The Impact of Resiliency and Adolescent Depression

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By

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Abstract

For over fifty years, psychologists and researchers alike have been looking for ways to increase the resiliency of adolescents. This paper reviews literature on how school counselors can help develop resiliency in adolescent depressed students in public schools in the United States. This review of literature will present a model of Strength-Based School Counseling which focuses on strengths to help develop resiliency and decrease depression in adolescents. It will examine components of resiliency, risk factors, school-based mental health services, causes of adolescent depression, school counselors’ implications, and an Adlerian approach to resiliency and depression.
Dedication

This master’s paper is dedicated to my son, Jesse Barta. Thanks for all your support, patience, understanding, and encouragement. Thanks for all your contributions that you took on while I focused on this endeavor; they were well appreciated. I also want to acknowledge and thank my family for always encouraging me along the way. Depression has impacted our family for many years; in spite of this, you have never given up hope in your battle with depression. You are an inspiration to me and many others; because of your vulnerability, faith, and strength to persevere.
Table of Contents

Abstract 2
Dedication 3
Introduction 5
School Counselors Helping with Adolescent Resiliency 11
  Components of Resiliency 12
  Assessing Resiliency 14
  Strength-Based School Counseling 15
  Mental Health Services in Public Schools 18
  Summary 22
Adolescent Depression 23
  Risk Factors 24
  Assessment 26
  Prevention 27
  Factors Impacting Depression 30
  Summary 34
Generational Implications on Depression 36
An Adlerian Perspective of Resiliency and Depression 37
Implications for School Counselors 42
Future Research Recommendations 45
Appendix A 47
Appendix B 48
The Impact of Resiliency and Adolescent Depression

Depression now arrives at a lot younger age. The number of children on mood-altering drugs tripled between 1987 and 1996. The suicide rate for young people has more than doubled and is the third leading cause of death for people aged 15 to 24. These suicidal thoughts are often brought on by depression (Twenge, 2006, p. 108).

To effectively treat depression, one must have a thorough understanding of what it is and the potential etiology of the disorder. The DSM-IV (American Psychiatric Association, 2000) identifies depression as a mood disorder or mental disorder. “Mood” is defined “as a pervasive and sustained emotion that colors the perception of the world” (p. 768). The mood disturbance is the primary feature of the individual’s problems; therefore, it is important for parents, school counselors, and medical professionals to evaluate the complex relationships among different system clusters and how environmental events influence their symptoms (House, 1999, p. 78). The DSM-IV defines several mood syndromes, which are then used in the criteria of several mood disorders. The mood disorders are identified as: Major Depressive Disorder (MDD), Dysthymic Disorder, Bipolar Disorder, and other Adjustment Disorders.

To meet the criteria for MDD, at least five of nine criteria are required and must be present during the same 2-week period or more in a child or adolescent. Symptoms must be present for most of the day, nearly every day, for at least 2-weeks and include: depressed mood, diminished interest/pleasure, significant weight loss or gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, difficulty concentrating, and recurrent thoughts of death/suicide ideation (American Psychiatric Association, 2000).
Dysthymic Disorder identifies a chronic depressive state of less severity than MDD. Symptoms include depressed mood for most of the day, for more days than not, and ongoing for at least two years. During this time, there must be two or more of the following symptoms: under- or over eating, sleep difficulties, fatigue, low self-esteem, difficulty with concentration or decision making, and feelings of hopelessness. There can also not be a diagnosis of MDD for the first two years of the disorder, and has never had a manic or hypo-manic episode (American Psychiatric Association, 2000).

For a diagnosis of Bipolar I Disorder, a person must have at least one manic episode. Mania is sometimes referred to as the other extreme to depression. Mania is an intense high where the person feels euphoric, almost indestructible in areas such as personal finances, business dealings, or relationships. They may have an elevated self-esteem, be more talkative than usual, have flight of ideas, a reduced need for sleep, and be easily distracted. Not as much research has been done on Dysthymia as on MDD but there is support for a biological undertone as well as maladaptive ways of coping with the environment (American Psychiatric Association, 2000).

Bipolar II Disorder identifies with periods of highs as described above and often followed by periods of depression. However, Bipolar II Disorder is different in that the highs are hypo-manic, rather than manic. In other words, they have similar symptoms but they are not severe enough to cause marked impairment in social or occupational functioning and typically do not require hospitalization in order to assure the safety of the person (American Psychiatric Association, 2000).

Adjustment Disorder is a mental disorder which identifies with clinically significant distress, impairment of adaptive behavior, or specific outcome risks. Adjustment Disorders are
generally in response to an identified psychosocial stress or stressor. Adjustment Disorders are excluded if the symptom meets the criteria for an alternative, specific Axis I disorder (House, 1999, p. 88).

There are many explanations for the origin of depression: genetic predisposition, over identification with parents who are depressed, loss of social reinforcement, loss of role status, or loss of meaningful existence (Ramsey, 1994). Perhaps the most universally accepted explanation of depression involves neurotransmitters. Any problem that disrupts the chain of neurotransmitter action can lead to imbalances. Three of the main neurotransmitters have been linked to depression; serotonin, dopamine, and norepinephrine. Serotonin is responsible for regulating many of the body’s functions such as, mood, appetite, sleep, aggression, and sexual behavior. Norepinephrine is believed to aid in recognizing and responding to stressful situations. Dopamine regulates the drive to seek out rewards and pleasure (Nemade, Staats Reiss & Dombeck, n.d.)

Depression is one of the leading causes of disability worldwide (Murray & Lopez, 1997). Depression is complex and affects adolescents physically, psychologically, developmentally, emotionally, and academically; adolescence is a key time in the diagnosis of depression. Depression rates increase dramatically from the early to late adolescent years (Hankin, 2006). Depression is a major mental health problem because the features of depressed mood may be compounded by the conditions that often coexist with depression. In 1994, the American Psychiatric Association, stated that other than depressed or irritable mood, typical diagnostic features of depression among adolescents include the following: increased emotional sensitivity, decreased energy level, increased fatigue, low self-worth or excessive feelings of guilt, recurrent
thoughts about death or dying, withdrawal from friends, sleep and/or appetite disturbances, and change in school performance (Rice & Leffert, 1997, p. 19).

Schools are focused on the here and now of behavior/academic problems and deficits of children and not enough focus is on prevention and strength-building. School counselors need to look at the students’ strengths and help students build upon them. If school counselors looked at what promotes and deters resiliency early, they could focus on strategies to reduce the risk for adolescents developing depression. School counselors could help adolescents develop necessary life skills to become more resilient. These life skills could promote a healthy well-being, academic success, and lessen the chances of developing depression.

Strengths-based school counseling (SBSC) can enhance the practice of school counseling in the 21st century as reflected in the comprehensive school counseling programs published by the American School Counseling Association. School counselors can help adolescents build strengths and provide resources to help adolescents develop resilience. They can advocate and promote for adolescents’ strengths and provide strength-enhancing environments to support a positive development in the academic, personal/social, and/or career development domains (Galassi & Akos, 2007).

School counselors can play a vital role in prevention efforts and help alleviate the enormous burden of depression in adolescence. School counselors need to be knowledgeable on the current research on depression and the effects resiliency has on adolescent depression. SBSC, providing mental health services in schools, and providing positive supportive environments may enhance the public school counseling programs in the United States (Edwall, 2012).
The purpose of this literature review is to investigate and learn what the literature says about resiliency and adolescent depression and if there is a direct relationship between resiliency and adolescent depression, to research and understand what factors related to resiliency are most likely to promote or hinder resiliency, the effect factors have on adolescent depression, and to research effective strategies for school counselors to develop resiliency in adolescent depressed students. This literature review also examines the components of resiliency, SBSC, mental health services in schools, assessing and preventing depression, and an Adlerian perspective.

In an on-going effort to predict the pro-social development of young people, resiliency has recently become one of the most important determining factors. Despite gender, socioeconomic status, and ethnic background resilient youth are able to develop into productive, mentally and physically healthy adults regardless of life's inherent stresses (Benson, Leffert, Scales, & Blyth, 1998). Since 1989, Search Institute has been studying the assets in the lives of young people; about three million young people have been surveyed in thousands of communities across North America (Search Institute, 2012). Researchers have learned a great deal in the past several decades about elements in human experience that have long-term, positive consequences for young people. Factors such as family dynamics, support from community and adults, school effectiveness, peer influence, values development, and social skills have all been identified as contributing to healthy development (Search Institute, 2012).

The framework of Developmental Assets is grounded in extensive research on what children need to succeed and is a holistic approach that looks at what young people need to thrive. The assets grow out of three types of applied research: Positive youth development, which highlights core processes and dynamics in human development that are foundational for growing up healthy, prevention, which focuses on protective factors that inhibit high-risk
behaviors such as substance abuse, violence, sexual intercourse, and dropping out of school, and resiliency, which identifies factors that increase young people’s ability to rebound in the face of adversity, from poverty to drug-abusing parents to dangerous neighborhoods (Search Institute, 2012).

The Developmental Assets, as referred in Appendix B, are 40 common sense, positive experiences and qualities that help influence choices of young people. The Search Institutes’ creation of the 40 Developmental Assets has created a simple system for families, schools, and communities to follow. Incorporating the developmental assets is an easy way to increase youth resilience by providing opportunities and support for youth to belong and contribute value in their community and therefore develop resilience in themselves.

Because of its basis in youth development, resiliency, and prevention research and its proven effectiveness, the Developmental Assets framework has become one of the most widely used approach to positive youth development in the United States (Search Institute, 2012). Research has proven that youth with the most assets are least likely to engage in four different patterns of high-risk behavior, including problem alcohol use, violence, illicit drug use, and sexual activity. The same kind of impact is evident with many other problem behaviors, including tobacco use, depression and attempted suicide, antisocial behavior, school problems, driving and alcohol, and gambling (Search Institute, 2012).

Resiliency has also helped protect individuals from depression and includes behaviors that can be taught to persons vulnerable to hardships, including mental illness (Smith, 2009). Resilience research has indicated that the presence of protective factors may moderate the effects of stressors and actually contribute to promoting mental health and prevent the development of psychopathology despite being exposed to significant stressors (Smith, 2009).
School Counselors Helping with Adolescent Resiliency

In most economically developed societies of the 21st century, schools play a central role in child development. In recent advances in theory and research on resilience in development, the school context has been implicated in diverse ways as a contributive and protective environment for children and adolescents. Resiliency is “the capacity to spring back, rebound, successfully adapt in the face of adversity and develop social, academic, and vocational competence despite exposure to severe stress or simply to the stress inherent in today’s world” (Henderson & Milstein, 1996, p. 7).

Schools are viewed as a system that may be threatened by adversities. A school that functions well in a context of adversity also can be said to manifest resilience and there is considerable interest in the resilience of classrooms or schools. During any given period of development, individuals are expected to engage successfully in the academic, social, and vocational domains of functioning (Masten, Herbers, Cutuli, & Lafavor, 2008, p. 3). For example, children in school are expected to do well in learning academic skills, forming and maintaining relationships with peers, and adhering to the standards of conduct for the classroom. Therefore, a child with major problems in any of these domains is not likely to be viewed as developing well and is considered “at risk” (p. 3).

The concept of risk or risk factor refers to any measurable predictor of an undesirable outcome. In research on young people over the past four decades, a wide variety of events and experiences have been studied as risks to child development, including effects of war, natural disasters, terrorism, family violence, divorce, maltreatment, and chronic conditions such as depression and poverty (Masten, et al., 2008, p. 5).
Investigators realized early in the study of various adversities that hazardous conditions and risk factors rarely arise in isolation, and they began to measure cumulative risk or aggregated life events. As the level of risk exposure accumulated, children often had worse outcomes, reflecting a risk gradient. Even at high cumulative levels of risk or adversity, some children were observed to be doing well; better than one would expect from the level of risk. This result indicates that other influences must be important to consider (p. 5).

If school counselors are to impact all students in meaningful ways they can’t continue to focus primarily on providing deficit-reduction services to a small percentage of the student population because deficit-reduction services don’t empower students, don’t serve all students, and don’t look at students’ positive characteristics. Therefore, school counselors’ focus must be on programs that impact academic knowledge and life and career skills, or strengths of every student (Galassi & Akos, 2007). “A strength may be defined as that which helps a person to cope with life or what makes life more fulfilling for oneself and others” (Smith, 2006, p. 25). Strengths are not fixed personality traits; instead they develop from peoples’ environment/climate, which is rooted deeply in one’s culture (p. 25).

**Components of Resiliency**

Children viewed as manifesting resilience in the context of serious adversity would be doing well in multiple domains, successfully engaging or accomplishing multiple essential developmental tasks. Resiliency has applicability not only to the type of services provided to all students in a comprehensive school counseling program, but is also especially relevant to the at-risk students which school counselors serve (Masten, et al., 2008, p. 3).

Research on resiliency theory has repeatedly demonstrated that most people are not permanently overwhelmed by and damaged by exposure to adverse life circumstances. Galassi
and Akos (2007) found that typically, 50% or more children who have unfortunately been reared under conditions of profound adversity (e.g., extreme poverty, neglect, and homelessness) develop into adults with healthy relationships, steady employment, and hope for the future (Galassi & Akos, 2007, pp. 33-34). These findings encouraged researchers to identify key protective processes and factors, in order to better equip the other 50% with resilience.

Protective processes/factors are associated with moderating or overcoming severe developmental risks. “They are traits, conditions, situations, and episodes that appear to alter, or even reverse predictions of negative outcomes and enable individuals to prevent life stressors” (Bernard, 1991, p. 3). These protective processes/factors are internal or they can be developed; such as intelligence, self-motivation, sociability, and being good at something. These processes/factors reflect the functional strengths operating in people, relationships, and environments that make resilience possible.

Masten (2008) described connected findings on promotive or protective factors as "the short list" of clues to what matters most for resilience in children. This list implicates a set of fundamental adaptive systems that keep human development on course. If these systems are developing and operating normally, they afford children considerable ongoing capacity for resilience. Masten argued that resilience typically results from the function of these basic protective systems; thus, “the greatest danger to children occurs when these protective systems themselves are damaged, destroyed, or undermined” (Masten, et al., 2008, p. 5).

A “short list” of strengths in the child, family, relationships, and the larger environment widely implicated in the resilience literature is presented in figure 1, as referred to in Appendix A. Effective schools and positive experiences have been implicated for decades as strengths or protective influences in studies of resilience (p. 5).
Assessing Resiliency

In order for school counselors to help adolescents rebound and successfully adapt in the face of adversity one must measure the personal attributes of the adolescent that are critical for resiliency. A tool to profile personal strengths, as well as vulnerability in adolescents is called the resiliency scales for young children and adolescents. The scales are composed of three global scales of 20-24 questions each; Sense of Mastery, Sense of Relatedness, and Emotional Reactivity (Prince-Embury, 2008).

It is important to assess resiliency to influence outcomes of many disorders and find patterns of strengths that can influence intervention strategies and goals. For instance, adolescents with depression or anxiety may have different prognoses and lengths of care depending upon their level of resiliency and course of care may vary for adolescents with adjustment reactions to divorce, loss, or other life events (Prince-Embury, 2008, p. 26).

The developmental audit is another tool used to assess resiliency in children and adolescents. It is a comprehensive strength-based means of assessment and treatment planning that identifies the coping strategies underlying a youth’s maladaptive and self-defeating behavior. The developmental audit is based on understanding a student’s “private logic” and goals as identified by Alfred Adler. This involves using the child as an expert in retelling his or her life story. The process of the audit entails spending time with the student, the family, and other key people in the student’s life to understand the child’s life space (Doerr, 2008).

The overall format of the audit includes the following: presenting the problem, significant life events, supports and strengths, private logic, coping strategies, and goals for growth. The developmental audit incorporates the “Circle of Courage” philosophy by looking at four central values: belonging, mastery, independence, and generosity. The “Circle of Courage” is a
framework used for identifying where the student’s circle is broken. This is where the student’s needs are unmet. It is used to begin to develop resilient coping mechanisms. Adolescents who can communicate about conflict and trauma are able to make sense of what has always seemed irrational and envision more promising outcomes (Doerr, 2008, p.26).

**Strength-Based School Counseling**

Schools afford many opportunities to assess and facilitate resilience among children at risk for poor outcomes due to adversity exposure; ranging from divorce, family violence, overcoming homelessness, and depression. School counselors can help adolescents cope with adverse circumstances by building self-efficacy, optimism, trusting and supportive relationships, and by building stress management skills to impact their vulnerability to stress.

The American School Counseling Association (ASCA), a National Model for school counseling, calls for school counselors in the 21st century to change the way they function and represents a significant step forward in the evolution of professional school counseling. ASCA emphasizes outcome-based, comprehensive school counseling programs that target academic, personal/social, and career development for all students (Glassi & Akos, 2007, p. vii). Recent advances in theory and research on resiliency have important implications for SBSC. It provides a framework for implementing comprehensive school counseling programs which enhances the ASCA National Model.

Galassi & Akos (2007) explained that research in education, resiliency, school counseling, and social work are beginning to witness a shift away from a deficit-orientated model of human behavior in order to incorporate a more strengths-oriented perspective. SBSC enables students to be successful in life and contribute to the society in which they live. The six major principles which form the foundation of SBSC are; promoting evidence-based student
strengths, promoting evidence-based strengths-enhancing educational environments, promoting context-based development for all students, emphasizing promotion over remediation and prevention, emphasizing evidence-based interventions and practice, and emphasizing promotion-orientated developmental advocacy at the school-building level (pp. vii-viii).

Out of the research on SBSC, Henderson and Milstein (1996) developed the resiliency wheel that presents a six-step strategy for fostering resiliency. The resiliency wheel model was created to assist schools in developing protective factors for student’s academic, social, and vocational success. Three of the protective factors are: pro-social bonding, clear and consistent boundaries, and life skills which focus on mitigating risk factors in the environment (Galassi & Akos, 2007, p. 34).

Pro-social bonding involves increasing connections between students and any pro-social person (e.g., mentor) or activity in the school environment (e.g., participating in sports). Research has repeatedly demonstrated that students’ need for belonging in the school community significantly affects academic attitudes, beliefs, behaviors, and achievement. Schools need to implement clear and consistent policies and consequences and help students develop life skills such as: conflict resolution, self-confidence, communication skills, and stress management skills (p. 34).

Kercher’s cross-age mentoring program (CAMPs), in which high school students mentor elementary and middle school students, provides an example of pro-social bonding and helps students develop life skills. These camp programs have resulted in increased school connectedness, self-esteem, social skills, and academic achievement for the children and mentors (Galassi, J. P., Griffin, D., & Akos, 2008).

The other three protective factors include the following: providing care and support, high
expectations, and opportunities for meaningful participation. The focus should be on increasing resiliency through building and strengthening protective factors in the environment. Resiliency research consistently indicates that the most important protective factors are adult caring and support. The resiliency wheel also provides school counselors with a conceptual framework for developing and implementing strength-enhancing and risk reducing environments for all students (Galassi & Akos, 2007, p. 34).

The goal is to understand how a system responds well or poorly to disturbances. School counselors can help contribute to adolescents’ resilience in many ways at multiple levels, including actions to promote positive relationships of school staff with all students and advocacy or intervention aimed at promoting student strengths (Masten, et al., 2008). In order to succeed at this goal, school counselors must also identify and study the strengths and protective processes which make a difference for the system when it is threatened. “Thus, the components of resilience include a focus on the positive outcomes of interest, the risk factors or threats to those outcomes, and potential strengths and protective factors that facilitate resilience in the context of these risks or threats” (Masten, et al., 2008, p. 3).

Some risk-focused strategies school counselors can use to promote better chances of developing resiliency in children is to identify and address important early risk factors for school success. Schools can include strategies to reduce bullying, discrimination, and violence through evidence-based interventions. School counselors also need to focus on building assets or character strengths associated with positive development. Examples of asset-focused strategies with the potential to promote competence include the following: providing mental health clinics, after-school programs, tutoring and homework services, and community activities (Masten et al., 2008).
Mental Health Services in Public Schools

Suicide and depression have an enormous impact on resiliency in youth. According to the Center for Disease Control and Prevention (CDC), in 2004 suicide was the third leading cause of death for children aged 10 to 14 years. As many as 40 million Americans suffer from depression, and approximately 3.5 million of them are children and adolescents, according to a 1999 report by the United States Surgeon General. Studies suggesting that every single day, in every single high school in America, adolescents are thinking about suicide or making actual attempts (Wright & Emmert-Aronson, 2007; U.S. Department of Health and Human Services, 1999).

Mental health disorders create enormous psychosocial and economic costs during childhood and adolescence, including reduced school achievement and increased child welfare and juvenile justice costs – estimated at $247 billion in 2007. Approximately half of all adults affected by mental health problems recall that their disorders started by their mid-teens (Edwall, 2012). The Minnesota Student Survey (2010), asked 6th, 9th, and 11th graders if they had a mental or emotional health problem that had lasted at least 12 months; 17% of males said yes compared to 29% of females.

The responsibility for children and adolescents’ mental health services has remained divided between the mental health system and the educational system. As many as 8% of adolescents suffer from Major Depressive Disorder, and the prevalence of adolescent suicide is increasing; at the same time, approximately 70% of children who need mental health services are not receiving them (U.S. Department of Health and Human Services, 1999).

In 2002, a research survey conducted by the CDC looked at youth risk behaviors. The CDC reports that 19% or 3 million of all U.S. high-school students have annually had thoughts
of suicide, and over 2 million of them made plans to carry it out. This comes to an average of more than 1,000 attempts a day nationwide, every day of the year. Depression plays at least some role in most of them. It is difficult for an adolescent to recognize their depression and be treated; most teenagers will not receive the help they need. The pain of depression can seriously deteriorate their capacity to learn and be successful in school (U.S. Department of Health and Human Services, 1999).

A study, published in 1995 by Culp, examined 220 adolescent students in the 6th through 12th grades. The researcher found among adolescent students with symptoms of depressed mood; 49% did not ask for help. Of those who did not seek help, 68% believed that they had to take care of their problems themselves. “If young people feel they need to handle their own problems, the question remains whether they are capable of doing so” (p. 834).

There is an obvious need for school counselors to educate youth about expected developmental changes and the problems that may result. The need for mental health services is apparent; however, not knowing about the availability and location of existing services reflects poorly on the schools and the community. Schools need to evaluate whether the mental health needs of the adolescent population are adequately being addressed, so certain students don’t fall through the cracks. Recent studies have suggested 12% to 15% of adolescents have psychosocial problems that warrant treatment, but only 1/3 of them actually receive treatment (Brener, Martindale & Weist, 2001).

It has only been within the past decade that school counselors and researchers have been interested in student depression. Prior to this time, depression in children and adolescents was viewed as non-existent or very different from that of adults. But recent research findings have changed these assumptions and suggest that depression is a major mental health problem within
this population (Ramsey, M., 1994).

Schools have a significant and sustained access to adolescents. Most adolescents spend one-half of their average waking hours in school. Schools can target larger populations of adolescents. Therefore, schools are ideally positioned to initiate and maintain activities and services to enhance the psychological development and well-being of adolescents (Fox & Harding, 2005).

Schools also have strong motivation to identify adolescents with social or emotional problems because they get in the way of all students learning. According to Fox and Harding (2005) one possible solution to increase schools ability to identify adolescents at-risk is to split the role of the school counselor into two separate positions, one position responsible for academics and career advising and one responsible for mental health and emotional problems (p. 92).

School counselors could and should play a critical role in assessment, intervention, and prevention of adolescent depression. Students are hampered by these problems to a degree that is limiting their ability to learn. Schools are legally responsible for the well-being of their students while these students are enrolled in their schools. Several courts have ruled that school counselors have a legal obligation to protect students if “they foresee, or should have foreseen that the student was potentially dangerous to himself or herself” (King, Price, & Telljohann, 2000, p. 260).

Children must be healthy in order to attend school and benefit from instruction, ensuring they have access to health care services and resources will allow them to be more successful in their education. It is estimated that 16.9 million children who are insured still experience significant barriers to accessing health care, such as high out-of-pocket costs, limited number of
available specialists and difficulty arranging transportation (Children’s Health Fund, 2011). Funding has been a challenging barrier to providing mental health services in schools, however, a provision of the Affordable Care Act (ACA), of 2010, authorizes funding to establish and expand school-based health centers. This provision will significantly increase and enhance access to mental health services in schools (Mock, 2003).

Engaging in collaborative relationships is beneficial and crucial for schools, because it maximizes time and resources. Collaborative relationships lead to increased identification of youth in need, improved treatment engagement/adherence, and improved student outcomes (Anderson-Butcher & Aston, 2004). Therefore, school counselors and mental health professionals should be proactive in initiating these important relationships with community health and mental health providers and with partners in the school building (e.g., school nurse, school social worker, school psychologist, and school mental health specialists).

The research on School-Based Mental Health (SBMH) has demonstrated improved school climate, reduced disciplinary referrals, and grade retention. Some studies demonstrated that greater provision of SBMH services positively correlated with increased standardized test scores and with improved academic performance. A longitudinal study examining SBMH centers found effects of high school students’ usage of medical and mental health service on their academic outcomes. Results indicated among high-risk students, there was a significant increase in grade point averages over time for students enrolled in mental health services as compared to those who were not using those services (Walker, Kerns, Lyon, Bruns, & Cosgrove, 2010).

School counselors have many roles, including a lot more administrative tasks and have a tremendous amount of students under their care. They have the ability to keep a close watch on students via teachers, peers, and school counselor visibility. This connection allows school
counselors to develop strong, trusting relationships with students. More mental health services in schools would benefit adolescents struggling with depression and increase their ability to learn and succeed in school (Wright & Emmert-Aronson, 2008).

Summary

Schools are in a powerful position to help support adolescents and families who don’t have strong protectors in their lives. School counselors can work to promote a school climate developed for mentoring relationships to emerge and have a tremendous effect on children’s degree of resiliency. Early action is crucial to avert the potentially disastrous effects of harmful stressors in an adolescent’s life (Fox & Harding, 2005).

Recent advances in theory and research on resiliency have important implications for SBSC; it is highly consistent with the findings and frameworks arising from research on resilience in adolescent development. Integrating SBSC with resilience-based frameworks and findings on positive development in adolescents has the potential to accelerate growth in the competence and resilience of adolescents. It provides a framework for school counselors to use to implement their comprehensive school counseling programs. SBSC also enhances the ASCA National Model and it recognizes the importance of cultural differences, promotes and allows resiliency to grow and develop, and identifies strengths that school counselors need to promote, as well as the types of environments that have been shown to promote those strengths (Galassi & Akos, 2007).

Schools need to evaluate whether the mental health needs of the adolescent population are adequately being addressed, so certain students don’t fall through the cracks. The passage of the Affordable Care Act will have profound ramifications for the field of children’s mental
health. As a result, it is important that school counselors are knowledgeable about the specific provisions that impact the students, families, and communities (Mock, 2003).

**Adolescent Depression**

Depression is a global issue and ranks higher than ischemic heart disease, violence, strokes, and traffic accidents. The rate of suicide among adolescents and young adults with a mood disorder is 25 times greater than the rate of suicide among the general population (Blumenthal & Hirschfeld, 1984). Rates of depression increase significantly throughout the adolescent period. Gender differences in the rates of depression typically emerge beginning at around age 13 or 14, with girls twice as likely to become depressed as boys. Because of the incidence rates of depression among adolescents and because most adolescents attend school, it is quite likely that school counselors will encounter depressed adolescents at some time. (Nolen-Hoeksema & Girgus, 1994).

Depression now arrives at younger ages. Adolescence can be a roller coaster ride of extreme highs and lows. Adolescents’ moodiness is so common that parents typically consider their mood swings as normal; although sometimes adolescents are actually suffering from depression. “In past generations, depression was considered afflictions of middle age, as it was unusual for a young person to be depressed, but now depression seems to be a rite of passage through adolescents and young adulthood” (Twenge, 2006, p. 106).

**Risk Factors**

Depression among adolescents takes a toll on effective functioning and on the emotional lives of adolescents. The consequences of depression make it compelling to identify risk factors associated with it and potential protective mechanisms that may be maximized in order to
enhance resistance to depression. These risk factors can be life events, individual characteristics, or ongoing circumstances in a person’s environment (Rice & Leffert, 1997).

Internal and external resources/assets may interact with the effects of major life events, individual characteristics, and a person’s environment. Internal resources/assets refer to aspects of the individual's personality, such as attitude, character, coping skills, intelligence, self-confidence, self-esteem, and perceived locus of control. Perfectionism is one example of an internal factor that may enhance or buffer negative life circumstances (Rice & Leffert, 1997).

External resources/assets refer to interpersonal sources of support and guidance, such as a solid relationship with a teacher, counselor, parent, or friend. Deficits in external resources also place adolescents at risk for developing depression. Some examples are: physical abuse, loss of a parent or close friend, poverty, bullying, divorce, and having a depressed parent (Rice & Leffert, 1997).

One implication of the various features of depression and co-occurrence of depression with many other psychological problems is that depressed mood may not always be the presenting problem among adolescents. Certainly, not all students with concentration problems have depression. However, it is in the best interests of the student and the school if the possibility of depression is at least considered (Blumenthal & Hirschfeld, 1984).

Stress results when one’s life desires conflict with reality. Stress can then lead to mental disorders, including depression if the stress is not managed and is making a negative impact on one’s life (Grisel, Ramussen & Sperry, 2006). Biological dispositions and early life experiences can contribute to emotional responses; therefore it is important for school counselors to examine students’ lifestyle, life tasks, and family atmosphere to see how the students are functioning.
Slavik and Croake (2006) further describe Individual Psychology’s view of depression as having to do with an individual's psychological tolerance, which is defined as the amount of the threat a person will bear before withdrawing from a difficult situation. People with low tolerance are hypersensitive and are ready to withdraw and stagnate when faced with adversity. People with depression have a mistaken believe that "I must be perfect" or "I must always be in control". These two factors result in discouragement. The depressed individual gives up without attempting to resolve the perceived conflict (p. 429).

**Assessment**

School counselors, teachers, and school nurses may be more likely to hear reports of academic difficulties, concentration problems, somatic complaints (e.g., headaches, stomach aches), nervousness, peer problems, and substance abuse rather than reports of depressed mood. School counselors, teachers, and school nurses need to be knowledgeable in the assessment of depression. Adolescents do not necessarily display the symptoms of depression as adults and therefore, may go unrecognized and not be referred for treatment. A school counselor has a variety of methods available to use in an evaluation. They may individually interview a student identified by a teacher as withdrawn and/or irritable, or whose academic performance has changed (Rice & Leffert, 2007).

A comprehensive approach to assessment is the best strategy. The school counselor may also consider the teacher’s exposure to the student and knowledge of other factors possibly contributing to the student’s difficulties. Parents, teachers, social workers, school psychologists, and school counselors input may also be solicited for additional information about the student.

To assist school counselors in the early identification of adolescent depression, the Reynolds Adolescent Depression Scale (RADS) is the only measure of depressive symptomatology
designed and developed specifically for use with adolescents, ages 13 through 18 (Ramsey, 1994).

RADS is a short, easily administered, self-report instrument designed to assess the severity of depressive symptoms. The RADS is descriptive, not diagnostic, in nature and screening. This provides an efficient and economical method for individual, small, or large group prevention screening. RADS can be administered by a school counselor and takes approximately 5 to 10 minutes to complete. The RADS consists of 30 four-point Likert-type response items. These items are based on symptoms for major depressive and mood disorders. RADS asked students to indicate whether the symptom-related item has occurred almost never, hardly ever, sometimes, or most of the time. Response items are then weighted from 1 to 4 points; the higher the score, the greater the level of depressive symptomatology and distress (Ramsey, 1994, p. 256).

An assessment for depression may need to be more thorough or formal. It could involve the services of a school psychologist, school counselor, or other professionals trained to administer and interpret psychological assessments. Schools may refer students to off-site locations for extensive assessment and counseling services, thus the school counselor plays a crucial role in the initial assessment and coordination of referrals and may also become involved in the treatment or follow-up plans. Schools are ideally suited to explain the necessity of such referrals to the student and parents, serving perhaps as a liaison between the referral agency and the family (Rice & Leffert, 1997, pp. 18-19).
Prevention

Adolescent depression can’t always be prevented, but some things can help reduce the chances of an episode of depression in an adolescent who is at-risk. Prevention efforts should target both specific and non-specific risk factors and enhance protective factors. Primary preventative interventions target the entire population of adolescents because all adolescents are likely to experience at least some risk factors for depression. The general idea behind primary prevention is to prevent depression before it starts. Helping an entire population of adolescents to develop internal and external resources should help to either prevent the later development of depression or lessen its intensity when adolescents are confronted with challenges. Thus, both overall risk as well as incidence of depression can be reduced (Clarke, Hawkins, Murphy, Sheeber, Lewinsohn, & Seeley, 1995).

An example of a primary prevention and mental health promotion program is the Penn Resiliency program (PRP). It is the most evaluated depression prevention program for youth. It was developed to target cognitive and behavioral risk factors for depression and focuses on encouraging optimism. “The PRP is a school-based program that teaches youth the connection between life events, their beliefs about those events, and the emotional consequences of their interpretations” (Gladstone & Beardslee, 2009, p. 214). The PRP has been found to have positive effects on risk factors for youth depression, especially for girls.

Activities or interventions that target a specific audience who have been exposed to known risk factors are considered secondary prevention. Examples include a program that targets adolescents for interventions who have at least one parent with a depressive disorder, programs that help young people adjust to the divorce of their parents, and programs that attempt to prevent depressed moods from becoming severe depression (Clarke, et al., 1995).
In one study of a secondary prevention effort, Clarke et al. (1995) targeted 150 sad or weakened adolescents who reported elevated depressed mood, did not meet criteria for a diagnosis of a major depressive disorder, but were considered at-risk for future depressive episodes. Adolescents were assigned to either a five-week (15 sessions) prevention course on coping with stress or they were assigned to a no-treatment, usual care condition. The prevention program is an after-school cognitive group intervention that was designed to enhance adolescent coping skills, especially skills that would challenge their depressive mood and perceptions and replace them with more adaptive thoughts (p. 312). Across a one-year follow-up Clarke et al. (1995) found fewer cases of mood disorders among adolescents who had experienced the course when compared with adolescents who had not. The incidence of depression among adolescents in the intervention group was one-half that of those young people not enrolled in the intervention (p. 312).

School funding can be challenging and it takes time, commitment, and patience from the school staff to get on board with the implementation and maintenance of the prevention program. School counselors can work directly with adolescents and can include individual and family counseling, psychotherapy, and group counseling. Short-term individual counseling usually begins by developing a relationship with the adolescent (Clarke et al., 1995).

The school counselor can then implement strategies to enhance the students’ internal as well as other external resources. For instance, coping or problem-solving strategies could be explored and implemented by school counselors. Adolescents can learn how to match appropriate coping strategies to the type of problem situations they encounter by helping them implement a plan of action. The situations would be situations that are under an adolescent’s
control; they would problem-solve, sets goals, brainstorm possible solutions, and anticipate consequences (Rice & Leffert, 1997).

Some other strategies that school counselors can use are emotion focused strategies. They may include relaxation techniques such as breathing exercises and yoga. Adolescents may use the relaxation techniques when circumstances are not under the adolescent’s control but are nevertheless upsetting. They can also incorporate cognitive interventions to challenge and revise inaccurate perceptions of students and others. Social skills could be addressed, practiced, and developed in order to increase their self-esteem and quality of relationships with peers and family members (Rice & Leffert, 1997).

School counselors can be effective facilitators of adolescent support groups for depression. Group counseling strategies can be similar to those used in individual counseling, although, the opportunity for development and enhancement of external resources can be greater in a group context then in an individual context.

Factors Impacting Depression

Today’s adolescents expect more out of life and are starving for affection. They experience instability with friendships and romantic relationships and are in a constant cycle of meeting someone, falling in love, and breaking up. Isolation and loneliness readily lead to anxiety and depression. Today’s adolescents live in an increasingly competitive world (Twenge, 2006).

The following risk factors commonly associated with depression are: family cohesion, social adjustment or support, academic pressure, and divorce. The identification of risk factors for depression is critical in determining the targets of preventive efforts. As cited early in my paper, protective factors are conditions or processes that work to moderate the negative effects of
risk factors, leading to resilient outcomes. They serve to protect those at risk for a negative outcome from developing problems and operate in ways that can decrease the risk itself, or enhance coping capacity. The effectiveness of a protective factor appears to depend on individual vulnerability, the degree of adversity, and environmental/situational factors (Carbonell, Reinherz, Giaconia, Stashwick, Paradis & Beardslee, 2002, pp. 251-252).

Individual protective factors include cognitive capacity and self-esteem. Family factors include cohesion, conflict management, and communication. Environmental factors may extend beyond the immediate family, encompassing social support, social economic resources, and characteristics of the peer culture (p. 252).

In a longitudinal, community-based study completed by Carbonell et al. (1977-1998) adolescent protective factors for those at risk for depression were identified that were associated with resilient outcomes in young adulthood. The sample for the study included four-hundred youth entering kindergarten in 1997 in one public school district participating in state-mandated testing of health, developmental, academic, and behavioral factors. The school district was located in a pre-dominantly White, working class and lower middle-class community in the North Eastern United States. Data was collected from multiple sources, including the participants, their mothers, their teachers, and trained clinical interviewers, at ages five, nine, 15, and 18, (Carbonell, et al., 2002).

The findings of the study suggests that the importance of family cohesion, social support, positive outlook, and favorable interpersonal relationships during adolescence for those at risk for depression is suggested by the strong association of these factors with positive functioning and well-being. The findings also suggest that a cohesive family environment can play a
powerful role as a protective factor in those at risk for depression. Our families shape who we are and a strong, healthy, caring family can make a lot of difference in our lives. When we don't have a supportive family, it's harder to thrive in life and to overcome the challenges that we face (Carbonell, et al., 2002, p. 256).

The Search Institute conducted a national research study to identify a set of family assets that make a major difference in the lives of both children and parenting adults. The family assets focus on how families function, not on their structure. They show us the ways families live their lives together and how they relate to each other (Search Institute, 2012).

According to the Search Institute’s research study on American family assets, the family assets that are important in the development of family well-being are as follows: nurturing relationships, establishing routines, maintaining expectations, adapting to challenges, and connecting to community. The more family assets a family experiences, the better off family members are in their adjustment. They are more satisfied with their lives, healthier, and more engaged with the community around them. Children from families with more assets are also more likely to engage in learning at school and develop close relationships with others (Search Institute, 2012).

Another risk factor associated with depression is academic pressure. Many high school students are under tremendous academic pressure. They are determined to attend an Ivy League university and strive for perfect grades, perfect ACT/SAT scores, and a long list of extracurricular activities. This new level of competition means that a lot more high school students are going to greater lengths to stand out. The number of high school students who took advanced placement (AP) exams in 2004 was 1.1 million, twice as many as in 1994 and six times as many as in 1984 (Twenge, 2006).
Media is also putting pressure on the younger generation of the world to be perfect. Twenge (2006), stated that “today’s adolescents have grown up with the idea and belief-courtesy of our culture and are inundated in materialism, consumerism, and false advertising” and “that we should have it all, do it all, and be it all, and be happy; and if they aren’t, something is wrong” (p. 130). Media has a lot of power and is everywhere. Media targets adolescents because they are easily persuaded and influenced. Adolescents are so concerned with how they look and how they are perceived.

After nearly 30 years of research, there is an emerging consensus in the sociological literature regarding the impact of parental divorce on depression in childhood and adolescence. Despite the enormous literature on this subject, the reasons why divorce has lasting emotional effects are not entirely clear. Many researchers have argued that divorce is stressful for adolescents because it is either accompanied by or is the source of other problems and stresses that pose more serious threats to children's well-being—in particular, persistent family conflict and economic hardship (Aseltine, 1996).

In a longitudinal study, completed by Meyer, Garrison, Jackson, Addy, McKeown & Waller (1990, 1991, & 1992), an interview sample of 454 students; 56% were female, 77% White and 70% seventh graders; the mean age was 12.7 years (range 11-16), the top six most significant life-event factors were; parents’ divorce, problems between parents, problems between the adolescent and his/her appearance, poor grades, death of a family member or close friend, and romantic loss (p. 51).

Divorce was the most significant life-event factor. Overall findings suggested that children from divorced families have been found to have more emotional and behavioral problems and do less well in school than children living with both parents. Researchers have
suggested that depression in children whose parents have divorced may be related to the ongoing conflicts and disappointments (Meyer, et al., 1993).

In 1988, Aseltine completed a study on parental divorce with adolescent depression. The participants included 1,208 ninth, tenth, and eleventh graders in three public high schools in the Boston metropolitan area. Three interviews were conducted in one year intervals and the data was examined. Overall, findings reveal that parental divorce is linked with adolescent depression. The most prominent explanation for the effects of divorce on children emphasizes the mediating role of secondary problems and stresses that typically accompany the breakup. Aseltine (1996) explain that divorce is seen as setting off a chain of negative events and transitions that are casually related to youths' psychological distress and may be more potent stressors than the physical separation of parents (p. 134).

The analysis of the findings, from Aseltine’s study suggest that some of the difficulties experienced by children in divorced families are relocation and changes in custody arrangements. Other difficulties, however, are indirectly related to the family breakup as a consequence of parental absence and the disorganization of family life. Daily living may become unstructured and chaotic and increasing absences of custodial parents from the home may make the supervision of adolescents problematic. Economic hardships and family conflict may also contribute to the transition of divorce (Aseltine, 1996, p. 143).

Adolescent depression is also influenced by many other genetic, situational or environmental factors and they can impact their life in negative ways; for instance, family history of mood disorders, a chemical imbalance in the brain, traumatic experience, and a history of child abuse or neglect (Aseltine, 1996).
Summary

The identification of risk factors for depression is critical in determining assessment and prevention efforts. School counselors need to look at the occurrence of negative events as a standard component of their profile for identifying youth at a higher risk for depression. School counselors can work individually, in groups, and incorporate guidance curriculum in classrooms to help adolescents prepare for difficult situations through the enhancement of internal and external resources. They can also facilitate in-service presentations to school personnel regarding identification of depression and interventions to help prevent and improve depression (Rice & Leffert, 1997).

School counselors can incorporate stress management and family change groups that focus on building coping skills and positive affirmations to counter their irrational beliefs. They can also support students impacted by divorce by incorporating depression-relevant guidance curriculum. Homework help, social skills, and peer mediation would also be beneficial for adolescents that are struggling with depression (Rice & Leffert, 1997).

Some other important factors that impact depression is the importance of family cohesion, social support, positive outlook, and favorable interpersonal relationships during adolescence for those at risk for depression is suggested by the strong association of these factors with positive functioning and well-being. The findings also suggest that a cohesive family environment can play a powerful role as a protective factor in those at risk for depression (Rice & Leffert, 1997, p. 31).

It is unclear why some adolescents who experience these negative life events are depressed and others are not. It may be that depression results from an inability to adequately cope with conflict or stress rather than the conflict or stress itself. However, the suggestion is
that a single negative event is not sufficient to indicate which students will experience depression. Many researchers have argued that a negative life event is usually accompanied by or is the source of other problems and stresses that pose more serious threats to children’s well-being (Aseltine, 1996, p. 133, 139).

**Generational Implications on Depression**

Putting self-first creates freedom but it also creates an enormous amount of pressure for adolescents to stand alone. This is the downside of the focus on the self-when adolescents are fiercely independent and self-sufficient, disappointments loom because they have nothing else to focus on. Many adolescents feel that the world demands perfection in everything, and some are cracking under the pressure. Their high expectations, combined with an interestingly competitive world, have led them to blame other people for their problems and sink into anxiety and depression (Twenge, 2006, p. 4).

Only 1% to 2% of Americans born before 1915 experienced a major depressive episode during their lifetimes, even though they lived through the Great Depression and two world wars. Today, the lifetime rate of major depression is 10 times higher; between 15% and 20%. Some studies put the figure closer to 50% (Twenge, 2006, p. 105). In one 1990s study, 21% of teens aged 15 to 17 had already experienced major depression. Although, some of this trend might be due to more frequent reporting of mental illness, researchers have concluded that the change is too large and too consistent across studies to be explained solely by a reporting bias. Mild depression wasn’t included in this study (Twenge, 2006).

The impact of bullying in schools is another factor that has gotten considerable attention. Bullying is now recognized as a widespread and often neglected problem in schools and it has serious implications for victims of bullying. Adolescents have easy access to things like
Facebook, Twitter, YouTube, chat rooms, and Skype. There are a lot of educational benefits to the surplus of information; however, there are also many disadvantages. Cell phones and social media have forced schools to deal with behavior problems, cyber-bullying, threats, and sexting (Twenge, 2006).

The National Crime Victimization Survey (NCVS) collects data on students ages 12–18. Cyber-bullying is distinct from bullying at school; while data on cyber-bullying are collected separately from data on bullying at school, the context for cyber-bullying may have developed at school. In 2009, the NCVS found about 28 percent of 12–18-year-old students reported having been bullied at school during the school year and 6 percent reported having been cyber-bullied. The percentages of students who reported being bullied or being subjects of selected bullying problems were lower for Asian students than for White, Black, or Hispanic students in 2009. For example, 17% of Asian students ages 12–18 reported being bullied at school during the school year, compared with 29% each of White and Black students and 26% of Hispanic students (The National Center for Education Statistics, 2009, p. 44).

School counselors and administration needs to be proactive in the fight against bullying. It is a widespread problem in schools and is often neglected; it has a huge impact and serious implications on the school’s environment. Students’ resiliency is impacted and the risk for depression is greater. Also, adolescents’ high expectations in a highly competitive world have led them to blame other people for their problems and sink into anxiety and depression (Twenge, 2006, p. 5).

An Adlerian Perspective of Resiliency and Depression

Alfred Adler was the founder of Individual Psychology and a pioneer in the psychotherapeutic field. Adler was the most attentive to the social context of each unique pattern
of individual subjectivity, and of any particular expression of discouragement (Griffith & Powers, 2007). For some children, the challenges of adolescence are too great. Adler believed that adolescence provides the child with new situations and new tests. Their mistakes in their style of life may reveal themselves. Children who have been trained and self-trained to be cooperators and contributors may be stimulated by their new freedom and may see the road towards fulfillment of their ambitions clear before them. Alfred Adler as quoted in Griffith & Powers (2007), stated that “others, who are less well-prepared to take advantage of the step toward adult responsibilities, will become discouraged at this point in their development;” and “thinking less of the satisfactions to be won than of the threat of failure implicit in the idea of falling short of their goals” (p. 2).

Adler identified one dynamic force that was responsible for all human behavior; striving from a felt minus to a felt plus (Ansbacher & Ansbacher, 1964). Humans are always striving for superiority and perfection. They attempt to avoid feeling less than others at any cost. This innate desire is present from birth and doesn't need to be taught (p. 104). This drive is what keeps humans moving forward.

Striving toward a felt plus is driven by a person's fictive goal. Mosak & Maniaci (1999) explained that fictive, or fictional, goals are subjective and identify what must be achieved in order to belong in life. In order to understand a person's goal, Adler believed that we need to understand his or her line of movement. People move towards goals in various ways; the most common goal is to belong. “All of us want to belong, and we establish a final, fictional goal that directs us to what we should be or accomplish in order to belong” (p.16).

Social interest or belonging is a fundamental desire. Children find the most efficient way to belong is within their family of origin. They often carry this role, or set of behaviors, into
adulthood and use it to fit in (Mosak & Maniacci, 1999, p. 102). “The development of the child is increasingly permeated by the relationships of society to him; therefore, it is necessary to understand a person's private logic and lifestyle as well as how they relate, and live, in the world” (Mosak & Maniacci, 1999, p. 97).

Adler believed that social interest is imperative in a person’s adjustment. There are numerous psychosocial factors that influence the life style, and Adler was particularly interested in not only how parents affected children but how children affected parents, children affected each other, and how the educational system reinforced or altered their life style (Ansbacher & Ansbacher, 1964; Mosak & Maniacci, 1999, p. 37).

The family atmosphere is an important factor. The emotional tone of the home, the family climate, can have a very large effect upon the developing mood of individuals. In conflicting atmospheres, children may develop anxious, guarded styles. In that same atmosphere, children may develop a hostile, aggressive posture and styles. In the same family, one child perceives atmosphere as typical and emotionally abusive, but another perceives the same atmosphere as typical or no big deal. The family atmosphere can be set up by any member of the family and can change. The parental relationship can have a profound effect. How parents get along with each other can have powerful influence upon the mood of the household and provide a model for children's relationships (Mosak & Maniacci, 1999, p. 38).

The school counselor should be taught to look at the purpose of behavior and ask the student if they feel like they belong. Also, it is important to look at where and how they are belonging because depression serves a purpose for the individual who identifies him or herself as depressed. Depression may be a way of protecting oneself from useless or harmless
circumstances. It may be used as a way of avoiding responsibilities and/or life's circumstances (Ansbacher & Ansbacher, 1964).

Depression can also be a result of difficulty within the life tasks. Failures and struggles within a specific life task often lead to stress. Alfred Adler identified three life tasks that individuals are continually challenged to balance. Alfred Adler, as quoted in Ansbacher & Ansbacher (1964), stated that “for a long time now I have been convinced that all the questions of life can be subordinated to the three major problems—the problems of communal life, of work, and of love” and “these three arise from the inseparable bond that of necessity links men together for association, for the provision of livelihood, and for the care of offspring” (p. 131).

The better a person is functioning in the life tasks, the more psychologically healthy he or she is. School counselors can use the life tasks to assist with identifying the student’s problems. How a person adapts to life challenges, in the life tasks, is crucial. In order to adapt, a person must find strategies that are useful in getting themselves to their goals. Most of the time, people manage to meet the life tasks, but some individuals meet them less frequently. Mosak and Maniacci (1999) stated: “it is not life that creates our problems; it is our solutions to life that creates our problems” (p. 98).

Encouragement as described by Alfred Adler is a crucial aspect of human growth and development. Adler stated, “altogether, in every step of the treatment, we must not deviate from the path of encouragement” (Ansbacher & Ansbacher, 1964, p. 342). In SBSC the focus is not on the problems and limitations of students, it is on their strengths and resources for finding and acting out solutions in the present. This type of approach is well affirmed by Watts and Pietrzak (2000): “the assumptions, characteristics, and methods of encouragement help to create an
optimistic, empowering, and growth-enhancing environment for clients; a place where they feel “en-abled” rather than “dis-abled” (p. 445). This can also be applied to students at school.

Alfred Adler defined organ inferiority as an inherited weakness of the organ or organ system. Resiliency has a lot to do with Adler’s theory about organ inferiority and what the outcome of organ inferiority is or what response it evokes. The outcome is simply a question of more or less courage. Courage is the willingness to act in line with community feeling (social interest) in any situation. It is fundamental to successful adaptation (Griffith & Powers, 2007).

Mosak and Maniacci (1999) stated, “to encourage is to promote and activate the community feeling, that is, the sense of belonging, value, worthwhileness, and welcome in the human community” (p. 20). Some children will overcome their organ inferiorities instead of becoming discouraged and some children unfortunately, will become discouraged. Discouraged children show their conflict and despair in obvious ways, or they disguise their real feelings. The discouraged person lacks the courage to operate on the useful side of life. When children become discouraged in finding their places usefully, they attempt to pursue one of four goals of mistaken behavior: attention getting, power seeking, revenge taking, and displaying inadequacy (Mosak & Maniacci, 1999).

Individual Psychology has similarities to the SBSC strategies discussed earlier in this paper. Adler believed that social interest was extremely important. Increasing social interest is believed to help improve depression. Ideas of Alfred Adler, the founder of Individual Psychology, continue to be applicable in the psychological field today. Much of his theory on depression’s etiology and treatment continue to be relevant. Adler’s main focus continues to be on purposeful behavior, faulty private logic, mistaken beliefs, and problems with the life tasks (Ansbacher & Ansbacher, 1964).
Implications for School Counselors

This literature review has answered the research question and it did live up to my expectations. In recent advances in theory and research on resilience in development, the school context has been implicated in diverse ways as a contributive and protective environment for children and adolescents. School counselors must identify and study the strengths and protective processes that make a difference for the school system when it is threatened. If school counselors focused on the positive outcomes, the risk factors or threats to those outcomes, potential strengths, and protective factors that facilitate resilience they could help students build resiliency and reduce the risk for developing adolescent depression (Henderson & Milstein, 1996, p. 7).

The findings of this literature review indicate a strong relationship between resilience among adolescents at risk for depression. The depressed adolescents experience the most difficulties in various areas of their lives and were found to be less resilient. Resilient adolescents were less at risk for depression because they have learned to get support in their efforts toward success and are willing to take risks in life. They were also able to look past their experiences and adversities with a sense of hope that enabled them to persevere and function well in young adulthood. Research has revealed that the identification of risk factors for depression is critical in order for school counselors to help develop resiliency in adolescents. The importance of family cohesion, social support, positive outlook, and favorable interpersonal relationships during adolescence for those at risk for depression is suggested by the strong association of these factors with positive functioning and well-being (Gladstone & Beardslee, 2009).

The Penn Resiliency Project (PRP) provides school counselors with an effective small
group counseling interventions that are effective for reducing depressive symptoms by promoting optimism and positive social skills in students, which in turn, has been shown to reduce the likelihood of adolescent depression. Cognitive-behavioral therapy (CBT) is one technique that has been shown to be effective in the prevention and treatment of mental health problems in children, adolescents, and adults (p. 214).

Recent advances in theory and research on resiliency have important implications for SBSC. School counselors who implement SBSC emphasize strengths. As strengths increase, problems tend to decrease. SBSC optimizes development by helping students be academically successful, promoting their health and character. These strengths have been shown to buffer against the development of a variety of psychological problems among youth, including depression (Galassi & Akos, 2007).

The massacre at Sandy Hook Elementary School showed we need a broader definition of school security, one that recognizes the importance of improving access to mental health care for our students. School counselors are among the first people called after tragedies strike their communities, from deadly accidents to intentional violence. They reassure students and help them cope in healthy ways. School counselors are often the first to recognize and respond to the early signs of mental illness and a child, but school counselors are spread too thin (Fox & Harding, 2005).

The research on SBMH has demonstrated improved school climate, more resilient adolescents, and the presence of SBMH centers has a direct relationship to reducing adolescent depression in public schools in the United States (Bruns, Walrath, Glass-Siegel & Weist, 2004). Research also shows that the more resilience a person demonstrates, the more likely they are to talk with school counselors or health professionals about depressive systems and seek care to
relieve those symptoms (Smith, 2009, p. 829).

School environment/climate can have a huge impact on resiliency, depression, and academics. Research on school environment has shown it has an impact on adolescent depression. In fact, reducing the burdens of poverty, exposure to violence, child maltreatment, and other forms of family instability may play an important role in the reduction of depressive disorders in adolescents (Gladstone & Beardslee, 2009, p. 218).

In 1992, Meyer, Garrison, Kirby, Jackson, Addy, McKeown, and Waller conducted a study that compared the relationship between undesirable life-events and depression in adolescents. Undesirable life-events or risk factors were more frequently reported by depressed than non-depressed individuals. The undesirable life events reported by the depressed students were as follows: their parent’s divorce, family conflict, failing a grade, and death of a close friend (p. 57). It was unclear why some adolescents who experience negative life-events are depressed and others are not; however, the occurrence of a set of negative events may indicate the need for greater concern. As such, school counselors should ascertain the occurrence of those negative events as a standard component of their profile for identifying youth at a higher risk for depression (p. 57).

Family atmosphere has an impact on resiliency and depression. Children from divorce families have been found to have more emotional and behavioral problems and do less well in school than children with both parents. Researchers have suggested that depression in children whose parents have divorced may be related to ongoing environmental adversity (Meyer, et al., 1993, p. 58). These findings should also be a component of school counselors’ process for profiling when identifying adolescents who are at a higher risk for depression.

In conclusion, schools and parents need to take a leading role in fostering resilience.
Schools may represent one of the most potentially protective environments; encouraging and supporting the development of assets that promote healthy well-being, belonging, and social interest. Educators need to view these assets as a fundamental part of the school’s mission and parents need to establish stable and meaningful relationships with their children (Doll & Lyon, 1998).

**Future Research and Recommendations**

School counselors need to promote support in the adolescents’ family, school and peer systems, as well as strengthening the adolescents’ resiliency; by focusing on creating a caring school environment. School counselors can take an active role in developing an inviting school community, by building close, mutually respectful, and supportive relationships in the school setting. These factors can promote students’ sense of school belonging, and enable the school to act as a support system for students, particularly those from a dysfunctional family, to offset anxiety or depression and gain support (Sun & Eadaoin, 2007).

Prevention programs targeting adolescent depression should include efforts to enhance the family environment. Family-based programs are indicated because parental psychopathology is associated with general dysfunction in parental and/or family environment. The school may provide a venue for hosting family relationship enrichment programs to help equip students and their parents with effective communication and conflict-resolution skills. Changing the family environment of at-risk adolescents may lower their risk for depression (Gladstone & Beardslee, 2009).

More research is needed to demonstrate the effectiveness of prevention programs and the need to consider the unique needs and experiences of children from different ethnic and cultural groups. Another area that may be subject to further research would be to see if resilience
interventions should target factors that generally found to be gender-related strengths (Hjemdal, Vogel, Solem, Hagen, & Stiles, 2011, p. 320).

Mental health and educational systems, collectively, have only served approximately 1/5th of children and adolescents who need mental health services. There needs to be more attention on school-based mental health systems. More education and research needs to be done to implement these systems to support children and adolescents. More research is also needed in Cognitive Behavioral Therapy to discern which particular school-based strategies are most effective to prevent adolescent depression to help school counselors enhance students’ overall academic success (Bruns et al., 2004, p. 491).

Promoting hope can help in increasing adolescents’ resiliency to buffer against the development of depression. Strength-based researchers, Pedrotti, Edwards, and Lope provide a convincing evidence-based argument for school counselors to promote hope in students. This outcome provides a useful beginning for exploring the impact of hope interventions. Future research in this area will also focus on hope interventions and their important role in protecting or mitigating depression in students (Glassi, Griffin, & Akos, 2008, p. 9).
Appendix A

Figure 1: The “short list” of Commonly Observed Predictors of Resilience in Young People

<table>
<thead>
<tr>
<th>Promotive/Protective Factors</th>
<th>Implicated Adaptive Systems (a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Positive relationships with adults</td>
<td>Attachment</td>
</tr>
<tr>
<td>• Effective parenting</td>
<td>Family</td>
</tr>
<tr>
<td>• Intelligence, problem-solving skills</td>
<td>Learning and thinking systems</td>
</tr>
<tr>
<td>• Perceived efficacy, control</td>
<td>Mastery motivation</td>
</tr>
<tr>
<td>• Achievement motivation, persistence</td>
<td>Mastery motivation</td>
</tr>
<tr>
<td>• Self-regulation skills</td>
<td>Executive function systems</td>
</tr>
<tr>
<td>• Effective stress management</td>
<td>Stress response systems</td>
</tr>
<tr>
<td>• Positive friends</td>
<td>Peer and family systems, attachment</td>
</tr>
<tr>
<td>• Faith, hope, spirituality</td>
<td>Religion, cultural systems</td>
</tr>
<tr>
<td>• Beliefs that life has meaning</td>
<td>Religion, cultural systems</td>
</tr>
<tr>
<td>• Effective teachers, schools</td>
<td>Education systems</td>
</tr>
</tbody>
</table>

(a) Many of these fundamental adaptive systems probably play a role in the development of most correlates of resilience. However, the adaptive systems listed for a particular predictor are implicated in a major way for that factor.

Figure 1. The “short list.” (Masten, 2008, p. 12-13).
40 Developmental Assets® for Adolescents (ages 12-18)

Search Institute® has identified the following building blocks of healthy development—known as "Developmental Assets"—that help young people grow up healthy, caring, and responsible.

<table>
<thead>
<tr>
<th>Support</th>
<th>1. Family support—Family life provides high levels of love and support.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Positive family communication—Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents.</td>
<td>3. Other adult relationships—Young person receives support from three or more nonparent adults.</td>
</tr>
<tr>
<td>4. Caring neighborhood—Young person experiences caring neighbors.</td>
<td>5. Caring school climate—School provides a caring, encouraging environment.</td>
</tr>
<tr>
<td>6. Parent involvement in schooling—Parent(s) are actively involved in helping young person succeed in school.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Empowerment</th>
<th>7. Community values youth—Young person perceives that adults in the community value youth.</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Youth as resources—Young people are given useful roles in the community.</td>
<td>9. Service to others—Young person serves in the community one hour or more per week.</td>
</tr>
<tr>
<td>10. Safety—Young person feels safe at home, and in the neighborhood.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External Assets</th>
<th>11. Family boundaries—Family has clear rules and consequences and monitors the young person’s whereabouts.</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Adult role models—Parent(s) and other adults model positive, responsible behavior.</td>
<td>15. Positive peer influence—Young person’s best friends model responsible behavior.</td>
</tr>
<tr>
<td>16. High expectations—Both parent(s) and teachers encourage the young person to do well.</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Constructive Use of Time</th>
<th>17. Creative activities—Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Youth programs—Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community.</td>
<td>19. Religious community—Young person spends one or more hours per week in activities in a religious institution.</td>
</tr>
<tr>
<td>20. Time at home—Young person is out with friends “with nothing special to do” two or fewer nights per week.</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Commitment to Learning</th>
<th>21. Achievement Motivation—Young person is motivated to do well in school.</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. School Engagement—Young person is actively engaged in learning.</td>
<td>23. Homework—Young person reports doing at least one hour of homework every school day.</td>
</tr>
<tr>
<td>24. Bonding to school—Young person cares about her or his school.</td>
<td>25. Reading for Pleasure—Young person reads for pleasure three or more hours per week.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Positive Values</th>
<th>26. Caring—Young person places high value on helping other people.</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Equality and social justice—Young person places high value on promoting equality and reducing hunger and poverty.</td>
<td>28. Integrity—Young person acts on convictions and stands up for her or his beliefs.</td>
</tr>
<tr>
<td>29. Honesty—Young person &quot;tells the truth even when it is not easy.&quot;</td>
<td>30. Responsibility—Young person accepts and takes personal responsibility.</td>
</tr>
<tr>
<td>31. Restraint—Young person believes it is important not to be sexually active or to use alcohol or other drugs.</td>
<td></td>
</tr>
</tbody>
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<thead>
<tr>
<th>Social Competencies</th>
<th>32. Planning and decision making—Young person knows how to plan ahead and make choices.</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. Interpersonal Competence—Young person has empathy, sensitivity, and friendship skills.</td>
<td>34. Cultural Competence—Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.</td>
</tr>
<tr>
<td>35. Resistance skills—Young person can resist negative peer pressure and dangerous situations.</td>
<td>36. Peaceful conflict resolution—Young person seeks to resolve conflict nonviolently.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Positive Identity</th>
<th>37. Personal power—Young person feels he or she has control over “things that happen to me.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>38. Self-esteem—Young person reports having a high self-esteem.</td>
<td>39. Sense of purpose—Young person reports that “my life has a purpose.”</td>
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<tr>
<td>40. Positive view of personal future—Young person is optimistic about her or his personal future.</td>
<td></td>
</tr>
</tbody>
</table>
References


Hjemdal, O., Vogel, P. A., Solem, S., Hagen, K., & Stiles, T. C. (2011). The relationship between resilience and levels of anxiety, depression, and obsessive-compulsive...


http://nces.ed.gov/programs/crime


