any sort of physical sensations that go with that?

ANGELA 13:
I just try and leave ..... It's just that I was, um, I know a lot of people, I'm very popular kind of in town and stuff and everyone tries to talk to me and I just have to get out of it somehow. Like I won't show them what I'm feeling 'cos I don't want them to know. I just act normal and then leave as soon as possible.

INTERVIEWER:
So the feeling is what?

ANGELA 14:
To get out as soon as possible, just leave. I get anxious... like butterflies in the stomach. I kinda get a bit sweaty, but I just have to leave. I panic and I need to leave... yeh...

The participants spoke in ways which suggested that their experiences of depression were constructed by other people to some extent. That is, the experience of depression and its treatment as perceived by other family members appeared to have a direct influence on the way that the participants construed their own experience of depression. This can be seen in the case of Anne cited above (Anne 80–

83, pp. 47-48) who had very definite views about what it meant to be depressed. These were based to some extent on a general family history of depression associated with a range of stressful family events including paediatric cancer in one of Anne's siblings.

It could be anticipated that the area of relationships would be a major focus for adolescents. They focussed on their relationships with family, school, peers, and significant others (e.g., sports coaches). However, it was also clear that their experience of depression was in some ways moderated by the influence of others, as well as moderating these relationships. That is, the experience of depression was a significant influence on social positioning. In some cases this took the form of a largely passive process which *happened to* the individual, while in other cases it was more active with the participants using the depression to manage their relationships.

This latter process was through various mechanisms, the most potent of which related to the threat of self-harm and suicide. In the following vignette, Angela reports on the reaction of her parents to her receiving a diagnosis of depression and anti-depressant medication from her general practitioner. This follows a period of time where Angela was open with her parents about her low mood and thoughts of suicide;

> *ANGELA 51:*
> *Yeh... I don't get as angry as much .... since I've been having them I haven't, I've cried a few times but not as often. It's not a happy feeling, it's just a neutral feeling, I don't get as much feeling as I did before.*
>
> *INTERVIEWER:*
> *And you think its the tablet that's done that?*
>
> *ANGELA 52:*
> *Yeh. Slightly.*

INTERVIEWER:
Could it be anything else?

ANGELA 53:
Or well, it's probably just because my parents know now that I am depressed, and you know, they've been making efforts and stuff.

INTERVIEWER:
They've been a bit more supportive ....

ANGELA 54:
Yeh... just ... keeping out of my way so that I can be by myself a little more.

INTERVIEWER:
And that seems to have helped.

ANGELA 55:
Yeh, dad's been giving me the car and stuff.

Conversation with Angela's parents suggested that they generally underestimated the severity of the risk associated with their daughter's behaviour, and that they often negated her experience of depression itself. Despite this their decisions were influenced by Angela's self-reported mood states. This finding was not unusual in subsequent interviews with the parents of the other study participants.

Agency. Despite reports of both loss of interest in previously enjoyed activities and loss of energy within the participant group there were examples of quite high levels of purposeful activity. A number of the participants were socially active, and active within the confines of a specific activity, e.g., surf life-saving, netball, hockey. Information from the participants' parents also indicated that an age-appropriate level of focussed activity was being maintained by some of the young people. However, this was the exception rather than the rule with most participants being

unable to sustain extended periods of physical activity, including the physical activity required to maintain progress at school.

Within the current data there were a number of examples of participants behaving in ways which could be construed as attempts to establish a sense of personal identity through exercising control over their environment, such as living arrangements, interactions with schools and education in general, their struggle to maintain part-time employment, their decisions about how they spent their time and money. They also reported interactions which developed their understanding of various social roles and relationships. However, within these various domains the endeavours of participants to gain some degree of control were generally ineffective or short-lived. Examples of this can be seen in the attempts of participants to avoid negative evaluations at school by school avoidance, the use of alcohol or other drugs by some of the participants, avoidance of friends, challenging which resulted in an escalation of conflict, all of which started as strategies aimed gaining a sense of control. It would not be justified to claim these difficulties as being necessarily related to the experience of depression, although the participants did report a significant number of unsuccessful attempts to gain control of their lives. It must be remembered that a period of experimentation is a predictable part of the life experience of most adolescents (Erikson, 1963, 1968; Marcia, 1966, 1980). Also, that the experience of depression implies a negative attributional style which may colour the way that life experiences are interpreted and reported.

Within the context of this study the term 'agency' also refers to the ability of the individual to produce an effect on their depression, i.e., being active in relation to

their depression. However, there was a general view expressed by the participants that they had very little ability or opportunity to influence their mood, or a wide range of other areas of their lives. Susan, 18 years old, expressed it as follows;

> *INTERVIEWER:*
> *Can we go back to the things that you said, and the first thing that you mentioned was the mood swing. Could you tell me a little bit more about what you mean by that?*
>
> *SUSAN 8:*
> *Um ... well, just that ... I don't know, it's really strange, like you get upset about something really small that you usually wouldn't get upset about. And you get really really upset, like um ... sometimes I'd just be ... you know, just bawling my eyes out for no reason and I just wouldn't be able to stop or anything. You just don't know what to do and think that there is no one that can help you. No one to talk to when there's plenty of people to talk to. I don't know, like sometimes I'd sit and ... I was telling a friend about this who is in the same situation as me and like sometimes when you get very very depressed you sit down and just stare at something, like anything and just stare at it for ages and ages and ages. If someone walks past or tries to get your attention you just feel like all this tension building up, like inside you. I don't know, it's really strange, but I talked to her about it and she knows that sort of thing as well. She had it a couple of years ago and she was on anti-depressants then.*

Others were more able to think about resistance, which seemed to require a sense of self-efficacy in relation to depression. However, in the few cases where thoughts of 'fighting back' against depression were evident these were clearly expressed;

> *CAROL 36:*
> *Yeh. If everything's overall bad, like if it's a horrible day, if it's, (yeh) if somethings gone wrong. If something goes wrong it's usually, it gets hold of me and that's really wrong, when I know it's not even that bad.*
>
> *INTERVIEWER:*
> *So it's like other things can sap your energy, like if you have an argument with somebody, or you feel bad about, something's happened at school, that can sap your energy, so if depression reaches up then... you've not no defence at all...*

CAROL 37:
Yeh, no defence at all.

INTERVIEWER:
But other days you're feeling really good, lots of energy, things are going great, depression reaches up, you can just stroll on by.

CAROL 38:
It's there, but I can (mmm)... get over it. I sort of say to myself "look... not today". Ha, ha, not today, not today...

INTERVIEWER:
Today's too good.

CAROL 39:
Today's too good for you to wreck it.

And the following example from the interview with Monica. This passage was taken from early in the interview when Monica was talking about her experience of suicidal thinking[2];

MONICA 23:
No. Like I've wondered about it, but no not really, I've thought what I'd do ... but ... like I was thinking about it and it just made me upset and stuff, you know, so I talk to myself not to do it... Why should I let this depression or whatever get the better of me sort of thing.

INTERVIEWER:
So you see yourself as sort of in conflict with depression in a way? (mmm) Like when you have thoughts about killing yourself, that's depression getting the upper hand?

MONICA 24:
Mmm. I sort of think why should I give someone the satisfactory of doing it ... I don't know...

INTERVIEWER:
Does that way of thinking help you cope in some way?

---

[2] This section of transcript is a good example of the interviewer using concepts that had been introduced by the participant earlier in the session, e.g., 'sapping energy' and 'having no defence against depression'.

MONICA 25:
Yeah, it does.

While they may be encouraging, these statements were made within the context of generally unsuccessful attempts to manage depression, hence the referral for specialist services. There was limited spontaneous use of behavioural strategies such as distraction, behavioural reactivation, relaxation, and no evidence that more sophisticated cognitive strategies were utilized. Not only did the young people report the direct negative impact of depression, but also presented as either accepting or being unable to resist a 'one-down' position within the relationship.

<u>Self-Concept.</u> Endeavours directed towards exerting a degree of control over the environment were not related solely at the management of external and social influences, but were also linked to how these events impacted on the participants' sense of themselves.

The young people in the sample were unanimous in raising issues about their own negative self-perceptions, generally self-criticism. What follows is an example taken from the interview the Olivia;

OLIVIA 1:
Well the ball's finished now, so that's sort of out of the way, gone, that was it. I was really worried about that (yeh) .... but I dunno, that was really .... a really bad night. I sat there the whole night thinking "Oh my God, everyone's looking at me ... I look so fat and ugly". I wasn't, oh, I dunno I wasn't really expecting anything wonderful beforehand because I went to the high school ball last year and it was really bad, but... I just wasn't .... that's just how I feel when I go out in public, everyone's looking at me .... and I spend all my time comparing myself to everyone else.

INTERVIEWER:
You compare yourself with other people .... ?

OLIVIA 2:
And I don't come out very well.

INTERVIEWER:
In what ways? What sort of things do you imagine?

OLIVIA 3:
Just that everyone's .... (tears) at school everyone's more intelligent than I am. Everyone's better than me in that, I don't know, that just makes me feel really bad because, oh I don't know.

INTERVIEWER:
Is this a new way of thinking for you Olivia?

OLIVIA 4:
Oh, it wasn't like this, it all started in March really .... me and my best friend fell out... we didn't talk for like a couple of months and ... I hardly ever saw her, I just started feeling really bad about myself, like, she didn't want to be my friend anymore because I was bad person, (sniff/crying) and things like that. And that's just when it all started, from then everything I thought about myself was always bad (sniff) and just, just everything was bad (sniff/crying) there was nothing good about me.

Olivia, previously seen as being intelligent and physically attractive by others and by herself, was struggling to find these attributes in herself at the time of the interview. Her intense self-criticism, even self-loathing is expressed in the references to herself as "fat and ugly", as a "bad person" whom nobody wants to befriend, and as lacking in intelligence. She ends with the heart-rending statement, "there was (is) nothing good about me". Her continual tearfulness during the interview provided an indication of the distress that these perceptions were causing her. Olivia seemed a little unclear about the specific causes of her change in fortunes, but dated it as originating several months earlier at a time when she had a 'falling out' with her best friend. Perceived social rejection fuelled an intense re-assessment of 'self' for Olivia

that, despite ample evidence to the contrary, lead Olivia to believe herself to be worthless, a bad person.

At 16 years of age Olivia was in the midst of working through issues of role and identity. To cause the level of distress encountered here the identified precipitating incident must have been more significant than Olivia states, been accompanied by other issues, or have caught her at a time when peer approval was crucial to her self-concept. Despite a degree of *rapprochement* between Olivia and her friend (Elaine), the damage to Olivia's conception of herself was still very much present at the time of the interview.

In the following section of transcript, still from Olivia, we see how the establishment of a new view of herself as having "problems" becomes the norm, a role or identity which is defended. She actively avoided exposing this part of herself to others despite the obvious emotional and social harm that it was causing her;

> *INTERVIEWER:*
> *You said that you have had quite a lot of time off school?*
>
> *OLIVIA 39:*
> *Well I was quite sick last term, I had the 'flu for just about the whole term so I had a lot of time off school last term, but this term I ... (sniff) I've had lots of time off school because of this. I just can't go, I don't feel up to it, I don't feel I can go and see my friends because (sniff) they, all like just start feeling sorry for me because I can't do this, but it's like a big act... they come up to me and they feel sorry for me, but then it's like they don't really care because they don't ring up when I'm away from school, they don't ask if I'm all right, or... because like if, when... if any of my friends were ever away from school I always ring and ask them how you were and everyone else would ring and ask them how they were, and it's like they don't care about me .... it's just me so who cares! (sniff/crying)*
>
> *INTERVIEWER:*
> *You feel that if they really did care they'd make contact?*

> *OLIVIA 40:*
> *Even Elaine, I mean, we made up, and now it's like she wants to be a good friend, so she asks what's wrong, but then she just forgets about it. (sniff/crying) Like it doesn't matter anymore. I'll tell her and if I've been okay one day at school and I'm happy she just forgets about it and thinks everything's all right again and it's not. (sniff)*

Olivia quickly slid further into a depressed state, and within days of the interview she was admitted for in-patient treatment of her depression amid fears for her physical safety.

Angela also had difficulty adjusting to 'loss', in this case it was a longer term loss of her family, particularly her parents. Garrod et al. (1999) refer to Marcia's (1966) concept of *moratorium* as "a time of deferred choice - (is) the period in an adolescent or young adult's life for resolving the identity crisis" (p. 9). For Angela, not only was this process attenuated by the lack of tangible adult presence and guidance, but also the boundary destroying influence of childhood sexual abuse. In this passage Angela is talking about the perceived loss of her friends (the first part of this excerpt was cited previously in relation to the same issue, the importance of peer relationships);

> *INTERVIEWER:*
> *At this time why did you end up going to John, Dr Smith?*
>
> *ANGELA 7:*
> *Well, I couldn't stand it anymore. I'd just been sad for too long. I had a party recently, me and my best .... I hadn't been really involved with my friends because I kind of you know, wasn't the same person that I was, and um, they probably thought that I was snubbing them or something, and they didn't turn up. And it really, it really brought my attention to the fact that what's the point now... you know. Friends that I trusted didn't come through for me. It was my birthday party and my best friends... yeh... they didn't turn up. They had excuses but I just didn't listen to them.*

INTERVIEWER:
And that for you was like the final straw...

ANGELA 8:
Yeh, (laughs) that was the final straw and I thought "right", and then I'd go to school every day because at the start of the year I'd taken too many days off school and if I take any more days off now I won't pass 6th form certificate, which means I have to redo 6th form and I really don't want to do that. So I'd go to school every day but I just wouldn't talk or anything, just do the work and go home, and sleep.

INTERVIEWER:
So you felt down, you felt low... you felt sad (yeh), but still felt that you had to keep going to school because...

ANGELA 9:
I just wanted to get out of that place, I just wanted to leave.

INTERVIEWER:
Which school do you go to?

ANGELA 10:
Rural. I used to go to Girls' Grammar but I got into some trouble there so they moved me.

(Pause)

INTERVIEWER:
So you had this situation at your birthday, which really made you feel down, (yeh) didn't feel like going to school but you forced yourself to go. (yeh) How did you get on with your friends when you were at school after...

ANGELA 11:
I just didn't talk. I just used to sit there... They'd talk to me and I'd say yes or no, but no in-depth conversation. I just used to read, just read lots of books, decided what I wanted to be and everything, and made plans so I could get out, you know. But, in terms of actually keeping the friendships going .... I couldn't be bothered.

(Pause)

I've got a really best friend who, I've been best friends with since I was 11, and she lives in town here and I still kept my friendship with her because she's just had a baby and I'm the god-mother and stuff.... and she was the only one I really talked to. But I never told her how I was feeling because I

> *knew that she had worries of her own, and she didn't need mine to add to her problems.*

At the age of 17 years Angela had been in a number of unsatisfactory sexual relationships, and had started to develop an unhealthy relationship with alcohol and other drugs. She described her relationship with her father as being close, although they lived as virtual strangers in the same house with their paths seldom crossing. Angela had equivocal feelings of love and contempt for her mother, and thinly veiled loathing for her step-father. She began the interview by stating that her depression had ".. been around for years", and that she was a sad child. Her recent experience with perceived lack of support from friends had done little to provide or enhance a supportive social context within which she could make progress in developing a sense of self as being socially attractive, intellectually able, and 'non-depressed', leaving the way open for self-doubt and associated negative cognitions. One theme that emerged from the initial interview with Angela was that a significant component of Angela's self-representation involved her being depressed.

The preceding examples are representative of a general theme that pervades the data. Events occurred within the lives of each of these young people, and others not reported here, that changed the view they had of themselves, changed their story. They were either invited, or forced to re-evaluate their self-conceptions in relation to their experience of depression, and their positioning in relation to the world. Harter (1996) suggests that there is a clear historical precedence for including negative self-evaluations as one of the constellation of symptoms experienced in depression; such self-evaluations were very apparent in the data reported here. However, it is also

clear that just as negative self-conceptions can precipitate depression, so depression perpetuates and compounds negative self-conceptions, further impeding the development of a clear sense of personal identity (self-concept).

DISCUSSION

The participants in this study were able to talk about a range of behaviours, relationships and events that they believed had both precipitated and maintained their depressed mood. This may not have been solely in response to a question such as, "Why do you think you got depressed?", indeed not all of the participants were able to answer this question when posed directly. This suggests that while experiencing a number of troubling life events the answer was more complex than being reactive to specific events alone.

Brown (1996) hypothesised that while a large number of research studies have found that the experience of negative or aversive life events is associated with the presence of depressed mood, it is the loss of a "cherished idea about oneself or someone close, and loss of role as well as loss of a person" (p. 154) that is important. Further, that these 'loss' experiences are more damaging if they occur within the context of personal humiliation, e.g., Anne's failure to obtain the grades to enter university; and the absence of social support. This would appear to be case for a number of the current participants both from the standpoint of an observer and from the self-reported subjective experience of the young people interviewed, particularly with reference to the perceived absence of social support. That is, themes of loss and alienation were widespread as were particular events which precipitated or exacerbated these feelings. The result of these events was not limited to separation

from family, friend and other forms of social support, e.g., structured activity, but also a sense of separation from themselves as evidenced by confusion, uncertainty, loss of confidence, expressions of negative self-conceptions. This social separation appeared to have been prompted by a range of processes. Within the social domain there were obviously attempts to minimise the aversive impact of negative experiences such as humiliation, shame, guilt. However, there was also a sense in which withdrawal was also perceived as potentially punishing to those who were seen as being implicated in the depressive experience of the participants, e.g., parents (especially fathers), boyfriends, peers.

During the course of this study it became clear that negative feelings such as shame and guilt were highly subjective in terms of both process and content. For example, Rachel worked hard to protect both her boyfriend from the negative evaluations of her own parents, and her parents from finding out about the difficult relationship she was having with her boyfriend. She reported feeling guilty about deceiving her parents, and also ashamed that she was unable to think of the best way to resolve her relationship problems. She eventually ended the relationship with her boyfriend, seeking the help of her mother in this, but she did not tell her parents the full extent of the emotional abuse that she had experienced. It was unclear whether this was based on denial of the full seriousness of events, a desire to protect her parents, or a sense of shame over her inability to cope with the relationship.

Given that 'significant' relationship events are not uncommon in the lives of either young people or adults, there remains a question of why some individuals react more dramatically with depression than others? One significant difference between

the age groups is likely to be the stability of identity structures prior to the onset of depression. For adolescents this relates to the 'childhood identity' referred to by Erikson (1963, 1968), concrete and pre-operational thought, and inflexibility in a world that works in one direction only. Adults will generally have the experience of successfully resolving the conflicts of their adolescent years, and more stable relationships to draw on. That is, they will have greater experience of handling turmoil, and more experience of generativity and flexibility. It is possible that the closer temporal proximity to basic identity forming experiences constitutes a more significant vulnerability. Another difference may be the robustness of support mechanisms that confirm or refute such re-evaluations. That is, not only do adults have a greater number of 'grounding' and 'positioning' experiences, but their worth is more likely to have been tested, the ground is firm and the pegs are well bedded in. While this may lead to a greater inflexibility for adults, it has the potential to leave adolescents with too much flexibility. What is clear is that statistically adolescents seem to be more vulnerable than adults to mood disorders, and that there is a clear association with the period of *identity development*.

Blatt and Zuroff (1992) explored aspects of interpersonal relatedness and self-definition within the context of depressive prototypes. They drew a distinction between what they saw as two forms, these being the *anaclitic* (or dependent) and *introjective* (or self-critical) types of depression, a distinction that finds parallels within other theoretical frameworks. The former is characterised by feelings of loneliness, helplessness, and weakness. These feelings create a desperate need to keep in close physical contact with need-gratifying others, a need to be nurtured and

protected. The introjective type of depression is characterised by self-depreciation and feelings of worthlessness, inferiority, failure and guilt. These feelings can lead to excessive attempts to compensate through high levels of competitiveness and hard work, leaving the individual vulnerable to the voices of perfectionism and further self-criticism. Not only are these presented as prototypes of depression, but also as demarking two types of experiences that lead individuals to become depressed; (a) disruption of interpersonal relations and (b) threats to self-integrity and self-esteem. These authors suggested that;

> *"Each of these theoretical positions .... distinguishes a depression initiated by disturbed interpersonal relationships from a depression initiated by some disruption in self-concept or identity."* (p. 529)

However, what is identity if not a self-perception that positions the individual within the social world. Perhaps this is the challenge of adolescent depression; supporting the development of robust self-conceptions, positively reinforcing social contexts, and the authoring of stories about oneself ('autobiographies') that are enduring, flexible and filled with hope. The challenge to the psychological therapist is to use therapeutic interventions that can contribute to the clarification and enhancement of self-conceptions in a way that facilitates positive self-esteem, positive cognitive style, and the development of robust and supportive social interactions.

Strengths and weaknesses of the study

This was a very enjoyable study to conduct and report. The participants were generally willing to have the session audio-taped without hesitation, and had fascinating 'stories' to tell. The difficult task of transcribing the tapes was completed by two enthusiastic administrative assistants which made the generation of useable data files very easy. Data analysis was interesting and thought provoking, as was the process of working the data into a form that could be reported.

However, there are certainly a number of ways in which this study could have been improved. First, despite the initial design decision that the study sample would include twelve consecutive referrals to the service in question in was not envisaged that these would be exclusively female. Depression in the child and younger adolescent population has been found to be split evenly between males and females, after the watershed of puberty the more familiar rates of depression are established, that is, females reporting higher rates of depression than males at a rate of 2:1 (Birmaher et al., 1996). With this in mind it would have been reasonable to expect that at least some males to be present in the stream of 12 consecutive referrals, but this was not the case. Therefore, rather than covering what young people say about their experience of depression, this account has been limited to an exposition of what a group of adolescent females reported.

Not only would the study have benefited from the inclusion of male participants, but it would also have benefited from the inclusion of some non-depressed 'control' participants who could have been asked to report about their

mood, life and relationships. However, the absence of a control group does nothing to invalidate what the participants in this study had to say.

The use of the GHQ-60 is another aspect of the study which may be considered less than satisfactory. The measure has a long history of use as a research instrument. However, for a 60-item instrument it yields little information. A shorted versions of the GHQ or a different measure of overall mental health status, such as the Symptom Checklist – 90 – Revised (Derogatis, 1983), may have been preferable.

CONCLUSIONS

The aim of this study was to explore more closely the presentation of a small group of young people who had been referred to a specialist child and adolescent mental health service because of concerns about their mood. Close scrutiny was given to their expression of issues and themes related to their self-conceptions as this was identified in the literature as an important area which has yet to be fully investigated in relation to depression. Data analysis and reporting highlighted three major themes around which the participants' discussion during interview could be organized, although there would undoubtedly have been many more thematic representations possible. The themes explored here were those of position, agency, and self-concept (identity).

There was a certain amount of uniformity in the way that the young people presented as evidenced by the relatively limited general taxonomy of conversational topics that was developed to describe the content of the session. Of course, it is possible that this reflects the relative power of the interviewer in relation to the

participants within this particular social context, especially with reference to decisions about appropriate/permissible topics of conversation. However, examination of the transcripts and the experience of working with the young people suggests that while being a possible way of explaining the content of the session, it is an unduly pessimistic interpretation of the relative roles occupied during the interviews. If, then, the apparent uniformity of conversational topics has at least some validity as a record of the participants' behaviours, thoughts and feelings, does this equate to a degree of uniformity of experience between the young people who were experiencing depressed mood? Are their experiences significantly different from those who are not depressed, or at least not as severely depressed, in terms of their reasoning about why their mood is the way that it is, their self-conceptions, their life experience?

These questions link well to the second study, reported in the following chapter, which was also anticipated at the end of the introductory chapter. The plan was to conduct both a qualitative and a quantitative study (Tashakkori & Teddlie, 1998) to complement each other in providing data regarding the experience of depression of New Zealand youth, and particularly the role of self-conceptions. The first study confirms the view that this may indeed be a significant factor, at least from the perspective of the young people who participated in the first study. They may not have stated it explicitly, but aspects of their self-conceptions were evident in the themes that ran throughout the analysis of their comments. The second study provided an opportunity to explore this from a different (quantitative) perspective, to

see whether self-concept emerged as a significant factor in that analysis, and explore various contextual elements that may relate to both self-concept and depression.

CHAPTER 3

Correlates of Adolescent Depression: Attributions, Self-Concept, Life Events, and Reasons for Depression.

This study was based on the assumption that depression is multi-faceted in both its origins and expression. This is consistent with models of depression of the type tentatively proposed in the opening chapter of this thesis. Clinical research suggests that depression is a heterogeneous disorder with the experience of clinically significant levels of depression being attributable to a number of factors.

There have been efforts to find biological causes of depression in children and adolescents which parallel those found in the adult population (Cytryn & McKnew, 1996). These efforts have been largely unsuccessful. Indeed, after reviewing research in this area, Brown (1996) concluded that only about eight per cent of clinically significant depression could be attributed to biological factors.

Social risk factors and their association with depression have been widely examined (Hammen et al., 1999; Hoberman et al., 1996; Horwood & Fergusson, 1998; Kutcher, Marton, & Boulos, 1993; Reinherz, Frost, & Pakiz, 1991). For example, a considerable amount of detailed research has focussed on the role of negative life events as risk factors for depression (Brown, 1993; Brown, Harris, & Hepworth, 1994; Daley et al., 1998; Paykel & Cooper, 1992; Williamson et al., 1998). Brown (1996) cites data from his own epidemiological studies which suggest that a significant number of individuals who experience depression will have been through some type of 'severe event' leading to an experience of loss;

> *The majority of these severe events involve some element of loss, if a broad definition is used that includes loss of a cherished idea about oneself or someone close, and loss of role as well as loss of a person.* (Brown, 1996, p. 154)

Brown identifies such a loss as being a highly significant risk factor for depression. However, it is not clear what the relationship is between significant life events, self-concept and the individual's experience and understanding of depression although, in general terms, these associations were confirmed by the data reported in the previous chapter.

Brown (1996) observed that common features of such loss experiences were a sense of humiliation and an absence of social support. He found that losses which occurred within a socially humiliating context (being 'put down' or trapped), and where there was an absence of robust social support, were more likely to be damaging and lead to an increased risk of depression. This was evident in the first study with the most significant events being focussed on relationships, particularly those involving peers. It seems likely that such losses impact not only on one's self-conceptions, but also on the way one feels about oneself (self-esteem). For adolescents, where the establishment of a sense of 'self' is a core developmental task (Erikson, 1963, 1968; Marcia, Waterman, Matteson, Archer, & Orlofsky, 1993), such a significant loss experience could be devastating. Mueller and Orvaschel (1997) observed that often adolescents do not have the robust social supports that enable them to easily maintain a strong self-concept when challenged. Indeed, the social

structures which adolescents develop for themselves, or are presented with, often emphasize transience and change rather than stability. Garrod et al. (1999) suggest that social trends such as the institution of compulsory secondary education places adolescents in a state of limbo where they are prevented from claiming either the 'fragility' of childhood, or the full autonomy of adulthood.

Harter and her colleagues have explored the relationship between self-concept, self-worth (self-esteem) and mood (Harter, 1990; Harter, Marold, & Whitesell, 1992; Renouf & Harter, 1990). She concludes that for children and young people the association between self-worth, the way one perceives (self-concept) and judges oneself (self-esteem), and mood is generally quite strong. It is suggested that this process is not a simple linear one, but is cyclical (Harter, 1990; Weinberg, Rutman, Sullivan, Penick, & Dietz, 1973) with lowered self-worth precipitating self-deprecatory ideation, which in turn negatively effects mood and further diminishes self-worth (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982; Fehon, Grilo, & Martino, 2000; Rosenfarb, Becker, Khan, & Mintz, 1998).

With self-concept and self-esteem among the potential mediating factors it is possible that stressful life events are less likely to have an impact on mood if they are seen as only indirectly related and non-causative. As indicated previously a substantial amount of research energy has been directed towards understanding the attributional style of both depressed and non-depressed individuals for everyday events, with more recent attention being focussed on the reasons that an individual gives for their depression. The explanations (reasons) that a person gives for an event will be influenced by a number of factors, including their previous experience of the

same or similar events, their sense of self-efficacy in relation to the event, their more general sense of personal 'power', and their self-esteem. It is likely that this wide range of explanatory influences are brought to bear on an equally large range of events, e.g., social interchanges, discrete behaviours, as well as internal affective states such as depressed mood.

Attributional style has been a focus of clinical interest and research for many working with depression since Abramson et al. (1978) presented a revision of Seligman's model of depression based on the concept of learned helplessness (Seligman, 1975). Seligman had suggested that when an individual has an expectation that control is not possible either in avoiding noxious experiences or securing positive experiences, then they take no action and exhibit patterns of cognitions and behaviours that are identified as symptoms of depression. Abramson et al. developed an attributional model that placed greater emphasis on the causes that were attributed to such events rather than the events themselves. In particular they focused on the way that negative events were attributed to stable and pervasive negative aspects of the self in individuals who were depressed.

Much of the research which has followed on attributional style has explored the differences in attributions that are made by depressed and non-depressed individuals for everyday events (Edelman, Ahrens, & Haaga, 1994; Johnson, Han, Douglas, Johannet, & Russell, 1998; Metalsky et al., 1987; Needles & Abramson, 1990; Peterson, Semmel, von Baeyer, Abramson, & Metalsky, 1982; Rodriguez & Pehi, 1998). These studies have explored the role of attributions, i.e., reason giving, with particular reference to the establishment of an explanatory style or pattern. They

have also explored the relationship between attributions and inferences about the self, and the implications of attributional style in relation to clinically significant change. There have been a number of large scale studies of attributional style in adolescents focussing on how attributional style relates to a range of depression-related variables (Gladstone & Kaslow, 1995; Nolen-Hoeksema & Girgus, 1995; Schwartz, Kaslow, Seeley, & Lewinsohn, 2000).

However, a different focus has been taken by Addis and his colleagues (Addis & Carpenter, 1999; Addis & Jacobson, 1996; Addis et al., 1995) in a series of studies focusing on the attributions, or explanations (reasons) given for depression itself. In their original study Addis et al. (1995) reported the development of a self-completion rating scale which they called the Reasons For Depression Questionnaire (RFD). A sample of 602 non-referred undergraduate students were asked to rate their agreement with 93 items which completed the statement "I am depressed because …". The authors were able to identify an eight factor structure to the responses. The factors identified were labelled to indicate the general area of explanation (Characterological, Achievement, Interpersonal Conflict, Intimacy, Existential, Childhood, Physical, and Relationship). A second study was reported within the same publication in which 133 depressed individuals completed the RFD as part of an assessment battery prior to entry into a depression program. This study generally confirmed the findings of the study with non-referred individuals.

Subsequently Addis and his colleagues have offered evidence that differences in the reasons that a person gives for their depression have a predictive relationship with treatment outcome (Addis & Jacobson, 1996). That is, in their study of 98

individuals allocated to either a 'behavioural activation' or cognitive therapy intervention, they found some evidence that treatment was more likely to be efficacious if it was congruent with the reasons for depression (attributions) given by the client.

Addis and Carpenter (1999) confirmed and extended the above results. In particular they found that more reason giving was associated with perceptions of lower credibility and more negative personal reactions to activation orientated treatment modalities. From their study sample of 51 adults, they found that the Characterological and Childhood subscale items were predictive of a positive reaction to more insight orientated interventions, and of a more negative personal reaction to activation orientated treatment rationales.

The validity of the RFD has been examined via the association of its constituent subscales with related measures. For example, the Interpersonal Conflict subscale items have been analysed in association with other measures of marital satisfaction, and work and leisure functioning. The RFD subscales have also been analysed in association with measures of more general attributional style, that is, in relation to reason giving for events in other areas of the respondent's life. The validity data for the RFD also suggests that the subscales are distinct from current depression. Reliability analysis (Addis et al., 1995) supports the structure of the RFD with both non-depressed and depressed respondents.

AIM OF THE STUDY

The focus of the study presented here was an examination of these various dimensions in relation to self-reported depressive symptomatology among a group of non-referred New Zealand adolescents. These various strands (life events, self-concept, attributions and reason giving for depression) have not previously been evaluated together as part of a multidimensional pathway to depressed mood among adolescents. In particular, the data were used to address a number of specific hypotheses which were either developed to corroborate, or extend the results of the first study.

1. Higher levels of depressive symptomatology will be associated with negative self-conceptions (Fine et al., 1993; Orvaschel, Beeferman, & Kabacoff, 1997; Palosaari & Aro, 1995; Roberts & Monroe, 1994). This may be mediated by the experience of negative life events.
2. Higher levels of depressive symptomatology will be associated with higher levels of negative life events (Brown, 1993; Brown, Bifulco, & Harris, 1987).
3. A high incidence of negative life events will be significantly associated with poor self-concept, general attributional style, and reasons for depression which are non-agentic.
4. Lower levels of depressive symptomatology will be associated with external, unstable and specific attributions for bad events, and more internal, stable and

global attributional styles for good events (Gladstone & Kaslow, 1995; Johnson et al., 1998; Rodriguez & Pehi, 1998).

5. The specific attributions that respondents make for their depression will be associated with their more general attributional style. The nature of this association will be mediated by the respondents' self-concept (Edelman et al., 1994).

Finally, an attempt was made to explore how these various vulnerabilities and risk factors worked together to predict symptoms of depressed mood.

Because the RFD had not been used in New Zealand before, the first analysis looked solely at the reasons for depression given by adolescents to check its psychometric properties, and a second analysis looked at self-concept more closely in relation to the other psychometric measures.

METHOD

Participants

The data reported here were collected from a community sample of adolescents attending three urban high schools in a provincial New Zealand city. The three schools were each single gender schools (one male only, two female only). Each school had a role of approximately 90% New Zealand/European students, the remainder being predominantly New Zealand Maori and Pacific Island students. About 10% of the roll in each school was made up of boarders, these being fairly evenly spread across the school years (grades). Boarders were generally the sons/daughters of farming families from the surrounding rural area (dairy farming).

Three hundred and twenty six young people completed rating scales. Their mean age was 15.24 years (range 11 – 19 years, *SD* = 1.7 years). One hundred and thirty four participants were male (*M* = 15.93, range 13 – 18.8, *SD* = 1.54), and 192 were female (*M* = 14.74, range 11 – 19, *SD* = 1.64).

Participants completed the BDI-II (Beck et al., 1996) and other scales measuring self-concept, attributional style, reasons for depression and life events. Data from 34 of the participants who completed the BDI-II was removed because they were under the 13 year age threshold for the instrument; seven further BDI-IIs were invalid because of missing data.

Measures

Further details of the psychometric measures used are included within Appendix B, although a summary is provided below.

Beck Depression Inventory - 2nd Edition (Beck et al., 1996). Details of the use of this measure were given in the previous chapter (p. 35).

Tennessee Self-Concept Scale - 2nd Edition (Fitts & Warren, 1996). The Tennessee Self-Concept Scale - 2nd Edition. (TCSC:2) is an updated version of a widely used measure of self-concept in children, adolescents (13 – 19 years) and adults. The second edition has been shortened from the previous edition, but retains fifteen subscales grouped into the areas of self-concept (Physical, Moral, Personal, Family, Social, Academic/Work), summary scores (Total Self-Concept, Conflict),

supplementary scores (Identity, Satisfaction, Behaviour), and validity scores (Inconsistent Responding, Self-Criticism, Faking Good, Response Distribution). It is an 82 item self-report checklist that allows the respondent to report how they perceive themselves by responding to the items on a five-point continuum from *always false* to *always true*.

The TSCS:2 has been used in a wide range of adolescent research including studies of both physical and psychological disorders. However, while many of these studies have examined self-concept and depression as independent variables there is, surprisingly, no research directly examining the relationship between the TSCS:2 and depression in adolescents.

Reasons for Depression Questionnaire (Addis & Carpenter, 1999; Addis & Jacobson, 1996; Addis et al., 1995). The version of the Reasons for Depression Questionnaire (RFD) used was that available in published form (Addis et al., 1995), with the addition of four 'Biological' items as suggested by the primary author (M. Addis, personal communication, September 3, 1997; Addis & Carpenter, 1999). The Biological subscale includes items which relate to physiological explanations for depression, e.g., chemical imbalance, aspects of the central nervous system. It has a different focus from the physical subscale which presents reasons for depression which emphasize exercise, eating, activity levels, etc. The measure as used comprised 48 items, each of which proposed a possible reason for depression worded in such a way that it could complete the phrase "I am depressed because …". Participants were asked to rate whether or not each particular reason caused them to be depressed on a

four point Likert scale (1 = definitely not a reason, to 4 = definitely a reason). The instructions indicate that if the respondent did not consider that they were depressed they should think of a time in the past when they were, and answer the questions according to the reasons at that time. For those that did not consider themselves to have ever been depressed, they were instructed to think back to a time when they were "extremely sad for more than just a little while".

The RFD subscale scores for participants are interpreted on the same continuum as for the completion of the rating scale, i.e., 1 = definitely not a reason, 2 = probably not a reason, 3 = probably a reason, and 4 = definitely a reason.

Some minor changes were made to the wording of four items to make them more appropriate for use with adolescents. For example, the wording of item 47, *My partner doesn't understand me*, was changed to read *My boy/girlfriend doesn't understand me.*

Attributional Style Questionnaire (Peterson et al., 1982). The Attributional Style Questionnaire (ASQ) was developed as a measure of individual attributions for events. It has been widely used in studies of depression over a number of years, assessing respondents' attributions for twelve hypothetical events. The events are divided into good events (e.g., 'You become very rich'), and bad events (e.g., 'You go out on a date and it goes badly'). The respondents are asked to provide a cause or reason for each event, and then answer three questions about the cause of each event which relates to the dimensions of Internality (internal/external), Stability (stable/unstable), and Globality (global/specific). Attributions related to the three

dimensions are rated on a seven-point scale with the above descriptors denoting the extreme values.

The ASQ was used in this study because of its ready availability, and the wealth of published research studies reporting its various psychometric properties. Theory and research suggests that attributional style for bad events is generally more relevant to mood disorders, with internal, stable and global attributional style for bad events being associated with depression (Edelman et al., 1994; Gladstone & Kaslow, 1995; Johnson et al., 1998; Needles & Abramson, 1990; Seligman et al., 1984).

Rodriguez and Pehi (1998) utilised the Children's Attributional Style Questionnaire (CASQ) in their study of depression, anxiety and attributional style in children in New Zealand. However, the published version of the CASQ (Seligman et al., 1984) was evaluated for use with children (8-13 years), not adolescents. Rodriguez and Pehi also report that the Positive Total and Total Composite scores were significantly lower than those reported overseas, and interpreted this an indication that further research was needed to establish the validity of the CASQ with New Zealand children. They also report no data concerning any gender differences for their sample. Thus, there was no compelling reason to favour use of the CASQ over the ASQ for the present study.

Life Events (Impact) Scale (Adams & Adams, 1991). The life event scale selected for use in this study was a short 13-item scale developed by Adams and Adams (1991) for their study on problem solving in adolescents. The emphasis of this scale is on the impact of a small number of events, rather than on a wide range of

events. Despite being developed for use in the United States of America, there appears to be a degree of overlap in these items with the sources of distress identified by adolescents in New Zealand as part of the Dunedin Multidisciplinary Health and Development Study (McGee & Stanton, 1992). McGee and Stanton found that issues of health/illness, changing school, moving house, family arguments, and parental separation were all rated as distressing by adolescents in their longitudinal study of young people in New Zealand; these issues are all represented on the Adams and Adams measure.

Respondents are required to rate 13 events according to the degree to which each has had a negative impact on their lives. Responses are made on a 5-point scale from *not at all* (0) to *a great deal* (4). This yields a total score range from 0 – 54.

Procedure

The study proposal was reviewed and approved by my local Regional Ethics Committee, and the Human Subjects Review Committee, School of Psychology, University of Waikato.

A passive consent procedure was adopted whereby parents/caregivers were provided with information about the research programme and were asked to contact me and/or indicate their preference to their son/daughter if they did not wish them to participate. This approach is consistent with the procedures outlined by Ellickson and Hawes (1989) and Hollman and McNamara (1999) in relation to passive parental consent. These procedures were deemed appropriate given the nature of the scales

being completed, the school context within which the research was being undertaken, the ensured anonymity of the participants, the ease with which students could opt-out of rating scale completion, and the ready availability of ongoing support from both within and outside the school system. As with active consent procedures, the students retained the right to decline participation themselves.

School principals and guidance counsellors were asked to nominate one class group within each year/grade for inclusion in the study. A brief summary of the purpose of the study was sent home to the parents/caregivers of all those in the nominated classes. At the time of data collection the class groups was reminded of the general purpose of the research project, which was to increase our understanding of depression in adolescents by gathering information from a community sample of non-referred individuals. Additional written information about the project was included at the start of the assessment pack. Participants were reminded that completion of any or all of the items in the assessment pack was voluntary, and that they could discontinue at any point. They were also informed verbally and in writing of the possible sources of support should they experience any adverse reaction associated with completing the questionnaires and rating scales. No personally identifying information was collected about the participants. Participants filled in the instruments as a package of psychometric measures completed in class time, in groups of up to 30 students. Completion of all the measures in the assessment pack took approximately one hour, this generally taking place within either an English or Social Studies period. Participants were given the choice to opt out by completing a puzzle page that was included with the questionnaire pack. In fact all students returned the questionnaires

with most or all of the rating scales completed. Participants were given a small gratuity (a $2 tuck shop voucher) after completion of the rating scales irrespective of the amount they had completed. They were not informed that they would be given the voucher prior to completion of the rating scales.

Copies of the information sheet and letters used in this study are included in Appendix B.

RESULTS

I. Analysis of the Reasons For Depression Questionnaire with Adolescents. [3]

The data were initially analysed using the factor structure suggested by the original authors. That is, the responses were organized according to the nine factor (subscale) model comprising the eight factors as indicated by Addis et al. (1995) and the additional Biological factor. A listwise deletion method was used where data were missing in order to maintain the integrity of the analysis. This meant that for some of the subscales the number of respondents reported dropped below the original 326 participants. Table 3.1 shows the number of items and maximum score for each subscale, number of respondents, mean and standard deviation for each subscale, mean and standard deviation for items within each subscale, and internal consistency coefficient (alpha) for each of the subscales. Mean subscale scores were derived by

[3] A version of this analysis was presented at the 2001 Annual Conference of the New Zealand Psychological Society, Auckland and is currently *in press* with the *Journal of Clinical Psychology*.

Table 3.1

Descriptive Statistics for Original RFD Factors

Subscale	Items [max. score]	*n*	Subscale *M*	Subscale *SD*	Item *M*	Item *SD*	Alpha coefficient
Characterological	10 [40]	319 (602)	17.16 (15.9)	7.66 (5.8)	1.72	0.77	.83 (.86)
Achievement	6 [24]	320 (602)	12.68 (14.5)	4.47 (4.8)	2.11	0.35	.85 (.85)
Interpersonal Conflict	6 [24]	320 (602)	11.93 (9.8)	7.67 (3.9)	1.99	1.28	.89 (.85)
Intimacy	5 [20]	320 (602)	10.37 (10.4)	3.96 (3.9)	2.07	0.79	.80 (.79)
Existential	5 [20]	318 (602)	9.69 (8.7)	4.26 (3.3)	1.94	0.85	.74 (.78)
Childhood	5 [20]	320 (602)	8.15 (7.8)	3.91 (3.4)	1.63	0.78	.88 (.84)
Physical	4 [16]	320 (602)	6.98 (7.1)	2.92 (2.8)	1.75	0.73	.81 (.79)
Relationship	3 [12]	315 (602)	4.63 (4.3)	2.57 (2.2)	1.54	0.86	.85 (.82)
Biological	4 [16]	319	5.55	2.23	1.39	0.56	.78

Note. The figures in parentheses are those reported by Addis et al. (1995) for their undergraduate sample. The Biological factor has been included although no comparative data from the original study are available.

summing the items on each subscale for each individual and then averaging these. These scores are included here to allow comparison with the original RFD study. The mean subscale scores were then divided by the number of items in each subscale to calculate mean item scores within each sub-scale. Unlike the mean subscale scores which vary according the number of items in each subscale, the mean item scores are

standardized to allow comparison between subscales. Mean item scores all fell within the range 1 – 4, and are quoted in all subsequent analyses.

A total of 285 complete and valid BDI-II forms were returned (M = 10.6, SD = 7.9). The descriptive statistics show that while this sample did not, on average, report levels of symptomatology associated with clinical depression, there were a number of participants who did report elevated levels of depression. Twenty eight participants (10%) indicated they were experiencing symptomatology consistent with *moderate* depression (BDI-II between 20 - 28), 10 (4%) reported experiencing *severe* symptoms (BDI-II over 29). These widely used threshold scores were obtained from the BDI-II technical manual (Beck et al., 1996).

A t-test comparing the means of the two gender groups (male, n = 133; female, n = 152) showed that there was no significant difference between their BDI-II scores ($t(283) = -1.248$, $p = .213$). Generation of Pearson's product- moment correlation coefficients showed that there was no statistically significant association between scores recorded on the BDI-II and the age of the respondents for the sample as a whole ($n = 285$, $r = -0.029$, $p = .63$), or for either males ($n = 133$, $r = -0.149$, $p = .087$) or females ($n = 152$, $r = 0.131$, $p = .109$) when analyzed separately. These results are a little surprising as Burke, Burke, Regier, and Rae (1991) and others, have found that later adolescence (15 – 19 years of age) is associated with a significant increase in the onset of depression, particularly for females. The non-significant association reported here may result from the relatively small number of participants reporting clinical levels of symptomatology.

Table 3.2 displays Pearson's product-moment correlations coefficients between the BDI-II and the RFD subscales, which were significant for all nine subscales. This shows that higher rates of reported depressive symptomatology were associated with the identification of a greater number of reasons for depression and/or higher rating on the reasons identified as compared with those not reporting high levels of symptomatology. The highest correlations were found between the Intimacy, Childhood, and Relationship subscales, with the lowest correlations being between RFD subscales and the BDI-II. This latter finding is appropriate as the RFD is not intended to be a screening device for depression.

Correlation analyses were conducted for each gender separately, but are not detailed here as there was little difference between the two groups.

To explore the finding that different rates of reported symptomatology were associated with different item scores on the RFD, I compared the RFD data for those who reported *moderate/severe* depressive symptomatology, that is, a BDI-II >19 (n = 36, 15 males and 21 females) with that of a similar number of participants who reported the lowest BDI-II scores, BDI-II < 3 (n = 28, 13 males and 15 females). Two of the 38 participants who reported *moderate/severe* depressive symptomatology were excluded from the analysis as they did not return useable RFD questionnaires. Table 3.3 shows the results of this analysis.

The two groups recorded significantly different mean item scores on all scales with the exception of the Relationship and Biological subscales, possibly a testament to the pervasiveness of these dimensions in the lives of adolescents.

Table 3.2

RFD Subscale Correlations with BDI-II, and Inter-correlations

Subscale	BDI-II	EXI	CHAR	IC	INT	ACH	CHI	REL	PHY
Existential (EXI)	.32								
Characterological (CHAR)	.32	.37							
Interpersonal Conflict (IC)	.17	.28	.26						
Intimacy (INT)	.45	.47	.39	.49					
Achievement (ACH)	.41	.57	.41	.33	.59				
Childhood (CHI)	.28	.36	.33	.42	.63	.44			
Relationship (REL)	.16	.29	.27	.43	.59	.34	.67		
Physical (PHY)	.36	.38	.34	.27	.48	.56	.42	.36	
Biological (BIO)	.19	.33	.43	.30	.45	.43	.59	.49	.46

Note. All correlations, $p < .01$

Table 3.3

RFD Subscale Correlations with High/Low BDI-II Score Groups

	High BDI-II $n = 36$		Low BDI-II $n = 28$		
Subscale	*M*	*SD*	*M*	*SD*	*t*
Characterological	2.04	0.54	1.36	0.40	5.651 **
Achievement	2.60	0.68	1.68	0.68	5.319 **
Interpersonal Conflict	2.28	0.77	1.80	0.72	2.625 *
Intimacy	2.78	0.78	1.74	0.80	5.237 **
Existential	2.32	0.86	1.62	0.66	3.630 *
Childhood	2.12	0.88	1.44	0.78	3.221 *
Physical	2.28	0.90	1.43	0.55	4.408 **
Relationship	1.83	0.97	1.53	0.90	1.311
Biological	1.55	0.60	1.40	0.68	0.980

Note. * $p < .01$, ** $p < .001$, two-tailed test

Despite encouraging results from the analysis based on the original factors it was decided to conduct a further factor analysis of the current data to explore the possibility that a different factor structure existed for our adolescent sample. All 48 items were subjected to a principal component factor analysis to assess the underlying factor structure. All cases were included although the listwise deletion option was used where data were missing. Eight factors produced eigen values greater than 1.0, accounting for 61.8% of the variance. Indeed, the first factor returned an eigen value of 16.96, and accounted for 35.3% of the total variance. Closer inspection of these results showed that the two factors that had the lowest eigen values contained few

items and had significant cross-loadings with other factors which made the results difficult to interpret. For this reason it was decided to conduct a second factor analysis using all 48 items with a specified six factor solution, and rotate the matrix to a Varimax solution. It was also specified that loadings less than 0.5 should not be reported. This six factor solution accounted for 56.9% of the variance, with the first factor accounting for 35.3% of the variance. It also resulted in the exclusion of 12 items which did not load above the more stringent 0.5 threshold on any of the factors. These items were predominantly from the original Intimacy and Existential subscales, and were distributed across five of the six factors at loadings between 0.3 – 0.5 under the revised factor analysis presented here. Table 3.4 shows the number of items, number of respondents, mean item score and standard deviation, internal consistency coefficient (alpha), and percentage of variance accounted for by each of the revised subscales.

The revised six factor structure remained fairly faithful to that of the original factor structure, although the Childhood and Relationship subscales combined to form a single Relationship factor, and the Intimacy and Existential subscales disappeared. The first factor (Relationship, 8 items) consisted largely of items that emphasized various aspects of relationships, both past and present. It included all of the items from the original Relationship subscale, all but one of the items from the Childhood subscale, plus one additional item. The extra item that was included ("I don't feel loved") appeared to be consistent with the general theme of the subscale. There was a second item which loaded on this factor ("I have a chemical imbalance"). However, despite its loading (0.575) it seems entirely incongruous with the other

Table 3.4

Descriptive Statistics for Revised RFD Factors

Subscale	Items	*n*	*M*	*SD*	Alpha coefficient	%Variance
Relationship	8	311	1.59	0.76	.91	35.3
Achievement	6	320	2.08	0.73	.84	7.1
Interpersonal Conflict	6	320	1.93	0.80	.89	4.4
Characterological	5	318	2.02	0.70	.77	3.7
Biological	6	315	1.40	0.53	.83	3.6
Physical	4	319	1.73	0.73	.81	2.8

items and was therefore excluded from subsequent analysis on theoretical grounds. The second factor (Achievement, 6 items) contained five items from the original Achievement subscale, and one item from the Existential subscale ("I can't decide what to do with my life"). Factor three (Interpersonal Conflict, 6 items) contained all the items from the original scale of the same name and no additional items. Factor four (Characterological, 5 items) was made up of four Characterological items, plus one item from the Intimacy scale ("No one really understands me"). The fifth factor (Biological, 6 items) consisted of three of the original Biological items, and three from the Characterological scale ("I inherited it from my parents", "I have always been this way" and "This is the way I've learned to be"). The first two of these appear to fit with the overall theme of this subscale. The third item is congruent if it is read as being a response to a developmental imperative. While this link is a little tenuous it was considered sufficient to merit retention of this item for theoretical reasons. The

sixth and final factor (Physical, 4 items) contained the four items from the original Physical scale. Table 3.5 shows the structure of the six factor solution, along with a list of the 13 items that were removed.

With the six factor solution there was also a direct correlation between subscale and BDI-II scores (Table 3.6). The reordering of the subscales resulted in a slight increase in the correlation coefficients in some theoretically related areas (Characterological, Relationships, and Interpersonal Conflict).

Analysis comparing participants with high and low reported levels of depressive symptomatology yielded significantly different mean scores on all but the Biology subscale of the revised RFD (Table 3.7). This indicates that, as with the original RFD, participants with higher levels of self-reported depressive symptomatology gave a wider range of reasons for their depression and/or rated these reasons as being more significant in explaining their depression.

It is of interest that despite the significant differences reported between the 'high' and 'low' depression groups, neither group strongly supported any of the subscales areas as providing *definite* reasons for depression. The mean subscale scores for the 'low' symptom group were all in the 1.09 - 1.73 range which indicates that the reasons associated with the respective subscales were generally not seen as being reasons for depression. For the 'high' symptom group the mean subscale scores ranged from 1.57 to 2.56, with four mean scores in the range 2.00 - 2.99. This suggests that members of the 'high' symptom group were more willing/able to identify items which were *probably* reasons for their depression. This trend is consistent with the previous analysis reported in this chapter using the original RFD factor structure, and is consistent with the data reported by Addis et al. (1995).

Table 3.5

Revised RFD Items, Revised Factors, Percentage of Variance, and Internal Consistency Coefficients

Factor	% Variance	Alpha coefficient	Factor loading	Original subscale
I am depressed because....				
1. Relationship	**35.3**	**.91**		
My family treated me poorly as a child			.809	CHI
Of certain things that happened to me as a child			.807	CHI
I haven't worked through things that happened to me as a child			.784	CHI
I had a difficult childhood			.754	CHI
My boy/girlfriend treats me poorly			.702	REL
My boy/girlfriend doesn't understand me			.616	REL
I'm stuck in a bad love relationship			.594	REL
I don't feel loved			.533	INT
2. Achievement	**7.1**	**.84**		
I've failed to achieve a specific goal I set for myself			.718	ACH
I am not fulfilling my potential			.694	ACH
I can't decide what to do with my life			.661	EXI
I'm not living up to my personal standards			.628	ACH
I can't get done the things I should be able to			.611	ACH
I have not become the person I set out to be			.553	ACH
3. Interpersonal Conflict	**4.4**	**.89**		
Other people criticize me			.742	CON
Other people don't like me			.721	CON
People treat me poorly			.669	CON
Other people isolate me			.624	CON
I can't make friends			.622	CON
People don't give me the respect I deserve			.549	CON
4. Characterological	**3.7**	**.77**		
I think about things in a depressing way			.632	CHA
I see the world the way it really is			.600	CHA
No one really understands me			.548	INT
This is the way I respond when things get tough			.523	CHA
I pay more attention to the bad things in my life than the good things			.518	CHA

5. Biological	**3.6**	**.83**		
My nervous system is just wired this way			.701	BIO
I inherited it from my parents			.679	CHA
This is the way I've learned to be			.619	CHA
I have always been this way			.614	CHA
It's basically caused by genetics			.588	BIO
It's a biological illness			.538	BIO
6. Physical	**2.8**	**.81**		
I don't get enough exercise			.761	PHY
I'm not active enough			.755	PHY
I don't take care of myself physically			.741	PHY
I don't eat well enough			.524	PHY

Items excluded following factor analysis

I have a chemical imbalance * (1)	.575	BIO
I haven't resolved some issues with my family (1)	.452	CHI
I have set no specific goals in my life (2)	.450	EXI
I'm not good at expressing my innermost feelings (2)	.433	INT
I can't accomplish what I want to (2)	.425	ACH
I haven't done anything important in my life (2)	.409	EXI
No one really cares about me (3)	.490	INT
I don't know who I am or what I stand for (4)	.459	EXI
I am a pessimist (always think the worst) (4)	.453	CHA
I'm stuck where I am in life, nothing ever changes (4)	.411	EXI
There is no one to share my innermost thoughts and feelings with (4)	.384	INT
That's just the type of person I am (5)	.415	CHA
I choose to be depressed (5)	.413	CHA

Notes. Codes indicate which subscale the item was placed in under the original nine factor structure (CHA – Characterological; ACH – Achievement; CON – Interpersonal Conflict; INT – Intimacy; EXI – Existential; CHI – Childhood; PHY – Physical; REL – Relationship; BIO – Biological).
* indicates item excluded on theoretical grounds.
Numbers in parentheses refer to the revised factors onto which the items had their primary loading.

Table 3.6

Revised RFD Subscale Correlations with the BDI-II, and Inter-correlations

Subscale	BDI-II	REL	ACH	IC	CHAR	BIO
Relationship (REL)	.24					
Achievement (ACH)	.36	.43				
Interpersonal Conflict (IC)	.26	.67	.45			
Characterological (CHAR)	.49	.50	.60	.59		
Biological (BIO)	.19	.51	.49	.50	.50	
Physical (PHY)	.33	.45	.52	.45	.50	.44

Note. All correlations, $p < .01$

Table 3.7

Revised RFD Subscale Correlations with High/Low BDI-II Score Groups

	High BDI-II $n = 36$		Low BDI-II $n = 41$		
Subscale	*M*	*SD*	*M*	*SD*	*t*
Relationship	2.00	0.83	1.44	0.81	2.792 *
Achievement	1.68	0.49	1.09	0.43	5.141 **
Interpersonal Conflict	2.30	0.78	1.73	0.72	3.002 *
Characterological	2.56	0.74	1.52	0.44	7.123 **
Biological	1.57	0.62	1.32	0.58	1.760
Physical	2.23	0.92	1.40	0.54	4.589 **

Note. * $p < .01$, ** $p < .001$, two-tailed test

Comments on the results of the RFD analysis

Some evidence was found to support the original factor structure of the RFD in its use with a sample of non-referred New Zealand adolescents. Descriptive statistics, measures of internal reliability and factor analytic examination point to a degree of cross-cultural stability in this measure. However, there was some reordering of the factors and items which suggests that relational reasons were of greater salience for youth in explaining depression than the characterological and physical based reasons associated with the original RFD when used with adults. This is certainly consistent with the developmental tasks of adolescence, including the development of personal and social identity (Garrod et al., 1999; Hoberman et al., 1996; Kazdin, 1993; Kroger, 1996), and is consistent with the findings from the first study.

Review of the factors via a further analysis revealed a more coherent six factor structure for the RFD when used with adolescents (hereafter referred to as the RFD-A, included in Appendix C), with much less re-ordering of items than when the original nine factor solution was applied. Two of the original factors were amalgamated (Relationship and Childhood) to form an 'enhanced' Relationship factor. This outcome was supported by the high correlation between these two relationship focussed subscales within the nine factor solution. This would appear to confirm the importance of this factor for adolescents, but also indicates the difficulty that younger respondents had in distinguishing between items of the three original relationship orientated subscales (Relationship, Childhood, Intimacy). The revised Relationship factor accounted for the largest single part of the variance, supporting

the relative significance of this dimension for youth in relation to affective functioning. Two of the original factors, each with a more diffuse focus (Intimacy and Existential) did not appear in the revised structure as separate subscales. One item from the Intimacy subscale became attached to the Relationship scale, the others, e.g., "No one really understands me", joined items from the Existential subscale, e.g., "I don't know who I am or what I stand for" in the group of items that participants seemed to find too hard to respond to with any consistency. The demands of adolescent identity/self-concept enhancement are likely to place such questions at the heart of this stage of development (Erikson, 1968, 1974), they are seen as central to the normal adolescent experience rather than being reasons for depression. It may be that for adults who complete the RFD, failure to resolve these issues during adolescence will have more significance as a reason for depression.

One result of the revised factor analysis, and the more stringent cross-loading criteria, was the production of an abbreviated version of the RFD that is both theoretically consistent with the tasks of adolescent development, and of enhanced clinical utility by virtue of its length, only 35 questions. All revised subscales had acceptable internal reliability scores, and significant inter-correlations. While this may indicate a degree of overlap in the subscales, the factor analysis indicates that the six subscales can be clearly distinguished from each other. There was a significant correlation between the RFD-A and the BDI-II although this was generally less than for the RFD-A internal correlations.

It is anticipated that the RFD-A, like the original RFD, may have utility in assisting practitioners to make quicker and more accurate allocations of clients to

different therapeutic programs. While the research has not yet been completed with adolescents there have been favourable results in this area reported with adults (Addis & Carpenter, 1999). The RFD-A and the original scale may also prove to have some use in assisting with ongoing therapeutic monitoring by allowing certain cognitive distortions about reasons for depression to be re-examined during the course of treatment. This has not been empirically tested and a first step would be to explore the test-retest validity of this instrument with a clinical sample. However, if a greater understanding can be obtained of why individuals believe themselves to be depressed these issues may be open to more direct and focussed attention in therapy.

For the purposes of reporting results based on the full data set from this survey study it appears that the RFD-A does possess adequate psychometric properties for use with adolescents, and therefore its use in preference to the original RFD seems justified.

II. Analysis of Correlates of Adolescent Depression. [4]

The first analysis reported on revisions to the RFD for use with adolescents within New Zealand. Although the original form of the RFD was administered, the data reported as part of this second analysis relates to the 35 items which constitute the shortened version of the measure (RFD-A, Fitzgerald & Richardson, *in press*).

[4] A version of this section was presented at the 2nd Child & Adolescent Mental Health Services Conference, Auckland, New Zealand in 2000 under the title "Correlates of Adolescent Depression: Attributions, Self-Concept, Life Events, and Reasons for Depression".

A descriptive summary of the results for the five individual measures is presented followed by a more detailed examination of interactions between instruments.

Individual Measures

Beck Depression Inventory (2nd ed.). As reported previously 285 valid BDI-II forms were returned (87% of sample). The mean score was 10.6 (*no/minimal* symptoms of depression), with a standard deviation of 7.94 and a range of 0 – 44 (*no* to *severe* symptoms of depression). The threshold scores were obtained from the measure's technical manual.

One hundred and thirty three males completed the BDI-II ($M = 10$, $SD = 7.61$, range 0 – 37) which accounted for 47% of those who completed this rating scale. Twelve males (9%) scored in the *moderate* symptom range, and four (3%) in the *severe* symptom range. One hundred and fifty two females (53%) completed the BDI-II ($M = 11$, $SD = 8.21$, range 0 – 44). Sixteen females (11%) scored in the *moderate* range, and six (4%) in the *severe* range. A t-test comparing the means of the two gender groups showed that there was no significant difference between their mean BDI-II scores, $t\ (283) = -1.48$, $p = .23$. There were no significant correlations between BDI-II scores and age for the sample as a whole, $r = -.03$, $p = .63$, or for the gender groups separately (males, $r = -.15$, $p = .09$; females, $r = .13$, $p = .11$).

Tennessee Self-Concept Scale (2nd ed.). The TSCS:2 has four validity scales designed to identify "defensive, guarded, socially desirable, or other unusual or

distorted response patterns" (Fitts & Warren, 1996, p.15). Scores outside predefined thresholds on these scales bring into question the overall reliability of the respondents' ratings on all scales of the measure. In a clinical setting these scores would be explored within the clinical interview, in this study they were used as a criteria for the removal of TSCS:2 data from further analysis.

Two hundred and seventy nine completed TSCS:2 forms were returned, 122 males (44%) and 157 females (56%). When forms deemed to be 'invalid' by virtue of extreme scores on the validity scales were removed, 209 completed scripts remained (75% of the original respondents to the TSCS:2), of which 91 (44%) were from males and 118 (56%) were from females.

Table 3.8 shows the summary statistics for the sample as a whole, male and female sub-groups, and the comparison of means between the two gender groups.

Male respondents generally recorded higher mean normalized T-scores across most response areas, with the exception of the Moral, Social and Achievement/Work Self-Concept scales and the Inconsistent Responding validity scale. Males were significantly more positive than females in Physical Self- Concept (their view of their body, state of health, physical appearance, skills, and sexuality), and Family Self-Concept (their feelings of adequacy, worth, and value as a family member). Females were significantly more positive in their Moral Self-Concept (their view of themselves from a moral-ethical perspective: sense of moral worth, feelings of being a "good" or "bad" person). Males were more likely than females to 'fake good', but were less prone to inconsistent patterns of responding on this measure.

Table 3.8

Tennessee Self-Concept Scales – 2nd Edition Means (Normalized T-Scores) and Standard Deviations for the Sample and Gender Group, and Gender Comparison

Area		Scale	Sample		Male		Female			
			M	*SD*	*M*	*SD*	*M*	*SD*	*t*	
Self-Concept	1.	Physical	44.91	10.51	46.82	9.63	43.44	10.95	2.32	*
	2.	Moral	46.63	9.68	44.62	9.02	48.18	9.92	-2.68	**
	3.	Personal	46.20	9.47	46.74	8.08	45.78	10.43	0.75	
	4.	Family	48.41	10.66	50.53	8.85	46.77	11.63	2.64	**
	5.	Social	48.10	10.53	46.75	10.37	49.14	10.58	-1.64	
	6.	Academic/Work	45.82	10.01	45.11	10.81	46.37	9.35	-0.90	
Supplementary	7.	Identity	45.19	9.94	46.52	9.05	44.18	10.49	1.69	
	8.	Satisfaction	47.03	9.20	47.36	7.83	46.78	10.17	0.47	
	9.	Behaviour	46.32	10.38	46.57	9.25	46.14	11.20	0.30	
Validity	10.	Inconsistent Responding	51.29	8.45	49.98	8.15	52.31	8.58	-1.99	*
	11.	Self-Criticism	52.12	6.21	52.33	6.32	51.96	6.15	0.43	
	12.	Faking Good	45.02	10.16	47.32	9.63	43.25	10.24	2.92	**
	13.	Response Distribution	44.47	10.10	44.51	10.18	44.44	10.08	0.05	
Summary	14.	Conflict	49.59	8.85	49.89	8.82	49.36	8.90	0.43	
	15.	**Total Self-Concept**	**45.64**	**10.19**	**46.03**	**8.68**	**45.34**	**11.22**	**0.50**	

Note. * $p < .05$, ** $p < .01$, two-tailed.

There was no difference between males and females on the Total Self-Concept scale which is the summary score reflecting the individual's overall self-concept, $t(205) = 0.50$, $p = .62$. This result held when an additional analysis was conducted using only data from participants aged 15 years and over (64 males, 69 females).

Reasons for Depression Questionnaire – Adolescent version (Fitzgerald & Richardson, in press). The mean subscale item scores for each of the six subscales are reported in Table 3.9 for the sample as a whole, and by gender. These reflect the average score for items in each subscale. Scores fall within the range 0 – 4. These data indicate that males were generally less likely than females to attribute depression to reasons identified within the RFD-A. This difference was statistically significant on four of the six subscales. Both males and females attributed depression primarily to problems with achievement e.g., I am depressed because .... *I've failed to achieve a specific goal I set for myself,* or *I am not fulfilling my potential.* Issues related to characterological factors, innate predisposition or personality, were also cited as being among the leading reason for depression e.g., I am depressed because .... *I think about things in a depressing way*, or *No one really understands me.* Both these categories were more often endorsed by females than males.

The RFD-A includes two additional questions, "Have you ever been depressed?" and "Are you reporting on a current or past experience of depression?". Three hundred and twelve students responded to the first question, 229 (73%) indicating that they either were depressed or had been depressed at some time. Of the 129 males who responded (41% of those responding to this question), 93 (72%)

Table 3.9

Reasons for Depression Questionnaire – Adolescent Version Subscale Item Means and Standard Deviations for the Sample and Gender Groups, and t-Test Values for Gender Comparison

	Sample		**Male**		**Female**		
Subscale	*M*	*SD*	*M*	*SD*	*M*	*SD*	*t*
Relationship	1.59	0.76	1.39	0.60	1.70	0.83	-3.92 **
Achievement	2.08	0.73	2.02	0.72	2.10	0.77	-1.02
Interpersonal Conflict	1.93	0.80	1.77	0.69	2.05	0.86	-3.19 **
Characterological	2.02	0.70	1.86	0.65	2.10	0.74	-3.12 **
Biological	1.40	0.53	1.37	0.52	1.45	0.53	-1.69
Physical	1.73	0.73	1.57	0.67	1.84	0.75	-3.34 **

Note. * $p < .05$, ** $p < .01$, two-tailed.

indicated that they either were depressed or had been depressed. Of the 183 females who responded (59% of respondents), 136 (74%) indicated that they were or had been depressed. With over 70% of respondents indicating a past or present experience of depression it is clear that, in the absence of any special considerations, the present sample of young people were extending their reporting of depression to include a wide range of experiences of low mood.

The second question asks whether respondents completed the RFD-A questionnaire with either a current or past episode of depression in mind. Two hundred and eighty five students gave useable responses to this question. Of this group 69 (24%) stated that they were referring to a current experience of depression. This group included 21 males and 48 females, and returned a mean BDI-II score of

15.7 (*SD* = 9.41). For those reporting on a past experience of depression the mean BDI-II score was 9.1 (*SD* = 6.70). Analysis of these mean scores revealed a statistically significant difference between the two groups with the 'current episode' group recording a mean BDI-II score about 7 points higher than the 'past episode' group, $t\ (80) = 5.10, p < .01$. This suggests that there was a fair degree of accuracy in self-reported depression among the group, with self-reported status being reflected in the BDI-II scores.

Attributional Style Questionnaire. Two hundred and seventy two completed ASQs were returned. Of these 112 (41%) were completed by males and 160 (59%) by females. Table 3.10 presents data for both the event areas (good and bad) for the group as a whole, and males and females separately. The scoring range is 0—7 for all event and domain areas. A comparison of the mean scores for male and female respondents is also provided.

When scoring for 'bad' events, low scores are preferable. This indicates that uncontrollable bad events are being attributed to external, unstable (changing) and specific (circumscribed) factors. Conversely, when scoring for 'good' events, high scores are more favourable. This indicates that good events are being attributed to internal, stable and global factors.

Males returned higher mean scores for all dimension and composite scores, although this difference was only significant on two dimensions (the Globality dimension in relation to both good and bad events), and the composite for bad events. These results suggest that the males were significantly more likely than the females to

Table 3.10

Attributional Style Questionnaire Means and Standard Deviations, by Gender

Event/Domain		Group *M*	Group *SD*	Male *M*	Male *SD*	Female *M*	Female *SD*	*t*
Good	Internality	5.11	0.98	5.19	0.99	5.05	0.96	1.18
	Stability	5.08	0.88	5.17	0.91	5.01	0.86	1.47
	Globality	4.78	0.94	4.93	0.93	4.67	0.93	2.32 *
	Composite	**4.99**	**0.78**	**5.10**	**0.79**	**4.92**	**0.77**	**1.84**
Bad	Internality	4.46	1.05	4.51	1.12	4.38	0.99	0.98
	Stability	4.62	0.91	4.66	0.92	4.59	0.91	0.61
	Globality	4.30	1.09	4.48	0.94	4.18	1.17	2.30 *
	Composite	**4.47**	**0.80**	**4.59**	**0.77**	**4.39**	**0.82**	**2.04 ***

Note. * $p<.05$, two-tailed.

make global rather than specific attributions for the causes of both good and bad events. That is, they were more likely to see the causes of events as transcending those events and being generally applicable, rather than being specific to particular circumscribed situations.

Attributing uncontrollable bad events to internal, stable and global factors is considered to be a risk factor for depression under the reformulated learned helplessness model of depression (Abramson et al., 1978). This profile was more strongly associated with the males in this sample. However, males also returned higher, more adaptive, scores on the ASQ for good events. The finding that males

returned more depressive-type attributional profiles is consistent with the higher than expected BDI-II scores for males compared to females in this sample, i.e., similar levels of depressive symptomatology reported by the two gender groups.

Life Events (Impact) Scale. All the participants completed the Life Events Scale. The mean total life event score was 17 (SD = 12.81, range 0 – 47) for males and 20 (SD = 14.15, range 0 – 49) for female respondents. The score range for this scale is 0 – 52, i.e., 13 items each scored on a 4-point scale. The difference between the mean scores for males and females was not statistically significant, $t(306) = -1.82$, $p = .07$. There was no significant association between mean total life events scores and age, $r = .08$, $p = .14$. A summary of participant's responses to each individual item is given in Table 3.11.

The items rated as having the most negative impact for the sample as a whole were *death of a family member or friend*, *failure of a test or course*, and *fighting/arguments within the family.* These items were rated highly by both gender groups, although males also rated *divorce/separation of parents* as being important. Females rated most of the life event items higher than males, the exceptions being *getting into trouble with law* and *breaking up with boy/girlfriend.* The differences between the gender groups were statistically significant on four items. These results indicate that the females in this sample perceived there to have been a greater negative impact resulting from the life events that they had experienced.

Table 3.11

Life Events Scale: Mean, Standard Deviations and Comparison t-Test Values for Ratings of Negative Effects for Each Life Event, for Whole Sample and Gender Groups

		Sample		Males		Females		
	Life event	*M*	*SD*	*M*	*SD*	*M*	*SD*	*t*
1.	Divorce/separation of parents	1.68	1.65	1.64	1.70	1.71	1.62	-0.40
2.	Alcoholism/drug abuse in family	1.27	1.59	1.12	1.52	1.39	1.64	-1.51
3.	Illness/injury to family member	1.57	1.36	1.44	1.36	1.67	1.36	-1.48
4.	Death of family member or friend	2.24	1.68	2.15	1.64	2.30	1.70	-0.83
5.	Fighting/arguments within family	1.75	1.30	1.44	1.29	1.97	1.27	-3.64 **
6.	Abuse by family member	1.50	1.73	1.39	1.68	1.58	1.77	-0.97
7.	Unemployment of family member	1.00	1.26	0.82	1.18	1.13	1.30	-2.20 *
8.	Move to a new neighbourhood	0.86	1.23	0.56	0.94	1.07	1.35	-4.03 **
9.	Starting at a new school	1.07	1.34	0.90	1.21	1.20	1.42	-2.07 *
10.	Breaking up with boy/ girlfriend	1.41	1.41	1.44	1.39	1.39	1.44	0.29
11.	Failing a test or course	1.79	1.27	1.76	1.34	1.80	1.23	-0.25
12.	Getting into trouble with law	1.45	1.56	1.49	1.53	1.42	1.58	0.42
13.	Personal illness/injury	1.43	1.35	1.32	1.29	1.51	1.40	-1.21

Note. * $p < .05$, ** $p < .01$, two-tailed.

Interactions

There were a large number of possible associations between the scales and their component sub-scales that were of interest. However, consideration here is limited to those interactions associated with the five hypotheses outlined at the start of the chapter. For each hypothesis a main analysis is reported which addresses the hypothesis as stated. Supplementary analyses are then reported which further clarify aspects of the main analysis, or extend it. Finally, an analysis is presented which combines all the measures used in an overall analysis of their relative contributions to the predication of adolescent depression as reported by the BDI-II.

1. Depressive symptomatology and self-concept

Hypothesis. Higher levels of depressive symptomatology will be associated with negative self-conceptions. This may be mediated by the experience of negative life events.

Main Analysis. Within the current data set the Total Self-Concept score from the TSCS:2 was used as an analogue for self-concept. The authors of this measure refer to the Total Self-Concept score as "... the single most important score on the TSCS:2. It reflects the individual's overall self-concept and associated level of self-esteem" (Fitts & Warren, 1996, p. 21).

Two hundred and sixty three Total Self-Concept scores were available for adolescents aged 13 years and over. This is somewhat lower than the number of questionnaires returned because of incomplete responses. Once cases were excluded because of scores above/below thresholds on the four Validity Scales, only 202 cases remained (89 males, 113 females).

All valid BDI-II and Total Self-Concept scores were subjected to correlation analysis. A scatterplot was obtained for the two sets of data which demonstrated the generally linear relationship between them (see Figure 3.1). The scores clustered uniformly around the regression line indicating that the assumptions of linearity and homoscedasticity were not violated. A statistically significant negative result was returned, $r = -.66, p < .001$, indicating that higher self-reported levels of depressive symptomatology were associated with lower Total Self-Concept scores.

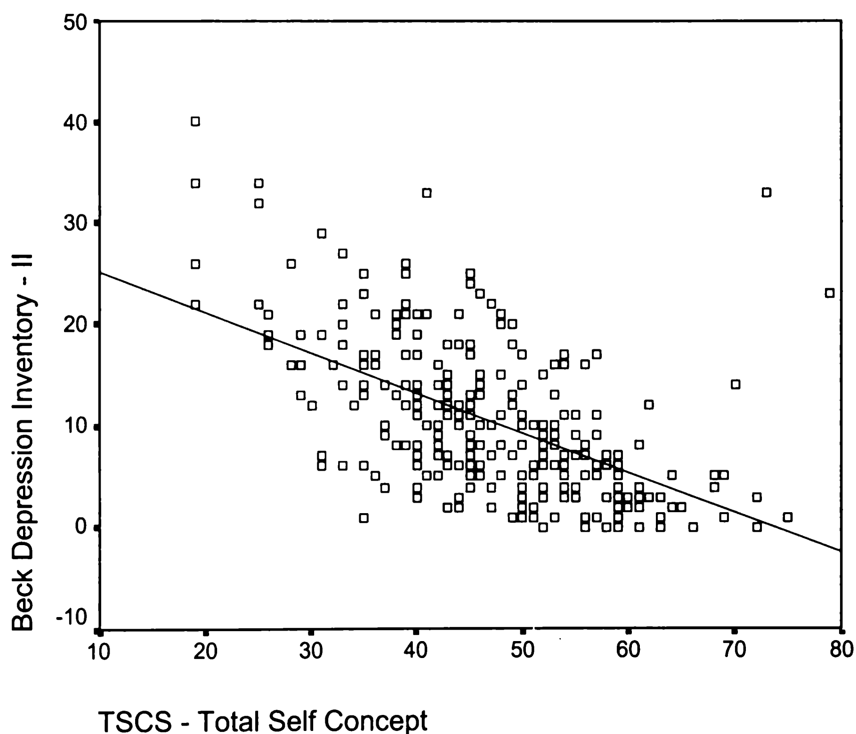


Figure 3.1 Scatterplot of the relationship between total score on the BDI-II and the Total Self-Concept subscale of the TSCS:2

In order to explore the possibility that the total scores on these two measures were mediated through the effect of life events as measured by the Life Events Scale a partial correlation co-efficient was calculated controlling for the effect of life events. Under these conditions the correlation between the BDI-II total score and the TSCS:2 Total Self-Concept score was unchanged, $r\ (191) = -.66, p < .001$, one-tailed. This indicates that for the current data life events had no role in mediating the statistical association between depression and self-concept.

Supplementary Analyses. A comparison was conducted between a '*non-clinical'* group (BDI-II score <14) and *'clinical'* group (BDI-II score >= 14) using all of the TSCS:2 subscales. These data are presented in Table 3.12.

The results show that the *clinical* group scored significantly lower on all subscales and summary scores with the exception of the Conflict supplementary scale. This provides further confirmation for the negative association between depressive symptomatology and self-concept. On all the self-concept area scores, and the supplementary and summary scores, a score below 40 indicates an area of clinical significance.

Finally, a regression analysis was conducted to explore the possibility that self-concept, as represented by the Total Self-Concept score was able to predict the level of depressive symptomatology reported on the BDI-II. A Simultaneous regression method was used with the BDI-II score as the criterion variable and Total Self-Concept score as the sole predictor variable. The resulting model showed that Total Self-Concept scores alone predicted 43.5% of the variance of the BDI-II scores,

Table 3.12

Tennessee Self-Concept Scales – 2nd Edition Means (Normalized T-Scores), Standard Deviations and t-Test Values Comparing '*Non-Clinical*' and '*Clinical*' Groups, by Subscale

	Non-clinical			*Clinical*			
Subscale	*n*	*M*	*SD*	*n*	*M*	*SD*	*t*
Physical Self-Concept	134	48.19	8.98	61	37.44	10.43	-7.36 **
Moral Self-Concept	134	48.84	8.45	63	41.89	10.65	-4.94 **
Personal Self-Concept	134	49.33	8.06	62	39.66	9.11	-7.49 **
Family Self-Concept	133	51.64	9.12	62	41.90	10.75	-6.55 **
Social Self-Concept	134	49.91	10.03	63	44.21	10.69	-3.65 **
Academic/Work Self-Concept	134	47.74	9.68	63	42.16	9.72	-3.77 **
Identity	134	48.53	8.45	62	38.45	9.77	-7.38 **
Satisfaction	134	49.76	7.82	63	40.92	9.29	-6.96 **
Behaviour	134	49.42	8.96	61	39.66	10.55	-6.67 **
Conflict	134	49.42	8.14	63	50.63	9.50	0.93
Total Self-Concept	133	49.11	8.43	62	38.32	9.93	-7.86 **

Note. ** $p < .01$, two-tailed.

$B = -.477$, $SE\ B = .039$, $\beta = -.662$, $p < 0.0005$. This confirms a strong link between self-reported depressed mood and self-concept.

2. Depressive symptomatology and negative life events

Hypothesis. Higher levels of depressive symptomatology will be associated with higher levels of negative life events.

Main Analysis. Two hundred and ninety three of those who completed the Life Event scale were within the 13 years and over age group required for valid completion of the BDI-II. Pairwise deletion was used to remove Life Event scale scores which were not paired with a valid BDI-II score. A significant correlation was found between the BDI-II score and the total Life Event score, $r = .18$, $p = .001$, suggesting that age was not a significant mediating variable.

Supplementary Analyses. Given the possibility that both scores were increasing with age, rather than being associated directly with each other, a partial coefficient was calculated in which the effect of age was controlled. Again, scores recorded for the sample as a whole showed a significant association between BDI-II and total Life Event scores when the effect of age was controlled, $r\ (281) = .18$, $p = .001$.

In order to explore the role of self-concept within the association between depressive symptomatology and life events a partial correlation analysis was conducted where the effect of the Total Self-Concept score was controlled. Under these conditions it was interesting to find that the positive correlation between symptoms of depression and life events disappeared, $r = .12$, $p = .10$. This suggests

that the association between life events and symptoms of depression may not be linear and direct, but mediated by self-concept, and possibly other variables.

As in the original Adams and Adams (1991) study, a comparison was made between mean life event item scores and levels of reported depressive symptomatology. In the present study this was achieved by comparing the life events scores of those who returned BDI-II scores below the threshold score of 14 (*'non-clinical'*), with those who scored at or above the threshold (*'clinical'*). The summary statistics for this analysis are presented in Table 3.13.

The *clinical* group scored higher on all items with the exception of *getting into trouble with law, death of family member or friend*, and *abuse by family member*, although the difference between the two groups on these items was not statistically significant. There were four items where the differences were statistically significant, with the *clinical* group scoring higher than the *non-clinical* group on; *failing a test or course, fighting/arguments within family, starting a new school*, and *illness/injury to family member*. This is a different pattern of responses from the original study which reported *breaking up with boy/girlfriend* and *unemployment of family member* as the items of significant difference between high and low depression groups on the Reynolds Adolescent Depression Scale (Reynolds, 1987).

It is of note that the items which distinguished between the *clinical* and *non-clinical* groups were not associated with events that one would intuitively consider to be the most disruptive or damaging, e.g., death, abuse, parental divorce, trouble with the law. The distinguishing items were ones that may be considered to be part of

Table 3.13

Life Events Scale: Mean, Standard Deviations and Comparison t-Test Values for Ratings of Negative Impact for Each Life Event, for '*Non-Clinical*' and '*Clinical*' Groups

	Life event	*Non-clinical*			*Clinical*			
		n	*M*	*SD*	*n*	*M*	*SD*	*t*
1.	Divorce/separation of parents	224	1.60	1.62	92	1.90	1.70	1.50
2.	Alcoholism/drug abuse in family	222	1.31	1.63	92	1.33	1.55	0.10
3.	Illness/injury to family member	224	1.48	1.34	91	1.85	1.37	2.18 *
4.	Death of family member or friend	225	2.30	1.63	92	2.17	1.76	-0.62
5.	Fighting/arguments within family	225	1.60	1.25	91	2.13	1.36	3.31 **
6.	Abuse by family member	225	1.53	1.74	92	1.49	1.75	-0.21
7.	Unemployment of family member	224	1.03	1.26	90	1.04	1.30	0.11
8.	Move to a new neighbourhood	224	0.78	1.04	92	1.09	1.51	1.79
9.	Starting at a new school	225	0.98	1.22	92	1.38	1.60	2.17 *
10.	Breaking up with boy/ girlfriend	225	1.38	1.39	91	1.55	1.51	0.97
11.	Failing a test or course	225	1.64	1.23	92	2.16	1.33	3.33 **
12.	Getting into trouble with law	225	1.54	1.60	92	1.37	1.47	-0.90
13.	Personal illness/injury	225	1.36	1.33	92	1.66	1.41	1.84

Note. * $p < .05$, ** $p < .01$, two-tailed.

general life experience for many young people, e.g., illness/injury to a family member, arguments, failing (struggling) at school.

Simultaneous regression analysis showed that the Life Events total score was predictive of levels of depressive symptomatology reported, Adjusted $R^2 = .022$, $B = .09$, $SE\ B = .032$, $\beta = .158$, $p = 0.005$.

In order to explore the possibility that some of the items on the Life Events scale were more predictive of the level of depressive symptomatology than others a stepwise regression analysis was completed using the individual Life Event item means as predictor variables. The final model summary (see Table 3.14) shows the five items that met the *F* statistic probability criteria for entry into the regression equation. Of these it was item five (*"fighting/arguments within family"*) that predicted the largest amount of variance in the BDI-II score. When combined these five items account for 13.6% of the variance in the BDI-II scores (*p < .0005)*.

Table 3.14

Summary of the Stepwise Regression Analysis for Life Events Questions Predicting Depression Score on the Beck Depression Inventory-II

Variable	*B*	*SE B*	β
Q5. *Fighting/arguments within family*	1.183	.398	.196
Q9. *Starting a new school*	1.092	.382	.184
Q12. *Getting into trouble with law*	-1.717	.391	-.338
Q11. *Failing a test or course*	1.066	.416	.174
Q13. *Personal illness/injury*	.930	.425	.161

3. Negative life events, self-concept and reasons for depression

Hypothesis. A high incidence of negative life events will be significantly associated with poor self-concept, general attributional style, and reasons for depression which are non-agentic.

Main Analysis. As already reported there was a significant correlation between life events and symptoms of depression within the current sample for both males and females. Further examination of associations with the Life Events scale revealed that there was no significant correlation between the total Life Events score and the Total Self-Concept score from the TSCS:2 (r = -.04, p = .282, one-tailed). This suggests that lifetime adversity, as measured by an admittedly limited range of life events, did not have a marked impact on self-concept.

As found previously a number of the items from the Life Events scale were better at predicting variance than the Life Events total score. In this case regression analysis found that three of the thirteen items from the scale were significant in predicting 7.3% of the variance in the Total Self-Concept score, $p < .0005$ (Table 3.15).

The results of a correlation analysis between the total Life Events score and attributions for good events on the ASQ was significant, $r = .12, p = .029$, one-tailed, while the association with attributions for bad events was non-significant, $r = .05$, $p =.225$, one-tailed. The direction of the correlation between life events and the ASQ composite for good events indicates a positive attributional style, i.e., higher Life Event scores were associated with more positive ASQ composite scores for good

Table 3.15

Summary of the Stepwise Regression Analysis for Life Events Questions Predicting Total Self-Concept on the Tennessee Self-Concept Scales (2nd Ed.)

Variable	*B*	*SE B*	β
Q11. *Failing a test or course*	-1.756	.615	-.220
Q4. *Death of a family member or friend*	1.688	.474	.284
Q9. *Starting a new school*	-1.177	.556	-.162

events. It is possible to interpret this as showing that the experience of negative life events helps individuals to be more able to make positive attributions about good events (appreciation).

It was hypothesized that negative life events would be correlated with responses from the RFD-A in general, and more specifically with 'passive' reasons for depression. That is, with those reasons over which the individual had less active control or less opportunity to change through direct action. In fact, the Life Events total score correlated significantly with all RFD-A subscales. As these were all significant it suggests that higher scores on the Life Events scale, i.e., greater number or impact of specific life events, is associated with a greater range of specific attributions for depression. This could be interpreted as showing that greater experience of life events either gave the young people in the sample more ways of explaining their depression (more reasons), or more reason to be depressed.

4. Depressive symptomatology and attributional style.

Hypothesis. Lower levels of depressive symptomatology will be associated with external, unstable and specific attributions for bad events, and more internal, stable and global attributional styles for good events.

Main Analysis. Two hundred and thirty seven adolescents aged 13 years or over completed the ASQ and the BDI-II. Pearsonian correlation analysis yielded significant correlations between the BDI-II and both the composite score for good events ($r = -.19, p = .001$, one-tailed) and bad events ($r = .35, p < .001$, one-tailed). With respect to good events the negative correlation indicates that as BDI-II scores increase the associated ASQ scores for good events decrease, meaning that good events are being attributed to external, unstable and specific factors. Conversely, for bad events, increasing BDI-II scores were associated with more elevated scores on the ASQ bad events composite indicating the accepted depressogenic attributional style of external, unstable and specific attributions for uncontrollable negative events.

Supplementary Analysis. To explore the relationship between depressive symptomatology and attributional style further a multiple regression analysis was conducted using simultaneous entry of the independent variables. Together the composites for both good and bad events accounted for 15.5% of the overall variance in reported levels of depressive symptoms. Both composite scores were deemed to have made a statistically significant contribution to the regression equation (Table 3.16).

Table 3.16

Summary of the Stepwise Regression Analysis for Attributional Style Questionnaire Composite Scores on the Beck Depression Inventory-II

Variable	*B*	*SE B*	β
ASQ – Bad Events Composite	3.430	.613	.350
ASQ – Good Events Composite	-2.176	.673	-.202

5. Reasons for depression, attributional style and self-concept.

Hypothesis. The specific attributions that respondents make for their depression will be associated with their more general attributional style. The nature of this association will be mediated by the respondents' self-concept.

Main Analysis. Addis and Jacobson (1996) proposed a summary statistic for the RFD which was computed by summing the average item rating for each of their eight subscales. A similar statistic was used here with the inclusion of the ninth subscale (Biological) which was not present in the original RFD measure.

A Pearsonian correlation analysis was conducted using data from the whole sample was used to explore the relationship between specific explanations/ attributions for depression gleaned from the RFD-A and more general attributional style from the ASQ. The RFD-A total score was significantly correlated with the ASQ composite for bad events ($r = .19$, $p = .002$, one-tailed), but not for good events ($r = -.10$, $p = .055$, one-tailed). This suggests that greater breadth and depth of reason giving about depression was associated with a more 'depressive' attributional style for bad events. When partial correlation coefficients were calculated controlling for

Total Self-Concept no significant association between the RFD total score and the ASQ composite scores remained. This suggests that self-concept as measured by the Total Self-Concept score does indeed play a mediating role between attributions for general events, and breadth and depth of specific attributions for depression. That is, the link between general attributional style and specific attributions (reasons) for depression depends, to some extent, on how the respondent views them self.

Supplementary Analysis. A regression analysis was conducted using the simultaneous entry method in order to examine whether the impact of life events was predictive of reason giving for depression in general terms, as measured by the RFD-A total score (Table 3.17). The result below shows that only three of the thirteen items from the Life Event Scale were significant in predicting variance (16.3%) in the RFD-A total score when added sequentially to the regression equation. This suggests that the experience of specific life events is somewhat predictive of a wider range of reason giving for depression. Again, it is interesting to note the life events that are most predictive of reason giving were not the more 'serious' events, but events more likely to be part of everyday experience.

Table 3.17

Summary of the Stepwise Regression Analysis for Life Events Questions Predicting Reasons for Depression

Variable	*B*	*SE B*	β
Q5. *Fighting/arguments within family*	1.068	.243	.262
Q13. *Personal illness/injury*	.518	.235	.133
Q11. *Failing a test or course*	.503	.249	.121

Overall regression analysis

Having data from a number of measures thought to be associated with vulnerability and risk for depression provided an opportunity to explore their relative usefulness as predictive indices. A regression analysis was conducted using the total score on the BDI-II as the criterion variable and TSCS:2 Total Self-Concept score, ASQ composite scores for both good and bad events, total Life Events score, and the total score from the RFD-A as predictor variables. Preference would have been given to the use of a stepwise regression method, however, because of the listwise exclusion of cases for which there was incomplete data the sample size was reduced to 152 cases. Because of this sample size it was thought prudent to use the more conservative simultaneous regression method. Initial correlation analysis showed that there were no problematic correlations between criterion and predictor variable which would make interpretation of the results difficult. Using the simultaneous method a model emerged showing that only two of the five predictor variables made a

significant contribution to predicting variability in the BDI-II score, and that these two predictor variables accounted for 48.1% of the variability (Table 3.18). Most of this predictive power came from the Total Self-Concept score. The remaining three variables (the two ASQ Composite scores and the total Life Events Scale score) were not significant predictors in this model.

Table 3.18

Summary of the Significant Variables in the Regression Analysis for all the Main Instrument Scores Predicting Depression on the Beck Depression Inventory-II

Variable	*B*	*SE B*	β
TSCS – Total Self-Concept	-.377	.053	-.528
RFD – Total Score	.365	.102	.248

DISCUSSION

The level of current self-reported *moderate* and *severe* depression among the sample (males, 12%; females 15%) was high when compared with the prevalence rates reported both in New Zealand (Fergusson, Horwood, & Lynskey, 1997) and internationally (Angold, 1988; Birmaher et al., 1996; Cantwell, 1996; Fleming, Offord, & Boyle, 1989; Garrison et al., 1997; Kutcher et al., 1993; Lewinsohn & Hops, 1993). The data reported in the current study are twice the generally accepted prevalence rate for depression in the adolescent population. This discrepancy is likely to reflect that rate at which formal and more severe depression is over-reported within

the adolescent population. The similarity in rates reported for males and females is characteristic of depression rates within a younger adolescent population, and marks it apart from depression in adults where prevalence rates are much higher in females (Fergusson et al., 1997; Hammen, 1997; Kaelber, Moul, & Farmer, 1995; Speier, Sherak, Hirsch, & Cantwell, 1995).

It is of interest that in response to the supplementary RFD-A question "Are you reporting on a current or past experience of depression?", 69 (24%) respondents indicated that they were reporting on a current episode of depression. This figure is about double the number of respondents identified by their BDI-II scores as reporting clinically significant levels of depressive symptomatology, i.e., four times that rate reported in the literature. Again, this supports the view that the respondents in this study were reporting on non-clinical low mood as well as depression. The higher than expected level of past depression reported by respondents suggests that the adolescents may have been more reliable informants in relation to contemporaneous experiences of depression and less reliable when reporting historical incidence.

The finding that those who reported a 'current' experience of depression scored significantly higher on the BDI-II than those who reported an experience of depression in the past suggests that there was some consistency in self-reporting of depression between the two sources. However, there continues to be debate about the use of self-report measures in assessing depression in young people. Coyne (1994), Vredenburg, Flett, and Krames (1993) and others questioned the usefulness of the BDI in providing an indication of the presence of clinical levels of depression after finding that college students recording elevated BDI scores did not go on to meet

diagnostic criteria for severe clinical depression. More recently Steer and Clark (1997) have found that the newer BDI-II does display good convergent validity with other measures associated with clinical depression within the adolescent population. Despite this they still call for further research to focus on the diagnostic reliability of the measure.

It is not surprising that the areas of achievement and personal attributes appear to provide a focus as reasons for depression within this age group. Côté (1996, 1997) proposed a model of adolescent identity development which emphasizes these dimensions, the *identity capital* model. Identity capital refers to possessions, e.g., material, characterological resources, achievements, that are held in esteem within the person's environment, and which bring recognition and status, thus enhancing identity. The emphasis on these particular reasons for depression within the present sample may result from the high level of scrutiny of these same variables in general. That is, adolescents may not just blame depression on difficulties in achieving their goals or their personal attributes, but blame all their problems on these factors. It would be of interest to explore reason giving within this age group in relation to a wider range of problems, e.g., anxiety, to examine if it differs from reason giving about depression specifically.

Despite similarity in the severity of depression between gender groups, females generally gave more reasons for depression, or marked the reasons they gave as being more important than males. It is unclear whether this is the result of a greater willingness or ability to introspect among females, or greater experience of the stated reasons and higher levels of resilience in the face of them. There is some evidence

suggesting the latter to be found in their higher level of reported experience of life events within the present study.

The scores recorded for the Life Events scale in this study were lower than those reported in the original study (Adams & Adams, 1991). There were few statistically significant differences between gender groups although females generally reported experiencing a greater range of events that had a greater impact on their lives. Of more interest is the finding that those who reported higher levels of depressive symptomatology returned higher life event scores, although this difference was generally not statistically significant. However, the life events that differentiated between those reporting clinically significant levels of symptomatology and those who did not were not the events that would be expected, e.g., death of someone close, abuse. The differences in association with depressive symptoms may not be linked with the specific event itself, but with more general aspects of the situation and the way that it is dealt with. For example, 'severe' events are more likely to attract peer and community support where less severe events are often faced alone. Therefore, it is possible that depressive symptomatology is associated more with perceived isolation in times of adversity than with the direct negative impact of a specific events.

The total Life Event Scale score was consistently less effective at predicting variability in the other measures than a number of the single items within the Life Event scale. The same items were not predictive in all cases, with different items predicting variance in the Total Self-Concept score, the BDI-II, etc. This suggests that different life events may impact on depression in different ways, i.e., some life events

may effect mood directly, others may impact on attributions, self-concept, or other pertinent domains. More research could usefully be undertaken on the differential impact of life events on mood, and the pathways of this influence.

Probably the most important finding of this study was that the Total Self-Concept score from the TSCS:2 predicted a sizeable portion of the variance of the BDI-II (43.5%). Higher levels of depressive symptomatology were associated with lower self-concept scores. There has been a long period of debate about the relationship between self-concept, self-esteem, self-evaluations, and depression in the literature (Blatt & Homann, 1992; Blatt & Zuroff, 1992; Brown et al., 1990; Fine et al., 1993; Harter, 1999; Harter & Marold, 1991; Orvaschel et al., 1997; Roberts & Monroe, 1994; Stern, Lynch, Oates, O'Toole, & Cooney, 1995; Tashakkori, 1993). The results obtained here support the view that they are related, although the direction of this relationship cannot be established from the current data. One possible scenario is that low self-concept makes one vulnerable to depression, while another is that depression damages self-concept and lowers self-esteem. Further exploration of this relationship within the adolescent population, and its relevance to clinical practice is required.

With regard to Brown's (1996) thesis that risk for depression increases with the experience of "severe events", there are certainly data to support this from the present study. However, questions are raised in response to this such as what constitutes a severe event? The data presented here suggest that significant life events are measured on a subjective scale where among the relevant characteristics are the impact that the event has on the individual's self-concept. Self-concept was found to

be a mediating factor between life events and depression. The same life events that had the greatest impact on self-concept, and hence depression, were also those that expanded the range and depth of reason giving about depression, these being mostly in the areas of personal achievement (failure) and perceived deficits in character/personality.

Strengths and Weaknesses of the Study

There are a number of changes which would have enhanced this study. First, although the psychometric measures generally provided both interesting and valuable data regarding the experience of depression among adolescents, there are improvements that could be considered. It would have been useful to have the participants complete the measures a second time to corroborate the results of the analyses conducted, and to examine the stability of the responses. Also, the measurement of life events had limitations. Although the questionnaire items did overlap with areas identified as being of particular relevance to New Zealand youth the resulting data was limited by the restricted range of the 13 items. The response categories ranged from *not at all* through to *a great deal*, with the assumption that the impact would have been to the respondent's detriment. Clearly this would not necessarily have been the case. That is, it is possible to consider a scenario where a change of school may have been interpreted as a positive event if, for example, it afforded improved educational opportunities, reduced bullying, re-acquainted the respondent with a close friend. While the measurement of the impact of general life events is justified in terms of providing a possible index of life change it is likely to

be events which have a negative and disempowering impact on the individual that are more likely to promote a depressive response. Therefore, the inclusion of a scale allowing respondents to indicate the negative or positive impact of events may be a useful addition.

CONCLUSIONS

The first interview study reported on the experience and perception relating to depression of a small group of clinic referred adolescent females. In particular there was a focus on their sense of self-concept and the way that this was influenced by their experiences of depression. The study reported here extended this to exploring various risk/vulnerability variables by measuring these, and experiences of depressive symptomatology, using a community survey approach. The respondents were over 300 non-referred adolescents attending one of three urban high schools. Of particular interest was the significant predictive association found between the measure of self-concept and depression, and self-concept and the other measures. The next step would appear to be exploration of the clinical utility of this link between self-concept and depression. It has appeared to be present in the experiences of the young people as reported in the clinical interview study, and reflected in the responses of the adolescent respondents to the self-report measures, can it be integrated as a component in a clinical intervention aimed at reducing depression in young people? This was the focus of the third study.

CHAPTER 4

The Impact of Self-Concept Enhancement on Adolescent Mood. [5]

Thus far this thesis has been an exploration of the way that depressed young people think about themselves and depression, the interaction between the two, and an exploration of the same relationship within a large group of non-referred adolescents. A qualitative methodology was used in the first study, and a quantitative approach used in the second. The focus of both studies has been to develop an understanding of the relationship between the self and depression, one that was supported by the young people who participated in the interview study, and was also reflected in the data from the community survey study. The challenge now is to use this understanding to appropriately place self-concept within a treatment programme addressing adolescent depression.

In the study reported in Chapter 3 it was found that self-concept, as measured by the TSCS:2 (Fitts & Warren, 1996), made a highly significant contribution to explaining variability in self-reported depressive symptomatology. Indeed, it accounted for approximately 44% of the variance in scores on the BDI-II (Beck et al., 1996).

[5] A version of this chapter was presented at the 2001 Annual Conference of the New Zealand Psychological Society, Auckland.

Other authors have also alluded to the importance of one's sense of self in relation to risk and experience of depression. Brown (1996) cites data from his own extensive studies on the question of why some people become depressed. There remains a subset of those who become depressed predominantly as a result of physiology and/or genetic predisposition. However, there are a large number for whom this is not true. Brown suggests that many of this group will have experienced some type of 'severe event'. There is extensive evidence that negatively construed life events can have a deleterious impact on mood (de Wilde, Kienhorst, Diekstra, & Wolters, 1992; Goodyer, 1995; Johnson et al., 1998; Williamson et al., 1998). What makes Brown's position of particular interest here is the observation that these processes can be mediated via their negative impact on one's sense of self. Brown also identifies other factors related to "loss of a cherished idea about oneself" (Brown, 1996, p.154) that are significant. This suggests that not only do negative life experiences influence mood, there is nothing new about this contention, but that the mechanism for this influence is via one's sense of self. If this is the case then not only are improvements in self-concept likely to have a direct result on mood, as suggested from the data from the second study, but may also have a protective effect by moderating the impact of negative life events.

Research studies focussing on self-concept enhancement have reported positive outcomes within educational settings (Hay, Byrne, & Butler, 2000; Lockhart & Hay, 1995; Marsh & Richards, 1988), although these have not been trialed with a clinical population. Lockhart and Hay report on the development of a programme (ABLE – Attribution, Behaviour, Life skills Education) which was designed to

enhance the self-concept and motivation of a group of underachieving, but academically gifted girls. Hay et al. applied the same programme to good effect with 20 non-gifted secondary school students identified as having poor self-concept and social relationship difficulties. Marsh and Richards examined the effect of an Outward Bound activity course on various aspects of self-concept with five groups of adolescents, totalling 66 participants. Despite positive results it must be observed that not only was this research reported over a decade ago, but it cites data collected up to 8 years before the research was published, meaning that some of the data was collected over 20 years before this thesis has been compiled. It is referenced here, in part, as an illustration of the dearth of published research on self-concept enhancement.

AIM OF THE STUDY

The current study was undertaken to explore the relevance of these findings in a clinical setting. If dysfunctional self-evaluations (self-concept) can be identified and moderated then it is possible that the negative impact of depressive symptomatology could be ameliorated. There is support for this contention in the theoretical literature, and in data from research involving non-clinical populations. However, there is only very limited consideration of this possibility in research involving a clinical sample. Harter (1999) reviews some of the research consistent with the perspective that low self-worth (self-concept) precedes depressed affect. Also, from her own research she provides support for the link between low self-worth and self-reported depressed mood (Harter, 1992).

The study reported here is a small scale pilot evaluation of the usefulness of conducting therapy for depression which focuses primarily on the enhancement of self-concept. Given the copious literature attesting to the efficacy of cognitive-behavioural treatments for depression it seemed both unreasonable and unnecessary to propose self-concept enhancement as anything more than an adjunctive element to such intervention programmes at this time. That is, the intervention protocol developed for this study could, if effective, supplement existing treatment protocols. For this reason it was considered necessary to develop an intervention that could be delivered quickly, for example, in three sessions. Because of the experimental nature of this intervention, in programme structure rather than specific content, it was also decided to limit the number of participants for this pilot study. Therefore, emphasis was placed on gathering the maximum amount of data (quantitative and qualitative) from fewer participants (six). Finally, a study design was used which allowed each participant to act as their own control by having a period of 'inert' contract-control. As this phase was presented first in all cases it addressed the ethical issue of removing a treatment which was hypothesised would be efficacious in favour of an intervention which was designed to be inert. It also addressed the possible 'lack or reversability' of the measures, that is, if the self-concept enhancement phase was effective it would be unlikely (and undesirable) for the various psychometric markers to decline during a subsequent control intervention phase as this would indicate reductions in positive self-concept, self-esteem, and an increase in depression. For this reason the self-concept enhancement intervention followed the control intervention in all cases.

METHOD

Participants

The participants for this study were a small number of consecutively referred adolescent clients from a provincial Child and Adolescent Mental Health Service in New Zealand. These clients were referred for help with mood difficulties. The study design required six participants aged 13-18 years to complete a planned intervention. This necessitated the engagement of seven adolescents because one participant (a fifteen-year-old male) dropped out after the initial assessment, presenting a level of suicidal risk that could not be managed within the study protocol.

The six participants who completed the study were four females and two males within the age range 13½ – 17½ years. They were referred by their general practitioner (2 participants), school counsellor (2), special educational advisor (1), and public health nurse (1). All the participants completed the BDI-II as part of the initial assessment battery. As a group their scores on this measure fell within the range 21 – 36 (M = 26.2), indicating a *moderate* to *severe* level of depression. Following the initial assessment it was confirmed that these BDI-II scores were consistent with the clinical presentation of each of participants.

Tables 4.1 to 4.6 provide a brief introduction to the six participants as they initially presented, along with data obtained from the preliminary assessment interviews.

Table 4.1

Kate – Background Information

Background: Kate, a 16-year-old, was referred to the Child and Adolescent Mental Health Service by her general practitioner on a semi-urgent basis reporting high levels of stress and an "underlying" depression. She presented to the doctor with signs of anxiety and panic, recent difficulties at school, an increase in non-specific tearfulness, and significant sleep disturbance. Her weight was stable, as was her appetite and eating patterns. There was no reported suicidal ideation. The doctor noted that both Kate's parents, who were very supportive of her, had been long term users of anti-depressant medication. Kate's general health was good. She was not taking medication for depression at the time of referral, but was taking an oral contraceptive.

Two primary precipitating factors were cited as being possible 'causes' of Kate's depression. The first of these was a change in high school which occurred some nine months prior to referral. This was largely at Kate's instigation because she wanted to pursue her Year 12/13 studies at a larger school than the one she was previously attending. Despite her apparent high level of motivation Kate reported that she found this change difficult. The second suggested cause of Kate's depression was the departure of her boyfriend to pursue training away from home. While the relationship was being maintained Kate did not feel secure in this.

Pre-intervention assessment: Prior to the first assessment appointment Kate completed the assessment battery.

Kate completed three subsequent sessions, each of which was focussed on facilitating the development of a positive self-concept, especially in those areas of her life which she believed constituted reasons for her depression. While these areas of focus were largely dictated by the material presented by Kate within the therapy sessions it was also informed by the relatively lower (more problematic) TSCS:2 subscale score for Physical Self-Concept (39/100), and higher scores on the RFD-A subscales for Physical (2.5/4) and Characterological (2.4/4) reasons for depression.

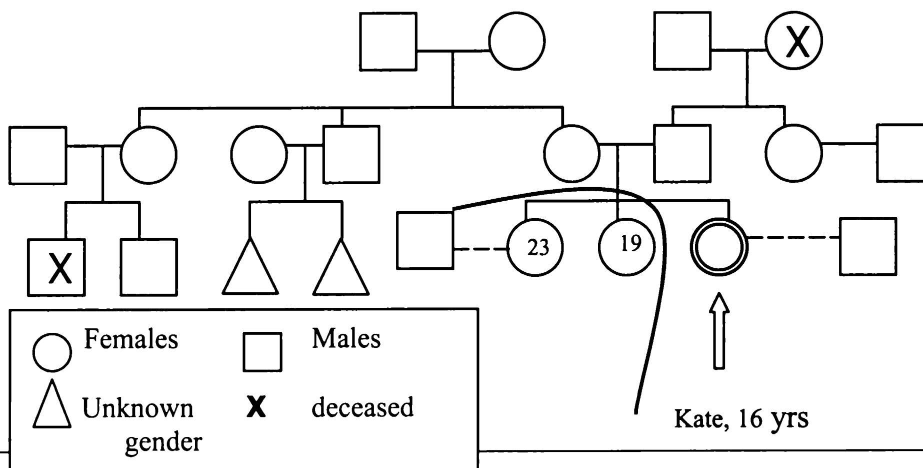


Table 4.2

Elizabeth – Background Information

Background: Elizabeth, a 15-year-old, was referred to the Child and Adolescent Mental Health Service by her family doctor with a diagnosis of depression. He started his referral letter by stating that Elizabeth's mother had a diagnosis of depression with psychotic features, and that her illness had "significantly affected" Elizabeth over the years. Her parents had been separated for about two and a half years, with Elizabeth remaining close to both of them. Elizabeth spent most of her time at home with her mother. However, this was limited by her status as a weekday boarder at a local girls high school. The referring doctor indicated that Elizabeth was not functioning well at the time of referral, finding it difficult to concentrate or perform adequately at school. The notes provided by the doctor suggested that Elizabeth had been taking on a parenting role towards her mother during recent bouts of illness, and that she had not coped well with this pressure. Despite getting on well with her father it was reported that she had been having some trouble with this relationship over recent weeks, a concern that was also apparent in her relationship with her brother, and with her mother's new partner. The doctor volunteered the opinion that Elizabeth was having difficulty concentrating at school because she was spending so much time worrying about family issues.

Pre-intervention assessment: Elizabeth presented at the initial assessment appointment with her mother so the first part of the interview was conducted with them together. Elizabeth indicated that she had been feeling very tired during recent weeks, and had experienced low energy. She said that she was becoming more frustrated by her mood changes and irritability, both of which she felt were uncharacteristic. She was getting upset over little things, or for no apparent reason. She reported no misuse of substances and was taking no medication. She was able to generate a short list of activities which she felt she was good at, both academically and within the sporting arena. Elizabeth reported enjoying the school boarding hostel, and felt that she had a good group of friends who were supportive of her.

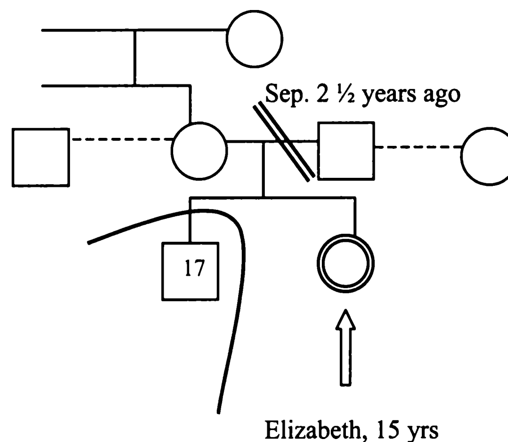


Table 4.2 contd.

She believed that there were a number of issues which had prompted her depression, including her mother's most recent episode of illness, and her (mother's) suicide attempt 18 months prior. She also reported having some ongoing difficulties in her relationship with her mother's new partner as she perceived him as usurping her place as her mother's primary confidante and 'caregiver'. She reported a generally negative relationship with her father's new partner, and a sense of loss in relation to a previously favoured family friend that she was no longer able to spend time with because the friend was now *persona non gratia* after having had a disagreement with Elizabeth's mother.

After completion of the pre-intervention assessment instruments and the initial interview Elizabeth attended for one appointment of non-directive counselling where the session agenda was established solely by Elizabeth in response to general prompts from the therapist such as *what would you like to talk about today?* or *how have you been this week?* This was followed by three sessions designated as 'self-concept enhancement' where the focus was more specifically on the development of positive self-concept. These were targeted more particularly on those areas of Elizabeth's self-conceptions which were identified by the TSCS:2 as being more problematic, i.e., Family Self-Concept (33/100) and Academic/Work Self-Concept (32/100). It was interesting to note that through the course of this intervention Elizabeth consistently cited her skill at cricket (provincial representative level) as being a source of great pride and strength to her, however, she only rated her Physical Self-Concept at 49/100. The preliminary agenda for our therapeutic contact was also set by her very high ratings of Interpersonal Conflict (3.5/4) and Achievement issues (4/4) as being reasons for her depression.

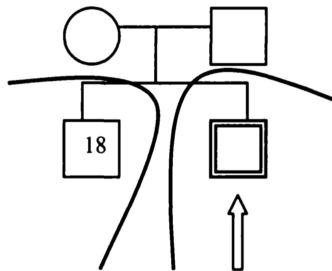
Table 4.3

Clifford – Background Information

Background: Clifford was a 16-year-old referred to the Child & Adolescent Mental Health Service by the guidance counsellor at a local boys high school. Clifford had been a full-time boarder at the school hostel since the start of the school year, i.e., about six months prior to his referral. His parents lived in a rural area of New Zealand where they owned a farm. Clifford had been enrolled at his current school by his parents against his wishes because they were concerned that he was 'mixing with the wrong crowd', and that this was having a negative impact on his progress at school.

Clifford's school guidance counsellor indicated that he believed Clifford was presenting with very low self-esteem and signs of depression, including difficulty getting up in the morning and signs of increasing social isolation. He reported that Clifford's school performance had deteriorated and that he lacked motivation to improve. The counsellor stated that Clifford had reported having no life goals apart from 'being happy', a state that had apparently eluded him for most of his life. Previously Clifford was known to be both keen and proficient at golf, soccer and tennis, activities that he no longer pursued. Indeed at the time of the referral he was quite disparaging about his abilities in these areas.

Clifford was not taking any medication at the time of his referral.



Clifford, 16 yrs

Pre-intervention assessment: Clifford was ambivalent about attending the initial assessment appointment as he believed that it had been arranged for him by his mother. However, he settled quickly into the session and started to share information spontaneously. The primary themes during the assessment were the sense of rejection which he felt on being sent away from home to attend a boarding school, and his separation from both his friends and his brother, who was training to be an engineer with the New Zealand Navy. Clifford felt that he had always been a fairly placid child, and had not caused his parents any undue hardship or difficulty until the previous year. He admitted that he had started to seek more independence the

Table 4.3 contd.

previous year, and that at times this had led to some disagreement between him and his parents. However, he felt angry towards his parents, particularly his mother, who appeared to have over-reacted to this challenge by insisting that Clifford leave home to attend boarding school. While Clifford was aware that his parents had used the rationale of separating Clifford from his 'undesirable' peer group and the good academic reputation of his current school to justify their decision, he felt that they had 'run away' from the challenge of having a teenage son who was just 'spreading his wings'. Clifford was particularly resentful about what he believed to be his parents' lack of willingness to try and understand him. He was also resentful that their decision had made it very difficult for him to maintain relationships with his friends back in his home town.

Prior to the first assessment Clifford completed the battery of rating scales. He then completed two sessions of non-directive counselling followed by three sessions of self-concept enhancement intervention. The preliminary focus of the three self-concept enhancement sessions (assessment periods 4-6) were the areas of Physical, Personal, Family and Academic/Work Self-Concept as identified by the TSCS:2. Particular attention was given to the latter two areas as these were also highlighted as concerns by the referrer. However, it was also noted that the individual self-concept areas were reported within the context of a low overall Total Self-Concept summary score indicating low overall self-concept and associated self-esteem (Fitts & Warren, 1996). These authors suggest that overall low levels of self-concept are associated with an individual who is less likely to say positive things about themselves, and is more likely to be anxious, depressed, unhappy, and exhibit little self-confidence. All these were apparent in Clifford's early sessions.

Table 4.4

Amanda – Background Information

Background: Amanda was a 17-year-old referred to the Child and Adolescent Mental Health Service by a special education advisor from Specialist Education Services. This referral was deemed to be semi-urgent by the referrer who indicated that Amanda had no family living within the local area, with her mother and siblings living in Australia, and her father living in a town approximately four hours drive away. Her father had lived locally but had moved away to find work soon after Amanda came to live with him. At the time Amanda had already enrolled on a course and had decided to stay rather than move with her father, although the latter did not seem to have been a real option for her.

The referrer indicated that Amanda had presented with very low mood, but that she smiled to "try and give a different impression". Amanda had stated that she felt like "a dead weight", and had often thought about suicide in the past. Suicidal ideation was also part of the current difficulties that Amanda faced. Although she had no definite plan at the time of referral she had commented to the referrer that at times she would sit under the shower or in her wardrobe for hours just crying and thinking about how everyone would be better off if she were dead. She was reported to have a very limited social life, and to being generally physically inactive. She stated that she had large debts as a result of her course fees, and lacked financial support from her parents. This pressure in relation to her course was compounded by her belief that she would almost certainly fail her course.

Amanda was living as a boarder with a woman who was a high school teacher, and worked as a private tutor out of regular school hours. There were no other people around at 'home' which left her alone for long periods during the evenings.

Amanda's physical health seemed to reflect her anxiety and depression. Just prior to referral she had been admitted to hospital after a severe dermatological condition which had been resistant to treatment.

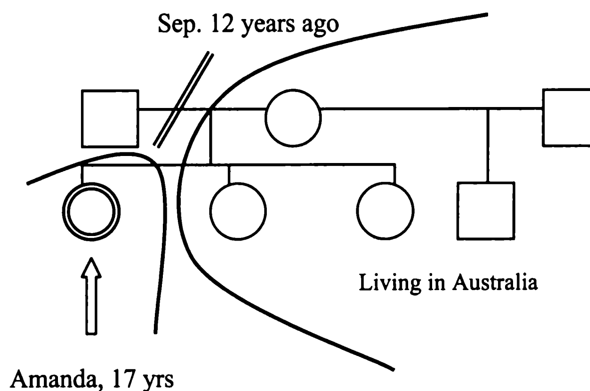


Table 4.4 contd.

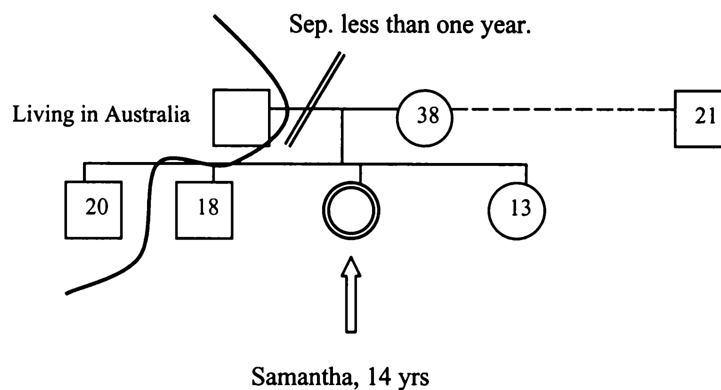
Pre-intervention assessment: Amanda attended the first appointment with great enthusiasm. She indicated that she had been seeking counselling for some time. She stated that some days her mood seemed quite stable, but not on others. On these latter days she felt confused as life did not "make sense".

One major source of stress was her course (vocational), which she felt was progressing very badly. She was the youngest in the class by a number of years. She believed that this was a significant factor in her sense of isolation, despite the efforts of her classmates to involve her in out of class activities. Her progress was also being severely compromised by difficulties associated with depression, e.g., difficulty with maintaining a good sleeping pattern, appetite disturbance, inability to concentrate and problems with her short-term memory, tearfulness, irritability, and social isolation/ withdrawal. The second major source of stress for Amanda was the sense of abandonment that she felt in relation to her family. She admitted that she may not have been the easiest teenager to live with when she was at home with her family, but did not feel that it was appropriate for her to be "disowned and abandoned" as was her experience.

Table 4.5

Samantha – Background Information

Background: Samantha, a 14-year-old, was referred by her high school guidance counsellor after he had met with her on two occasions because of difficulties at school. The counsellor reported that Samantha was struggling under a high level of stress, and felt that she was getting depressed *again*, a view that was consistent with her self reported low mood, low level self-harm, and suicidal ideation. The main source of stress was believed to be Samantha's family, which had undergone some significant changes within the previous eighteen months.



Pre-intervention assessment: Samantha was very keen to attend the initial assessment appointment and share her story of family change and associated episodic depression. She indicated that while she had thought about suicide previously she doubted that she would attempt to take her own life because of her positive relationship with her boyfriend. In actuality this relationship proved to be far less supportive than Samantha initially stated. She talked about an episode of self-harm which occurred about four months prior to referral when she had cut the back of her arms with a craft knife, although this had caused only superficial cuts. Samantha reported using alcohol as a way of coping with her depressed mood, although this too was fairly superficial.

She reported generally doing well at school, achieving good grades, and having excellent teacher and peer support. However, she indicated that her recent performance had not been up to her usual standards, and this was what had led to her seeking the help of her guidance counsellor. She had found herself withdrawing from her friends, crying for no apparent reason, experiencing changes in her eating and sleeping patterns, and having a 'nervous breakdown' in class. This latter experience met the criteria for a panic attack when described subsequently.

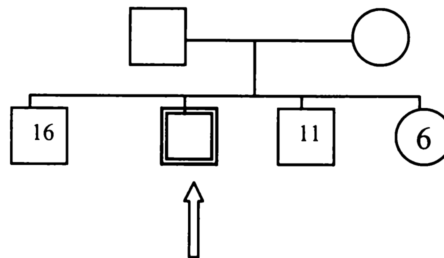
Table 4.5 contd.

Samantha saw two recent changes within her family as precipitating her low mood. The first was her father's decision to leave the family earlier in the year. While this was not unexpected the fact that her father then moved to Australia to avoid prosecution by the Inland Revenue Department was a source of great embarrassment to her. Samantha also reported that her father had attempted suicide on three occasions and was taking anti-depressant medication at the time he left the family home. The second major change was the decision that Samantha's mother made to enter into a relationship with a man 17 years younger than she was, another source of public embarrassment for Samantha. Samantha felt that this had the effect of placing her in competition with her mother for who had the most generous, loving, and sensitive boyfriend, and negated a more usual mother-daughter relationship between them. The other relationship which was causing Samantha some concern, and would eventually become the main focus of her difficulties was the one she had with her own boyfriend, an 18-year-old.

Table 4.6

Thomas – Background Information

Background: Thomas, a 13-year-old, was referred by the Public Health Nurse attached to his school because of significant concerns about the possibility of self-harm. Thomas lived with his family in a rural settlement about 10 kilometres away from a main provincial city.



Thomas, 13 yrs

Thomas presented to the Nurse as tearful and very sad. She indicated that he was not sleeping well, waking between 2 – 3 am each day. She reported that Thomas had said that he was very unhappy, and that there was no fun in his life. He had stated that life was 'too hard', that he didn't think that he was good at anything, and that he seemed to have lost the ability to control his feeling as he was crying at times and not knowing why. He had attended appointments with his school guidance counsellor and school principal, but reported that these had not helped him. The Nurse indicated that she had talked to Thomas' mother who was also very concerned about him. She reported that Thomas had recently been talking about a 27-year-old friend of the family who had successfully completed suicide by hanging about two years previously. Thomas had previously been the victim of bullying at school. At the age of 7 years he underwent major surgery to remove a tumour. There were apparently a number of complications following this operation and he remained concerned that the tumour would return despite the reassurances of his surgeon. This fear was compounded by the failure of his family doctor to request that tests to be completed to allay Thomas' anxiety.

Pre-intervention assessment: Thomas appeared keen to attend the initial assessment appointment, which was held in the presence of both his parents. Thomas completed all the rating scales prior to the first assessment appointment, and at the end of the intervention period. During the first assessment session much of the information provided by the referrer was reviewed and confirmed, with Thomas placing clear and specific emphasis on family relationships as being a major concern for him, and in particular his place within the family. Both parents were clearly concerned for Thomas and wanted to support his therapy.

Measures

Data were collected primarily in two ways, through the use of psychometric measures and the collection and coding of audiotaped segments from each intervention session as participants responded to five standard probe questions. Further detail of the interventions used to enhance self-concept was obtained by audio-taping two longer segments of in-session interactions.

Psychometric instruments

Psychometric data were collected using a number of measures. The following were used before the commencement of the intervention to establish a baseline, and at the end of the research phase of the therapy, that is, after the completion of the third self-concept enhancement session. A smaller subset of the measures, or their short form versions, was administered on a sessional basis, to track both change and assist in the planning of the therapy. Further details/copies of the psychometric measures are included in Appendix C, with brief details being given below.

Beck Depression Inventory - 2nd Edition (Beck et al., 1996). Details of this measure were given as part of the first study (p. 35)

Youth Depression Adjective Checklist (Carey, Lubin, & Brewer, 1992). The Youth Depression Adjective Checklist (Y-DACL) is a brief 22-item checklist for measuring dysphoric mood. It was initially developed for determining changes in depressive status in both research and clinical contexts. The instrument contains both

positive (8 items) and negative (14 items) adjectives that are rated by the respondent according to whether they are appropriate descriptors of the way they are feeling at that time. The Y-DACL can be quickly administered and scored. The scale total score is obtained by adding the number of positive adjective not endorsed to the number of negative items endorsed, yielding a maximum score of 22, with higher scores indicating more negative mood evaluations. The measure performed well in the original reliability and validity studies which were conducted with large samples of non-referred, and emotionally disturbed and depressed youth (Carey et al., 1992), and in subsequent studies (Lubin & McCollum, 1994; Lubin et al., 1994a; Lubin et al., 1994b). The version used here is focussed on recording state-dependent rather than trait-dependent depressive mood.

Reason For Depression Questionnaire – Adolescent version (Fitzgerald & Richardson, in press). The first analysis included in the second study was a re-evaluation of the RFD's psychometric properties for use with adolescents in New Zealand. As a result of this analysis an adolescent version of the RFD (called the RFD-A). The RFD-A consists of 35 items in the form of "I am depressed because..." followed by a specific reason. Respondents rate each item on a four-point scale (1-4) from *definitely not a reason* to *definitely a reason*. Factor analysis has identified six primary subscales for the RFD-A (*Characterological*, *Interpersonal Conflict*, *Achievement*, *Relationship*, *Physical*, and *Biological*). Statistical analysis of the internal consistency of the RFD-A subscales returned alpha coefficient scores of

between .77 and .91, showing acceptable levels of item consistency within the revised subscales.

Life Events Checklist (Johnson & McCutcheon, 1980). The Life Events Checklist (LEC) is a 50-item checklist measure of child and adolescent life events that, unlike many other self-report measures of life events, draws a distinction between positive and negative life events. It is composed of 46 items on which the respondent indicates whether each of the events have occurred within the last year. They then endorse the events as either 'good' or 'bad', and finally rate the degree of impact they have had on a 4-point scale (0 = *no effect* through to 3 = *great effect*). There are four optional item spaces for respondents to note other events if they wish. In addition to the original study there have been a number of other studies exploring the psychometric properties of this instrument (e.g., Duggal et al., 2000; Johnson & Bradlyn, 1988).

Tennessee Self-Concept Scale – 2nd Edition (Fitts & Warren, 1996). Details of this measure were given in the previous chapter (p. 92).

The full 82-item questionnaire takes 10-15 minutes to complete, with respondents rating the items on a five-point scale from *always false* to *always true.* There is a short form (TSCS:2-SF) which consists of the first 20 items only, and this shorter form was used for the sessional assessment to explore any small changes in self-concept. Use of the short form yields only the Total Self-Concept summary score.

Self-Esteem Scale (Marsh, 1996). The Self-Esteem Scale (SES) used in this study was a 7-item refinement of Rosenberg's original 10-item uni-dimensional self-esteem scale (Rosenberg, 1965). The seven items contained in the scale used here were selected because they have been the focus of substantial statistical examination by virtue of their inclusion on the U.S. Department of Education's National Centre for Educational Statistics database. This has led to their periodic re-evaluation including large scale examination of their psychometric properties (Marsh, 1996). In the form presented here respondents are asked to rate their level of agreement with seven statements, four positive and three negative, on a 4-point scale (1-4) from *strongly disagree* to *strongly agree*. The items are concerned primarily with an evaluation of self-worth. Positive validation research using this measure has been conducted by Yelsma and Yelsma (1998).

Audiotaped Interview Segments

Participants were asked to answer five standard questions at the start of each session. Their responses were audiotaped and transcribed, with their knowledge and consent. The purpose was to obtain qualitative data about self-concept which could complement the quantitative data from the psychometric instruments, and to provide data about the clinical efficacy of the interventions. Participants were be asked to sign an audio tape consent form at the time of first contact with the service, and asked to confirm this consent verbally each time audio taping was undertaken. I developed the

five standard questions, listed below, as a way of accessing statements of self-concept in a uniform manner.

1. If I ask someone who knows you really well to describe you as you have been over the last few days, including today, what would they say?
2. Please describe briefly one event that has happened within the last few days that typifies your life at this time.
3. Please describe one way in which you see your life, as it is today, as being different from how you would like it to be.
4. If you had a wish today, and you could change one thing about yourself as you are at this moment, what would you change?
5. Over the last few days, what aspect of yourself have you been least happy with? (this could be a behaviour, a way of feeling, a personality characteristic etc.)

Two longer audiotape recordings were made and later transcribed of segments of the self-concept enhancement sessions. This was to generate a more detailed and permanent record of the content of these sessions which could later be used to illustrate various aspects of the intervention.

Procedure

As with the previous two studies the study proposal was reviewed and approved by my local Regional Ethics Committee, and the Human Subjects Review Committee, School of Psychology, University of Waikato.

The single exclusion criteria used at the time of initial referral was age, with only young people aged 13 years and over being considered for the study. This

threshold was in place to maintain the focus on adolescents and because it marks the lower standardization limit of the BDI-II. The upper limit was established by the service within which the study was conducted. The reason for not specifying other exclusion criteria at this point in the process was because of the often unreliable nature of referrals. The service also routinely accepted unscreened self-referrals for adolescents.

Once a referral indicating a mood problem (or similar) had been accepted the client was contacted by post with the offer of an appointment. This was usual procedure for the service. However, the adolescent was also sent an information sheet explaining the research study, including the audio taping of session segments. They were also sent the audio consent form, and a number of rating scales with a request that these be completed prior to attending the first appointment and be returned in a stamped addressed envelope. It was made clear that if they preferred not to complete the consent form and/or instruments this would in no way effect the assistance they received from the service. Copies of the study documentation (initial contact letter, information sheet, consent form) is included in Appendix C. The following rating scales were included for completion at the time of the initial assessment; BDI-II, Y-DACL, TSCS:2, SES, RFD-A, and LEC.

At the start of each session participants were asked to complete the Y-DACL, SES and TSCS:2-SF. They were also asked the five standard audio taped questions.

The initial assessment appointment followed the course of a standard first clinical interview (Mental Health Commission, 2000). That is, the focus was on gathering information about the client and the difficulties they were experiencing.

Specifically it included information about the young person's experience of depression, evaluation of their safety, and consideration of a formal diagnosis using DSM-IV criteria for mood and other disorders.

It was planned that should a participant drop out of the study at any time through failing to complete questionnaires, audio recordings, or sessions, they would be replaced with the next appropriate referral to the service for whom full consent was received. Participants would continue to be recruited until full data were available for six participants. However, this contingency was not required as all the participants who started the intervention trial provided a full data set.

In order to explore the efficacy of intervention techniques focussing on self-concept enhancement, a design was used whereby such techniques were introduced into the participants' therapy sessions after varying amounts of more non-directive counselling. That is, after a standard initial assessment interview, participants commenced with between 0 - 5 sessions of non-directive counselling (contact control) before being introduced to the 'trial' (treatment) condition. This design addressed the problem of the anticipated lack of reversibility in the experimental treatment. That is, treatment efficacy could not be evaluated if the self-concept enhancement intervention was delivered first and proved highly effective as the participants' mood may have improved sufficiently to encounter a 'ceiling effect' during the non-directive counselling phase.

Participants were assigned to a treatment programme on the basis of their place in the referral stream with the first client receiving no non-directive counselling sessions and subsequent referrals receiving from one to five counselling session

followed by the experimental intervention. Figure 4.1 gives a graphic representation of the study design.

Non-directive counselling. Within the study there were two ‘experimental’ conditions. The first condition involved non-directive counselling which provided an attention/contact control condition. Here the focus was on the utilisation of non-directive counselling techniques such as paraphrasing, reflecting, and active listening. The aim was to maximise client-therapist 'congruence', thus enhancing rapport. However, it was deemed important that the therapist did not initiate therapeutic change, leaving this to the client. Under this condition there was no predefined session content as this varied in response to what the client initiated in each session.

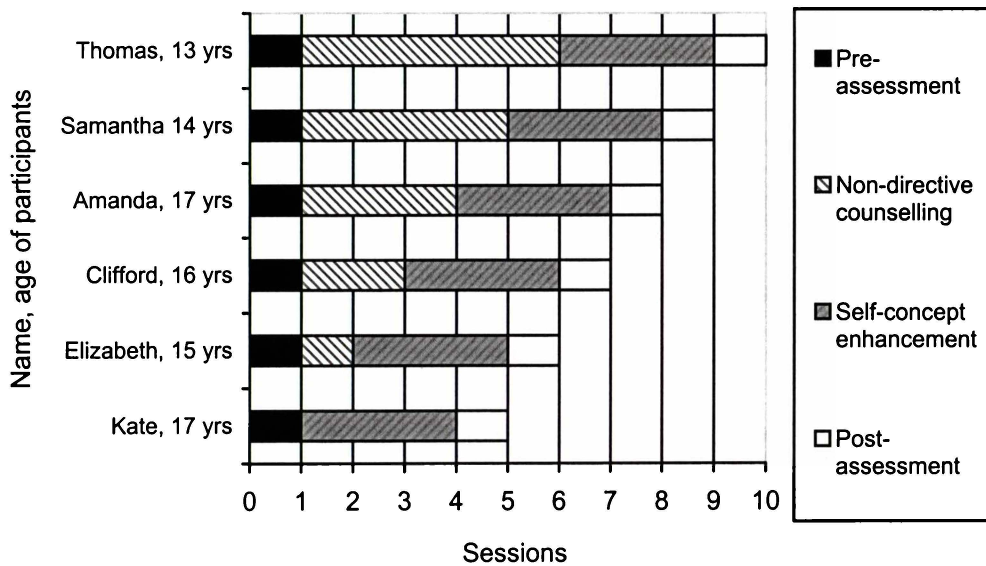


Figure 4.1 Study design outline indicating session content for each participant.

Self-Concept Enhancement (SCE). The second condition consisted of the application of various therapeutic techniques aimed at self-concept enhancement. In general terms these were focussed on,

i. enhancing skills for monitoring the status of the participant's self-concept,
ii. examining and externalizing negative aspects of the adolescent's self-concept,
iii. internalizing positive aspects of self-concept,
iv. building stability in self-concept, and
v. enhancing skills that support the development and maintenance of positive self-concept.

The SCE sessions contained some programmed elements which were introduced in a standardised way. However, it is acknowledged that the strict application of a programmed intervention within a clinical setting can be difficult. Flexibility and clinical judgement were also required as the areas of low participant self-concept on the TSCS:2 also had to be integrated into the overall treatment plan.

The component parts of the SCE interventions were developed from a number of sources and generally fell into one of three technical areas. There were techniques and strategies focussed on recognising and promoting personal *behaviours* that were consistent with the development of a positive self-concept, and/or restrictive to the development of negative self-conceptions. Secondly, there were *cognitive* strategies aimed at enhancing ways of thinking which were affirmative and supportive of the development of a sense of self-worth, as opposed to negative modes of thinking which were both restrictive and personally diminishing. Finally, there was

a focus on positive and fulfilling *interpersonal interactions* which, while overlapping to some extent with the first two areas, did seem to include distinct areas of activity.

The *behavioural components* of the SCE sessions was developed from a number of sources including the ABLE (Attribution, Behaviour, Life skills Education) programme which was develop by Lockhart and Hay (1995) in Australia to enhance the self-concept of students via an in-school programme focussing primarily on improving conflict-resolution and problem-solving skills. Elements from a second programme, entitled PRIDE (Personal and Racial/ethnic Identity Development and Enhancement), were also used (Yancey, 1998). Yancey reported successfully using a range of role-modelling and role-playing techniques to enhance the self-image of a group of adolescents in foster care in New York City. While these various programmes were not developed for use with depressed youth, the strategies which they utilised to promote positive self-concept are generic and widely used in many such programmes. For this reason I thought it would be appropriate to incorporate them into the current study.

Cognitive components were introduced, in part, because they have proven effectiveness in facilitating symptomatic change in depressed adolescencts (Brent et al., 1997; Clarke et al., 1992; Lewinsohn & Rohde, 1993; Rohde, Lewinsohn, & Seeley, 1994; Wilkes et al., 1994). While there have been no reliable studies on the role of cognitive therapy in the enhancement of self-concept, as opposed to self-esteem, there is a growing literature attesting to the association between *positive thinking* and good mental health (MacLeod & Moore, 2000; Philpot & Bamburg, 1996; Wilkinson & Kitzinger, 2000). Within the self-concept literature this focus is

expressed in terms of *affirmational* and *negational thinking*, that is, the expression of one's self-concept through stating what one is and is not. McGuire and McGuire (1991) researched the relative potency of these two styles of thinking on the development of positive and robust self-conceptions in a large sample of children and adolescents. As may be expected they found that affirmational thinking was more sophisticated than negational thinking. They also found that the affirmed-self, the self-image based on affirmational thinking, was depicted more in terms of social interaction with other people, rather than physically acting on other objects. Given the developmental stage of adolescents it was thought appropriate to attempt to promote such affirmational thinking with respect to the self.

Harter and Marold (1991) proposed a model of the determinants of self-worth that involved interpersonal interaction, and considered its implications for adolescent risk of depression and suicide. This model places significant importance on the role of parents and peers both in the establishment and maintenance of one's self-concept, and in the provision of a social context that is conducive to the development of high or low risk interactions.

The third element of the SCE intervention therefore consisted of techniques aimed at developing and maintaining positive social interactions. Some of these were taken from standard social skills programmes, in particular the adolescent group depression programme developed by Clarke, Lewinsohn, and Hops (1990). This programme has been thoroughly evaluated and has a number of well developed exercises. The programme's focus is generally cognitive-behavioural, with more emphasis on the behavioural components. There are sessions on communication, and

negotiation and problem solving which provided a source for the development of strategies that could be used in the current study. However, as the aim here was to facilitate improvement in mood via positive changes in self-concept, the various strategies were employed to provide a forum within which social aspects of the self could be explored, evaluated and changed. For this reason social change was not prescribed.

Having developed a rationale for the inclusion of certain strategies and techniques, these were organised into the allocated time so that each of the three domains could be expressed within the three session. For this reason the session focus needed to remain flexible. It was decided to start with a session organised around the participants' self-acceptance and the development of affirmational thinking. This was followed by a session facilitating monitoring and planning in relation to self change, which included social change. The final session emphasised the behavioural components of change planning, action and re-evaluation. In summary, the elements of the SCE programme were as follows;

Session 1 – Self Acceptance

Aim: to help the client identify 'likeable' aspects of themselves, and 'pleasurable events/activities' within their environment.

Techniques: Imagery of worthiness (usually preceded by some form of 'tension release' e.g., relaxation or physical exercise), activities (role-play), self-affirmations, re-authoring their autobiography, listing perceived strengths and weaknesses, empty chair dialogue (between liked and disliked parts of the self), drawing to enhance physical sensitivity, genogram mapping, story telling.

Session 2 – Self Monitoring

Aim: to enhance to ability of the client to notice aspects of positive self-concept, and notice the detrimental impact of negative views of the self. Also, to notice when aspects of positive self-concept can be further enhanced.

Techniques: Thought/feeling diary (especially noting self-evaluations), role-playing, 'interviewing' the self and/or 'depression', thought detection.

Session 3 – Goal Setting and Accepting Success

Aim: to emphasize intentionality and agency in relation to the enhancement of self-concept, internalize locus of control, and develop opportunities and strategies for evaluating positive change.

Techniques: Practise goal setting which is non-perfectionistic, or overly reliant on external arbiters. Imagery techniques to identify goals and rehearse achievement.

While this intervention may seem to contain elements designed to enhance social skills, the focus here was not skills training. Hersen, Bellack, Himmelhoch, and Thase (1984), Kazdin, Esveldt-Dawson, and Matson (1983), Reed (1994), and others have explored the contribution of social skills training to the amelioration of depressive symptomatology. However, interventions based on developing social skills tend to focus on a skills deficit model of social interactions, with negative or low self-concept being seen primarily a result of such deficits rather than playing a role in the lack of social skill utilisation.

Promoting behavioural activation that is positive and focussed is known to be a significant component of cognitive treatments for depression (Dobson, 1989). However, again the focus is not specifically on the enhancement of self-concept. The

purpose here was to intervene at the level of self-conceptions on the assumption that they play an important role in mediating an individual's response to depressive risk factors (e.g., certain life events, attributional style), and that they constitute a vital component of the individual's ability to return to a state of effective and 'normal' functioning..

Clinical Vignettes

The therapy remained as faithful as possible to the form outlined in the study design. However, as indicated previously, the highly personal nature of psychotherapy demanded that the therapist remained flexible in meeting the needs of the client. In the current study the individual case studies provide some indication of session content. In addition, two segments of session material were recorded and transcribed to provide further information on which the nature of the intervention session could be gauged. These transcriptions are included here together with annotated comments which have been added to aid interpretation and assist in the assessment of treatment integrity. In both cases I am the therapist referred to.

Samantha

Interview date: 21st November 2000
Session: 6 of 7 (2nd of 3 self-concept enhancement focussed session)

Therapist:
So, Samantha, you were talking about the argument that you had with your boyfriend this week, and how you have dealt with it in a slightly different way than you have before.

Samantha:
Before, like when me and Sam would have a fight I would get really hurt and tell myself that he doesn't love me any more and doesn't want to be with me an stuff like that, but this time I though 'no', he is part of the reason that we are in this mess, I am not going to let him dump all the guilt and the worry onto me.

Therapist:
What has helped you to think in this different way?
(internalising locus of control, reinforcing positive change)

Samantha:
Well ... I just saw that this is a relationship and that we are both a part of it, but that I end up doing all the work. It is not just about Sam loving me, because that gives him all the power. Like, if he stops loving me then the relationship is over, and if he keeps loving me then the relationship is still on .... It's all about what he does, not about me or what I want. I think I am more important than that. What I think about things matters. ...... Also, if he has all the say in whether our relationship keeps going then he had better start taking some more care of it, and of me.

Therapist:
So, it sounds like you are starting to see yourself in a different sort of way in your relationship with Sam.
(reinforcing images of worthiness and personal empowerment)

Samantha:
Hummm. I do really like Sam. He is fun and into a heaps of interesting things, but he doesn't think about us, just about himself. I think that sometimes he thinks it is cool to have this chick following him around. Like I am one of his pastimes or possessions rather than being a person. I have decided that he either has to start seeing me as a separate person that he makes a choice to be with and spend time with ... or he is going to regret it. I made him sit down and listen to what I had to say over the weekend. I am not usually an 'in-your-face' type of person, but I made Sam listen. He surprised me too, he like understood what I was saying.

Therapist:
How did that make you feel about yourself?
(prompting exploration of 'self' – self monitoring)

Samantha:
Good actually. I think I had been holding back a bit because I thought Sam would get pissed off and just say 'see ya', or something like that. But he was really good and understood what I said. I felt a bit stupid 'cos I

was thinking why didn't I talk to him about this before, I should have said all this stuff before.

Therapist:
Do you have an answer for yourself?..... why you didn't say those things before.
(prompting self-exploration and evaluation – self acceptance)

Samantha:
I think I was too scared of losing Sam, but I also think that I didn't know what I wanted to say. I didn't know how to talk to him about these things. It's funny because I can talk to my friends about Sam, but I couldn't talk to Sam about Sam.

Therapist:
What image do you have of yourself now when you think of yourself in your relationship with Sam?
(directly questioning current self-representations)

Samantha:
I think I am stronger than before. Before I would have been in the shadows, not hiding but just not out in the open. Also, I would be following behind Sam. Now I think we are more standing next to each other. I think I am stronger and more confident, I have a clearer idea of what I want. I also think that it has been good for Sam. Not that he used to sort of carry me, but now he doesn't have to do that at all, I am more an equal part of the relationship.

Therapist:
If you were to track that picture of yourself forward into the future how would you want it to look in say … six months?
(goal setting in relation to 'self', self acceptance)

Samantha:
Yeh. I really don't know if Sam and me will still be together or not. I would like to think that we will be 'cos I like him heaps. If we are not together I will still have a clearer picture of what I want out of a relationship, and an idea of how to go about getting it.

Therapist:
Samantha, do you think that this view of yourself as what …. clearer thinking, more assertive, perhaps stronger, is a sort of 'self' that you can see being useful elsewhere?
(this is an excellent example of a multi-function question which supports self-concept development. This is supported by Samantha's response, which suggests that it has opened up new ways of thinking about herself. The question reinforces positive self-representations by explicitly reflecting

them back. It also prompts for positive self-evaluations and supports the generalization of positive self-representations to new settings)

Samantha:
Hummm … I hadn't really thought about that … but I guess that it could be. You know that I was talking before about the hassles that I have with my mum ….

Therapist:
Yes.

Samantha:
…. well one of the biggest things that annoys me is the way that she always talks about herself and doesn't listen to me. When I want to talk to her about me and Sam she always turns it around so that she is talking about her and her boyfriend. Like, I will say that Sam and I went to such and such a place, the beach or a party and mum will say 'Oh that's nice, Paul took me to a nice beach and it was wonderful and blah blah blah'.

Therapist:
How might this new version of yourself deal with a situation like that?
(goal setting via rehearsal which promotes generalization of positive self-representations)

Samantha:
In the past I have just listened and said 'Yeh yeh' and then walked away, usually very angry 'cos mum can't be happy for me. But I think I need to be clear about what I want to say to mum and not get put off by her talking about her and Paul.

Therapist:
So how would that work? At the weekend you and Sam had what sounds like a real 'heart-to-heart' and maybe got some things about your relationship sorted out. Imagine that you wanted to tell your mum about this. To start with, what would you say? Let's do a little role play.
(a move towards goal setting – emphasizing intentionality and agency in relation to the enhancement of self-concept. Also, exploring revision to Samantha's self-conceptions via a role play, in this case around the theme of assertiveness in relationship with her mother)

Samantha:
Okay …. So I'd say something like …. Mum, Sam and I were not getting on too well last week and it got to a point where I had to get some stuff sorted out with him, about our relationship. It was really hard 'cos I thought it might mean that we would split up, but it went really well and we are getting on really well now.

Therapist:
And as your mum I would say .... Well, that's nice Samantha. It's good that you talked to Sam. Paul and I talk together all the time and we have such a happy relationship. We don't think that we would get on so well if we didn't have such a wonderful open relationship where we can talk about anything we want. Paul is so easy to talk to.
(developing the role play scenario)

Samantha:
That's exactly what mum does, she goes off my point and onto hers.

Therapist:
How is your more assertive and strong self going to deal with this, what are you going to say to your mum?
(again, a good example of a multi-function question. In this case focussing on reinforcement of positive self-representations by reflecting them back to Samantha, while also encouraging exploration and evaluation within the context of the role play)

Samantha:
I'd say ... that's nice mum, but I wanted to tell you about me and Sam not talk about you and Paul. Can you just listen to what I have to say first?

Therapist:
Can you picture yourself saying that to your mum?
(self-monitoring)

Samantha:
Not really. It's what I'd like to say to her. She would listen, but I don't think it would change much.

Therapist:
It might not change her behaviour much, but how would it make you feel about yourself?
(response to Samantha's apparent loss of confidence in her revised self-representation prompting a refocusing of attention to internal representations rather than external manifestations)

Samantha:
It would feel sort of good to be clear with mum even if she kept going off the point. At least she wouldn't be getting away with it. I don't think she does it on purpose, usually. I think it is just a habit that she has got into.

Therapist:
Are there other places that you can picture this newer version of yourself being of use?

(prompting for other situations within which revised self-images may have an impact on behaviour and relationships)

Samantha:
Humm (pause) ..... I think there are some situations with friends that I could deal with by being more direct. Like, my friends are important to me, but I think that they take advantage of that sometimes, and I let them. In the end it is not good for them or me. Like the other week when we were at Weld Road. I told you about that didn't I?

Therapist:
Yes you did.

Samantha:
I got really scared that someone was going to die and it would be my fault 'cos I was meant to be looking after them when they had been drinking. Really it was stupid 'cos they shouldn't drink so much that they couldn't be safe themselves, do you know what I mean? It was not fair on me to have to take care of all these really drunk and stoned people doing crazy things. If I know that they are going to do that sort of stuff again I just won't go with them, it freaked me out.

Therapist:
What did you find out about yourself from that experience?
(prompting for self-monitoring)

Samantha:
(Pause)
That I'm not really as strong as I want to be, or as strong as I thought I was. I thought I could cope, but I couldn't.... but I have been thinking about it and I don't think any of my friends could have coped with the situation either.

Therapist:
So how does it make you feel about yourself now?
(prompting for positive self-evaluation, self-acceptance)

Samantha:
I feel weak, but I know that no-one else could have dealt with it any better, so I shouldn't feel bad, no-one got hurt. But I still didn't like it. I have promised myself that I will not get myself into that situation again.

Therapist:
So if you are out with your friends again and they say "Hey, we're going on a bender can you be like the designated minder person for us", what will you say?
(rehearsal)

Samantha:
I'd say "no way, if you want to do that shit then go and find some other idiot to hold your hand"!

Therapist:
How would it be for you to say that to a friend if they asked?
(self-monitoring)

Samantha:
They could ask, if they didn't accept my answer then they wouldn't be much of a friend.

(Pause)

Therapist:
Samantha, can I ask you, what do you think you can do to keep this strong and assertive view of yourself clearly in place over the next few days? How are you going to hold on to it?
(a good question promoting internal locus of control, goal setting, and planning for success)

Samantha:
Hummm .. I'm not really sure. I guess the more I try and be clear with people about what I want the more it will become a habit for me.

Therapist:
Can you get an image or picture of yourself in your mind that sort of shows you being clearer with people?
(supporting imagery representing positive self-conceptions)

Samantha:
Yes, I suppose so. I could picture myself talking to my mum and not letting her change the subject on to her.

Therapist:
Can you see that in your mind?

Samantha:
Yes (*smiling*), standing there with my hands on my hips or wagging my finger at mum saying "No mum, I'm not here to talk about you again because I have something I want to say".

Amanda

Interview date: 24th November 2000
Session: 6 of 6 (3rd of 3 self-concept enhancement focussed sessions)

Therapist:
We have been talking a bit about making choices ... where to live, your course, and making a choice about your mood. Can you say a little bit more about those things.

Amanda:
Well ... a few weeks or months ago there was a lot going on in my life and I was not happy. I think part of the problem was that I didn't really feel in control of how I came to be here or doing the course I am on. It felt like I had been dumped into something that I didn't want. From there I just kept on thinking that way, but more recently I have started to think that I have a choice, that things can change if I want them to. I think that this is helping me to feel a bit better in myself, and better about what I'm doing right now.

Therapist:
How does thinking that way help?
(prompting exploration of positive self-representations. Within this context this appears similar to techniques employed within Cognitive-Behavioural Therapy, i.e., challenging of negative cognitions)

Amanda:
Before I used to see myself as weak, weak, weak. Like things happen to me and I'm so pathetic that I couldn't do anything about it even if I had wanted to. Now I feel much more in control. I don't see myself as a superhero or anything like that, I'm just me, but that is enough and if it doesn't work for other people then that's their problem not mine.

Therapist:
You said that you're no superhero (*Amanda laughs)*, if not then how do you see yourself?
(prompting positive self-image, self-acceptance)

Amanda:
(pause) .... I know how I'd like to see myself, as this awesome woman who can do anything she wants ..... but I don't think I'm quite there yet. I am starting to believe that it is okay for me to choose what I should do, but I think I will only be making small decisions for a while. I hope that it is something that will get easier in time. I guess I'm sort of learning to walk by myself in a way. I have always had others to make decisions for

me, or help me out when things go wrong. Being rejected by my family, and being dumped here by my dad made me feel really alone and although I used to act all grown up back home it is different when you have to do it for real with no-one to help.

Therapist:
A real baptism of fire, you did it the hard way.
(self-acceptance, internalising locus of control)

Amanda:
It is not how I would have chosen to leave home, but I guess I have to take some of the blame for that because some of the things I was getting up to at home were pretty bad. Not that I'm ashamed of what I was doing, but I can see how it was difficult for my family.

Therapist:
So, how do you see yourself in relation to your family now, what sort of family member are you?
(self-monitoring, especially in relation to others – mutual influence)

Amanda:
I think I am a bit of a black sheep. I haven't really tried to keep in touch with my family although dad does visit sometimes. I miss my friends from home heaps, but I can't say that I really miss my family. They are probably still angry with me for leaving the way I did, I was so angry with what my Gran was telling me to do that I just packed my bags and moved in with a friend and never went back. I'm sorry for the way things turned out, but I don't think I have to take all the blame.

Therapist:
Amanda, how do you see yourself being in say, six months?
(internalising locus of control, goal setting, planning for success)

Amanda:
Well, I will be near the end of my course if I decide to stay. I will have heaps of friends in New Plymouth, or I'll be back in Huntly. I'll be very rich and all my family will love me ... no (*laughs).* I hope that I will be more settled in my mood, not so tearful and more able to concentrate and sleep well. I am fed up with feeling down all the time, it is really hard to get anything done, course assignments, or going out, or things like that.

Therapist:
And what are you going to have to do to make sure that these things happen?
(goal setting)

Amanda:
I've got to keep thinking positive thoughts and find ways to feel good about myself ... right? The trouble is when I get down it is still hard to drag myself back up. When everything is going well it's cool, but when I feel down it is still hard to know what to do to get out of it. It seems ... it's like being in a dark hole where the sides are wet and slippery and you can't get a really good grip to climb out. I guess that's where friends and family are useful, except I don't really have either at the moment, or I didn't have.

(pause)

But I do think that I have some more ideas about how to get myself out of the pit without the help of other people, and I don't panic so much as I used to. I feel stronger in a way.

Therapist:
How do you feel about that?
(self-acceptance)

Amanda:
Really good. I don't think I'm back to normal yet, but I am a whole lot better than I was a couple of moths ago.

RESULTS

Each of the six participants returned complete data for the pre- and post-intervention assessments and the data collection within each session. A descriptive summary of these data are presented, followed by individual case presentations.

Measures

Beck Depression Inventory – 2nd edition. At the time of the initial assessment the participant's scores on the BDI-II were within the range 21 – 36 (M = 26.2, SD = 5.98). This indicates an overall *moderate* level of depression among the participants.

When the post-intervention data was collected the range of scores was 1 – 18 (*M* = 8.3, *SD* = 5.96) indicating *minimal* levels of depression. This suggests that the participants were experiencing, or at least reporting, fewer symptoms of depression at the end of the intervention than they were at the beginning.

Youth – Depressive Adjective Checklist. The Y-DACL was used to monitor fluctuations in participants' mood from session to session. It was also completed as a part of the pre- and post-intervention measurement battery. At the time of the initial assessment, scores on the Y-DACL for the six participants fell within the range 5 – 16 (*M* = 11, *SD* = 3.58) on the 22 point scale. Lower scores indicate less frequent selection of self-descriptors associated with low mood and/or more frequent selection of descriptors describing better mood states. At the post-intervention assessment the range of Y-DACL scores was 1 – 9 (*M* = 4.5, *SD* = 2.74). Scores on this measure reduced for all participants with the reduction being between 3 – 13 points. This result supports the data from the BDI-II in finding a gradual improvement in mood for all participants over the course of the intervention period.

As data from the Y-DACL were collected at each session, it was possible to compare the scores from before and after sessions with a non-directive counselling focus, and with scores following sessions with a self-concept enhancement focus. The data marking the transition between the two intervention modalities were taken from the first self-concept enhancement session as this was the final data which was not influenced by the specific self-concept enhancement intervention as session data were collected at the start of each session. Friedman's test was used to compare the Y-

ADCL ratings of the six participants across the three time periods (pre-intervention assessment, transition from non-directive counselling to self-concept enhancement focussed therapy, and post-intervention assessment). These results are presented in Table 4.7.

Analysis indicated that there was a significant difference in the median Y-ADCL scores of the six participants over the three time periods. Post hoc analysis using the Wilcoxon test for post hoc comparisons (Munro & Page, 1993; Pett, 1997), with an adjustment of alpha to .017 to accommodate the increased risk of a Type I error, indicated that while there was no significant difference in the participants' Y-DACL mood ratings from pre-intervention to transition, there was from transition to post-intervention. This indicates that the overall improvements in self-reported mood were associated with more specific improvements recorded during the self-concept enhancement phase of the study.

Table 4.7

Y-DACL Summary Statistics and Comparison at Pre-Intervention, Transition, and Post-Intervention

					Friedman	
Y-DACL ratings	*N*	*M*	*SD*	*Mdn*	χ^2	*p*
Pre-intervention	6	11.0	3.58	11.5		
Transition	6	7.5	3.27	7.0	11.273	.004
Post-intervention *	6	4.5	2.74	4.0		

Note. * Significantly different from transition, $p<.017$, one-tailed.

Reasons for Depression Questionnaire – Adolescent version. The RFD-A was completed as part of the pre- and post-intervention assessment. The mean subscale scores for the participants at both these times are given in Table 4.8. Also included for comparison are the subscale means and standard deviations reported in the previous study. On this measure subscales scores are rated on a 4-point scale (1 - 4) with higher scores being associated with items/subscales that are seen as giving a reason why the respondent was depressed.

There was slightly more reason giving (frequency and/or significance) among the current participants than was found when this measure was used in the second study (Chapter Three). Also, over the course of the intervention there was a slight increase in reason giving (frequency and/or significance) among the current participants, with the largest change occurring in the *Relationship* domain. There was no change within the *Interpersonal Conflict* domain, and a slight decrease within the *Achievement* and *Characterological* areas. It is interesting to note that as with the standardization study, the main reasons for depression given at both the pre- and post-intervention stages were within the *Achievement* and *Characterological* domains, although these were the two subscales that were scored lower at post-intervention. It is possible that the act of talking in therapy was associated with a broader appreciation of possible reasons for depression. Also, that pre-therapy reason giving, which tended to emphasise personal failure, was modified to highlight relationships and the more immutable personal domain of biology. This may be seen as a movement away from personal responsibility for depression in favour of a more contextual focus.

Table 4.8

Mean RFD-A Subscale Scores from Pre- and Post-Intervention Battery Completion.

Subscale	Pre-intervention		Post-intervention		Data from standardization study	
	M	*SD*	*M*	*SD*	*M*	*SD*
Relationship	1.6	0.41	2.0	0.65	1.59	0.76
Achievement	2.8	0.97	2.5	0.79	2.08	0.73
Interpersonal Conflict	2.2	0.86	2.2	0.54	1.93	0.80
Characterological	2.6	0.38	2.4	0.48	2.02	0.70
Biological	1.5	0.41	1.7	0.74	1.40	0.53
Physical	1.9	0.75	2.2	1.06	1.73	0.73

Life Events Checklist. The LEC was completed as part of the pre- and post-intervention assessment battery. The scale allows respondents to indicate which life events they have experienced during the previous year (unit rating) and rate the degree of impact these events have had on their life (negative and positive impact rating).

At the pre-intervention stage the six participants indicated that they had experienced a total of 60 significant life events within the previous twelve months (range: 4 – 21, M = 10 events). Of these events 44 (73%) were rated as being negative events (range: 3-13, M = 7.3 events). The most frequently cited negative life events were "*failing an exam*" which was endorsed by four participants with a mean impact rating of 1.75 (out of 3) , and "*serious illness or injury of family member*" (3

participants, mean impact = 2.33). The range of possible scores is 0 – 3, with higher scores indicating greater impact (negative or positive). Participants cited three further items with a similar frequency ("*moving to a new home*", "*changing to new school*", and "*brother or sister leaving home*"). However, in some cases these events were rated as being negative while they were seen as being positive events by other participants. The life event data from the study reported in the previous chapter showed that "*death of a family member or friend*" was followed by "*failing a test or course*" as the most widely experienced negative life events on the rating scale used in that study (Adams & Adams, 1991). This suggests that there is some consistency in item response between the current study and data from other life event research in New Zealand (McGee & Stanton, 1992).

At the post-intervention completion of the LEC the participants indicated that collectively they had experienced only 53 significant life events (range: 3 – 18, M = 8.8 events). Of these, 36 (68%) were deemed to be negative events (range: 2 – 10, M = 6 events). The profile of most frequently endorsed items remained generally unchanged from the pre-intervention completion of the scale. The reason for reporting the results from the re-administration of this scale here is not because it constitutes an outcome measures in a strict sense, but to see if changes in the reporting of life events were associated with changes in the level of depressive symptomatology reported. A possible mediating factor here could be attributional style, which has been found to be more internal, stable and specific for negative events among depressed children and adolescents (Nolen-Hoeksema, Girgus, & Seligman, 1992). However, plotting the impact score for negative life events (sum of

ratings assigned to negative life events) against BDI-II scores from both the pre- and post-intervention assessment did not support further investigation of any association between these scores.

Tennessee Self-Concept Scales. The TSCS:2 was completed in full as part of the pre- and post-intervention assessment battery. The shorter form was completed at the start of each intervention session under both conditions. This shorter form yields the Total Self-Concept summary score, but does not produce the other subscale scores. The Total Self-Concept score is considered by the scale authors (Fitts & Warren, 1996) to be the single most important TSCS:2 score. The score is in the form of a normalized T-score (range 0 – 100, $M = 50$, $SD = 10$).

At the time of the pre-intervention assessment the six participants returned a mean Total Self-Concept summary score of 43.8 (range 34 – 66, $SD = 11.6$). Two participants scored below 40 which is the threshold indicating respondents who are doubtful about their own self-worth. There was a general trend for the Total Self-Concept summary scores to increase over the course of the intervention period. By the final assessment the mean Total Self-Concept summary score for the participants was 47 (range 42-54, $SD = 4.4$).

Again, Friedman's test was used to analyse data from the pre- and post-intervention assessments, and the transition session, i.e., the last session prior to commencement of the self-concept enhancement focussed sessions. The summary statistics are presented in Table 4.9.

Table 4.9

TSCS:2 Total Self-Concept Summary Score Statistics and Comparison at Pre-Intervention, Transition, and Post-Intervention.

Total Self-Concept scores	*N*	*M*	*SD*	*Mdn*	*Friedman*	
					χ^2	*p*
Pre-intervention	6	43.8	11.57	41.0		
Transition	6	40.8	4.36	39.5	6.333	.042
Post-intervention *	6	47.0	4.38	47.0		

Note. * Significantly different from transition, $p < .017$, one-tailed.

The Friedman test results show that there was a significant difference between the median scores on the TSCS:2 Total Self-Concept summary score of the participants over the three time periods. The mean scores show that the self-concept of the participants as recorded by their Total Self-Concept summary score actually dropped during the non-directive counselling phase of the intervention. Post hoc analysis was completed using Wilcoxon's test for post hoc comparisons with alpha set to .017. This test revealed that there was no significant difference between the pre-intervention and transition median scores, but returned a statistically significant difference between the transition and post-intervention scores. That is, while The Total Self-Concept summary score decreased from the pre-intervention to transition assessment this change was not statistically significant. However, the increase that occurred between the transition and post-intervention assessments was significant. It was during this period that participants received the intervention focused on enhancing self-concept.

Self-Esteem Scales. The first completion of the SES yielded a mean score of 8.5 (range 5 – 13, *SD* = 3.21). The range for this scale is 0 – 21, with higher scores indicating better self-esteem. At the post-intervention assessment the participant's mean score had increased to 15.7 (range 14 – 18, *SD* = 1.51). Summary data from the three change points in the data are given in Table 4.10.

Friedman test analysis results show a significant difference in median scores over the course of the intervention. This difference was accounted for by an overall difference between pre-intervention and post-intervention scores.

Table 4.10

Self-Esteem Scale Summary Statistics and Comparison at Pre-Intervention, Transition, and Post-Intervention.

					Friedman	
SES scores	*N*	*M*	*SD*	*Mdn*	χ^2	*p*
Pre-intervention	6	8.5	3.21	7.0		
Transition	6	11.0	3.85	12.0	8.455	.015
Post-intervention *	6	15.7	1.51	15.00		

Note. * Significantly different from pre-intervention, $p<.017$, one-tailed.

Case studies [6]

The quantitative analysis presented above is of value in providing an initial oversight of the intervention outcomes. However, the small sample size makes it difficult to be sure that the results can be relied upon. This is not to say that such analysis is unwarranted. Pett (1997) suggests that the use of non-parametric statistical analysis has particular usefulness in health care research because it is robust in dealing with smaller samples and unusual distributions. Indeed, most of the analyses that she used to illustrate the usefulness of these statistical techniques have an equally small sample size (n = 10). The statistical analysis presented above must be supplemented with data that support the validity of the results, and attest to the clinical significance of the general findings (Ogles, Lunnen, & Bonesteel, 2001; Russell, 1994).

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[6] Quotations are incorporated in all the case studies when this is deemed useful in reinforcing or elucidating the points being made. These quotations are taken from the participants' responses to the five standard questions posed at the start of each of the intervention sessions, and are referenced as such (Session Type/Session Number/Question Number). The session type refers to either Non-Directive Counselling (NDC) or Self-Concept Enhancement (SCE). The session number refers to the sequential number of the intervention sessions. The question numbers are as follows; (1) If I ask someone who knows you really well to describe you as you have been over the last few days, including today, what would they say? (2) Please describe briefly one event that has happened within the last few days that typifies your life at this time. (3) Please describe one way in which your see your life, as it is today, as being different from how you would like it to be. (4) If you had a wish today, and you could change one thing about yourself as you are at this moment, what would you change? (5) Over the last few days, what aspect of yourself have you been least happy with?

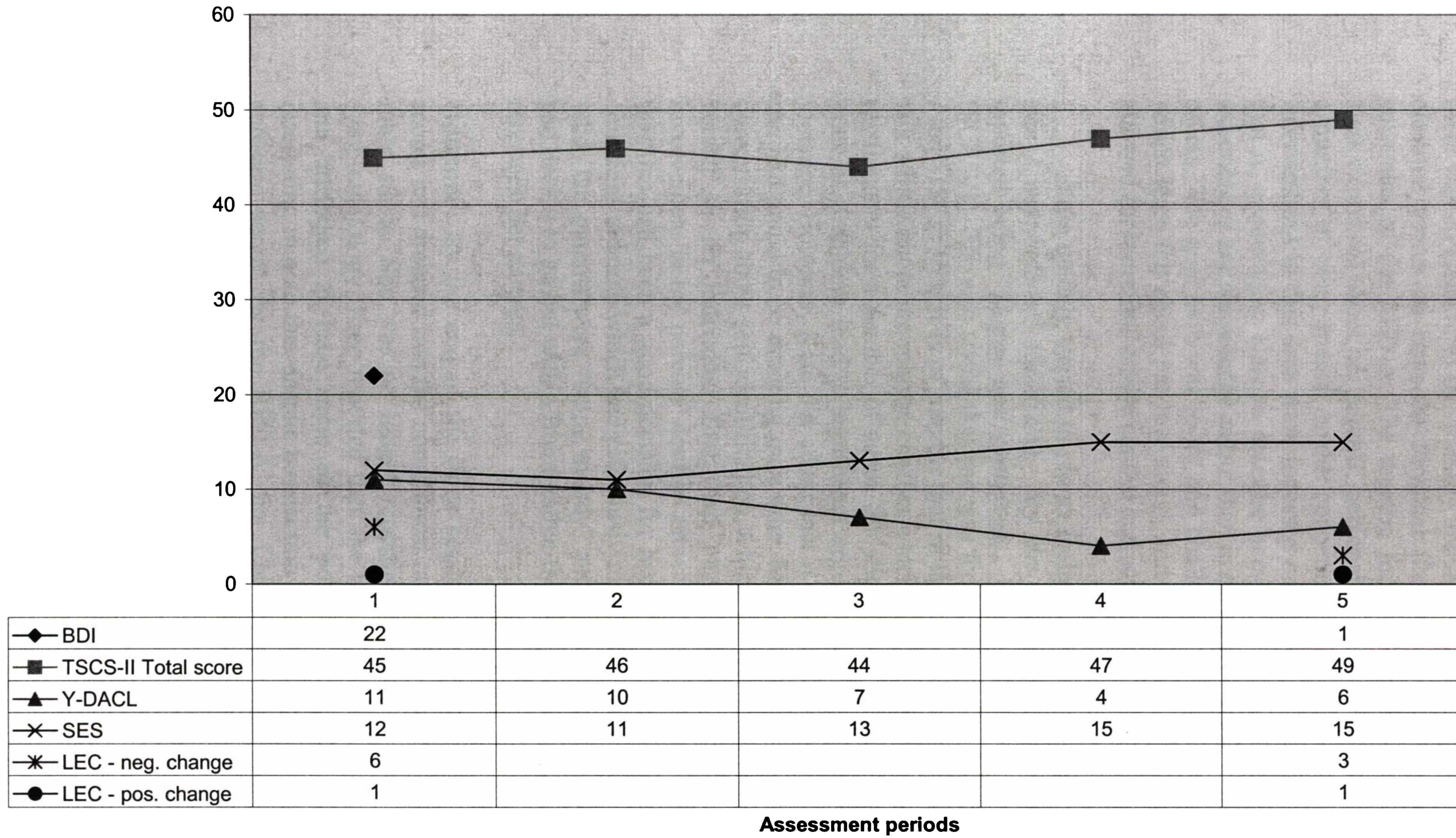
Kate

Self-concept enhancement (sessions 1-3): During the therapy sessions Kate presented issues related to her imminent school exams, concern over her separation from her boyfriend, and worry about her inability to sleep and feel rested. These were issues that had been presented by the referrer. Additionally, we also considered aspects of family conflict, Kate's fear that she was becoming depressed just like her parents, and an experience of sexual assault in her pre-teen years were also considered. During the course of Kate's sessions she was open and spontaneous in her presentation and displaying a positive approach to the therapy. She was also clearly able to use the time between sessions to maintain and enhance the progress she quickly made.

Figure 4.2 shows the data obtained on the key indicator measures over the course of five administrations, i.e., at the start (1) and end (5) of the evaluated therapy period, and at the start of each of the therapy sessions (2-4). Over the course of the three self-concept enhancement sessions Kate's Total Self-Concept score increased, as did her score on the Self-Esteem Scale. Her mood rating on the Y-DACL and depressive symptom score on the BDI-II both decreased, the latter showed a large reduction. Kate's clinical presentation also changed with a reported reduction in her tearfulness, and improved ability to settle to sleep at night. She still presented with worries about her school work until after her exams were completed, at which time these worries were replaced with concerns about her future at work. Finally, Kate's impact rating for negative life events decreased.

At the time of the first assessment interview Kate stated "*I spend a lot of time alone, or doing nothing. I miss my boyfriend, and worry too much about school, and my future*" (SCE/1/3), also that she had been "*...a bit more 'picky' over small things* [and] *focussing on the bad things with* [her] *mum*" (SCE/1/2). When asked what she would like to be different she said that she would like "*...not to get upset about everything*" (SCE/1/4).

Initially the intervention focussed on self-concept enhancement within the context of Kate's physical self. This was achieved through the use of positive visualisation, promoting positive affirmations, evaluation of negative cognitions, and generally helping Kate to explore aspects of her personal learning/social history which may have impacted on this part of her self-view. It was during these discussions that Kate's experience of being raped as a ten-year-old was disclosed. She indicated that this issue had not caused her particular distress in previous years, but that she had been thinking about it more since beginning a sexual relationship with her boyfriend, and since his departure for University.



	1	2	3	4	5
BDI	22				1
TSCS-II Total score	45	46	44	47	49
Y-DACL	11	10	7	4	6
SES	12	11	13	15	15
LEC - neg. change	6				3
LEC - pos. change	1				1

Figure 4.2 Kate's session summary scores on the individual clinical measures.

The second area of initial focus was Kate's belief that she was depressed because of Characterological reasons (on the RFD-A), i.e., that there was an element of inevitability about it. This was complemented by elevated scores on both the Physical (2.50/4) and Biological (2.17/4) subscales of the RFD-A. The therapy focussed on the concerns which Kate expressed about her parents' personal experience of depression, and a number of other mental health concerns within her extended family. Interventions in this area were focussed on aspects of self-identification, that is, encouraging Kate to describe herself in terms of personal skills, experiences and knowledge rather than in terms of the life experiences of others. The goal here was to try and challenge the sense of inevitability which Kate felt about her low mood, and reinforce a perspective which allowed for more immediate control and action.

Kate quickly started to report feeling *"more my usual self. More like I was before."* (SCE/2/1). By the end of the third session she reported being *"Happy and contented...* [with] *No tears, lots of fun."* (SCE/3/1). She also stated that she was feeling *"...really happy with who I am"* (SCE/3/1). It is of interest that in the third session Kate started to talk a little about the marital conflict which had been part of her parents' relationship for a number of years. She did not see this as being a major issue as it seldom lead to significant arguments, and never to domestic violence. However, Kate did admit that it was a chronic problem which she had found to be draining over time. She also stated that the previous conversation about self-identification, which she had interpreted as seeing herself as an individual first, had prompted her resolve to avoid involvement in her parents' conflict either passively or actively. She felt that this had been a good decision for her as it had helped her to avoid situations at home which had previously made her feel low. For example, when her parents were "being moody" and not talking to each other she had decide to go out with a friend rather than stay at home and attempt to reconcile her parents.

Outcome: By the end of the three session intervention Kate's BDI-II scores had dropped into the non-clinical range, and her presentation was more stable. She was no longer reporting the presence of depressive symptomatology. Kate reported that she had found the sessions helpful and attributed at least some of the positive change to them. It is interesting to note that despite a reduction in her Physical and Biological subscale scores on the RFD-A, her Characterological subscale score increased. This is the subscale reflecting reasons to do with the person's cognitions and personality. It is not surprising given the issues discussed that Kate recorded a higher score at the end of the intervention on the RFD-A subscale for Relationships, and a lower score on the TSCS:2 subscale for Family self-concept. Issues related to her sexual assault,

parental relationship, and the absence of her boyfriend were all likely to have contributed to these scores.

Follow-up with Kate two months after discharge found her maintaining her mood, ready for work, and optimistic about the future.

Elizabeth

Non-directive counselling (session 1): During the intervention sessions Elizabeth talked about the *"nasty separation"* between her parents and difficulties between her mother's partner (David) and herself. And example of this latter conflict was related to the resentment the Elizabeth felt when she had believed that she prevented her mother from taking her own life earlier the previous year. She reported that David had taken the "credit" for this despite only arriving on the scene towards the end of events. Elizabeth admitted that she felt angry, resentful and jealous towards David because of this. She also raised her concern about the inheritability of her mother's depressive tendencies.

A major focus of the therapy session was the difficulties that Elizabeth's reported having at school. She indicated that *"school is not my favourite thing, and I am not their favourite student."* This was certainly reflected in reports of her academic progress, but not of her application/effort, or behaviour. Elizabeth presented with difficulties in concentrating and short-term memory, and while these were likely to have been contributing to her academic difficulties it did not appear that they were solely due to her lowered mood. Elizabeth reported being well settled in the boarding hostel, and having a number of good and supportive friends.

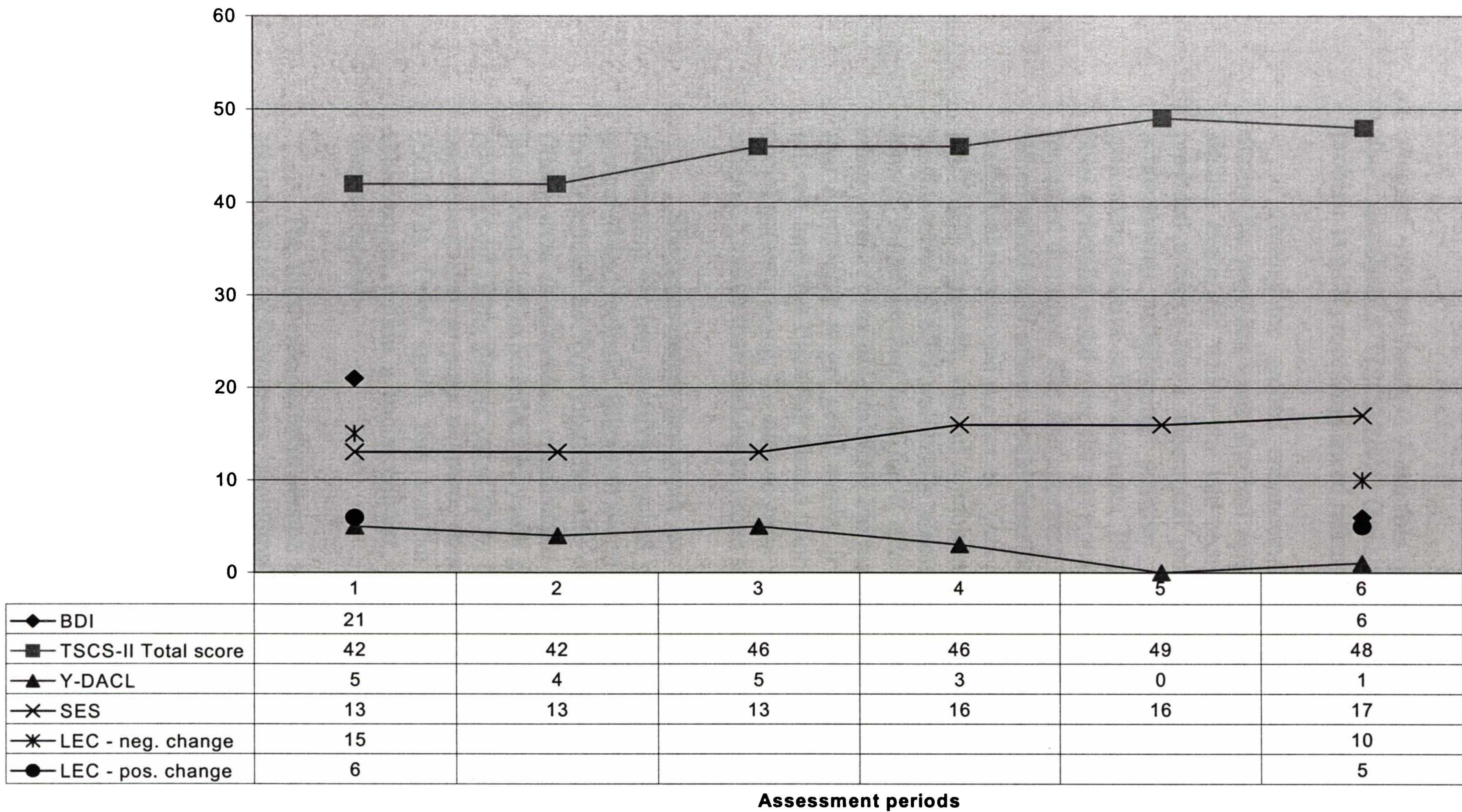
During the first session, which was nominated as a non-directive counselling focussed session, Elizabeth talked about having had depressed times, some *"hyped-up times"*, and some *"normal"* times during the previous week. She also spent a good deal of time talking about her mother's mental health history and exploring the impact that this had had on her life in the past. Elizabeth also talked about some of the rules at school that caused her difficulty, primarily because of her growing interest in body piercing. When asked how she thought others would describe her at that time Elizabeth indicated that she thought others would see her as *"Energetic, interested in things"* (NDC/1/1). She also stated that she had been having fun, *"Life is normally fun, but it is different when I go to school. It's nice to see my friends, but hard to do the work."* (NDC/1/2).

Elizabeth did not present with any suicidal ideation at any time during the assessment and intervention period.

Over the course of the intervention Elizabeth's BDI-II scores gradually decreased and there was a clear improvement in self-esteem and self-concept as recorded on the psychometric measures used for the study. Figure 4.3 gives a summary of data obtained on the clinical measures over the course of the six administrations.

Self-concept enhancement (sessions 2-4): The focus of these sessions was initially to be on Family self-concept and Academic/Work self-concept as these were the problematic areas as indicated by the TSCS:2. They were also the areas identified as being reasons for depression in Elizabeth's RFD-A results.

Elizabeth reported low perceived effectiveness within her school setting, and reported little optimism about being able to improve. In the sessions Elizabeth was also able to brainstorm ways of gaining additional assistance with her school work, and feedback from her teachers about her relative strengths and weaknesses. She was able to role-play some of these scenarios in the session. Elizabeth spent some time considering the origin of these messages about being unable to achieve at school, and was able to attribute them to her own parents lack of achievement in this domain, and to the subtle way they communicated with her regarding school tasks and progress. At the end of the first enhancement session Elizabeth indicated that people who knew her well would see her as being, *"Happy, excited, hyperactive again ... Strange."* (SCE/2/1). Elizabeth stated that she *"... act(s) really weird sometimes ...I just mumble about things, just like a toddler. I don't mumble to anyone except myself. It is fun, keeps me entertained."* (SCE/2/1). While not indicative of depression this does suggest a degree of confusion, and gives the impression of social isolation and loneliness. Elizabeth stated that she was very happy to see a friend who had recently returned from an overseas trip. Again this was stated in a way which suggested that Elizabeth was socially isolated in the absence of this friend. At the end of this session there was also a very poignant reminder of how Elizabeth saw herself in relation to school. In response to the question "Please describe one way in which you see your life, as it is today, as being different from how you would like it to be", Elizabeth commented, *"I'd like to quit school, people think I am stupid. I am in the class where they put all the stupid people who can't learn."* (SCE/2/3). It is interesting to note that Elizabeth does not say that she is "stupid", and she gives the impression that although she has been placed in the class with "people who can't learn" this does not apply to her. She went on to say, *"I'd like to be smarter so that I could understand things faster. People get*



	1	2	3	4	5	6
BDI	21					6
TSCS-II Total score	42	42	46	46	49	48
Y-DACL	5	4	5	3	0	1
SES	13	13	13	16	16	17
LEC - neg. change	15					10
LEC - pos. change	6					5

Figure 4.3 Elizabeth's session summary scores on the individual clinical measures.

annoyed with me because I ask lots of questions, but that's because I don't understand." (SCE/2/4). Once again, Elizabeth stresses that her problem is with processing speed rather than latent academic ability.

During the second enhancement session Elizabeth stated that during the previous week she had received results from a recent social studies exam, for which she had received a grade of 80%. This topic provided a focus for a substantial part of the session, acknowledging achievements, reinforcing positive feelings of achievement, and generating positive self-statements. Elizabeth reported that her mood had been generally good over the previous few days, although her sleeping remained disturbed. She also appeared very distracted during the session. When asked how others would describe her over the preceding days she stated that they would see her as *"Quiet ... because I've been very tired."* (SCE/3/1). However, she did acknowledge that, *"Getting back my social studies mark of 80% was really pleasing. I was feeling quite proud of myself. I had worked hard for it after my disappointing test mark the other week. I was able to show the teacher, and the others in the class that I was able to get good marks. It was great."* (SCE/3/2). It is of interest here that Elizabeth placed importance on her exam mark within a social context, being *"... able to show the teacher, and the others in the class ... "*, rather than seeking to prove something to herself.

She considered her goals as a representative cricket player, challenging her less positive physical self-concept, but also keeping her grounded and realistic. Elizabeth described a positive experience relating to her cricket as 'typifying' her life over the last few days, *"My Rep. Coach went to a meeting in Auckland where they read my letter out* [a letter about her experiences in youth grade cricket], *he said it sounded really good. Some people came up to him after and said that they were impressed, and to pass on their thanks for the effort I had put in."* (SCE/3/2). Once again, this was an example of the importance of achievement within a social context, what Côté (1996) referred to as identity capital.

The third enhancement session again commenced with a focus on school based achievements, including a good exam result in science (82%) and anticipated good performance in a recent music exam. The focus of the intervention here was enhancing the internalised positive regard of others through cognitive rehearsal and visualisation. As her schooling seemed particularly poignant and reinforcing to Elizabeth it was felt to be the most useful focus in building positive self-regard and a sense of self-worth. Elizabeth also indicated that she was feeling more positive in her home environment. It was useful at the end of the session

to have the opportunity to check Elizabeth's progress with her mother, who indicated that she felt Elizabeth had been making steady and positive improvements over the sessions and particularly over the previous two weeks. At the end of the session Elizabeth indicated that *"Everything has been going really well. I think people would say that I have been working harder and have had more energy."* (SCE/4/1). She continued, *"I feel really good about myself at the moment. I need to keep up the work at school so that I keep getting good test marks, but I think I can do that now."* (SCE/4/5). This statement reveals the development of some positive sense of self-worth which was encouraging in the face of her previous low self-esteem in the area of her academic endeavours. She also indicated that she had decided to spend more time with her father. She acknowledged that at the time of her parent's separation her mother had needed her more than her father. However, she now recognised that she needed time with her father, and that she had decided to make that a priority, *"... and I am really looking forward to that."* (SCE/4/3).

Outcome: By the end of the five sessions Elizabeth's scores on all of the psychometric measures had moved in a direction indicating more adequate functioning. While she had only made preliminary steps in dealing with the stresses in her life that appeared to have been related to her low mood, Elizabeth perceived her progress as positive and was keen to continue with the techniques she had learned during her therapy sessions.

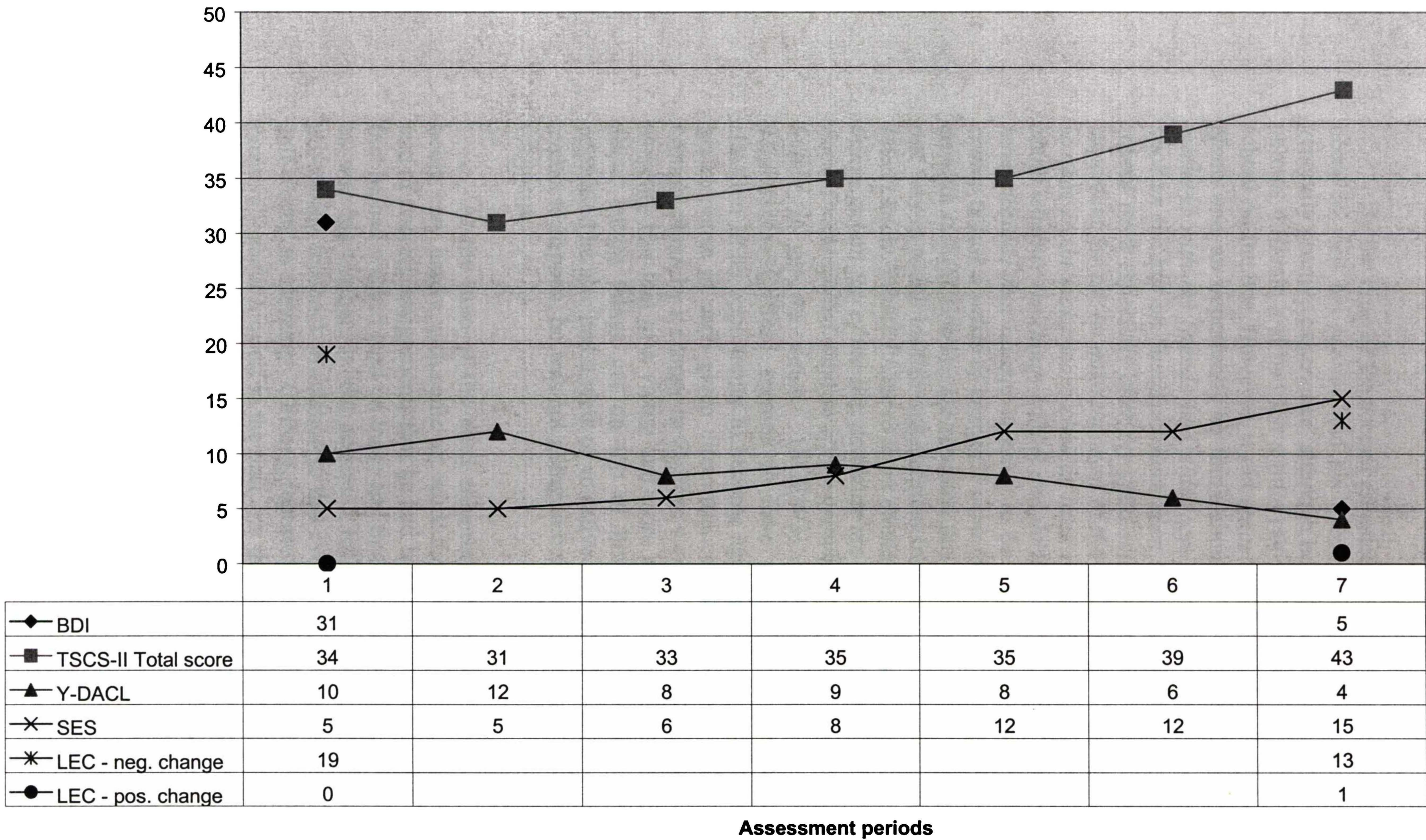
There was a reduction in overall reason giving for depression by the end of the sessions. However, behind this result was a decrease in reason giving associated with Interpersonal Conflict and Achievement, and a marked increase in reasons associated with Biological reasons for depression. While not a significant factor at the time of the pre-intervention assessment the biological reasons for depression, e.g., "I inherited it from my parents", "It's basically caused by genetics" clearly became relatively more important as the other factors were addressed during the therapy.

Clifford

Non-directive counselling (sessions 1-2): During the two non-directive counselling sessions Clifford's main focus was on his anger about being placed at a local high school as a boarder. This anger appeared to be directed primarily at this parents, but also at the school. However, he acknowledged that the school was not to blame, and was indeed a very good school. He reported feeling socially isolated, although various aspects of his discussion of this suggested that this was often self imposed isolation in the face of concerted efforts by the school and his peers to

involve him in various activities. In many ways Clifford was not doing well at school. The outcome of these sessions was one of catharsis for Clifford. He made no spontaneous attempt to set goals or resolve the stressors that he talked about. Consistent with a learned helplessness model of depression he presented as generally despairing that anything he did or was likely to do would make any difference to his situation, *"I wish I did not always feel so angry and resentful. I find myself being angry with the guys at the boarding hostel, but it is not their fault. My parents made the decision and no-one else."* (NDC/1/4). Clifford's scores on the various session measures are presented in Figure 4.4.

Self-concept enhancement (sessions 3-5): At the third intervention session, the first with a clear self-concept enhancement focus, Clifford reported some improvement in his mood. He had received a good grade (84%) in a science test, and had continued to receive a lot of support from staff at his school. The session focussed on his part in this as a way of enhancing his sense of control and choice within the school environment. Further discussion of Clifford's academic record at his previous school suggested that he had excellent aptitude and potential. Clifford grudgingly admitted that his parents had sent him away to school *because* they saw him as academically able and were concerned that he would not realise his potential at his previous school because of its size and the distraction of his peers. While he believed that his parents saw his friends as having a negative influence on him Clifford spoke of them in very positive terms and clearly missed having access to them, *"I would still prefer to be nearer to my friends in* [town]. *I am going home again this weekend and am really looking forward to it. I know I will feel bad when it is time to come back here, but I just have to make the most of it."* (SCE/3/3). Attention in the session was given to the positive aspects of the decision his parents had made, and their motivation of apparent concern. Clifford seemed able to appreciate this. This was achieved by brainstorming reasons why his parents may have made this decision, and selecting those reasons which were most consistent with his parents other behaviours. This latter step was incorporated to provide an opportunity to counter reasons such as "because they hate me and want me out of their lives". The general goal was to increase empathy and identification with his parents, and hopefully enhance Clifford's sense of family self-concept, i.e., his sense of adequacy, value and worth as a family member.



	1	2	3	4	5	6	7
BDI	31						5
TSCS-II Total score	34	31	33	35	35	39	43
Y-DACL	10	12	8	9	8	6	4
SES	5	5	6	8	12	12	15
LEC - neg. change	19						13
LEC - pos. change	0						1

Figure 4.4 Clifford's session summary scores on the individual clinical measures.

By the time of the second enhancement session Clifford had been home to visit his parents and his friends. He reported that this was a generally positive experience, although he had found the last day with his parents difficult, and had felt a little sad when he was travelling back to school on the bus. However, it did seem that the weekend trip home had given him an opportunity to think about his situation. *"I had a good weekend with my friends and didn't get too down when I had to come back on the bus on Sunday. I have been thinking about focussing on my school work especially after my good science test last week. I think it is important for me to make the most of the opportunity to get good grades so that I can make more choices later on. I have been trying to think about whether the things I think and do help me or get in the way, and I have decided that always wanting to be at home even when I have no choice is just a waste of energy. I want to be there, but I'm not ... so get on with it."* (SCE/4/1). He repeated this theme when asked to describe one way in which his life was different from how he would like it to be. " *I don't know. I think I have to work on making the best of a situation. I let things get on top of me like dominate me when I can't do anything about them. I need to find ways to either get what I want or walk away without letting it get me down."* (SCE/4/3). From a position of learned helplessness Clifford seemed to have partially re-conceptualised his situation as an opportunity to become agentic and make decisions about his response in each given circumstance. This change may have been brought about by a change in Clifford's view of himself, his self-concept, as being less that of a victim and more an active player. His comments about letting things get on top of him suggest that despite feeling oppressed he also had a view of an active participant who allowed certain events to happen, he was not going to continue being an entirely passive recipient.

At the time of the third enhancement session Clifford reported being very happy with some art work that he had completed, this being one of two big assignments that he had handed in for marking. He stated that he had worked hard on these and that he was pleased with the result, as was his teacher. In the session Clifford focussed on receiving and processing feedback in relation to this event, allowing a positive sense of self-worth to develop. Clifford reported that he had always thought positively about himself in the past, but thought that his parents' decision to send him away to school had undermined this somewhat. He stated that he was feeling optimistic about using his time at school productively, a statement of intent that he did not want his future to be jeopardised because of a decision made outside his sphere of influence. While Clifford did not say that he was happy to be living away from home he did acknowledge that his mood was a little better and stated that he did

not want to spend the rest of the school year feeling angry and resentful. *"I have been feeling really positively about myself. I can't think of anything that I am really unhappy with, not anything big anyway."* (SCE/5/5).

Outcome: By the end of the research sessions Clifford was approaching the end of the school year. He was keen to complete his exams and return home. He had not fully accepted the prospect of returning to boarding school the following year and remained hopeful that his parents would relent. However, he did state that he felt better able to cope if he had to return. The strength in this decision making, and the positive attitude to his family were primary sources of material for this third session, as was his continuing progress with the academic demands of the school.

Over the following summer months Clifford telephoned the service to record his thanks for the support he had received, this was not something that usually happened once adolescent clients had been discharged. He indicated that he had done well in his exams, and that both he and his parents were pleased with the results. In fact, his parents were so pleased with how he had coped, and with the maturity that he was displaying that they gave him the choice of school venue for the following year. He elected to remain at home and return to school in his home town.

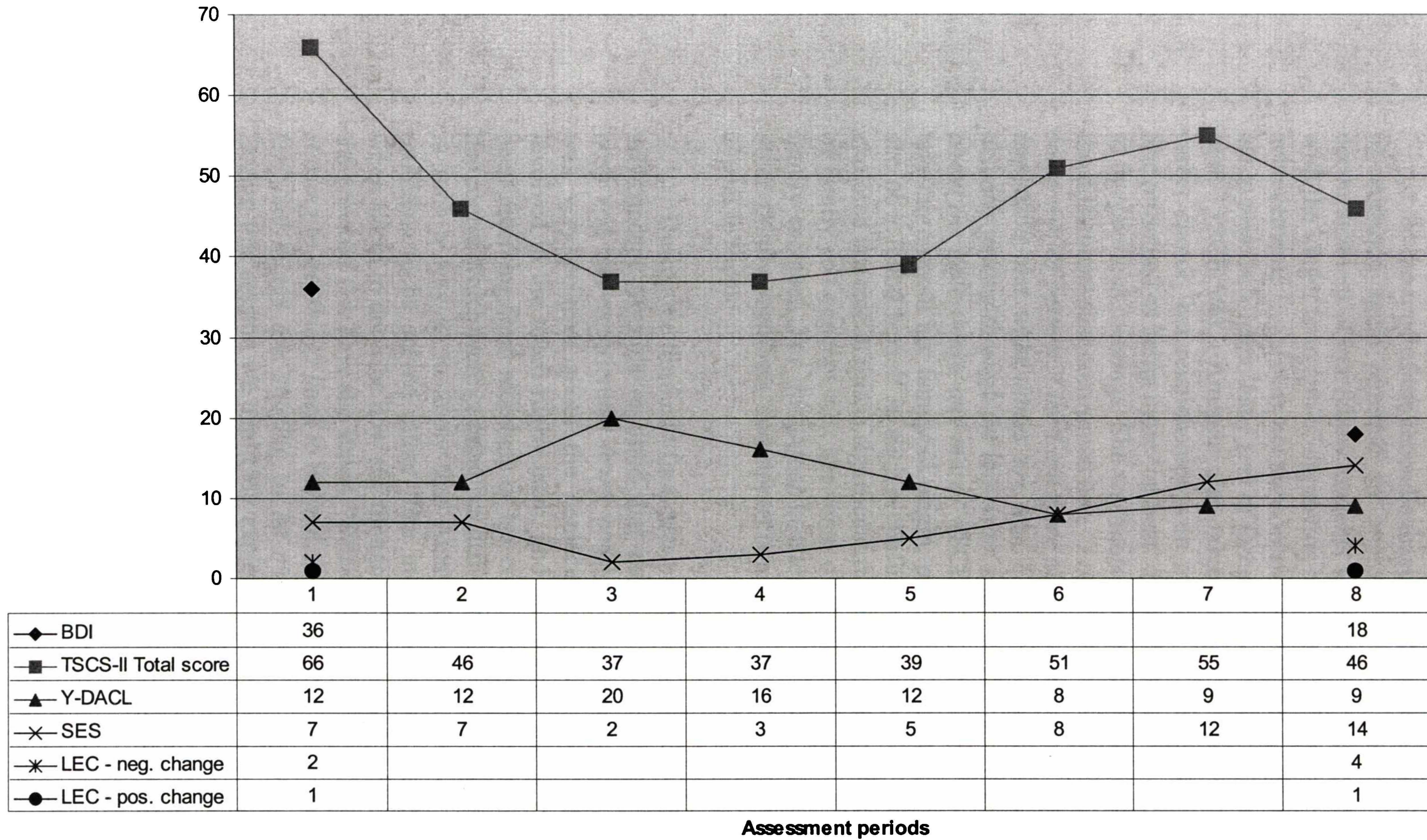
Amanda

Non-directive counselling (sessions 1-3): Following the initial assessment interview it was planned that the intervention would start with three sessions of non-directive counselling. However, during the second and third of these sessions it proved necessary to engage in a more active intervention as it became clear that Amanda's risk of self-harm was increasing. This was precipitated by two incidents that occurred during one day of Amanda's course. The first of these was being informed that she would not be able to participate in a planned field placement because she had not completed enough of the class-based course work. Secondly, she performed badly in a class practical test that she believed she would have been able to pass easily at another time. These events caused her to become significantly distressed, having to leave the classroom. While she reported being well supported by her tutor and classmates, she indicated that she had been acutely embarrassed by her inability to cope. The second and third counselling sessions focussed on assisting Amanda to manage her safety by supporting her as she challenged her negative cognitions, and by establishing a robust safety plan. It is interesting to note that during these three sessions her Total Self-Concept summary

score on the TSCS:2 dropped, as did her self reported self-esteem rating. Her score of the Y-DACL increased over this period. These data are reported in Figure 4.5.

Self-concept enhancement (sessions 4-6): The preliminary focus of the self-concept enhancement sessions (assessment period 5-7) were issues which had contributed to the elevation of Amanda's suicidal risk. In addition there was a focus on aspects of Physical, Personal, Family, and Social Self-Concept as identified by Amanda's initial completion of the TSCS:2. These general themes were consistent with the issues identified by the referrer, and identified within the initial assessment interview.

During the first self-concept enhancement session Amanda reported that her mood had improve a little after the period of lowered mood and increased suicidal ideation evident during the previous two sessions. Amanda reported that she was not experiencing any significant difficulties, although she stated this in a way which signalled acceptance, even resignation to the fact of problems in her life, rather than demonstrating an ability to meet and resolve her problems. It would not be reasonable to expect that she was "trouble free" so soon after expressing such clear suicidal thoughts. This presentation was consistent with Amanda's initial reports of very positive self-concept. Fitts and Warren (1996), indicate that very high Total Self-Concept summary scores (> 69) can be considered to be unusual, and are often associated with serious psychological distress or disturbance. They go on to suggest that a person returning such a high score may be experiencing a sense of failure and unhappiness. This would appear to be the case for Amanda. She talked more about her perceived failure and humiliation while at Polytech., and her inability to rectify this situation in any way. In response to this we spent some time completing a brainstorming exercise in order to generate possible courses of action, followed by role playing of some of these scenarios. During these activities Amanda was often distracted off task. She stated that this was usual for her at that time, but was a source of frustration to her and was something she wanted to do something about (a first sign of spontaneous agency), *"I don't find it easy to keep focussed on things that I need to do. My mind keeps wandering onto other things, real time wasting things. I would like to be able to sit down at my computer and work for like three hours and write lots of stories and get up to date."* (SCE/4/3). Towards the end of the session Amanda was encouraged to think about her physical health status and consider planning a course of action that would enhance this. She was also able to spend some time backgrounding her family, particularly focussing on ways that she was similar or different to various members of her extended family, and whether this was desirable or not. She also talked about what she had to offer her family, and what they had to offer her at that time.



	1	2	3	4	5	6	7	8
BDI	36							18
TSCS-II Total score	66	46	37	37	39	51	55	46
Y-DACL	12	12	20	16	12	8	9	9
SES	7	7	2	3	5	8	12	14
LEC - neg. change	2							4
LEC - pos. change	1							1

Figure 4.5 Amanda's session summary scores on the individual clinical measures.

At the time of the second enhancement session (assessment period 6), Amanda again reported an improvement in her mood. With the encouragement of her fellow students she had joined a touch rugby team with the longer term aim of improving her fitness, she saw this as a major achievement, " *... I was not sure when this woman on the course asked me to join their team, but I sort of forced myself and I'm happy that I did now.*" (SCE/5/4). Amanda also talked about her goals regarding her career choice, her relationships with friends and family, her social life. She presented as being more 'up beat' during this session when compared to the previous meetings. She was more optimistic in her attitude towards the difficulties that confronted her, *"I think I have started to see things in some sort of pattern. Like I am more able to think about what things are important and what things are not. I know that I still have problems actually getting through the important stuff but I'm not getting so up tight about the little things any more."* (SCE/5/3). Amanda was also keen to talk more about her family of origin, particularly about the reasons why she now found herself in such a conflictual relationship with them. She explored her role in this, a significant part of further developing her sense of family self-concept, i.e., her sense of adequacy, worth, and value as a family member. For this Amanda attempted to take the perspective of other family members and appreciate how her past and present must appear to them.

During the third and final session focusing on the enhancement of self-concept Amanda reported that she had been keeping herself very busy and had experienced fewer problems keeping herself on-task. She was very positive about the contacts she had made through being involved in the touch rugby team, and the general support that she had been receiving from members of her course. She talked about aspects of her course which were causing her difficulty, although this was presented in such a way as to imply that Amanda was starting to see these as problems to be solved rather than inevitable outcomes. For example, when asked to describe how she thought others would have seen her over the previous few days she stated, "*Better again. Still staying focussed and starting to get things back to normal. I know I have a way to go yet, but I feel like things are starting to be more positive for me.*" (SCE/6/1). During this session we explicitly explored issues around Amanda's self-concept, how she saw herself. This was considered with particular reference to her social and family relationships, and her own physical self. Issues related to past, present and future self-perceptions (desired self) were explored from the perspective of Amanda herself, and her beliefs about how others saw her. Consideration was given to how these were maintained and reinforced, or refuted and changed. At the time of this final session there was no ongoing suicidal ideation expressed,

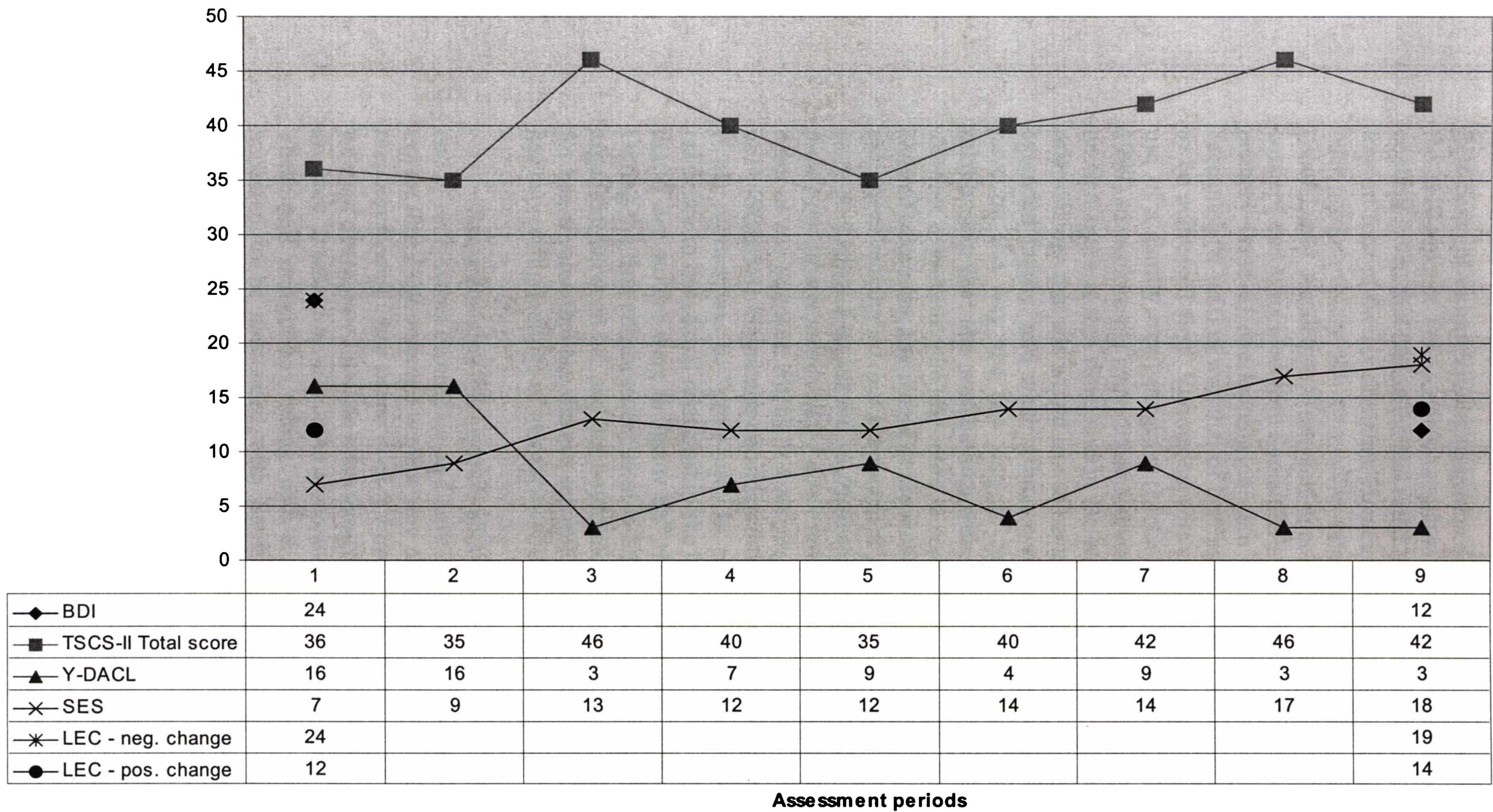
although this had been present up to this point. Amanda generally reported feeling in a better mood than previously, but still had times of lowered mood, *"Still a bit tearful and lazy, but I am getting things completed which is the main thing."* (SCE/6/5). Amanda had initiated contact with her father, a relationship which she saw as very problematic. She reported feeling a great sense of achievement at having contacted him, and was happy that they were able to talk about family matters on the telephone. Her father had suggested that he visit, an event which Amanda had agreed to but about which she felt some trepidation. However, she believed that it would be likely to yield some benefits in terms of family reconciliation. On discussion she remained adamant that her family remained at least partly responsible for the breakdown in relations between them and herself.

Outcome: By the end of the third self-concept enhancement session Amanda was able to state clearly that she had some positive things happening in her life, and was feeling optimistic, "*Things are not perfect, far from it, but I feel much more in control, much better about myself and the choices I am making, and I'm starting to have a bit more fun than I was a few weeks ago.*" (SCE/6/4).

The intervention with Amanda did not end after the three self-concept enhancement sessions and subsequent completion of the post-intervention assessment package. Therapeutic work continued with Amanda making progress on her course and with her family over a period of several weeks. She continued to experience bouts of depression, which were not completely resolved by the end of the therapy.

Samantha

Non-directive counselling (sessions 1-4): After the initial data gathering and interview Samantha commenced with four sessions of non-directive counselling (assessment periods 2-5). She stated that her goal at that stage was to receive help with managing the stressful situations that she associated with becoming depressed. As can be seen from the session data reported in Figure 4.6, Samantha recorded changes on the Total Self-Concept summary score and Y-DACL over the course of these counselling sessions, although the initial gains made in the area of overall self-concept were quickly lost.



	1	2	3	4	5	6	7	8	9
BDI	24								12
TSCS-II Total score	36	35	46	40	35	40	42	46	42
Y-DACL	16	16	3	7	9	4	9	3	3
SES	7	9	13	12	12	14	14	17	18
LEC - neg. change	24								19
LEC - pos. change	12								14

Figure 4.6 Samantha's session summary scores on the individual clinical measures.

Self-concept enhancement (sessions 5-7): The initial focus planned for the self-concept enhancement sessions was on general aspects of self-concept given that Samantha had rated her own self-concept as being very low on four of the six domains. However, it transpired that despite this it was predominately the two areas rated as being more unproblematic (Social and Academic/Work self-concept), in addition to Family self-concept that coincided with Samantha's most significant concerns. As the primary issue of overlapping concern recorded on the TSCS:2 and by Samantha in-session was that of her family, this was selected as the area to be addressed first. Various aspects of this were explored through the use of a family tree/genogram (McGoldrick, Gerson, & Shellenberger, 1999) to explore the impact that individual family members were having on Samantha at that time, and in the past. She also explored the type of relationships that she would like to have with members of her nuclear and extended family, and what influence such a change would be likely to have on the way she saw herself. Samantha focused mainly on the relationship that she was having with her mother at that time, *"I had another argument with my mum a couple of days ago. She is so self-centred about her boy-friend at the moment. I wanted to tell her about me and Steve making up, but she just kept going on about how her and Neil were so happy. I makes me so frustrated that she is so selfish. I wish it didn't because it means that I don't have much of a relationship with my mum at the moment. Partly it's my fault, but mostly she needs to grow up!"* (SCE/5/3). Samantha considered the impact that it may have on her if her mother was to "grow up". In particular she discussed this with reference to the sexual relationship she had with her boyfriend. She stated that if her mother were to "grow up" she may be less supportive of this. During the first enhancement session Samantha also talked about a recent argument between her and her boyfriend. This raised issues of his respect for her, a value that she did not see reflected in his behaviour. This led to her expressing feelings of insecurity within the relationship.

Samantha also felt insecure about her school work, *"We have our end of year exams coming up an I have been told by my teachers that they expect that I will manage without any problems. It was good to hear that they have confidence in me even if I don't have much in myself. ... I am worried about how I will do even though my teachers did say that I would do okay. It would be nice to have more confidence in myself."* (SCE/5/2). These self perceptions, along with a recent conflict with her mother appeared to be associated with Samantha's generally low mood and difficulties coping with a number of facets of her life at the time. When asked to state the thing about herself she was least happy with at that time Samantha said, *"After the trouble last time with Steve and this time with my mum, and with my exams coming up I think it has all been getting on top of me a little bit."* (SCE/5/5).

At the start of the second self-concept enhancement session Samantha reported that her mood was slightly improved, but that she had experienced more difficulties with her eating. Specifically, she had felt more disinclined to eat to the point where she had started missing occasional meals. She indicated that this had been a problem previously, although further exploration suggested that both the past and present eating problems were not of clinical significance. This focus provided some insight into Samantha's very low rating on the Physical self-concept subscale.

Family issues and Samantha's perception of herself as a member of her family were the dominant themes in the second session. Her mother had received a telephone call from her father informing her of Samantha's apparent wishes and activities, many of which were not true, e.g., her desire to leave school, regular and excessive alcohol use. He stated that Samantha had informed him of these things during a recent telephone call, a claim which Samantha denied. These comments had the effect of undermining Samantha's mother (i.e., how was it that Samantha's father knew about these things and she didn't?) and prompted further conflict between Samantha and her mother. Samantha stated that these 'mind-games' were typical of the way her father related to the family.

Samantha was asked how she saw herself, especially in relation to others. She stated that she was *"independent, challenging and defiant, but also open-minded and tolerant"*, and that she usually needed to learn *"... the hard way"*. However, she also stated that she had a more sensitive and responsible side to her personality, and that she often placed the needs of others before her own. Samantha indicated that she saw herself as being different from other members of her family as she can be more thoughtful with respect to others, more task motivated, and more active. It seemed that this perception of difference was what, in part, led to her positive feelings of independence. Unfortunately it also seemed to have prompted the perception of herself as being isolated from both her family and friends. Samantha also stated that she often felt frustrated in her relationships with her family, and that she 'bottled' these angry feelings up. In the session Samantha was encouraged to focus on the more positive and functional attributes which she presented, and explore the appropriate application and use of these. Also, she explored how these self-views were developed and maintained by her own actions, and the actions of those around her. At that point the ongoing difficulties that Samantha was experiencing with her boyfriend again became a topic of discussion. It seemed that despite Samantha's continued statements to the effect that he was always unconditionally supportive he was often undermining in both the things that he would say about her, and in his actions, *"Me and Steve*

had another split this week, but I don't think it got me down as much as the last one. I was able to tell him what was pissing me off about his behaviour, and get him to talk to me. I think I was a bit more assertive that I have been before. I know that relationships are two way things, but Steve doesn't behave as if it is. He is happy if everything is going his was, and moody if it isn't, it doesn't seem to matter to him what I think or want. I think he understood that when I told him. I want to be with him, he's fun, but not if I have to do all the giving and get all the worry." (SCE/6/1). It seemed that Samantha had been able to talk to her boyfriend about their relationship although it was not clear whether the events leading to the initial argument had been resolved. Within the session Samantha was able to generate some ideas about what needed to happen to manage this relationship, and reported that this was helping her to feel more confident and positive about herself, *"I don't like being selfish, I hate it when other people only think of themselves, but I think I need to be a bit more selfish ... like with my time."* (SCE/6/5).

At the time of the third self-concept enhancement session Samantha's scores on the mood and self-concept rating scales suggested improvements within both domains. This was despite that fact that Samantha had experienced another temporary separation from her boyfriend, who was becoming increasingly possessive of Samantha and was experiencing difficulty in tolerating her spending time with her friends when he was not present. She reported being a little 'down' because of this, but was adamant that she was not going to allow him to prevent her seeing her other friends, or be responsible for her mood. She stated that she had come to a realization that the relationship with her boyfriend would not last, and that she was finally happy to accept this. However, she had also realized that she did not feel happy with the idea of being alone. Samantha spent some time talking about the way that she could feel alone when she was in the company of friends because they seemed to be less mature than her and not interested in the same things. That is, while her school friends were very supportive, they did not meet all her needs. Samantha reported feeling neither supported or understood by her mother, who she saw as unduly distracted by her own interests. Samantha spontaneously observed that her social supports were more active and obvious when she was depressed. Despite the theme of loneliness, Samantha presented as positive and optimistic during this session, perhaps motivated by increased self awareness, *"I think things are going much better than they were. I am thinking more about things, and myself. I feel like things are starting to get back on track, back to normal again."* (SCE/7/4). This greater sense of self-satisfaction (personal self-concept) was explored via direct comparison with past actions and future goals.

Samantha had also been working hard at school. She reported that she had been doing well in her school exams, and was feeling very optimistic about the results, *"My exams are going well. I have just about finished. I have been really focussed over the last week. I expect to do okay. I have had a lot more energy and been feeling really positive."* (SCE/7/1).

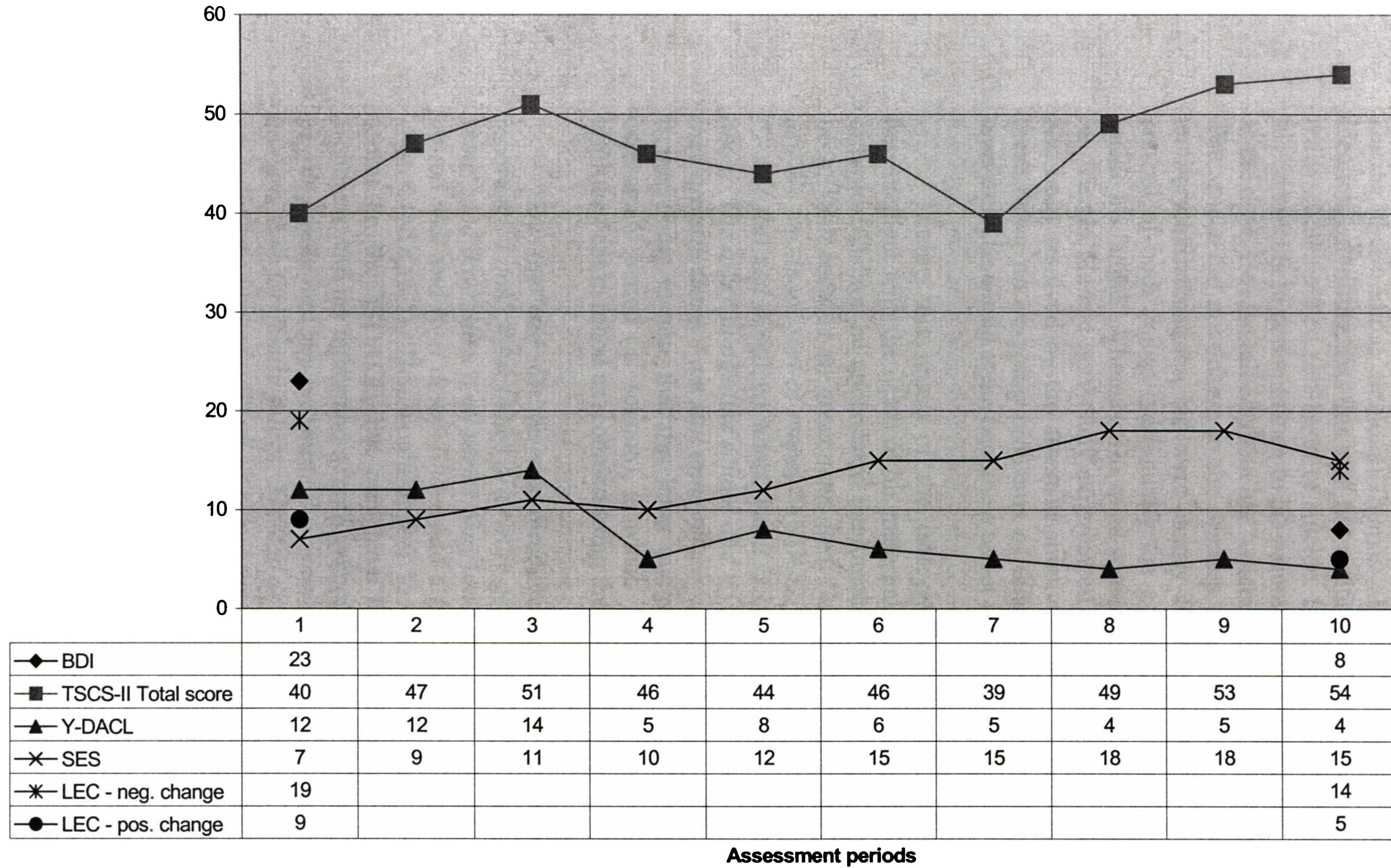
Outcome: By the end of the self-concept enhancement sessions Samantha's Total Self-Concept summary score had improved from 36 to 42, although this is still well below the mean score for her age. The authors of this measure suggest that scores below 40 indicate that the respondent may be doubtful of their own overall self-worth (Fitts & Warren, 1996). Family self-concept (pre-intervention score 34, post-intervention score 61) and Social self-concept (58-62) were enhanced during the intervention stage. However, Samantha's Academic/Work self-concept dropped despite her positive effort at school. At the time of completing the post-intervention rating scales Samantha was awaiting her exam results and her score may have been influenced by this contextual factor. Samantha's Physical self-concept score remained essentially unchanged. Despite her low score in this area, indicating general dissatisfaction with her body and possibly distorted body image, it did not form a major focus of attention during our sessions. In retrospect this may have been a therapeutic error as Samantha did mention problems related to food and eating during the last of the self-concept enhancement sessions.

Samantha's reason giving around her experience of depressive symptoms was largely unchanged over the course of the intervention with the exception of *Relationship* factors being more readily identified as constituting reasons for depression.

Samantha continued in treatment for several weeks after the post-intervention measures were completed, reporting improvements in her general mood as sessions continued. She finally separated from her boyfriend, a development which she managed well. She also achieved good results in her school examinations.

Thomas

Non-directive counselling (sessions 1-5): Following the initial assessment interview Thomas received five sessions of non-directive intervention, where he generally set the session agenda. The psychometric data for these sessions is shown as assessment periods 2-6 in Figure 4.7. The focus of these sessions was largely on Thomas' family relationships, especially on the relationship with his father. Thomas stated that he did



	1	2	3	4	5	6	7	8	9	10
BDI	23									8
TSCS-II Total score	40	47	51	46	44	46	39	49	53	54
Y-DACL	12	12	14	5	8	6	5	4	5	4
SES	7	9	11	10	12	15	15	18	18	15
LEC - neg. change	19									14
LEC - pos. change	9									5

Figure 4.7 Thomas' session summary scores on the individual clinical measures.

not feel that he was getting enough attention or time from his father, who he perceived as favouring his younger brother (11 years old). He believed that this was because his father and younger sibling shared an interest in fishing and sport, activities which were of little interest to Thomas. During these initial sessions Thomas also talked about his suicidal ideation, admitting that this was not a significant issue as he had never really contemplated self-harm or suicide. He stated that he had intended his comments to communicate to his parents how unhappy he was feeling at the time. He also talked about his "voices", one good and the other bad. The voices did not adhere to the primary characteristics of pathological auditory hallucinations, but were clearly Thomas' thoughts as he felt in control of both voices (particularly the good voice), and located them inside his "mind". Thomas also spent some time talking about school and his friends. He had previously experienced some bullying at school. This had been resolved by the assertive involvement of his teacher. Despite there being no on-going problems of this nature Thomas continued to worry that he would again become a target for bullying.

During this phase of the intervention Thomas experienced a bereavement with the death of his maternal great grandmother. However, in typical fashion he understated the impact of this by saying that he had been, *"Sad because my great nana died. I am not as perky and happy as I usually am, more sort of mopey"* (NDC/2/1), and the following session, *"I still feel sad about my nana, but it is only one more thing to be sad about. The other things like school and my family don't seem so bad, but they are still there, I am still unhappy about other things."* (NDC/3/3). It is interesting to note that this latter quotation is taken from the fourth assessment period (3rd session), at which Thomas reported a significant improvement in mood as recorded using the Y-DACL.

By the end of the non-directive counselling phase Thomas reported, *"I don't think things are really getting any better for me. I have some good days when it all seems okay, and other days when things don't go too well and I get down. I have had a few bad days over the last few days."* (NDC/5/1). This would appear to conflict with generally lower scores on the Y-DACL, but may have been precipitated by a recent argument with his father and a more general feeling of isolation, *"No-one in our family has any patience. Everyone is so busy that we don't have enough time for family things. My dad is so busy that he doesn't have enough time to spend with all us kids. I get sad that he spends more of his free time with my brother than he does with me."* (NDC/5/3).

Self-concept enhancement (sessions 6-8): The focus of the self-concept enhancement sessions was dictated by Thomas' lower self-concept scores in the areas of physical, personal and social self-concept as highlighted on the TSCS:2. We also added a focus of family self-concept which, while not very low on the TSCS:2 was clearly an ongoing issue for Thomas.

Thomas spent some time during the first enhancement session talking about his physical health. He talked about the tumour that had been removed surgically when he was seven years old and how this event had impacted on his view of life and his sense of his physical self. While he became distressed about this during the session he was able to think about what actions would help him in progressing this issue to a point of greater resolution. Thomas also stated his belief that it was his lack of a strong and positive sense of his physical self that characterised the division between himself and his father, and himself and his younger brother. While he did not have a physical disability or poor physical health he did lack interest in activities with a high aerobic component. Therefore it may be possible to view his low sense of physical self-concept as being less to do with latent ability, but more as a response to the deleterious effect that he saw it having on other aspects of his life. We explored this further using positive visualization and cognitive restructuring, and also focussed on alternative ways of viewing his relationship with his father. It became clearer that his father was very supportive of Thomas in a number of ways, particularly in relation to his generally caring and kind nature, and his obvious ability within the academic domain.

The second enhancement session continued with a focus on Thomas' family, although this was extended to include other members of his nuclear and extended family. Thomas had suggested the establishment of family meetings, *"We are going to try a time every Sunday when we can review the week, sort of. They said it was a good idea that we talk about things that make us cross or upset, rather than just ignoring them. I am really pleased, I hope it works."* (SCE/7/2). This spontaneous act was seen as a positive change by Thomas' mother, who was also reported to have noted other changes in Thomas, *"I think I have been thinking more positively about myself this week. Mum said that she thinks I have been less moody and more getting involved in the family"* (SCE/7/1), although Thomas himself remained more cautious, *"I still feel sad about things and I would like that to change."* (SCE/7/3). It should be noted that despite this caution Thomas recorded a large improvement on the Total Self-Concept summary score from the TSCS:2 at the start of the second enhancement session.

A further focus of this session was on Thomas' peer relationships, particularly at school. He had a positive view of himself and his work within the school environment. However, he reported feeling somewhat isolated from his peers with the exception of two good friends. He was able to generate some advantages of having a small friendship network, for example, fewer friends may give an opportunity to get to know each one better. Thomas admitted that he did enjoy his friendships and had a lot of common interests with his best friends. He stated that he felt that he should have more friends, and that he thought his parents would agree with this view. This statement was discussed in terms of both the quality and quantity of significant relationships.

The final enhancement session found Thomas in good spirits having had a better week, *"I have been happier this week. I think I have been good at saying more clearly what upsets me, and what I am thinking. Mum says it is really good and that she is pleased with the progress I am making."* (SCE/8/1). This was a marked difference from the statement made at the end of the non-directive counselling sessions which seemed to imply that no progress had been made. Thomas' first family meeting had gone well, with Thomas making prior overtures to his father to go fishing together. When asked about this Thomas indicated that despite not being interested in fishing he had decided that spending time with his father was more important, and that if he had to go fishing to achieve this then it was a 'price' he was willing to pay. In part this decision seemed to have been prompted by discussion in the previous session about friendships.

Outcome: At the time of the post-intervention assessment Thomas was reporting non-clinical levels of depressive symptomatology and a much more positive mood. In all domains of his self-concept as measured by the TSCS:2 he recorded scores within the average range for his age. Thomas continued in treatment for a number of sessions after the completion of data collection in order to continue working on aspects of his self-concept and self-esteem. Also, he underwent a thorough medical examination in response to his concerns about the re-growth of his tumour and was given a clean bill of health.

Comment on the case studies

The individual case studies provide clinical support for the results of the quantitative analysis reported above. In terms of depressive symptomatology, the participants confirmed the impressions gained from their completion of the self-

report measures that they were less troubled by depression at the end of the intervention phase than they were prior to it. This was reflected in a general reduction in the level of reported depressive symptomatology and their presentation of improvements in mood. While BDI-II scores suggest that depressive symptomatology had reduced markedly for all the participants, three of the six required ongoing intervention in addition to the sessions allocated by the study design before their symptoms of depression and clinical presentation had reduced sufficiently for discharge.

The gradual reduction reported in the Y-DACL coincided with the changes in the way that participants spoke about their mood. There were clear changes in the direction of talking more about experiences of positive mood, and optimism for the future. In general their language became more agentic and future-orientated.

The RFD-A showed limited change. What changes there were lay predominantly in the direction of the issues uncovered during the intervention sessions as being more significantly related to the participants' current mood states. The lack of significant change may be an indication that the reasons given for depression are connected to more general attributional style and reason/explanation giving on a broader scale. As a group the participants were more likely to endorse the *Characterological* and *Achievement* domains on the RFD-A as providing the reasons for their depression. This certainly coincides with both their developmental life tasks (development of personal identity and their school activity/education), and the data presented during the intervention sessions. The latter was heavily ladened with discussion of personal identity issues, and school/academic focussed difficulties.

The measures for self-concept (TSCS:2) and self-esteem (SES) both showed quantitative improvements over the course of the intervention. Again, this was confirmed by the changes that occurred within the clinical sessions on the basis of both presentation and self-reporting. Participants were able to engage in self-concept enhancement focussed activities and, sometimes with surprising spontaneity, use these as a basis for initiating change in their lives. They were also able to talk in a more focussed way about how events were impacting on them, their self-concept, and their sense of self-worth. All participants made statements implying a clearer sense of personal direction and self-knowledge, understanding 'who they were', why they were reacting in particular ways, and confidence in their ability to initiate and manage change. While not the primary focus of the intervention it was not at all surprising that self-esteem improved in conjunction with the apparent enhancement of self-concept.

DISCUSSION

The purpose of this study was to explore the relationship between depression and self-concept in adolescents within the context of a psychotherapeutic intervention. In particular, I sought to obtain data regarding both the possibility of delivering an intervention focussed on self-concept enhancement, and its efficacy. Information relating to the mood of the participants was collected via standardized rating scales which were appropriate for the client group. These were used to measure pre- and post-intervention levels of depressive symptomatology, and reason giving for depression. Scores from one of these rating scales, the Y-DACL, were also

collected on a sessional basis to assist in tracking changes in mood states. These data were supplemented by additional information from the assessment and intervention sessions that were conducted. The self-concept data were obtained from age appropriate psychometric instruments measuring both self-concept and self-esteem, and was also augmented from clinical data obtained from the assessment and intervention sessions.

The results provide support for the contention that the clinical interventions influenced the participants' self-concept, and that improvements in self-concept were associated with decreased depressive symptomatology and improved self-reported mood state and self-esteem. The small sample size requires that caution be exercised when interpreting the results of the statistical analysis, however, the results of that analysis are supported by both the clinical presentations of each of the participants and the clinical information that they provided during the intervention sessions.

It is certainly not being claimed that three sessions of self-concept focussed therapy led to complete symptomatic improvement. Three of the participants continued in therapy for a number of sessions after all the study data had been collected. A fourth participant moved out of the area soon after all the data had been collected and despite making telephone contact with the service to offer thanks and confirm that he was doing well there was no way to corroborate this. It is of note that the two participants who did not require or request on-going intervention after the SCE sessions were those who had received the fewest non-directive counselling sessions (0 and 1). This may provide support for the view that interventions with depressed adolescents should be active and structured in preference to a more passive

and reserved approach. It also suggests that in some cases ($^1/_3$ in this study) an immediate, active and focussed intervention designed to address issues of poor self-concept may be particularly efficacious in addressing low mood in adolescents.

Given that this study was developed to provide a context for the development and piloting of the SCE rationale and techniques, further study is required to refine the techniques and their presentation, and explore their usefulness with a larger sample of adolescents.

The psychometric measures used appeared to work well although they do have limitations. Instruments were selected because they were short, allowing compilation of an assessment battery, and they could be used a number of times. It was also necessary for them to be valid for use with a sample population aged between 13-19 years. It would have been a useful adjunct to formalize the collection of family, school and personal data about the participants from third parties. While the presentation of the participants in the session suggested more positive self-concept and improved self-esteem there was little opportunity to check on the expression of this outside the session. Anecdotal evidence from, for example, Elizabeth's mother, and the fact that Clifford's parents were willing to allow him to make the decision about the venue of his ongoing school placement, suggests that the positive changes reported in session were generalized to other environments, at least with these two participants. However, there could be alternative explanations offered for these changes. Extending the range over which the psychometric data were collected would have helped to answer such concerns.

Brown's (1996) contention that loss, including loss of role, especially when experienced under humiliating circumstances, constitutes a risk factor for depression was supported by the clinical data reported here. All the participants reported events and concerns related to loss of role/status and humiliation or shame. These experiences were reported to have occurred at times of generally lowered social support. For example, Angela's classroom experience of being told that she would not be going on the class field placement because her work was not adequate, a public declaration that was quickly followed by her humiliation at being unable to complete a simple technical task in class that she would have been able to complete at other times. Angela was supported by her classmates, but had difficulty accepting this support as she reported feeling much younger than them and did not see them as peers. At that time she had limited contact with her family, who lived elsewhere in New Zealand, and was living in a boarding arrangement which afforded her little support.

While it is reasonable to see which type of events as taxing within the context of the participants' life stage they would certainly not constitute significant life events in a objective sense. This reinforces the view that life events, and any changes in self-conceptions and self-worth that follow from their experience, form a highly personal and complex system. It is also interesting to speculate that not only do life events have an undeniable effect on self-concept and self-esteem, but that the social and experiential context within which life events are processed is established and maintained in part by one's self-conceptions. In this fashion negative self-

conceptions and low self-esteem are both vulnerability factors and consequences of depression (Harter, 1999).

While there was little obvious change in the range of reasons participants gave for their experience of depression, the RFD-A does seem to be useful both intuitively and clinically. The lack of change in scores belies the interesting data regarding the relative placing of the domains, with the *Characterological* and *Achievement* domains being checked more frequently as representing the reasons why the participants were depressed. The *Characterological* domain contains items which are related to the individual's sense of themselves, that is, their experience of depression is influenced by personal attributes and characteristics. The *Achievement* domain relates not simply to school based activity, but to more general goal setting and attainment. The essence of the self-concept enhancement intervention was to assist in the generation of a more positive and robust sense of self, willing and able to take responsibility in an assertive way, but also unwilling to adopt the mantle of 'victim'. Therefore, one would expect the RFD-A domain profiles to bear a close resemblance to that reported in the second study, but for the *Characterological* and *Achievement* domains to be cited less often as constituting reasons for depression by the end of the self-concept enhancement intervention. Indeed, the movement of the domain scores for the participants as a group was in the general direction that would be anticipated following an intervention aimed at enhancing self-concept.

Limitations of the Study

The pilot nature of this study, and the methods of data collection and analysis introduced a number of limitations. The number of participants was small, and though an extensive data set was collected for each it cannot be claimed that the participants were truly representative of the adolescent population as a whole. For less tentative claims to be made about the value of self-concept enhancement as an adjunctive intervention for adolescent depression a larger scale data collection study would need to be undertaken.

The study is also limited by the involvement of the researcher as the sole provider of the intervention phases, this being a source of potential bias. In this regard, validation of SCE as an active component of treatment for depression would also require a more explicit demarcation of the intervention protocol via documentation/manualization, and delivery by 'neutral' therapists. Clearer documentation focussing on the core components of SCE, and a regime of reviewing session content would also allow for treatment integrity to be evaluated. This was provided in a very limited way in the study reported here by the provision of two extended transcripts of session content. More formal integrity checks would involve a more structured session sampling and rating procedure.

Finally, caution needs to be exercised over the extent to which SCE focussed interventions can supplement cognitive-behavioural, or other treatments for depression. As indicated previously, various elements of SCE are already contained within a number of existing treatment approaches. In these cases the additional benefit of introducing SCE as a specific focus of the intervention is likely to have less

impact than in programmes where there is no attempt to enhance self-concept. However, it is my contention that the development and enhancement of self-concept is such a core task for adolescents that additional focus on this would be efficacious even in treatment programmes that currently have a more disparate focus on self-concept enhancement.

CONCLUSION

The aim of this study was to explore the possibility of generating and delivering a clinical intervention to depressed adolescents which focussed on the enhancement of self-conception, and evaluate its efficacy. The study reports a small scale pilot programme which produced interesting data which would appear to support the utility of this approach and justify further work on developing the program. The next step would be to refine and manualize the programme so that it could be delivered to a larger sample in a consistent fashion.

CHAPTER 5

General Discussion

The focus of this thesis has been the exploration of the role of self-concept in adolescent depression. Initial data was obtained from a group of adolescents who were asked to comment on their experience of depression. These comments were viewed in the light of a model synthesising current thinking on both adolescent depression and self-concept development. These data were confirmed and extended through the addition of data from a larger community sample of young people which focused on the psychometric evaluation of these two areas. Finally, the clinical application of procedures designed to enhance self-concept was explored with a small group of young people.

Main Outcomes of the Research Programme

The first study made the link between self-concept and depression, at least from the perspective of the adolescents who provided the data. This was interpreted as providing evidence that the sense of self held by young people was related to their experience of depression. The data are complex, and it is clear that the relationship between one's sense of self and depression is not a linear one in which particular characteristics of self-concept constitute a simple cause or consequence of depression. That is, a negative sense of self is not sufficient to precipitate a depressive episode, nor is a positive self-concept complete assurance against depression. In addition to *self-concept* (especially self-criticism), the young people alluded to themes of

positioning (social interaction and reciprocity) and *agency* (power) as being significant component in their experience of depression. Aspects of the self were located within a social context in which power and powerlessness were features. The combination of these factors may indicate that while negative self-concept is a risk factor for depression when mediated via poor self-image and low self-esteem, risk is significantly increased in situations which the young person interprets as being socially detrimental (embarrassing, unsupportive, frightening, unfamiliar), or over which they have relatively little control. These contextual elements will be familiar for many who have experienced low mood, but may be particularly poignant for adolescents who, almost by definition, find themselves in challenging social environments and with varying degrees of control as they attempt to establish their own identity.

Three primary themes were developed on the basis of a number of more specific results which are summarised below,

- An apparent willingness on the part of the young people to accept the diagnostic label as being explanatory. This was despite the general unwillingness of their parents to accept the diagnosis of depression at all.
- The high frequency with which the young people made external attributions with regard to the reasons why they were depressed.
- The themes of poor self-esteem and low self-concept were generally present in the narratives of all the young people interviewed.

- A stated lack of personal power or influence to make any significant changes which may effect their depression (reliance on medication, feelings of helplessness and hopelessness, external attributions).
- The presence of significant life events that could have impacted on the development of robust self-concept for the young people.
- Life events which were considered significant were often related to social relationships, rather than individual attributes or non-social events.
- Anecdotal evidence that the actual and historical levels of depression within the adolescents' families was high.

Each of these results contributed to the overall view that there was a close relationship between depression and the way the young people who participated in the first study perceived themselves.

The second study, which was planned to complement the first, confirmed and further developed the data obtained from the first study using a larger sample pool drawn from a different population, i.e., a community sample of non-referred adolescents. In it I explored aspects of the link between depression and self-concept using various psychometric measures (Table 5.1).

The most significant finding from this study was the confirmation of the link between increased severity of depression and lower levels of self-concept. Indeed, the Total Score Scale from the TSCS-2 was significantly associated with scores on the BDI-II, with the Total Score Scale predicting 43.5% of the variance of the depression score. Physical Self-Concept was the domain that was most frequently

Table 5.1

<u>Domains of the Integrated Model of Depression and Self-Concept, and the Instruments Used to Evaluate Them.</u>

DOMAIN	PSYCHOMETRIC INSTRUMENTS
Environmental events/early experiences	Life Events Schedule
Attitudes/beliefs/assumptions	Reasons for Depression Questionnaire
Attributional style	Attributional Style Questionnaire, Reasons for Depression Questionnaire
Self-concept/self-image	Tennessee Self Concept Scales – 2nd ed.
Depression	Beck Depression Inventory – 2nd ed.

reported as being low. This relates to the way the individual views his or her body, state of health, physical appearance, skills, and sexuality. The second lowest self-concept domain was Personal Self-Concept, the individual's sense of personal worth, feelings of adequacy as a person, and self-evaluation of the personality apart from the body or relationships to others.

This study assisted by providing further data relating to a number of aspects of the proposed integrated model of depression and self-concept presented in the first chapter. It highlighted the nature of a number of the relationships, e.g., providing further data on the relationship between life events and self-concept, life events and attributional style, specific and general attributional style. These data are useful in

hypothesising pathways to depression, and the relative influence of the factors involved.

The third study was an attempt to apply the results and ideas developed from the first two studies to a clinical setting in which the focus of attention was the enhancement of self-concept with a small group of depressed adolescents. The psychometric measures explored in the second study were used to monitor the change process along with interview data, drawing on the experiences gained during the first study.

Despite the small sample size, and with the caution that this necessitates when interpreting statistical results, there were significant improvements in both severity of depression and regular mood monitoring scores between the end of the 'control' intervention and the end of the self-concept enhancement intervention. The Total Self-Concept measure decreased, showing poorer self-concept, during the control intervention phase, but increased to better than the baseline level by the end of the experimental intervention. Self-esteem also improved over the course of the interventions. Greater confidence exists in these results because they were consistent with the qualitative clinical data obtained from the participants.

While the intervention methods employed in this study were not very different from those employed within other intervention programmes, they were drawn from a wide variety of approaches, and were applied in a rigorous manner. They were implemented in a concentrated format with the primary intention of enhancing self-concept.

A Revised Model of Depression and Self-Concept in Adolescence.

Given the above summary, how do these data impact on the model of depression and self-concept proposed in the first chapter? As was pointed out in the introductory chapter, a number of models of depression have been applied, or considered applicable, to adolescents. Generally these are not satisfactory as they fail to address two key elements of depression within the adolescent age group. First, they fail to recognise the specific environmental and social demands placed on adolescents. Second, they fail to take a developmental perspective. The development of a sense of self is crucial in this regard.

Not all the young people appeared to have low levels of self-esteem, or at least not constantly. For this reason there is a need to hypothesise an alternative route by which self-conceptions can influence depression without requiring a consistent lowering of self-esteem. The easiest route would be to expand the definition used by the cognitive theorists to describe "core beliefs" or "schema" (dysfunctional attitudes/assumptions/beliefs). Within a cognitive framework, core beliefs are long-standing thoughts and images which have a generalised role in assisting an individual to make sense of their environment. They may have a direct and specific impact on an individual's response to given situations, but are more likely to be mediated through an intermediate belief system and/or automatic thoughts. Of particular interest within this framework is a view that depression is based on dysfunctional core beliefs, and that they can be changed (Beck, 1995).

One problem when dealing with adolescence is the potentially close temporal relationship between the core beliefs, dysfunctional attitudes, and the actual experiences that give rise to these. For example, core beliefs related to one's physical

self-concept ("I am too ugly to ever get a girlfriend") may not emerge until adolescence. In this way isolated incidents which may constitute 'activating events' - events which promote automatic thoughts and actions - could also be formative events in the sense of being virtually the sum total of an individual's experience within a particular domain. This may go some way to explain the sometimes dramatic and idiosyncratic reaction to specific events in the life of young people. That is, they are not interpreting a single social event against a backdrop of numerous similar experiences, but an event that constitutes a significant portion of their entire experience within a particular domain.

An example of over-reliance on limited experience would be in the establishment of intimate relationships. Relationship difficulties for adults can certainly be traumatic and can provoke a range of difficult emotional responses. However, they are often experienced within a context which has included previous relationship challenges, these being of varying degrees of severity and consequence. For an adolescent, who has limited experience of intense and intimate relationships by virtue of their developmental stage, even unremarkable fluctuations in such a relationship may result in significant distress.

Therefore, rather than focussing on dysfunctional attitudes, assumptions and beliefs it may be more appropriate to consider a lack of 'fit' between cognitive and social functioning, with developing thoughts and beliefs being applied too stringently, or in some way inadequately to social settings. To achieve this within the model (Figure 5.1) some association needs to be made between multiple self-concepts (Harter, 1999; Marsh & Hattie, 1996; Osborne, 1996), which are beliefs about the self, and more general attitudes, assumptions and beliefs. This is not to wholly

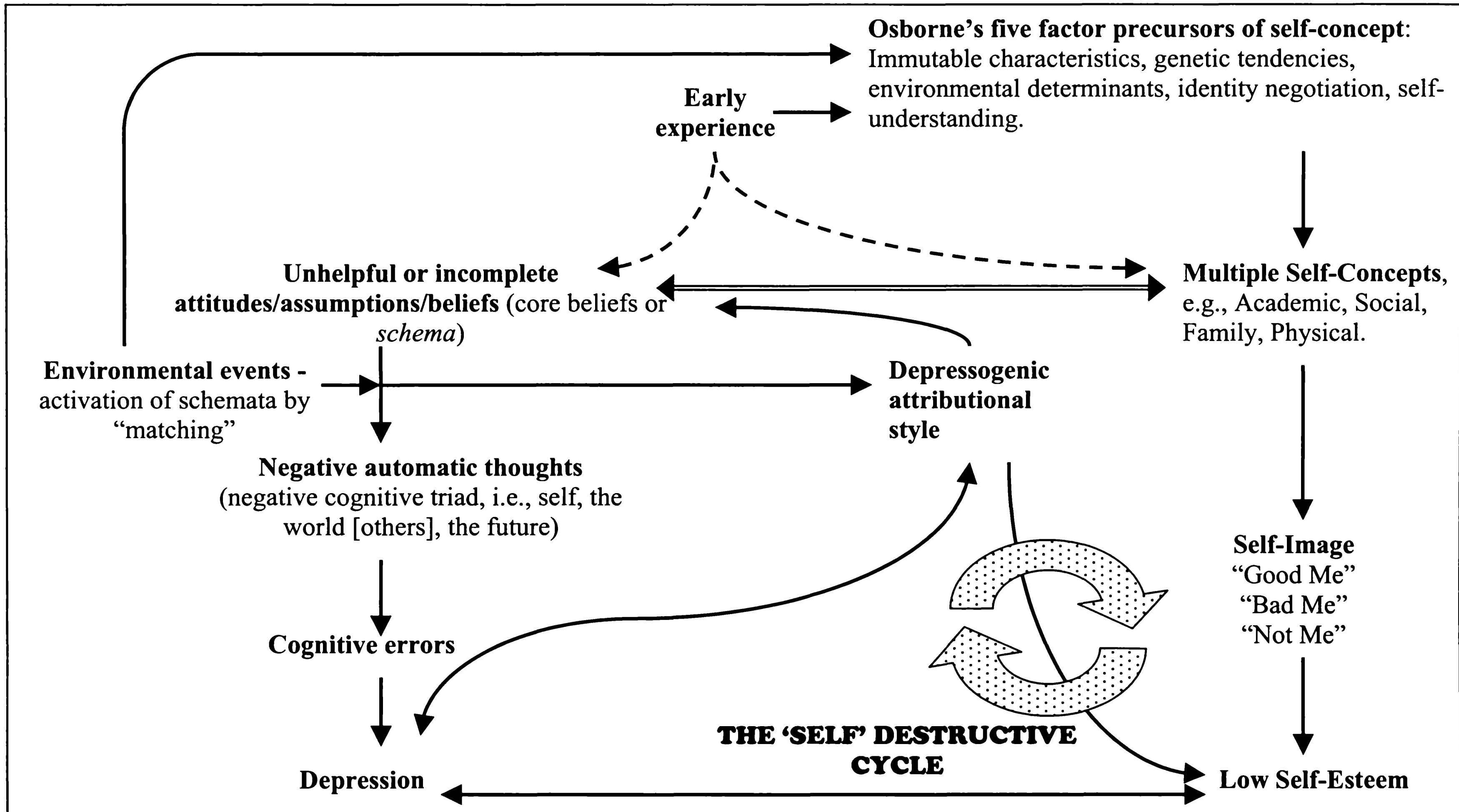


Figure 5.1 Revised model of depression and self-concept

replace a link between dysfunctional, or incomplete, core beliefs and depression; clearly to do so would be inconsistent with a substantial research literature. Rather, what is proposed is an expansion of the role of core beliefs to accommodate aspects of the social/interactional context and the dynamic nature of the environment within which adolescents operate.

The new model locates self-concept as a risk factor for depression when mediated via self-image and self-esteem, that is, if an individual has poor self-concept in a number of areas (personal, family etc.) which precipitates internal self-image statements such as "Bad me", or in current vernacular "I suck". This impacts on self-esteem, promoting feelings of worthlessness, hopelessness, which plays a role in precipitating depression. Conversely, self-concept can be impacted on by depression when mediated via a recursive cycle involving low self-esteem, or via the confirmation of dysfunctional attitudes, assumptions and beliefs, "See I was right to think that nobody loves me". This could be referred to as a *'self' destructive cycle*. It is possible that where a developing sense of self is heavily influenced by the destructive effects of depression the individual comes to adopt a self-concept in which depression forms an integral part, "I am sad and depressed, it is who I am". Birmaher et al. (1996), Hoberman, Clarke, and Saunders (1996), and others have reported the high rates of life-time recurrence of depression in individuals who experienced their first Major Depressive Episode during their adolescent years. It would be interesting to explore the hypothesis that these individual had fallen victim to a 'self' destructive cycle and have come to view the experience of depression as an integral part of who they are.

The new model provides a vehicle for integrating two areas of research and clinical endeavour. At this stage the synthesis is rudimentary and will need further work. However, even at such a basic level it does assist with the generation of some interesting research questions, e.g., how does chronic depressed mood impact on the development of self-concept, especially if a first episode occurs during pre-adolescent years? Are some self-concept domains more critical than others in terms of vulnerability and resilience in the face of depression? How does one distinguish forms of depression which are predominantly self-concept based? Can we develop and evidence based to support the existence of a 'self' destructive cycle in adolescent depression?

Implications

It is important to remember the context within which this research was conducted. Aotearoa/New Zealand is a country which was largely isolated from the developments in Europe, Asia, and the Americas until the early to mid-1800's. Starting in the middle of the 19th century there was a period of rapid colonisation by European immigrants (referred to as *Pakeha*, people from other places), primarily from the United Kingdom, to the point where the dominant culture in terms of language, family and social structures, administration etc. are not those of the indigenous Maori people. For most young New Zealanders of European origins, and many Maori, the issues and difficulties that they experience would be familiar to young people from other Western cultures. However, New Zealand continues to struggle with balancing the rights of Maori with those of newer settlers, the English,

and more recently people from South Africa, Korea, Somalia, and Eastern Europe. While Maori and the other cultures represented in New Zealand society are likely to have different perspectives on the significance, or otherwise, of various life events, social influences, etc., this does not negate the importance for young people to find their place within their community, the meeting of the 'self' and the wider social network. No assumptions are being made here about a 'right' way of doing this. This thesis is focussed on one potential difficulty that can occur if an individual's sense of self is not positive and robust, if it is not supported and nurtured by their social networks, and if negative self-conceptions are left unchallenged.

It also seems important to acknowledge that there is not a one-to-one association between poor self-concept and depression. There is not agreement about what poor self-concept actually is. If this were socially defined we may find that good self-concept would be defined in terms of conceptions that lead to pro-social behaviour, law abiding and responsible. However, for a young gang member this would be unlikely to prove very maladaptive. A self-conception which represented the young person as 'bad', a street-wise survivor who would meet violence with greater violence, may prove to be more useful. This is one advantage of Côté's identity capital model (Côté, 1996, 1997), it makes no assumptions about the absolute value of a self-perception, attribute, or behaviour, all are specific to the situation or context. This suggests that there is a degree of fluidity in self-concept which is not well reflected in the psychometric measures that we have access to. Particular self-conceptions, such as Anne's thwarted view of herself as a successful university student, proved too fragile in the face of the challenge then she failed to gain

university entrance, hence her depression. Anne's response was to work harder while maintaining the same self-concept, however, an alternative strategy may have been to change her self-concept to that of a young person who did not attend university. This would have been a difficult task, but one for which she would have been able to find significant social support. In New Zealand a majority of young people do not go on to tertiary education.

There is a large body of literature which supports the effectiveness of cognitive-behavioural interventions, especially when combined with anti-depressant medication. However, it is being proposed here that closer attention could usefully be given to ensuring that such interventions are appropriate for adolescents. Among other things this means taking into account the developmental and social tasks of adolescents, including the development of a sense of self. From a psycho-analytical perspective, Blos (1967, 1980) refers to the *second individuation process* as occurring in adolescence. The first individuation process occurs as the infant starts to become aware of their physical autonomy and separation from their mother. The second individuation process entails the adolescent in negotiating a parallel separation from their parents and wider family of origin as they move out into the world and develop their own social identity. This process involves not only a loosening of the ties to their family, and the past, but a strengthening of the associations that they have with their own peer group, their own generation, and a clarifying of who they are as an individual. Whether or not one agrees with Blos' basic approach, his general description of the process seems fitting, and it is this process which needs to be accommodated.

According to a multi-dimensional approach to self-concept, there are a number of ways that one's sense of who one is can be divided up. While this is likely to leave the individual with an overall view of self, referred to as *global self-worth*, individuals are generally well able to segregate their view of themselves, e.g., "I look good, I am athletic, but no good academically". As alluded to previously, these aspects of self-concept are both personally and socially defined and corroborated, the "Me-Self" and "I-Self". Where the individual acts and interacts in ways which are valued and supported they are likely to enhance self-concept (Côté, 1996, 1997). However, it seems important to observe that this does not imply that an individual has to act or interact in a principled and pro-social manner to be supported in achieving a functional and balanced sense of self. That is, anti-social acts may enhance status and reinforce a positive self-concept if they are located within the appropriate context, e.g., a gang or other such peer setting. In this way we can see that self-concept is not a static paradigm, as functional levels of self-concept can be considered to be context specific. This implies that programmes which incorporate the assessment and enhancement of self-concept need to be flexible and individualised, seeing the young person within their social context. While this view is acknowledged in many approaches it is sometimes given no more than lip-service as it is perceived to constitute an onerous task that would distract energy and resources from the generally individual emphasis of treatment.

The third study provides an intervention outline that could usefully be developed further by both the drafting of more comprehensive documentation regarding the intervention process, and by conducting further evaluation of the

intervention with both clinical and non-clinical groups. Self-concept enhancement should be seen as an adjunct to the more standard intervention strategies, particularly in cases of more severe depression. However, it may serve as a useful protective intervention with adolescents who are more at-risk, e.g., those already experiencing lowered mood, those with a history of significant life events, those possessing a negative attributional style.

The enhancement of self-concept within a primary or secondary preventative framework would also be consistent with the New Zealand Health and Physical Education curriculum (Ministry of Education, 1999). This curriculum contains a stream focussing on personal health and physical development which has achievement aims targeting the establishment of personal identity and self-worth. While this is framed in general terms it would be possible to take a self-concept enhancement focus and make it part of a wider high school experience. This could also be extended to include education for teachers and parents on various aspects of the recognition and treatment of depression in adolescents. Working through the school curriculum to enhance self-concept would not be a sufficient intervention in assisting adolescents to work through issues associated with clinical depression. However, it could play a role in both 'inoculating' young people against the poor self-concept and low self-esteem that is implicated in the development of mood disorders, and aid in the early detection of 'at-risk' adolescents.

Finally, this thesis draws on two substantial bodies of research, those focussing on depression and self-concept. Unfortunately, despite growing research activity in the area of adolescent depression, the models generated are often not

adolescent specific or appropriate. Conversely, while the establishment of a sense of self, a core task of adolescence, is at the centre of renewed research interest, little attempt has been made by the theorists and researchers to link their work with the prevailing models within the clinical field, and with depression. The studies and model presented in this thesis represent an attempt to synthesise these two areas of endeavour. I will undoubtedly have made errors, and there will be inadequacies, but I believe that the data contained in this thesis do provide a useful basis upon which further theoretical, empirical and clinical activity can be based.

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Appendices

1.1 Beck Depression Inventory – 2nd edition

For copyright reasons the Beck Depression Inventory – 2nd edition (BDI-II) cannot be reproduced here. However, a summary of the scale is provided below.

The BDI-II consists of 21 self-report items measuring the severity of depressive symptomatology. The items focus on the following range of symptoms,

1. Sadness
2. Pessimism
3. Past failure
4. Loss of pleasure
5. Guilty feelings
6. Punishment feelings
7. Self-dislike
8. Self-criticalness
9. Suicidal thoughts or wishes
10. Crying
11. Agitation
12. Loss of interest
13. Indecisiveness
14. Worthlessness
15. Loss of energy
16. Changes in sleeping pattern
17. Irritability
18. Changes in appetite
19. Concentration difficulty
20. Tiredness or fatigue
21. Loss of interest in sex

The items are of a standard format with respondents being asked to select the one statement within each item group that best describes the way that they have been feeling over the last two weeks. Items are scored on a 0 – 3 scale, yielding a BDI-II score in the range 0 – 63.

<u>Specimen items:</u>
Question 1.

1. I do not feel sad.
2. I feel sad much of the time.
3. I am sad all the time.
4. I am so sad or unhappy that I can't stand it.

Question 7.

1. I feel the same about myself as ever.
2. I have lost confidence in myself.
3. I am disappointed in myself.
4. I dislike myself.

1.2 General Health Questionnaire - 60

For copyright reasons the General Health Questionnaire – 60 (GHQ-60) cannot be reproduced here. However, a summary of the scale is provided below.

The GHQ-60 is a self-administered rating scale aimed at detecting psychiatric disorders in community populations. Respondents are asked to rate their health status *over the past few weeks* in relation to 60 probe items. For each item there are four response categories offering options indicating '(much) better than usual' to '(much) worse than usual' depending on the wording of the probe item. This method of item presentation is utilized to reduce the likelihood of response set errors occurring. There are a number of methods for scoring the GHQ. The method which appears to be most consistent with the nature of the probe items is referred to as the Simple Likert method (0-1-2-3), where a score of '0' is allocated to the response to each item indicating the most positive health status, and a '3' is assigned to the response indicating most negative or poorest health status. This yields a maximum summed score for this scale of 180, with higher scores indicating worse self-reported health status. Summed scores can be interpreted by reference to threshold scores established by the authors. With the GHQ-60 a threshold score of 39/40 is suggested as indicating 'caseness', i.e., respondents recording a score above their threshold are likely to being experiencing a significant level of mental health difficulties.

The factor structure of the GHQ-60 has been found to be complicated with a number of research studies finding between seven and nineteen factors. However, among the consistent findings in these factor analytic studies is a clear component relating to depression. Also, the items which constitute this factor show a high degree of consistency.

<u>*Specimen items:*</u>

HAVE YOU RECENTLY:

1 – been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
11 – found yourself waking early and unable to get back to sleep?	Not at all	No more than usual	Rather more than usual	Much more than usual
47 – found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
53 – been feeling hopeful about your own future?	More so than usual	About the same as usual	Less so than usual	Much less hopeful
56 – felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual

1.3 Client information sheet

Feeling Low ?

It is not unusual for people to feel down or have low energy now and then. This could be the result of problems with a relationship, problems at school or work, the loss of someone or something important to us. For some people, and this includes both young and old, low mood can make ordinary daily tasks difficult.

Feeling low or down is far more common than many people think. Among young people it has been estimated that as many as 1 in 10 will experience this problem at some time during their teenage years.

If the problems of severe or long lasting low mood are not addressed then it can put pressure on friendships and families, slow progress at school etc. In some cases it can pose a threat to life as the young person fails to take care of themself, or even actively looks for ways to end their life.

Research over the last 20 years has tried to find out why young people get to feeling low, and how this can be resolved. We know more than before about low moods, and are certainly better at helping young people fight low moods than we were before. However, there is always room for improvement !

The Feeling Low ? Project.

Our current research is looking at different ways of helping young people cope when they are feeling low or down. The first stage of this is to learn more about how young people and those around them think about their moods and their feelings. For example, where they come from, what ideas they have about how to cope with, or get rid of the low moods.

In order to get this information, these 'stories', we are talking to young people who are feeling down, young people who do not, and the parents or caregivers of young people.

Our focus for this project will be on interviews with young people and their parents/caregivers. So, although we are asking those we interview to complete two short rating scales these are not the main focus. In order to allow the interviews to be analysed fully we will be audiotaping them. When the information is taken from

the tapes any names etc. will be altered so that those being interviewed cannot be identified. We will not be playing the tapes to anyone else.

The information from the interviews and rating scales may be used in published articles.

If you have any questions or comments about any aspect of the project please do not hesitate to make contact.

John Fitzgerald
Clinical Psychologist

Child & Adolescent Community Centre
Taranaki Base Hospital
New Plymouth
06-753-7790

1.4 Audiotape consent form

Feeling Low ?

Consent Form

PLEASE READ AND SIGN ....

We have received a copy of the leaflet outlining the project and have had an opportunity to discuss our involvement with the Feeling Low ? project.

We understand that each participant will be asked to complete one audiotaped interview and two rating scales.

Participation in the project is on the understanding that such action will have no detrimental effect on services offered or received, either now or in the future. We also understand that we may refuse to participate in the project, or withdraw at any time without explanation, and without any detrimental effect on services offered or received either now or in the future.

While the information relating to us will be rendered anonymous we understand that the overall results of the project may be shared through production of research reports.

Parent/Caregiver

By signing this consent I am/we are indicating my/our willingness to participate in the research project as outlined, and consent to the participation of my/our son/daughter.

Signed .... Dated ....

Signed .... Dated ....

Young Person

By signing this consent I am indicating my consent to participate in the research project as outlined.

Signed .... Dated ....

2.1 Reason for Depression Questionnaire

This questionnaire presents you with a number of reasons why you might feel depressed. Each reason is given as a statement in the form of, "I am depressed because..." followed by a specific reason. For each statement, consider whether or not this particular reason causes you to be depressed. If you are not currently depressed, think of a time in the past when you were depressed and answer the questionnaire according to what the reasons were at the time.

Have you ever been depressed ? (Circle One) YES NO

If you don't think you've ever been depressed, think back to a time when you were extremely sad and it lasted more than just a little while.

Are you reporting on a current or past experience of depression?

(Circle One) Current Past

In a few sentences please describe what you think causes or caused your depression.

____

____

____

____

____

____

Now, turn the page and rate each reason for depression.

Rate each reason on the following scale:

1 = definitely not a reason
2 = probably not a reason
3 = probably a reason
4 = definitely a reason

I am depressed because....

1.	I see the world the way it really is	1	2	3	4
2.	I can't accomplish what I want to	1	2	3	4
3.	I don't feel loved	1	2	3	4
4.	that's just the type of person I am	1	2	3	4
5.	no one really cares about me	1	2	3	4
6.	I can't decide what to do with my life	1	2	3	4
7.	this is the way I've learned to be	1	2	3	4
8.	I haven't resolved some issues with my family	1	2	3	4
9.	I think about things in a depressing way	1	2	3	4
10.	no one really understands me	1	2	3	4
11.	my family treated me poorly as a child	1	2	3	4
12.	my boy/girlfriend treats me poorly	1	2	3	4
13.	I have not become the person I set out to be	1	2	3	4
14.	other people isolate me	1	2	3	4
15.	of certain things that happened to me as a child	1	2	3	4
16.	I haven't done anything important in my life	1	2	3	4
17.	other people criticise me	1	2	3	4
18.	I'm not living up to my personal standards	1	2	3	4
19.	I choose to be depressed	1	2	3	4
20.	I haven't worked through things that happened to me as a child	1	2	3	4
21.	there is no one to share my innermost thoughts and feelings with	1	2	3	4
22.	I had a difficult childhood	1	2	3	4
23.	I'm not active enough	1	2	3	4
24.	I don't take care of myself physically	1	2	3	4

Rate each reason on the following scale:

1 = definitely not a reason
2 = probably not a reason
3 = probably a reason
4 = definitely a reason

I am depressed because....

25.	I have a chemical imbalance	1	2	3	4
26.	I am a pessimist (always think the worst)	1	2	3	4
27.	I inherited it from my parents	1	2	3	4
28.	it's a biological illness	1	2	3	4
29.	I don't eat well enough	1	2	3	4
30.	I am not fulfilling my potential	1	2	3	4
31.	other people don't like me	1	2	3	4
32.	I don't know who I am or what I stand for	1	2	3	4
33.	I don't get enough exercise	1	2	3	4
34.	I have always been this way	1	2	3	4
35.	my nervous system is just wired this way	1	2	3	4
36.	I've failed to achieve a specific goal I set for myself	1	2	3	4
37.	I can't make friends	1	2	3	4
38.	I can't get done the things I should be able to	1	2	3	4
39.	I have set no specific goals in my life	1	2	3	4
40.	people treat me poorly	1	2	3	4
41.	people don't give me the respect I deserve	1	2	3	4
42.	this is the way I respond when things get tough	1	2	3	4
43.	it's basically caused by genetics	1	2	3	4
44.	I'm stuck where I am in life, nothing ever changes	1	2	3	4
45.	I pay more attention to the bad things in my life than the good things	1	2	3	4
46.	I'm stuck in a bad love relationship	1	2	3	4
47.	my boyfriend/girlfriend doesn't understand me	1	2	3	4
48.	I'm not good at expressing my innermost feelings	1	2	3	4

2.2 Introductory letter to students and parents

Child & Adolescent Community Centre
Taranaki Base Hospital
New Plymouth
tel: 06-753-7790
fax: 06-753-7791
e-mail: cahms.cacc@thcl.org.nz

Dear Student & Parents,

I am writing to inform you of a study we are conducting at this time. The project focuses on the work we do with young people who are feeling down and are finding it difficult to cope day-to-day.

We have recently finished a study with some of the young people who were referred to our service because of depression. From this we have learned more about the things that young people feel are important when thinking about the causes and course of their depression. What we would like to do now is find out if it is possible to identify these same things in a group of young people who are not being assessed within our Centre, but who are at school. The idea is to find out how common the things are that depressed young people talk about, is it just part of being an adolescent, or is it different in some way?

The reason for this letter is that we are approaching students at two local high schools to complete some rating scales for us which focus on mood and life-events, how the students see these two things (attributions), and how they see themselves (self-concept). This study involves a number of young people (approx. 300) completing the rating scales within one school lesson (max. 50 minutes). The questionnaire completion sessions will usually be scheduled to coincide with non-core subject classes. There will be no need for students to put their names on the completed rating scales. Students have the right to decline to be involved either at the start of the data collection sessions, or during the session. If a student declines they will simply continue with their allocated classroom work as usual.

We have been given permission and support from the school principals to conduct this research within their schools.

A summary report of the results will be available via the school once the study has been completed.

We expect that the results of this study will have a positive impact on the quality and appropriateness of services we are able to off to youth throughout Taranaki.

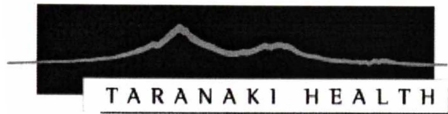
We would be grateful if you could discuss this project at home so that your son/daughter can give or withhold their consent when invited to participate at school. If you have any question about this project please feel free to contact me at the Child & Adolescent Community Centre, Taranak Base Hospital on 753-7790.

Many thanks for giving your consideration to our project.

Yours sincerely

John Fitzgerald
Senior Clinical Psychologist

2.3 Face sheet to rating scale battery



Child & Adolescent Community Centre
Taranaki Base Hospital
New Plymouth
tel: 06-753-7790
fax: 06-753-7791
e-mail: cahms.cacc@thcl.org.nz

Dear Student,

Thank-you for agreeing to help with our ongoing research study of adolescents and their emotions. We hope that you will find these questionnaires interesting. Your responses will certainly help us develop a better understanding of how young people think and feel about themselves and their emotions.

Just a quick reminder that you can withdraw your co-operation at any time, and there is no penalty ... it is your choice.

On with the task .....
First, please fill in the section below giving us a few details about yourself. It is important that this is completed otherwise we will not be able to use your completed questionnaires. Note that you are not required to give your name, so your responses will be anonymous. At the top of each page there is a pack number. This does not identify you, it is simply a way to know that each of the questionnaires you complete were filled in by the same person in the event that they are separated from each other when we are doing our analysis.

Gender: male / female (delete one)

Age:_______ years

School:____

Form:______________

Ethnic group:________________________________

Thank you.

Secondly, please complete the five questionnaires that follow. Each one is printed on different coloured paper for ease of identification. Please read all the items carefully, and complete all items.

Finally, please remember that your school has a school counsellor. If you feel low or upset as a result of completing these questionnaires, please feel free to contact your school counsellor. Alternatively, you can refer yourself to our service at the Child & Adolescent Community Centre, Taranaki Base Hospital (753-7790). Our service is free and confidential.

Thank-you again for your help.

John Fitzgerald
Senior Clinical Psychologist

2.4 Attributional Styles Questionnaire

Please try to vividly imagine yourself in the situations that follow. If such a situation happened to you, what would you feel would have caused it? While events may have many causes, we want you to pick only one - the *major* cause if this event happened to *you*. Please write this cause in the blank provided after each event. Next we want you to answer some questions about the *cause* and a final question about the *situation*. To summarize, we want you to:

1. Read each situation and vividly imagine it happening to you.
2. Decide what you feel would be the *major* cause of the situation if it happened to you.
3. Write one cause in the blank provided.
4. Answer three questions about the *cause*.
5. Answer one question about the *situation*.
6. Go on to the next situation.

Situation 1.

You meet a friend who compliments you on your appearance.

1. Write down *one* major cause ______________________________

2. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

Totally due to other people or circumstances	1 2 3 4 5 6 7	Totally due to me

3. In the future will this cause be present again? (circle one number)

Never present	1 2 3 4 5 6 7	Always present

4. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

Just this situation	1 2 3 4 5 6 7	All situations

5. How important would this situation be if it happened to you? (circle one number)

Not at all important	1 2 3 4 5 6 7	Extremely important

Situation 2.

You have been looking for a job unsuccessfully for some time.

1. Write down *one* major cause ______________________________

2. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

Totally due to other people or circumstances	1 2 3 4 5 6 7	Totally due to me

3. In the future will this cause be present again? (circle one number)

Never present	1 2 3 4 5 6 7	Always present

4. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

Just this situation	1 2 3 4 5 6 7	All situations

5. How important would this situation be if it happened to you? (circle one number)

Not at all important	1 2 3 4 5 6 7	Extremely important

Situation 3.

You become very rich.

1. Write down *one* major cause ______________________________

2. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

Totally due to other people or circumstances	1 2 3 4 5 6 7	Totally due to me

3. In the future will this cause be present again? (circle one number)

Never present	1 2 3 4 5 6 7	Always present

4. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

Just this situation	1 2 3 4 5 6 7	All situations

5. How important would this situation be if it happened to you? (circle one number)

Not at all important	1 2 3 4 5 6 7	Extremely important

Situation 4.

A friend comes to you with a problem and you don't try to help.

1. Write down *one* major cause ______________________________

2. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

Totally due to other people or circumstances	1 2 3 4 5 6 7	Totally due to me

3. In the future will this cause be present again? (circle one number)

Never present	1 2 3 4 5 6 7	Always present

4. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

Just this situation	1 2 3 4 5 6 7	All situations

5. How important would this situation be if it happened to you? (circle one number)

Not at all important	1 2 3 4 5 6 7	Extremely important

Situation 5.

You give an important talk in front of a group and the audience reacts negatively.

1. Write down *one* major cause ______________________________

2. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

Totally due to other people or circumstances	1 2 3 4 5 6 7	Totally due to me

3. In the future will this cause be present again? (circle one number)

Never present	1 2 3 4 5 6 7	Always present

4. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

Just this situation	1 2 3 4 5 6 7	All situations

5. How important would this situation be if it happened to you? (circle one number)

Not at all important	1 2 3 4 5 6 7	Extremely important

Situation 6.

You do a project that is highly praised.

1. Write down *one* major cause ______________________________

2. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

Totally due to other people or circumstances	1 2 3 4 5 6 7	Totally due to me

3. In the future will this cause be present again? (circle one number)

Never present	1 2 3 4 5 6 7	Always present

4. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

Just this situation	1 2 3 4 5 6 7	All situations

5. How important would this situation be if it happened to you? (circle one number)

Not at all important	1 2 3 4 5 6 7	Extremely important

Situation 7.

You meet a friend who acts hostilely toward you.

1. Write down *one* major cause ____________________

2. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

Totally due to other people or circumstances	1 2 3 4 5 6 7	Totally due to me

3. In the future will this cause be present again? (circle one number)

Never present	1 2 3 4 5 6 7	Always present

4. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

Just this situation	1 2 3 4 5 6 7	All situations

5. How important would this situation be if it happened to you? (circle one number)

Not at all important	1 2 3 4 5 6 7	Extremely important

Situation 8.

You can't get all the work done that others expect of you.

1. Write down *one* major cause ____________________

2. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

Totally due to other people or circumstances	1 2 3 4 5 6 7	Totally due to me

3. In the future will this cause be present again? (circle one number)

Never present	1 2 3 4 5 6 7	Always present

4. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

Just this situation	1 2 3 4 5 6 7	All situations

5. How important would this situation be if it happened to you? (circle one number)

Not at all important	1 2 3 4 5 6 7	Extremely important

Situation 9.

Your boyfriend/girlfriend has been treating you more lovingly.

1. Write down *one* major cause ______________________________

2. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

Totally due to other people or circumstances	1 2 3 4 5 6 7	Totally due to me

3. In the future will this cause be present again? (circle one number)

Never present	1 2 3 4 5 6 7	Always present

4. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

Just this situation	1 2 3 4 5 6 7	All situations

5. How important would this situation be if it happened to you? (circle one number)

Not at all important	1 2 3 4 5 6 7	Extremely important

Situation 10.

You apply for a position that you want very badly (eg. important job, position within the school) and you get it.

1. Write down *one* major cause ______________________________

2. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

Totally due to other people or circumstances	1 2 3 4 5 6 7	Totally due to me

3. In the future will this cause be present again? (circle one number)

Never present	1 2 3 4 5 6 7	Always present

4. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

Just this situation	1 2 3 4 5 6 7	All situations

5. How important would this situation be if it happened to you? (circle one number)

Not at all important	1 2 3 4 5 6 7	Extremely important

Situation 11.

You go out on a date and it goes badly.

1. Write down *one* major cause ________________________________

2. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

Totally due to other people or circumstances	1 2 3 4 5 6 7	Totally due to me

3. In the future will this cause be present again? (circle one number)

Never present	1 2 3 4 5 6 7	Always present

4. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

Just this situation	1 2 3 4 5 6 7	All situations

5. How important would this situation be if it happened to you? (circle one number)

Not at all important	1 2 3 4 5 6 7	Extremely important

Situation 12.

You get a raise (ie. more money).

1. Write down *one* major cause ________________________________

2. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

Totally due to other people or circumstances	1 2 3 4 5 6 7	Totally due to me

3. In the future will this cause be present again? (circle one number)

Never present	1 2 3 4 5 6 7	Always present

4. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

Just this situation	1 2 3 4 5 6 7	All situations

5. How important would this situation be if it happened to you? (circle one number)

Not at all important	1 2 3 4 5 6 7	Extremely important

2.5 Tennessee Self-Concept Scales – 2nd edition

For copyright reasons the Tennessee Self-Concept Scales – 2nd edition (TSCS:2) cannot be reproduced here. However, a summary of the scale is provided below.

The adolescent form of the TSCS:2 is standardized for use with respondents aged from 13 – 18 years. It is an 82 item self-report checklist that allows the respondent to report how they perceive themselves by responding to the items on a five point continuum from *always false* to *always true.*

The assessment yields fifteen subscale scores grouped into four areas,

Validity scores
- Inconsistent responding
- Self-criticism
- Faking good
- Response distribution

Summary scores
- Total self-concept
- Conflict

Self-concept scales
- Physical
- Moral
- Personal
- Family
- Social
- Academic/work

Supplementary scores
- Identity
- Satisfaction
- Behaviour

There is a shorter form of the TSCS:2 which only generates the Total Self-Concept summary score.

<u>*Specimen items:*</u>

3. I am a member of a happy family.
9. I am not as smart as the people around me.
33. I am a hateful person.
39. I am hard to be friendly with.
64. I feel good most of the time.

2.6 Life Events (Impact) Scale

This is a straightforward rating scale in which you are given 13 family and personal events with potential to cause distress among young people. For each item you are asked to rate whether the event affects you in a negative way, using this scale;

0 = not at all
1 = only a little bit
2 = a moderate amount
3 = quite a lot
4 = a great deal

The item negatively affects you

1.	Divorce/separation of parents.	0	1	2	3	4
2.	Alcoholism/drug abuse in family.	0	1	2	3	4
3.	Illness/injury to family member.	0	1	2	3	4
4.	Death of a family member or friend.	0	1	2	3	4
5.	Fighting/arguments within family.	0	1	2	3	4
6.	Abuse by family member.	0	1	2	3	4
7.	Unemployment of family member.	0	1	2	3	4
8.	Move to new neighbourhood.	0	1	2	3	4
9.	Starting a new school.	0	1	2	3	4
10.	Breaking up with boy/girlfriend.	0	1	2	3	4
11.	Failing a test or course.	0	1	2	3	4
12.	Getting into trouble with law.	0	1	2	3	4
13.	Personal illness/injury.	0	1	2	3	4

3.1 Youth - Depression Adjective Checklist

Tick the words that describe how you are feeling at this time.

Awful	
Blue	
Fit	
Good	
Glad	
Heartsick	
Hopeless	
Jolly	
Joyous	
Lifeless	
Lost	
Lucky	
Merry	
Rejected	
Strong	
Suffering	
Sunk	
Terrible	
Tortured	
Uneasy	
Unhappy	
Wilted	

3.2 Reason for Depression Questionnaire – Adolescent Version

This questionnaire presents you with a number of reasons why you might feel depressed. Each reason is given as a statement in the form of, "I am depressed because..." followed by a specific reason. For each statement, consider whether or not this particular reason causes you to be depressed. If you are not currently depressed, think of a time in the past when you were depressed and answer the questionnaire according to what the reasons were at the time.

Have you ever been depressed ? (Circle One) YES NO

If you don't think you've ever been depressed, think back to a time when you were extremely sad and it lasted more than just a little while.

Are you reporting on a current or past experience of depression?

(Circle One) Current Past

In a few sentences please describe what you think causes or caused your depression.

____

____

____

____

____

____

Now, turn the page and rate each reason for depression.

Rate each reason on the following scale:

1 = definitely not a reason
2 = probably not a reason
3 = probably a reason
4 = definitely a reason

I am depressed because....

1.	I see the world the way it really is	1	2	3	4
2.	I don't feel loved	1	2	3	4
3.	I can't decide what to do with my life	1	2	3	4
4.	this is the way I've learned to be	1	2	3	4
5.	I think about things in a depressing way	1	2	3	4
6.	no one really understands me	1	2	3	4
7.	my family treated me poorly as a child	1	2	3	4
8.	my partner treats me poorly	1	2	3	4
9.	I have not become the person I set out to be	1	2	3	4
10.	other people isolate me	1	2	3	4
11.	of certain things that happened to me as a child	1	2	3	4
12.	other people criticise me	1	2	3	4
13.	I'm not living up to my personal standards	1	2	3	4
14.	I haven't worked through things that happened to me as a child	1	2	3	4
15.	I had a difficult childhood	1	2	3	4
16.	I'm not active enough	1	2	3	4
17.	I don't take care of myself physically	1	2	3	4
18.	I inherited it from my parents	1	2	3	4
19.	it's a biological illness	1	2	3	4
20.	I don't eat well enough	1	2	3	4
21.	I am not fulfilling my potential	1	2	3	4
22.	other people don't like me	1	2	3	4
23.	I don't get enough exercise	1	2	3	4
24.	I have always been this way	1	2	3	4
25.	my nervous system is just wired this way	1	2	3	4

Rate each reason on the following scale:

1 = definitely not a reason
2 = probably not a reason
3 = probably a reason
4 = definitely a reason

I am depressed because....

26.	I've failed to achieve a specific goal I set for myself	1	2	3	4
27.	I can't make friends	1	2	3	4
28.	I can't get done the things I should be able to	1	2	3	4
29.	people treat me poorly	1	2	3	4
30.	people don't give me the respect I deserve	1	2	3	4
31.	this is the way I respond when things get tough	1	2	3	4
32.	it's basically caused by genetics	1	2	3	4
33.	I pay more attention to the bad things in my life than the good things	1	2	3	4
34.	I'm stuck in a bad love relationship	1	2	3	4
35.	my boyfriend/girlfriend doesn't understand me	1	2	3	4

3.3 Life Event Checklist

Below is a list of things that sometimes happen to people. Put an 'X' in the box by each of the events you have experienced during the past year (12 months). For each of the events you check also indicate whether you would rate the event as a *good* event or as a *bad* event. Finally, indicate how much you feel the event has changed, or has had an impact or effect on, your life by placing a circle around the appropriate statement (no effect – some effect – moderate effect – great effect). Remember, for each event you have experienced during the past year, (1) place an 'X' in the box to indicate you have experienced the event, (2) indicate whether you viewed the event as a good or bad event, and (3) indicate how much effect the life event has had on your life.

To get some idea of the type of events you will be asked to rate, please read over the entire list before you begin. Only respond to those events you have actually experienced during the past year.

	Event		Type of event (circle one)		Impact or effect of event on your life			
1.	Moving to a new home	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
2.	New brother or sister	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
3.	Changing to new school	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
4.	Serious illness or injury of family member	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
5.	Parents divorced	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
6.	Increased number of arguments *between* parents	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
7.	Mother or father lost job	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
8.	Death of a family member	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
9.	Parents separated	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
10.	Death of a close friend	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
11.	Increased absence of parent from home	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
12.	Brother or sister leaving home	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
13.	Serious illness or injury of close friend	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
14.	Parent getting into trouble with law	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect
15.	Parent getting a new job	☐	Good	Bad	No effect	Some effect	Moderate effect	Great effect

16.	New stepmother or stepfather		Good	Bad	No effect	Some effect	Moderate effect	Great effect
17.	Parent going to jail		Good	Bad	No effect	Some effect	Moderate effect	Great effect
18.	Change in parent's financial status		Good	Bad	No effect	Some effect	Moderate effect	Great effect
19.	Trouble with brother or sister		Good	Bad	No effect	Some effect	Moderate effect	Great effect
20.	Special recognition for good grades		Good	Bad	No effect	Some effect	Moderate effect	Great effect
21.	Joining a new club		Good	Bad	No effect	Some effect	Moderate effect	Great effect
22.	Losing a close friend		Good	Bad	No effect	Some effect	Moderate effect	Great effect
23.	Decrease in the number of arguments *with* parents		Good	Bad	No effect	Some effect	Moderate effect	Great effect
24.	Male: girlfriend getting pregnant		Good	Bad	No effect	Some effect	Moderate effect	Great effect
25.	Female: getting pregnant		Good	Bad	No effect	Some effect	Moderate effect	Great effect
26.	Losing a job		Good	Bad	No effect	Some effect	Moderate effect	Great effect
27.	Recognition as a top student		Good	Bad	No effect	Some effect	Moderate effect	Great effect
28.	Getting your own car		Good	Bad	No effect	Some effect	Moderate effect	Great effect
29.	New boyfriend/girlfriend		Good	Bad	No effect	Some effect	Moderate effect	Great effect
30.	Failing an exam		Good	Bad	No effect	Some effect	Moderate effect	Great effect
31.	Increase in the number of arguments *with* parents		Good	Bad	No effect	Some effect	Moderate effect	Great effect
32.	Getting a job of your own		Good	Bad	No effect	Some effect	Moderate effect	Great effect
33.	Getting into trouble with police		Good	Bad	No effect	Some effect	Moderate effect	Great effect
34.	Major personal illness or injury		Good	Bad	No effect	Some effect	Moderate effect	Great effect
35.	Breaking up with boyfriend/girlfriend		Good	Bad	No effect	Some effect	Moderate effect	Great effect
36.	Making up with boyfriend/girlfriend		Good	Bad	No effect	Some effect	Moderate effect	Great effect
37.	Trouble with teacher		Good	Bad	No effect	Some effect	Moderate effect	Great effect
38.	Male: girlfriend having abortion		Good	Bad	No effect	Some effect	Moderate effect	Great effect
39.	Female: having abortion		Good	Bad	No effect	Some effect	Moderate effect	Great effect
40.	Failing to make a sports team		Good	Bad	No effect	Some effect	Moderate effect	Great effect
41.	Being suspended from school		Good	Bad	No effect	Some effect	Moderate effect	Great effect
42.	Having 'fail' grades on school report		Good	Bad	No effect	Some effect	Moderate effect	Great effect

43.	Making a sports team		Good	Bad	No effect	Some effect	Moderate effect	Great effect
44.	Trouble with classmates		Good	Bad	No effect	Some effect	Moderate effect	Great effect
45.	Special recognition for a sporting performance		Good	Bad	No effect	Some effect	Moderate effect	Great effect
46.	Getting put in jail		Good	Bad	No effect	Some effect	Moderate effect	Great effect
	Other events which have had an impact on your life. List and rate.							
47.			Good	Bad	No effect	Some effect	Moderate effect	Great effect
48.			Good	Bad	No effect	Some effect	Moderate effect	Great effect
49.			Good	Bad	No effect	Some effect	Moderate effect	Great effect
50.			Good	Bad	No effect	Some effect	Moderate effect	Great effect

3.4 Self-Esteem Scale

This scale asks you to rate your level of agreement with each of the following seven statements on a scale from 1 = *strongly disagree* to 4 = *strongly agree.*

Rate each statement by circling the number that reflects you response:

		Strongly disagree			*Strongly agree*
1.	I feel good about myself.	1	2	3	4
2.	I feel I am a person of worth, the equal of other people.	1	2	3	4
3.	I am able to do things as well as most other people.	1	2	3	4
4.	On the whole I am satisfied with myself.	1	2	3	4
5.	I certainly feel useless at times.	1	2	3	4
6.	At times I think I am no good at all.	1	2	3	4
7.	I feel I do not have much to be proud of.	1	2	3	4

3.5 Appointment letter

<Date>

<address>

Dear **<parents & client>**

We have recently received a referral from **<referral source>** indicating that you are currently experiencing some difficulties and asking us to give you whatever help and support we can. I am able to offer you an appointment at <**time**> on <**day, date**> at the Child & Adolescent Community Centre, Taranaki Base Hospital (map attached). I expect that this appointment will last about one hour. If the time or date of the appointment is inconvenient for you please do not hesitate to contact me so that we can make alternative arrangements.

In the meantime I would like to take this opportunity to inform you of a study we are conducting which focuses particularly on our work with young people who are feeling down. This study involves completion of some rating scales, both before the first session, and at each session. We are also audio tape recording a small section of our interviews, a part when I am asking five standard questions. I have enclosed a separate sheet giving more information about the project, and inviting you to be a part of this study.

If you decide that you want to take part in the study please follow the instructions in the attached information i.e., complete and return the rating scales, and then just turn up for your appointment. If you have any questions about the project please do not hesitate to contact me at the number above.

If you do not want to take part simply turn up for the appointment time above and we will continue as usual. Declining to take part will not effect the service you receive from us in any way.

Many thanks for giving your consideration to our project.

Yours sincerely

John Fitzgerald
Senior Clinical Psychologist

3.6 Project information sheet

'How do you feel?' project

Information sheet

It is not unusual for people to feel down or have low energy now and then. This could be the result of problems with a relationship, problems at school or work, the loss of someone or something important. For some people, and this includes both young and old, low mood can make ordinary daily tasks difficult.

Feeling low or down is far more common than many people think. Among young people it has been estimated that as many as 1 in 5 will experience this problem to a significant degree at some time during their teenage years.

If the problems of severe or long lasting low mood are not addressed then it can put pressure on friendships and families, slow down progress at school etc. In some cases it can pose a threat to life as the young person fails to take care of themself, or even actively looks for ways to end their life.

In our own recent research we have found that the way a person views themself, their 'self-concept', can have a significant impact on their mood. We are currently trying to explore this further by collecting more information about self-concept and mood in young people, especially where mood is low.

In order to get this information we are asking young people who are feeling down to complete some rating scales for us while we work with them to raise their mood. These rating scales mostly ask about mood and self-concept. We ask those who are part of the project to complete the full versions of these scales before and after we work with them, and to complete much shorter versions of some of the scales at each weekly counselling session. We make use of several of these scales in our regular work with young people, so lots of other young people have completed them.

We also have five or six specific questions that we are asking everyone in the project, we ask these same questions on a few occasions and audio tape the answers. We are not taping whole counselling sessions. When the information is taken from the tapes any names etc. will be altered so that those being interviewed cannot be identified. We will not be playing the tapes to anyone else.

When someone decides to join the project they are free to leave at any time without it having a negative impact on the counselling they receive.

We have developed a consent form so that you have an idea what you would be agreeing to.

What should you do if you are willing to be part of our project?

I have included the rating scales that need to be completed at this time, along with a stamped addressed envelope. If you are willing to be a part of our project simply;

1. sign the consent form enclosed, and get your parent(s) to sign it if you are under 16 years of age,
2. complete that rating scales, and
3. send the completed consent form and rating scales back in the envelope provided.
4. All you have to do then is just turn up to your appointment.

If you have any questions or comments about any aspect of the project please do not hesitate to make contact.

John Fitzgerald
Senior Clinical Psychologist

Child & Adolescent Community Centre
Taranaki Base Hospital
New Plymouth
06-753-7790

3.7 Consent form

'HOW dO YOU feel?' project

Consent Form

PLEASE READ AND SIGN ....

I have received a copy of the information sheet outlining the project and have had an opportunity to discuss our involvement with the **'HOW dO YOU feel?' project**.

I understand that I will be asked to complete a number of rating scales and have a segment of counselling sessions audiotaped, as outlined in the project information sheet.

Participation in the project is on the understanding that such action will have no detrimental effect on services offered or received, either now or in the future. I also understand that I may refuse to participate in the project, or withdraw at any time without explanation, and without any detrimental effect on services offered or received either now or in the future.

While the information relating to me will be rendered anonymous I understand that the overall results of the project may be shared through production of research reports.

Young Person

By signing this consent I am indicating my consent to participate in the research project as outlined.

Signed .... Dated ....

Parent(s)/Caregiver(s) *(required if the young person is under the age of 16 years)*

By signing this consent I am/we are indicating my/our knowledge and support of our son's/daughter's participate in the research project as outlined.

Signed .... Dated ....

Signed .... Dated ....