Mental Illness in Adolescents: Preventative Measures through Therapeutic Services

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Abstract

There have been multiple studies done on mental illnesses in adolescents, looking at causes, effects, and preventative measures. This research proposal looks at the effects of psychotherapeutic and cognitive-behavioral therapy on adolescents suffering from mental illnesses such as depression and anxiety. The proposed study will compose of 300 adolescents, age 11 to 18 who have a diagnosis of anxiety or depression, and 200 adults age 30 years or older who had participated in a therapeutic process as an adolescent in order to treat their mental illness. This would be a 12 year longitudinal study with participants would attend a follow-up to be reassessed for their mental illness (depression or anxiety, respective to the participant) every two years. This study seeks to determine if participating in psychotherapeutic and cognitive-behavioral therapy as an adolescent reduces the occurrence of mental illness as an adult.

A study done in 2004 through 2011 reported that an average of eight percent of adolescents (ages 12-17) suffered from a major depression episode over the course of that year (Federal Interagency Forum on Child and Family Statistics, 2011). Kessler, Avenevoli, and Merikangas (2001) suggest that doesn't seem like a very large number, but consider the numbers when broken into smaller age categories, it seems more serious; although only 4 percent of adolescents age 12-13 suffer from a mental illness, this triples to 12 percent at ages 16-17. Studies have also found that adolescents diagnosed with a mental illness such as depression or anxiety, there is a 70 percent rate of recurrence within five years and 50 percent rate of recurrence during adulthood (Kessler et al., 2001).

Mental illnesses in adolescent years can have many lasting effects through their adult life (Jayson, 2008). Mental illnesses such as depression and anxiety affect one's ability to concentrate and maintain their energy which can lead to problems at school and work, as well as those they work with (Jayson, 2008). Studies through time have shown that having a mental illness, especially at a young age, can increase the chances of other major problems such as substance abuse, eating disorders, addiction, reckless behavior, violence, self-harm, and suicide (Kessler et al., 2001). The worst of these is when mental illnesses lead to suicide. In 2006, Jayson conducted a study covered by USA Today showed that 55 percent of students in an undergrad program thought about suicide (Jayson, 2008).

There is a connection between mental illnesses and further negative behavior in adolescents and adults (Kessler et al., 2001). How can we treat one's mental illness and prevent the onset of other problems in the future? There are many treatment plans, but how do we know which one is best? When faced with a problem such as this, we must look into every possible option. One of the most common treatment plans for mental illnesses is therapy. In order to

discern if therapy is an effective form of treatment, we must investigate this question: does engaging in a therapeutic process in adolescent years prevent mental illness in adult years?

Review of Literature

With the advancements in society and medical science, we are seeing the human lifespan being extended, and as society is living longer, we are discovering more illnesses. Mental illness has become rampant throughout our society, and figuring out how to treat it has been a struggle for doctors. There are many different stresses that surround us in our everyday lives, and this has led to a spike in adolescent depression. These mental illnesses have been associated with short and long term functional impairment, morbidity, and mortality (Ryan, 2003). Youth with major depressive disorder (MDD) often have co-morbid disorders such as anxiety disorders, dysthymia, disruptive disorders, and substance abuse (Angold, Costello, & Erkanili, 1999). These disorders can make it very difficult for children and adolescents to properly excel in school and other activities (Angold et al., 1999). In his 2003 study, Ryan stressed the importance of finding a long-term treatment for child and adolescent MDD. Over the past thirty years, the rate of mental illnesses in adolescents has increased (Ryan et al., 1992), and we now see 14 percent to 25 percent of adolescents experiencing at least one episode of MDD (Kessler et al., 1998).

The British Association for Behavioral and Cognitive Psychotherapies (BABCP) says that cognitive behavioral therapy (CBT) is a psychotherapeutic treatment for a wide variety of disorders, such as phobias, addiction, depression, and anxiety (BABCP, 2005). CBT is a short-term therapy option that focuses on getting clients to identify and change their destructive behavior and/or thought patterns that are having a negative effect on the client's behavior. The BABCP note that the concept behind CBT is that thoughts and feelings play a fundamental role in our behavior, so the goal if CBT is to teach clients that they can take control of how they

interpret and deal different aspects of the world around them, even if they cannot control the aspects themselves (2005). CBT starts by learning how thoughts, feelings, and situations contribute to behaviors and then moves on to focus on the behaviors themselves. This is a very gradual process to help clients make a behavior change (BABCP, 2005).

CBT has been tested and evaluated by many doctors, and the results have been mixed. Shirk, Kaplinski, and Gudmundsen (2009) did a study with fifty adolescent (of all genders, races, and with varying ages) diagnosed with various depressive disorders who were treated by eight psychologists. These psychologists were doctoral-level and followed the twelve-session individual CBT protocol. The adolescents in this study were found to have a number of traumatic experiences and suicide attempts in their past. The post treatment response to this CBT study showed that 64 percent of the participants responded positively. Compared to other similar studies, this particular study had one of the highest responder percentages. Shirk e al. (2009) found this CBT treatment to be rather effective, although they did note that this had not been evaluated as a long-term treatment plan. What made this plan different and ultimately more successful than the other studies was that this study was school-based rather than hospital-based. This proved to be more promising and effective (Shirk et al., 2009).

In 2008, Stice, Rohde, Seeley, and Gau conducted a study in which involved high-risk participants who were divided into two different groups in order to compare two different treatment plans for depression and anxiety. One group was put into a standard group CBT while the other was given group supportive-expressive therapy (SET). SET, like CBT, is a short-term treatment used to reduce disorders such as depression, anxiety, and opiate drug dependence and abuse (Stice et al., 2008). The goal of SET is to help patients make strong and supportive relationships in order to give the patient a secure and stable support in their life, and to give them

to tools they need to work with their ongoing interpersonal problems (Luborsky, 1984). In the Stice (2008) study, the participants did not differ on demographic factors researchers could not establish a baseline. The mean scores for treatment expectancy were similar, which suggested that each treatment would have similar outcomes (Stice et al.). Attendance to the sessions was fairly equal between both groups with an average of 45 percent attending all six sessions. At the end of the study, however, 84 percent of participants in the CBT group felt as if they were prepared to avoid future depression, whereas only 63 percent of the SET group felt prepared. Initial results would indicate a strong positive effect through CBT, but at the six month follow up, the percentages had been reduced, showing that both CBT and SET cannot be used as a long-term treatment for depression and anxiety in adolescents (Stice et al., 2008).

It seems as if these approaches do not have the longevity that is needed in order to treat depression and anxiety. This is exactly what Jacobs (2010) and Spence (2005) try to test. Jacobs and his team reviewed many different studies done on different methods of behavioral therapy to determine which method was most effective and promising. What Jacobs found, however, was that although CBT looked most promising, it only held results for a few months and was not an effective treatment. Similarly, Spence and his team did a study on school-based CBT and compared results through a four year period. The results from this study proved to be disappointing. Both teams through their studies and research concluded that it is absolutely necessary for there to be a long-term treatment option for children and adolescents with disorders such as depression and anxiety.

When we remember what Angold's study told us ("Youth with major depressive disorder (MDD) often have co-morbid disorders such as anxiety disorders, dysthymia, disruptive disorders, and substance abuse" [Angold, Costello, & Erkanili, 1999]), we can see the urgency in

finding a therapy method that will give adolescents the tools they need to overcome their disorders so they can lead their life without disruption. These studies have shown that CBT is an effective treatment, but each team that ran these studies agreed that CBT is not effective for a long-term treatment of child and adolescent MDD.

Methods

Several Studies have examined different methods of treatment for both youth and adults with mental illnesses such as depression and anxiety, as well as the long term effects of these treatment methods. For this study we will focus on this question: does engaging in a therapeutic process in adolescent years prevent mental illness in adult years? A particular focus of this study will be on cognitive behavioral therapy (CBT). The British Association for Behavioral and Cognitive Psychotherapies (BABCP) defines CBT as a psychotherapeutic treatment for a wide variety of disorders; it is short term and focuses on getting clients to identify and change destructive behavior (BABCP, 2005). This study will be longitudinal, with participants attending a follow-up periodically for twelve years.

Research Design

To answer this question, we will use a qualitative longitudinal study with a needs assessment design. Participants will be chosen based on a volunteer basis, our focus being on those already in or willing to begin a therapeutic process to lessen their mental illness symptoms. Before the study begins, each participant must be assessed to determine their level of illness so we are able to track their progress using the Patient Health Questionnaire (PHQ-2 and PHQ-9). Patient Health Questionnaires incorporate DSM-IV diagnostic criteria, and they are brief and useful in clinical practice. At predetermined points throughout the therapeutic process, the participants will be assessed again using PHQ-9. After each participant has finished their

process, they will participate in a follow-up assessment every two years for the next twelve years. There will also be a group of older participants who have already completed their therapeutic process who will be interviewed and asked to participate in the same follow-ups in order to compare data.

Participants

This study will be composed of three hundred adolescents, age eleven to eighteen, who have been diagnosed with anxiety and/or depression, and two hundred adults, age thirty or older, who had a diagnosis of anxiety and/or depression as an adolescent and have received treatment. Participants will be recruited via flyers from fifteen different counseling centers. Upon response from the flyer, the prospective participant will be mailed more information about the study and the informed consent form.

Instruments

The instrument used for this study will be the PHQ-2 (Appendix A) and PHQ-9 (Appendix B). PHQ-2 will be used at the beginning of the study along with PHQ-9. Each follow-up assessment will only use PHQ-9, with the exception of the last assessment, which will include both forms.

Data Collection

Information will be obtained from the informed consent (Appendix C), PHQ-2, and PHQ-9 which will be mailed to participants after their initial response form the flyer. PHQ-2 will be sent out with the initial forms as well as in year twelve for the final follow-up. PHQ-9 will be sent out to participants every two years. The participants who have agreed to be interviewed about their past therapy will be recorded via a tape recorder to ensure that every detail is correct.

Data Analysis

Data from the questionnaires will be recorded in a logbook for each participant along with a transcript of their interview, as it applies. Recordings of depression and/or anxiety levels will be compared between treatment and age groups. These findings should show the feasibility of therapeutic processes as a method of treatment for mental illnesses such as depression and anxiety.

Feasibility

In 2001, Kessler found that in adolescents diagnosed with a mental illness such as depression or anxiety, there is a 70 percent rate of recurrence within five years and 50 percent rate of recurrence during adulthood (Kessler, Avenevoli, & Merikangas, 2001). Kessler showed that having such a mental illness can increase the chances of other major problems such as substance abuse, eating disorders, addiction, reckless behavior, violence, self-harm, and suicide. In today's society, the general population is very health conscious; people are always looking for ways to avoid illness, but mental illnesses are often not thought of and as Kessler showed, if people do not take care of your mental health at a young age, it could create major problems in their adult life. As depression and anxiety are becoming increasingly more common in our society (Ryan et al., 1992), we are in need of a preventative measure for all these illnesses. Those who are in their adolescent years or those with loved ones in this age group will be concerned with the results of this study, as well as those who work with people in this age group such as counselors or teachers.

Limitations

Because this proposed research is a longitudinal study that will span twelve years, there is a decent probability that participants will drop out along the way for various reasons such as relocation or disinterest. The hope of those conducting the study is that there will be enough

participants to ensure that even with dropouts, there will be enough to ensure that there will be a pattern in the resulting data.

Ethical Considerations

All participants will sign an informed consent form before entering the study and will have the option to meet with researchers as needed for questions or concerns pertaining to the study. Participants will not be identified by name at any point during the study; instead they will be assigned numbers to protect their identity. Assessments and interviews, along with any personal information that allows the participants to be identified, will be recorded, transcribed, and kept in a password protected file. The only instance in which this data will be discussed is between researchers in regard to the study.

It is important for the participants to know that the process of counseling may be uncomfortable and that as researchers, we cannot fully prepare them for what the process may be like. However, it is equally important for the researchers to explain to each participant that they have the right to withdraw from the study at any time.

Implications

Should this study reveal a more effective long term treatment for mental illnesses such as depression and anxiety, these findings could alter how counselors go about treating their adolescent patients in the future. These results could also allow counselors to better care for their adult patients.

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Appendix A

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

REFERENCE: http://www.cqaimh.org/pdf/tool_phq2.pdf

Appendix B

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Column Totals	_____ +	_____ +	_____	
Add Totals Together	_____			

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

REFERENCE: http://www.cqaimh.org/pdf/tool_phq9.pdf

Appendix C

CONSENT TO PARTICIPATE IN RESEARCH

Name of Study Subject: _____

You are invited to take part in this research study. This form tells you why this research study is being done, what will happen in the research study, and possible risks and benefits to you. If there is anything you do not understand, please ask questions. Then you can decide if you want to join this study or not.

A1. INTRODUCTION – WHY ARE WE ASKING YOU ABOUT THIS STUDY?

You are invited to participate in this research study because you showed interest in the flyers that were sent out. A total of about 500 people are expected to participate in this study nationally.

A2. DO I HAVE TO BE IN THIS STUDY?

You can decide whether to take part in this study or not. You are free to say yes or no. Even if you join this study, you do not have to stay in it. You may stop at any time.

A3. WHY IS THIS RESEARCH STUDY BEING DONE?

The purpose of this study is to observe and analyze the effects of psychotherapeutic and cognitive-behavioral therapy on adolescents suffering from mental illnesses such as depression and anxiety. The hope is that the results will show methods of long-term treatment.

B1. WHAT WILL HAPPEN IF I TAKE PART IN THE STUDY?

After your initial intake assessment, you will take part in psychotherapy or cognitive-behavioral therapy and will be mailed a follow-up assessment every two years.

B2. HOW LONG WILL I BE IN THE STUDY?

You will be in this research study for about twelve years.

B3. CAN I STOP BEING IN THE STUDY?

You may stop at any time. If you decide to leave the study, please let the study team know.

C1. WHAT RISKS OR PROBLEMS CAN I EXPECT FROM THE STUDY?

You may feel that some of the questions we ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately.

Another risk may be loss of confidentiality. Every effort will be made to keep your study records confidential but we cannot guarantee it.

C2. ARE THERE ANY BENEFITS TO TAKING PART IN THE STUDY?

This study may or may not help you, but we hope the information from this study will help us develop a better treatment for depression and/or help us provide better mental health services to adolescents.

D1. ARE THERE ANY COSTS TO BEING IN THE STUDY?

There are little costs for being in this study; the counseling professionals will be provided by us, but we do not reimburse for mileage.

D2. WILL I BE PAID FOR BEING IN THE STUDY?

You will not be paid for participating in this study.

D3. WHAT HAPPENS IF I AM HARMED BECAUSE I TOOK PART IN THE STUDY?

No funds have been set aside to pay any costs if you are harmed because of this study. If you think that you were harmed because of this study, let the study director know right away. By signing this form, you do not give up your right to seek payment for harm you receive while participating in this study.

E. PERMISSION TO COLLECT, USE AND SHARE HEALTH INFORMATION

E1. What health information will be collected and used for this study?

No prior health information is needed; everything that is needed for our study will be collected in the assessments we provide.

E2. Who will see the health information collected for this study?

Only those conducting the study will have access to the results of the assessments.

We may record your research information, including results of tests, procedures or questionnaires done for research. As a result, this research information may be seen by people allowed to see your medical records for healthcare operations or treatment, by those you allow to see your medical records by giving written permission, and by others when required by law.

We will not use your health information for a different study without your permission, or the permission of a hospital research review board (IRB). Once all personal identification is removed, the information might be used or released for other purposes without asking you. Results of the study may be presented in public talks or written articles, but no information will be presented that identifies you.

E3. How long will you keep the health information for this study?
If you sign this form, we plan to keep your information for 10 years after the research study ends in case we need to check it again for this study.

CONSENT TO PARTICIPATE IN THE STUDY

By signing my name below, I confirm the following:

- I have read (or had read to me) this entire consent document. All of my questions have been answered to my satisfaction.
- The study's purpose, procedures, risks and possible benefits have been explained to me.
- I agree to let the study team use and share the health information and other information gathered for this study.
- I voluntarily agree to participate in this research study. I agree to follow the study procedures as directed. I have been told that I can stop at any time.

IMPORTANT: You will receive a signed and dated copy of this consent form. Please keep it where you can find it easily. It will help you remember what we discussed today.

Subject's Name *please print*	**Subject's Signature**	**Date**
Name of Legally Authorized Representative (if applicable**)** *please print*	**Signature of Legally Authorized Representative**	**Date**
Name of Witness (if applicable**)** *please print* (for short form consent process, or consent of blind or illiterate subject)	**Signature of Witness**	**Date**

A copy of this form is available for you to keep.

(Modified from Medical College of Wisconsin non-interventional consent form template, 2012)