

CASE STUDY #1: THE DEPRESSED TEEN

“She was moody and withdrawn.”

Reverend Lisa Dunn is pastor of a medium-sized church in the Midwest, in which the Jordan family has been involved for several years. They became especially active after the death of their youngest son from leukemia one year ago. Their sixteen-year-old daughter, Jean, had become noticeably withdrawn from both family and friends in the past several months and had become less interested in her appearance. Jean stopped participating in the youth group and her grades dropped at school. She was moody and had become pessimistic in her outlook toward life. She developed a short fuse and complained of feeling worthless. Recently, friends reported that they had seen Jean drinking with a group of older students after school. Jean had been very close to her younger brother and appeared to have been the most affected by and least accepting of his death.

It is important to have an accurate picture of Jean's alcohol use and emotional state. The rapid and negative changes in her life suggest something serious has developed. Is she using alcohol in an attempt to cope with unresolved grief related to the death of her brother? It is not uncommon for alcohol and drug abuse to mask depression and grief reactions. Depression is one of the most common forms of emotional problems in young people. Experts estimate that about one in twenty teens is depressed (Reynolds, 1995), while one in four depressed adolescents use drugs or alcohol to cope with the problem (Fleming and Offord, 1990). The drop in Jean's grades may signal decreased concentration and slowed thinking, also common in depression.

The use of alcohol for self-medication is often the pattern of individuals with poor coping skills and high addictive potential. How much is Jean in denial about her alcohol abuse? Does she minimize her alcohol use? How much insight does Jean have into her problem?

RESPONSE TO VIGNETTE

Jean has many of the signs of a teen who has an alcohol-abuse problem and depression: she has withdrawn from family and friends and has stopped activities she had enjoyed at church. She has difficulties at school and has had a significant negative change in her mood and thinking. Her family reports that Jean has decreased interest in her physical appearance. She may have developed peer relationships with youth who are using alcohol.

Reverend Dunn and Jean's parents decided to talk to Jean about her new behaviors. The pastor used her active listening skills while assessing Jean's emotional state. Reverend Dunn established a safe and caring relationship as she empathetically responded to Jean at the family home. The teen confessed increasing use of alcohol. When the pastor reminded Jean of how much her family loved her and was concerned about her, she broke down and wept. She began to express her deep grief over the death of her beloved brother. With gentleness and support, Rev. Dunn encouraged Jean to grieve her loss, understanding that each individual has a unique way to grieve, and that Jean will need to mourn her brother's death according to her inner timetable.

After Rev. Dunn and Jean's family had their intervention with her, Jean agreed to see a psychiatrist, Dr. Barbara Miller, who specializes in teenage substance-abuse problems. The physician advised a medical examination to rule out physical problems that could have triggered the depression, but no underlying medical issue was found that would account for the depression. Jean was also assessed for anti-depressant medications and was given a prescription to help her through the first several months.

Over the months of therapy, it became clear that Jean had begun to rely on alcohol and was drinking to self-medicate her depression. Jean was successfully treated as an outpatient for alcohol abuse and depression.

The psychiatrist also noted that Jean's family needed to address its poor communication, which became pronounced after the death of a family member. Jean's substance abuse was, in part, a symptom of their pain as a family and their inability to express their anguish in a way that could bring healing. With several months of therapy, the family was able to develop deeper bonding and a renewed faith as they worked together through the crisis.

DIAGNOSTIC CRITERIA

Alcohol abuse has as its basic feature a pattern of use characterized by negative, recurrent, and significant consequences related to repeated use. This diagnosis requires only one of the following criteria over the course of twelve months (APA, 2000):

1. Recurrent alcohol use results in a failure to fulfill major obligations at home or work (such as repeated neglect of school responsibilities).
2. Repeated use of alcohol in situations in which such use is known to be physically hazardous.
3. Recurrent alcohol-related legal problems.
4. Continued use despite having persistent or recurrent social or interpersonal problems resulting from the effects of the alcohol (such as arguments with friends or family members about the consequences of using the substance).

An adolescent is diagnosed with a *major depression* when there have been two weeks or more of feeling sad, gloomy, depressed, irritable, or experiencing a loss of interest, motivation, or enjoyment in usual activities (APA, 2000). Along with a depressed mood or loss of interest, the person must also have had two or more weeks of at least four of the following eight symptoms:

- fatigue or loss of energy
- lethargy or increased restlessness (agitation)
- loss of appetite and weight or excessive appetite and weight gain
- difficulty sleeping or sleeping too much
- loss of social or sexual interest
- feelings of worthlessness or excessive guilt
- difficulty concentrating
- feeling that life is not worth living, wanting to die, or feeling suicidal

TREATMENT WITHIN THE FAITH COMMUNITY

Research has shown that stable families lower the risk of alcohol and drug abuse, so church programs that focus on strengthening

the family can be a preventive strategy (Johnson et al., 1996). A strong youth program that promotes good communication and social skills is a valuable preventive measure as well. Teen alcohol and drug abusers tend to have poor assertion skills, high social anxiety, and low self-worth. Social skills training can enhance coping, self-control, social problem solving, negotiation skills, and assertiveness, as well as increasing the ability to resist peer pressure (Haggerty et al., 1989).

Encouraging teens and their families to be active in the life of the community of faith is in itself an important preventive strategy when addressing substance abuse. Youth who practice their religious faith have more positive social values and caring behaviors and their families are more stable than those who do not practice their faith. Surveys have found that adolescent regular church attenders are half as likely to use alcohol as teens who do not attend church regularly (Gallup and Bezilla, 1992). These findings add to the extensive research supporting the social benefit of nurturing, nonpunitive religious practice in limiting and preventing alcohol and drug use (Gorsuch, 1995).

Religion can protect children and their parents against depression by acting as a buffer against stressful events. According to researchers at Columbia University, children whose mothers are religiously committed are less likely to suffer depression (Miller et al., 1997). The study found that the daughters of mothers for whom religion was highly important were 60 percent less likely to have a major depression. A second study found that frequent church attenders in Texas with high spiritual support had lower levels of depression than their peers without religious involvement (Wright et al., 1993).

Although many clergy report that depression is the most common problem that they are asked to help people overcome, they are often inadequately trained to identify depression or suicide risk (Weaver, 1995). In a national survey of clergy and pastoral care specialists, only one in four believed the church was offering helpful programs for depressed teenagers, and pastors ranked their effectiveness with teen depression as generally poor (Rowatt, 1989). The study underscores the need for clergy and other religious leaders to learn to recognize mental health problems in teenagers competently and to train members of their faith communities

to provide emotional support to youth and their families. Positive social relationships outside one's immediate family are a protective factor against developing emotional problems like depression in at-risk youth (Huntley and Phelps, 1990).

TREATMENT BY MENTAL HEALTH SPECIALISTS

When considering referring a teen to a mental health professional, it is important to ask what plan of action the specialist will use. A pastor or other religious professional needs a basic understanding of standard treatment protocols to assess whether a mental health professional is knowledgeable and experienced in treating individuals and their families. Here is an example of the sort of treatment considerations one would make in a treatment plan for an adolescent suffering from alcohol abuse.

In the beginning, a therapist would encourage Jean to tell her story and empathize with her viewpoint to foster a therapeutic alliance. The mental health specialist would ask Jean to discuss her understanding of the negative consequences of alcohol use and assess her level of insight into her situation and whether she is in denial. It would be valuable to provide reassurance that help is available and that change happens with commitment.

The family would be involved early and often in treatment to lend support and insight, since treatment without their involvement has little hope of success. In Jean's case, the family could be an important part in healing unresolved grief. It would also be helpful to develop a substance-abuse history of the extended family, since relatives with abuse issues increase the risk of addiction. A referral to Alcoholics Anonymous' teen program (Alateen) can provide Jean with education and continued encouragement for abstinence. The early stages of abstinence require considerable support, and the therapist will make clear that occasional relapses are possible and need to be seen as "human slips," not "failures" that confirm Jean's sense of low self-worth.

A therapist would continue to work with Jean and her family to prevent relapse and work through temporary relapses if they occur. Sessions would continually review the reasons for the recovery process; provide support, reassurance, encouragement, and praise for ongoing work; and explore for insight into the roots

of the addiction. The therapist would encourage Jean to become involved in extracurricular social, athletic, or artistic activities with positive peer groups and to expand her interests. It would be important to identify and address family problems that may be complicating Jean's alcohol abuse. Family sessions could be used to teach communication skills and explore underlying family dysfunctions (such as an inability to express feelings) that may be related to the addictive behavior.

Regarding depression, a combination of cognitive-behavioral therapy, medication, and family therapy is the standard treatment. Significant depressive symptoms in teenagers can be treated with medication. They can be likened to a cast on a broken arm—a temporary support that promotes healing. Any medication for minors must be carefully monitored, given the ongoing physical and psychological development of young people.

In cognitive-behavioral therapy, there is an attempt to change depression-producing beliefs and attitudes to healthier, more realistic ones. Behaviors that produce pleasure and fulfillment are also encouraged. Many depressed adolescents define their life situation in global terms like “nothing is working out” or “I can't do anything right.” Depressed youth tend to conclude the worst, dwell on negative details, and devalue the positive, especially when they have overly critical parents. Cognitive-behavioral therapy seeks to stop or modify these pessimistic “automatic thoughts” that people use to define themselves, their environment, and the future. If these beliefs go unrecognized and unchallenged, such distorted thinking will result in continued depression. Usually treatment involves self-monitoring of mood and activities, often in the form of keeping a daily log.

CONCLUSION

Jean is fortunate to have a psychologically minded pastor who was prepared to connect her with a specialized mental health professional who has the training and experience to help her effectively. Jean also has several factors going for her that point toward a long-term positive outcome. Importantly, she has the motivation to change and has responded well to treatment. In addition, she has the valuable support of her family and church community.

HELPFUL BOOKS

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