MINDFULNESS AS A THERAPEUTIC INTERVENTION FOR TEEN DEPRESSION IN EDUCATIONAL SETTINGS

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This master's project, written under the direction of the candidate's master's project advisory committee and approved by members of the committee, has been presented to and accepted by the faculty of the Kalmanovitz School of Education, in partial fulfillment of the requirements for the Master of Arts degree.

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Abstract

Teen depression is a vast and pervasive issue with a myriad of possible causes and manifestations. as a subject. Research continues to unpack the nuanced pathology of depression in teens, with modern social, psychological, and development factors at the forefront. Educational systems and health care systems label the problem as ever-evolving and growing. An integrative approach to working with teens in school settings addresses equity issues while also treating the symptoms. The intervention integrates cognitive behavior therapy practices with mindfulness theory and techniques. It is highly influenced by mindfulness-based cognitive therapy and adds a strengths-based and social justice foundation to the modality. A mindfulness-based group for teens in a school setting compiles evidence-based practices and theoretical orientations to provide effective and efficient treatment. Further research is needed to assess possible causes and links to teen depression as well as the reliability and validity of the program.

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Dedication

I chose to dedicate this project to the teens that I have worked with this past year. Their vast capacity for healing inspired this project.

Chapter I

Introduction

Mindfulness is a spiritual and psychological practice of paying attention to the present moment in a non-judgmental way (Kabat-Zinn, 1979). The essence of the mindfulness practice is originally discussed in ancient texts such as *The Yoga Sutras of Patanjali* or the *Bhagavad Gita* dating back to 3000 - 2000 BC. The practice of mindfulness described in these transcendental texts indicates a striving of complete and total awareness of the present moment. According to these ancient traditions, mindfulness was incorporated into daily life to promote physical and mental wellbeing and to become more unified with God or a higher power.

The modern integration of Eastern and Western perspectives in the mental health field provides a widened view of health and wellbeing. However, the concept of mindfulness has the potential to be marketed as a quick fix to serious mental health issues. It is important to note that the implications of colonization bled into the practice's translation from the East into the West. There are layered issues of accessibility and commodification when it comes to Westernized mindfulness.

The crossover of mindfulness into the West can be traced back to the 1960s and 1970s when yoga and meditation practices started to become more widely accepted as health and wellness practices. Thich Nat Hanh originally spread mindfulness teachings in the West alongside other spiritual leaders in the 1960s and 1970s. The Buddhist and Hindu roots of the practice were frequently misunderstood as being a part of organized religion or following a strict method of spirituality. The media used to portray mindfulness practices as radical and foreign. It has only recently become more accepted in the mental health and medical fields as an evidence-based technique and theoretical orientation. An early adopter of mindfulness as a

theoretical framework of psychotherapy, Jon Kabat-Zinn (1979) defined mindfulness simply: “Mindfulness is an awareness that arises through paying attention, on purpose, in the present moment, non-judgmentally” (Kabat-Zinn, 1979). There are countless other professionals in a variety of fields who started to bring mindfulness into mainstream practice in the medical and mental health models around this time. Kabat-Zinn, however, took his own form of pilgrimage to answer personal questions about the meaning and purpose of his life. As a Western medical doctor at the University of Massachusetts, his personal interest in answering life’s unanswered questions was unsatisfied with traditional Western medicine (Maraji, 2022). In his quest to lead the charge, the more he integrated mindfulness into his practice with patients suffering from physical health conditions, the more he noticed significant improvement. His initial inkling led to systematically randomized and controlled trials to measure the effectiveness of mindfulness as a therapeutic intervention. His journey combined with his expertise as a medical doctor led him to become the face of mindfulness in the medical field and eventually into the mental health space.

As acceptance of mindfulness as a mental health technique increases in application, the recent epidemic of depression in teenagers is an urgent problem that may be addressed through a mindfulness lens. According to national conversation and statistics, teenagers today struggle with mental health issues more than at any other recorded time (Katz et al., 2019). Researchers explore the possible confounding factors contributing to alarming rates of mental health struggles among the youth population. Specifically, there are increasing instances of teenagers ages 13-17 struggling with depression. According to CDC data, of teenagers ages 13-17 years old 15.1% experienced a major depressive episode, and 36.7% encountered persistent feelings of sadness or hopelessness in the year 2018 (CDC, 2018). There are multidimensional mental health issues that are comorbid with depressive episodes or major depressive disorder. Furthermore, the CDC data

suggests anxiety and depression rates consistently increased from 5.4% in 2003 to 8% in 2007 and 8.4% in 2012. As teen mental health continues to decline the need for effective interventions increases with immediacy (CDC, 2018). While major depressive disorder is cited to be the most likely to be comorbid with other mental health disorders, it is rated to be the most prevalent disorder for youth ages 12-17 (CDC, 2018). As mindfulness continues to evolve in psychotherapy, application of a mindfulness lens can be useful to assess the problem of teen depression.

There is a persistent problem of teenagers suffering from depression without proper support. This problem is increasing and is comorbid with other disorders such as anxiety, substance use, and suicidality (CDC, 2018). A mindfulness application of ancient wisdom and empirical research to support clients with this diagnosis in psychotherapy modality can support students develop coping skills to help manage their symptoms. According to Kabat-Zinn's (1979) work, mindfulness allows present-moment awareness of automatic thoughts and overrides negative emotional reactions. Heightened awareness promotes more autonomy, a sense of control, and increased feelings of empowerment (Kabat-Zinn, 2003). This project aims to deepen understanding of mindfulness in the therapeutic setting by examining the rates of depressive symptoms in teens ages 13-18. The proposed mindfulness intervention aims to acknowledge and support teenagers' struggles with depressive symptoms with mindfulness as the theoretical framework and tangible psychotherapeutic tool.

Background of the Problem

Various factors contribute to teen mental health. Researchers such as Bitsko et al. (2022) and Katz et al. (2019) have dedicated their studies to understanding teenage depression, anxiety, substance abuse, and suicidality, and have both found patterns of increasing instances of

depression in teenagers. This particular body of research covers the broad scope of common mental health disorders among teens and the history of prevalence, assessment, diagnosis, and treatment planning of depression in teens.

The history of teen psychology and mental health is important to understand to conceptualize the problem accurately. In the early 1960's Erik Erikson's seminal work focused on stage development throughout a lifespan. Erikson posited that adolescence is a time of a conflict between identity development versus role confusion. This life stage in particular marks a tumultuous time in an individual's life that is depicted as role exploration, 'teen phases', and personality development (1960). The theorist commented on the fluid and volatile nature of the teenage years regarding identity formation, role exploration, and social learning experiences in the field of developmental psychology. The American Academy of Children and Adolescent Psychiatry (2012) highlighted the modest beginnings of child mental healthcare in the medical model of psychiatry. The field of psychiatry narrowly investigated the biological underpinnings of mental disorders and developed psychopharmacology to treat the disorders without consideration of other contexts (AACAP, 2012). As a result of this misperception, the exclusion of environmental causes and interventions was often left out when treating mental health disorders. The field of psychotherapy, however, was in premature stages of understanding the cognitive, emotional, and social aspects of teen mental health.

While psychiatry was rising in relevance and popularity to assess, diagnose, and treat mental health disorders, school psychology and school counseling were growing simultaneously, according to Flaherty and Osher (2002). Specifically, school-based mental health services developed during the industrialization era of the 1930s to address the shifting developmental needs as child labor was decentered (Flaherty & Osher, 2002). While educational mental health

initiatives were devised to address academic and behavioral problems, the 1960s brought in an era of promoting community mental health clinics, school-based health clinics, full serviced special needs classes, schools, and overall expanded systematic approaches. This development coincided with a societal change in the 1960s and 1970s with a broadened and more holistic view of community mental health and school-based mental health. Federal policies and funding were also vital in the growth of mental health services for youth, such as the Individuals with Disabilities Education Act of 1975, the National Agenda for Improving Results for Children and Youth with Serious Emotional Disturbance of 1994, and the Center for Mental Health Services of the US Department of Health and Human Services funding Safe School/Healthy Student grants nationwide (Flaherty & Osher, 2002). The development of school-based mental health disciplines, government policies, and funding for youth services overall increased the availability of mental health professionals in school settings.

There was a nationwide reckoning of the mental health problems arising in children. Services and funding were increased to address a growing problem of emotional, behavioral, and academic struggles in schools. Although it is difficult to trace the exact trajectory of psychopathology in youth during the twentieth century, the data points to a steady incline in rates of emotional disturbances over the second half of the twentieth century (Collinshaw et al., 2008). As the medical model advanced psychopharmaceuticals, the prevalence continued to increase. Longitudinal studies attempting to track undiagnosed mental health struggles by age cohort are difficult to find concrete figures on. In the twenty-first century, the CDC as well as other researchers note a steady increase in mood disorder rates in teens (CDC, 2018). In response to the increase in depression in teens, the CDC surveyed the prevalence of depression in teens for ten years extending from 2008 to 2018. The results of this groundbreaking study indicated a

sharp increase in depressive symptoms in 13-18-year-olds (CDC, 2018). The focus on depression in teens has been the center of attention for CDC studies, as it is cited as one of the most common mental health struggles in teens. Depression can take on many forms of manifestation and comorbidity with other emotional issues such as anxiety, substance use, academic performance, loneliness, and attention deficit hyperactivity disorder. There is still a looming gap in the research that points to causes for the increasing prevalence of depression and how depressive symptoms manifest in teens.

To assess the national state of teen depression in the present day, a study conducted by Bitsko et al. (2022) for the Centers for Disease Control indicated that national averages had consecutively increasing rates of teen mental health disorders in the years 2020-2022. The researchers noted that 36.7% of high school students reported feeling persistent sadness or hopelessness and 18.8% of high school students disclosed serious consideration of suicide at least once within the past year (Bitsko et al., 2022). Moreover, there are confounding influences that are likely contributing to the increasing rate of depression in teens within the years 2020-2022 such as the rise of social media usage, political polarity, and the COVID-19 pandemic.

Depressed teens with diverse cultural backgrounds need an intervention specifically designed to be generalizable and accessible. The problem is examined with a trauma-informed and social justice lens to study the disparities in treatment accessibility across cultural contexts. This developmental period and diverse cultural contexts are relevant factors when developing a holistic mindfulness intervention. There are disparities across the lines of race, class, ethnicity, and more that affect access to mental health services. Teenagers, usually in high school, depend on school-based resources to see mental health professionals, such as school psychologists,

school counselors, and special learning services (Flaherty & Osher, 2002). The unique manifestation of depression in teenagers is an understudied population and is becoming a nationwide issue that requires a sense of urgency to resolve.

Statement of the Problem

The problem includes an examination of teenagers' struggle with depressive episodes and major depressive disorders in an educational setting and investigates the applicability of a mindfulness intervention to address teen depression. The increasing instances of depression paired with the comorbidity of other mental health disorders call for swift action to tackle one of the most significant threats to teen mental health. Mindfulness is a vehicle to provide a social justice approach to therapy - one that includes all cultural contexts and lived experiences of individuals. Therefore, mindfulness is a useful intervention in a school-based setting to address the development needs of the population as well as handle the complexities of sociopolitical factors. Kabat-Zinn's work in mindfulness based cognitive therapy provides ample evidence that mindfulness can help resolve depressive symptoms in clients (Kabat-Zinn, 2003). With a social justice approach to mindfulness, there is the possibility to expand support to more teens with depression from diverse backgrounds. The increasing rates of depression among teenagers need to be met with an evidence-based and targeted intervention that captures the wholeness of the client.

Purpose and Significance of the Project

This project incorporates the existing body of empirical evidence to build a relevant intervention to take direct action on teenage depression. The theoretical eclecticism of mindfulness aims to support students through their unique set of conflicts that may be impacting their mental health. The examination of the causal factors, symptom manifestations, and current

treatment options for teens with depressive symptoms is crucial to developing a suitable mindfulness intervention for teens with depression.

This project aims to outline an application of group mindfulness for depressed teens that includes current techniques and strategies for treatment, as well as discover the crossover between mindfulness and other theoretical orientations to treat teen depression. The mindfulness framework taking on the prevalent issue of depression in teen mental health to decrease symptoms and facilitate positive change within clients is nuanced and called for to address this mental health phenomenon.

Theoretical Orientation

The proposed intervention of this project is rooted in Jon Kabat-Zinn's work of mindfulness in psychotherapy. While Erikson emphasized insights that draw attention to the underpinnings of adolescent development, Kabat-Zinn's model of psychotherapy lays a foundation for supporting teens during this critical phase of development for the proposed intervention in Chapter III. Mindfulness in psychotherapy known as "Mindfulness-Based Stress Reduction" integrates components of mindfulness in an eight-week program for adults struggling with chronic health conditions (Kabat-Zinn, 1979). Findings emerged from initial studies conducted in the 1980s by Kabat-Zinn and his associates. The data indicated improvements in the state of the health conditions after the 8-week mindfulness training, and eventually, in the early 2000s, the mindfulness approach was tailored to treat depression symptoms and also revealed statistical significance (Kabat-Zinn, 2003). Ultimately, this took the form of modern MBCT, "Mindfulness-Based Cognitive Therapy." It continues to be developed to this day, Kayuken and colleagues (2010) considered both emotional and cognitive reactivity when tailoring the MBCT approach to psychotherapy with teens (Kayuken et al., 2010). While

working with clients demonstrating depressive symptoms, the data suggested that the mechanism of MBCT that affects change remains unclear; however, the researchers were able to measure augmented self-compassion and mindfulness defined as less reactivity in depressive thinking (Kayuken et al., 2010). By utilizing mindfulness as a therapeutic tool, the researchers were able to track change within clients by measuring the cultivation of self-compassion and decreased reactivity of thoughts.

Kabat-Zinn, considered to be a founder of mindfulness in psychotherapy, originally developed a unique protocol of combining mindfulness interventions with stress reduction techniques to work with clients struggling with stress management. This intervention, known as Mindfulness-Based Stress Reduction (MBSR) initially treated clients struggling with stress due to physical health conditions such as cancer, HIV/AIDS, diabetes, and general chronic pain. The preliminary studies yielded significant results marking an improvement in patients' stress levels as well as physical benefits in their health condition (Kabat-Zinn, 1979). This early significance in the mindfulness field paved the path for future studies involving mindfulness as a therapeutic intervention. The improvements in physical health conditions prompted Kabat-Zinn to extend beyond the medical field and into the mental health space. He then developed a program that integrates mindfulness with cognitive-behavioral therapy to treat adults with depressive symptoms because of their overlapping approaches centered on awareness (Williams et al., 2008). Kabat-Zinn along with other researchers translated the usefulness of cognitive-behavioral therapy with depressed clients with a mindful approach to promote resilience and prevent relapse (Williams et al., 2008). The acute success that MBCT had with treating depression allowed for more randomized trials to study the generalizability of the intervention. The usefulness of MBCT has been tailored to meet the needs of varying populations, mental disorders, and chronic health

problems. As the application of MBCT expands into modern-day Western medicine, it is critical to examine pressing mental health concerns that plague America's youth.

Kabat-Zinn's original work serves as the groundwork for an eclectic approach to mindfulness in psychotherapy when working with teens that display symptoms of depression. The original research does not include the population of teens or students, however, many researchers within the past decade have used Kabat-Zinn's work on mindfulness to devise an integrative approach to treat teen depression. The versatility of MBSR, MBCT, and other modalities of treatment involving mindfulness allow the intervention to be crafted to suit the developmental age and psychological needs of the client to ultimately create a meaningful and useful form of psychotherapy.

In sum, the proposed mindfulness intervention targets teens suffering from depressive symptoms in a group setting at a school. The specific therapeutic tool of mindfulness promotes a social justice approach and sees the lived experiences and cultural contexts that contribute to the individual's unique mental health status. Chapter I studies the prevalence of teen depression and explores the origins of mindfulness and how it has been adapted to Western psychotherapy. Chapter II examines the current body of research on teen depression and the current treatment strategies implemented to target the disorder. Chapter III proposes the mindfulness intervention specifically adapted for teens suffering from depression to support a social justice approach to counseling. Lastly, Chapter IV analyzes the intervention's applicability and generalizability beyond teen depression in school-based settings.

Chapter II

Literature Review

Chapter I highlighted the urgency of addressing the intricacies and nuances of mental health for teens with depression. Explicitly looking at depression, the CDC (2018) noted the increasing instances of depression in young people and cited the comorbidity of depression with other mental health disorders such as anxiety, loneliness, and substance abuse. As the epidemic of depression in teens worsens; the CDC indicates that teens reporting persistent feelings of hopelessness rose from 26 to 44 percent in the last decade (Thompson, 2022). Confounding factors contribute to the growing problem of teen depression, such as social-political turmoil, increased social media usage, and the aftermath of the COVID-19 pandemic. An accessible and practical treatment approach is vital to tackling teen depression which is currently the largest source of mental health issues in youth.

Teen Depression

The American Psychological Association describes depression as “a negative affective state, ranging from unhappiness and discontent to an extreme feeling of sadness, pessimism, and despondency, that interferes with daily life” (APA, 2022). Often, depression is a general term used to label a wide range of experiences. The vague use of the term ‘depression’ is used to describe a depressive episode to name a major depressive disorder. *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.) aims to categorically define depression by specifying the individual's diagnostic criteria to meet over a certain period. The DSM-V TR diagnosis of Major Depressive Disorder serves as a framework for understanding clinical depression by clearly outlining the criteria and duration.

The DSM-V TR lists the following criteria outlining the symptoms associated with major depressive disorder. At a minimum, the patient must meet five or more symptoms for at least two weeks. Symptoms include depressed mood, loss of interest or pleasure in many activities, weight loss, insomnia or hypersomnia, psychomotor retardation or agitation, fatigue or loss of energy, feelings of worthlessness or guilt, inability to think or concentrate well, repeated thoughts of death, suicidal ideation, or suicide attempt (Criterion A 1-9, DSM-V TR, 2022). The depressed individual experiences significant distress and impairment in functioning. Furthermore, the effects of a substance or medical condition are ruled out to meet the diagnostic criteria for Major Depressive Disorder (Criterion B & C, DSM-V TR, 2022). Unfortunately, the undiagnosed cases of depression remain under-assessed or may not meet the criteria provided. For example, the DSM provides a spectrum to reflect the severity of cases; however, the DSM as the only diagnostic tool is not viable. Symptoms can manifest differently depending on culture and identity. Therefore, the DSM may not accurately account for the range of symptoms experienced by culturally and ethnically diverse populations. Also, teens frequently have the tendency to under-report symptoms, leading to potential underdiagnosis and treatment. The DSM provides a framework for understanding depression; however, the lived experience of those who do not receive a diagnosis or support is important to include during the assessment process.

Depression in teenagers is largely similar to adult depression with a few exceptions. As teenagers transition from childhood to adulthood, their symptoms vary between two developmental stages. Therefore, the complexity of symptoms experienced in teens may present in ways not clearly defined in the DSM V TR. A study examining the current barriers to assessment and treatment for teen depression conducted by Wisdom et al. (2004) applied a grounded theory approach in a focus group of teens diagnosed with depression. The most pressing concerns of teens included parent involvement and the impact a diagnosis has on a

developing identity (Wisdom et al., 2004, pg. 1227[ST1]). The complex nature of adolescent stage development poses a threat to accessing support and the potential of stigmatization. The barrier of facing stigma or judgment may hinder individuals with depression from seeking support. Therefore, parents may need additional support to distinguish between the symptoms of depression and typical characteristics of adolescent stage development to establish appropriate norms and expectations.

According to the Mayo Clinic (2022), teen depression is displayed in numerous ways. The two most prevalent changes associated with teen depression are emotional and behavioral changes. Emotional changes include internalized feelings of sadness, hopelessness, worthlessness, anger, irritability, loss of pleasure, loss of interest, and suicidality (Mayo Clinic, 2022). This broad range of emotional experiences overlaps with the DSM-V TR criteria for depression. However, it may be expressed differently when compared to adults due to developmental differences. In a meta-analysis, Wisdom et al. (2004) elaborated on the distinction of teen versus adult depression further by highlighting that people close to teens may be best suited to identify behavioral or emotional changes. By asking teens questions about their experience, there is an increased likelihood of seeking assessment and diagnosis (Wisdom et al. 2004). A close adult may notice emotional or behavioral changes and inquire if there is a reason for the observed change. Sometimes, a teen may lack the awareness to notice the changes or possibly may feel that no one observes them. Hess et al. (2004) administered a depression awareness program for teenagers and discovered significant knowledge gaps in symptom identification and treatment options (Hess et al., 2004). Although this may have changed in the last two decades, it is worth noting. A social network of caring adults can increase access by connecting teens to resources and support. The identification of depression in teens is complex and can differ from the process for adults.

Despite the significant differences in symptom presentation between adults and teens, there are common behavioral changes in both demographics. Teens may experience behavioral changes related to depression such as exhaustion, insomnia, lack of concentration, poor academic performance, isolation, lack of hygiene, self-harm, and suicide plans or attempts (Mayo Clinic, 2022). This is not an exhaustive list of behavioral symptoms of depression however, it encapsulates many common symptoms that teens can experience while depressed. The externalized symptoms can inform targeted approaches to identify a depression diagnosis. Even though some behavioral changes are generalized, assessment should extend beyond the detection of common emotional and behavioral changes.

Assessments

Assessments help identify depression in a school-based setting. An educational setting is a strategic site to screen, assess, and treat depressed teens. Cuijper et al. (2006) conducted a meta-analysis to examine the effectiveness of mental health assessments in school-based settings. The meta-analysis included over 5800 students from eight different studies spanning (10?) years. Data extracted from the meta-analysis suggested that the most effective forms of assessment included multi-stage screenings and a variety of inventories to measure depression (Cuijpers et al., 2006). The results indicated that assessments act as the first step in recognizing symptoms, measuring prevalence, and connecting struggling students to resources (Cuijpers et al., 2006). To remove barriers in assessing teen depression, utilizing a school-based approach can reach more people, increasing accessibility and treatment options. Morey et al. (2015) examined the current prototypes of depression screening in place at public schools and how assessment standards impacted teen mental health outcomes. The findings suggested that a multiple-stage screening standard can support the prevention of mild cases developing into more severe criteria (Morey et

al., 2015). Therefore, a school-based screening utilizing depression assessments increases the potential of identifying depression in the early stages and improves accessibility to treatment options. In addition, a key outcome of using assessment is identifying existing cases of depression and improving the prognosis of teens with depression. The school-based approach to assessment is vital in addressing the population of teens suffering from depression.

Even though universal assessment strategies offer benefits, effectiveness varies. Beck et al. (2021) evaluated the current screening tools used to identify depression in teens and analyzed the benefits and risks of assessment strategies. The authors found that selection and confirmation biases were important considerations when designing randomized controlled studies due to inherent biases within the diagnostic tool, such as selection bias and publication bias (Beck et al., 2021). These biases inherently affect the results of the meta-analysis. Furthermore, the systematic review concluded that efficacy varies due to the differences in settings, populations, and overall format of the assessment (Beck et al., 2021). This study suggested that effectiveness in assessment cannot be measured accurately due to confounding factors such as biases, varying formats of assessment, and lack of diverse populations. Beck et al. (2021) highlighted the inconclusiveness of assessment tools because the field lacks a uniform approach to measuring the effectiveness and efficacy of assessment tools and procedures.

Despite the universality of assessments and inventories to detect depression in teens, it is important to examine validity and reliability. Brooks and Kutcher (2002) examined some of the common diagnostic tools used to evaluate teens and their symptoms of depression. The results of Brooks and Kutcher's (2001) findings were based on the analysis of 160 studies on diagnostic instruments and their applicability and effectiveness for teens. They identified over 33 different tools and narrowed the review to focus on the 12 most common assessment practices (Brooks & Kutcher, 2001). They generalized that the studies measuring efficacy were inconsistent from one

study to another, there was a lack of reliability and validity in the studies, and there was a shortcoming in tailoring the tools for developmental sensitivity. Developmental sensitivity refers to the general understanding of physiological and psychological milestones at the time of adolescence, while also providing careful attention to individual and group differences (Brooks & Kutcher, 2001). These specific shortcomings point out the flaws in the field's congruency and effort to develop succinct protocols to accurately assess teen depression. The findings suggested that the disorganized research methods comparing assessment strategies hinders research on teen depression. In addition, Sekhar et al. (2019) examined the effectiveness of screening protocols to detect depression in a nationally representative sample of over 400,000 adolescents (Sekhar et al., 2019). All of the participants were privately insured and had access to interventions and support. The researchers concluded that despite the economic privilege of the participants, assessment for major depressive disorder did not make a statistically significant difference in outcome (Sekhar et al., 2019). Therefore, assessment cannot be used alone in identifying depression. The lack of significance suggests that a uniform, universally implemented strategy would be difficult to execute and would not be a single solution to the problem. Assessment is a pivotal point to gauge prevalence and identify barriers to receiving support; however, it is unclear if assessments and screening protocols in any particular setting are useful.

Factors

The biopsychosocial model of health and disease is a useful framework for conceptualizing teen depression. Originally developed by George Engel (1977), the biopsychosocial model of disease suggests a bidirectional and interdependent relationship between the biological, psychological, and social components of mental disorders. The model serves as a starting point to understand an individual's intrapsychic, genetic, and environmental

factors (Frazier, 2020). Frazier (2020) stated that the strengths of the model invite interdisciplinary and epistemological insight into health and disease. The biopsychosocial perspective suggests that depression has physiological, psychological, and social factors that impact onset and outcomes. As a result, teen depression should include a comprehensive model of assessment and treatment that addresses the various factors impacting the adolescent. Integrating various correlational factors and systemic influences can broaden and deepen the scope of teen depression through the means of assessment and treatment.

Age

Depression can affect any person throughout their lifetime; moreover, statistics show that 1 in 3 women and 1 in 5 men will experience an episode of depression at least once before the age of 65 (Dattani, 2022). Definitions of episodes vary; the DSM-V TR defined an episode as lasting for at least two weeks and exhibiting at least five criteria (American Psychological Association, 2022). The teenage years are perceived by the layperson to be vulnerable and turbulent. Teen development is a factor in developing depression. Erik Erikson (1960) developed the psychosocial theory of development that outlines key developmental stages that correlate with distinct conflicts. Erikson's developmental theory conceptualizes psychological dysfunction as the inability to resolve the posed conflict. Erikson argued that teenagers face the complex conflict of identity versus role confusion, implying increased levels of stress (Erikson, 1960). A seminal piece by Erikson (1970) titled *Autobiographical Notes on the Identity Crisis* detailed the inner workings of the adolescent subconscious and its critical role in personality development. Incorporating the psychosocial stage of development may deepen the current understanding of possible factors contributing to teen depression. Erikson's developmental theory is a useful framework to capture the complexities of mental health challenges in teens.

Teens are vulnerable to developing depressive symptoms due to the complexity of the biological and cultural transitions from childhood to adulthood. In other words, mental development and differing generational experiences may be influencing the mental health of today's teens. Twenge et al. (2019) evaluated the factors of age, generational period, and cohort trends in the context of increasing teen depression rates in the past decade with over 600,000 participants (Twenge et al., 2019). The researchers found that the combined factors of cohort and cultural influences had the most distinct impact on the mental health of teens. Specifically, the cohort of late Millennials to late iGeneration (1990-2005), facing the rise of technology and declines in sleep prioritization, is substantially vulnerable to depressive symptoms (Twenge et al., 2019). This study points to the generational influences that affect specific cohorts of teens. With a deeper analysis of the causes of teen depression, the vulnerability of age, cohort, and simultaneous cultural influences may capture the prominent risk factors of depression. Further analysis of the confounding influences of these factors points to age as a significant component in understanding teen depression and its prominent risks.

Isolation

The correlation between social isolation and depression in teens is also necessary to unpack. In particular, relationships and depression. The growing body of research regarding attachment theory by Bowlby (1957) provided a framework for identifying social factors linked to the development of depression. In his seminal piece, Bowlby (1957) studied World War II orphans who severely lacked human touch and connection, followed their development and recorded functioning in relationships in adulthood. Bowlby's theory stemmed from specific observations over the course of the participants' lives, and he later proposed that a newborn's connection to their caregivers or lack thereof creates a template for relationships in later life

(Bowlby, 1957). Human beings are social creatures by design, and a newborn's first relationships in life will significantly influence their ability to connect with others as teenagers and adults later in the human lifespan. Mary Ainsworth (1970) compounded on Bowlby's original work in attachment and coined the term 'attachment styles.' In her seminal study named 'The Strange Situation,' Ainsworth and Bell (1970) identified three attachment styles: secure, anxious, and avoidant. Secure attachment involved infants and caregivers bidirectionally engaging and attuning to one another, while anxious attachment consisted of the inability of the caregiver to soothe the infant while the avoidant attachment style showed little to no effect on the caregiver in the study (Ainsworth & Bell, 1970). Mary Main (1986) replicated the strange situation and identified a fourth attachment style known as disorganized attachment style. Main found that some infants displayed signs of both anxious and avoidant styles (Main, 1986). Attachment theory and research on the Strange Situation demonstrated the importance of infant and caregiver attachment, even when the infant matures into an adult. Applying attachment and relationship research deepens the understanding of social factors that correlate to depression or lack thereof.

Differences in attachment style may lead to differences in mental health outcomes and relationship satisfaction. Dagan et al. (2018) conducted a retrospective analysis of 55 studies examining the relationship between attachment styles with mental health outcomes. Participant data was collected via self-report utilizing specific clinical criteria. They identified that anxious, avoidant, and disorganized attachment styles can lead to increased vulnerability to pathologies in adulthood (Dagan et al., 2018). The early formations of socially adaptive or maladaptive responses may harm relationships and the attachment style may lead to interpreting future interactions as unsatisfying, unfulfilling, or stressful. This meta-analysis also indicated that early attachments and current relationships may play a significant role in the cause and onset of

depression (Dagan et al., 2018). Therefore, it's relevant to consider the social aspects of depression and to note that securely attached people may be prone to isolating behaviors as well.

Social networks provide insulation to stressors, including mental health disorders, according to Adedeji et al. (2022). The German-based study collected data from 446 adolescents and concluded that teens' peer relationships showed a significant influence in regard to developing depressive symptoms. Moreover, the higher quality of peer relationships predicted a protective effect against developing depressive symptoms later on (Adedeji et al., 2022). Bifulco et al. (2019) measured the associations between attachment style, severe life events (trauma), and depression experiences. The study has over 200 participants and noted the inextricable relationship between insecure attachment styles, increased instances of severe life events, and exhibited depressive symptoms. Both variables of insecure attachment and styles and encountering severe life events correlated to more recent depressive symptoms and a history of depressive disorder (Bifulco et al., 2019). The inference of the vulnerabilities in relational attachment styles emphasizes the potency of attachment theory in mental health. The sociability of humans is influential in tandem to depression identification, onset, and recovery.

Social contexts are relevant considerations when it comes to assessing and identifying depression in teenagers. Social isolation is a risk factor for depressed teens, according to Wichers and Bringgman (2020). The research studied the correlational relationship between depressive symptoms and solitude inertia. They defined solitude inertia as an individual's likelihood of staying in a state of solitude and discovered that people with higher tendencies to stay in solitude inertia showed more depressive symptoms eight weeks later than their baselines (Wichers & Bringgman, 2020). The concept of isolation is relevant as a factor of depression in teens. If teens have a stronger inertia towards solitude, there is an increased likelihood to develop symptoms of

depression. This study suggests that levels of isolation may be a compounding factor of teen depression when generalizing to the larger population.

Social isolation not only refers to time spent alone but also includes exclusion, rejection, and bullying. The pervasiveness of bullying via social exclusion victimizes 1 out of 5 high school students (CDC, 2018). In a study conducted by a Turkish researcher, Mehmet (2021), social exclusion and ostracism correlated with rates of depression, stress, and anxiety. Exclusion refers to active experience of rejection while ostracism is defined as isolation after social exclusion. The data revealed that both factors related to the prevalence of depressive symptoms and ostracism, in particular, were the most potent indicator of depression in the realm of isolation (Mehmet, 2021). Research regarding the interaction of these factors among youth requires further investigation. According to Rudert et al. (2021), peer ostracism can negatively impact youth social development and mental health three years into the future. Therefore, the data suggest that isolation does not only encapsulate solitude; experiences of rejection and bullying increase the likelihood of developing depressive symptoms (Rudert et al., 2021). The social factors related to the development of teens can indicate depression and other negative mental health consequences. Understanding teen depression through a social lens points to isolation, exclusion, and bullying as significant factors.

COVID-19 Pandemic

An additional influence on teen depression coincides with the impact of COVID-19 and the mandated quarantine. A quantitative study conducted by Styck et al. (2021) aimed to measure the self-reported impacts of K 12 students' stress levels. They found that the start of the pandemic triggered significant increases in academic stress among high school students (Styck et al., 2021). The data suggest that a stressful environment (i.e., virtual school at home) correlated

with negative mental health outcomes. Using a questionnaire, Styck et al. (2021) identified academic stress, fear of missing events, fear of illness, and social isolation were the most common stressors. The compounding effect of multiple stressors influenced students' self-reported levels of anxiety and stress, both of which are linked to comorbidity with depressive symptoms (Styck et al., 2021). This historical event has disrupted and indisputably increased stress levels among teens, making it an important context to consider.

Although many students returned to classrooms, the residual effects of COVID-19 continue to present. It is critical to consider the drastic changes in 2020 and 2021 in relation to mental health. The legacy of this collective event is undeniably impactful on teens' development and mental health. Barbosa-Camacho et al. (2022) in Mexico measured the impact of virtual learning on students' risk of developing depressive disorders, anxiety disorders, and overall academic performance. Barbosa-Camacho et al. (2022) recorded a 61.5% likelihood of depression due to the impact of COVID-19 (Barbosa-Camacho et al., 2022). The immediate effects of the pandemic correlated with an increased number of students struggling with depressive symptoms (Barbosa-Camacho, 2022). The demographic of students from Mexico provides a close-up look into the pandemic's initial impacts on teenagers.

Additionally, the initial findings in a study conducted by researchers in Australia showed heightened depressive symptoms during school closures and also measured increased levels of loneliness (Houghton et al., 2022). As society moves towards a post-pandemic world, the aftermath of the pandemic is not yet fully understood, and perhaps it is still impacting students and their mental well-being. The COVID-19 pandemic is a continuously evolving crisis that is layered and complex. Research indicates that major historical events such as pandemics can contribute to an increased prevalence of depression in teens.

Social Media

It is also important to consider the prevalence of social media as an influential social setting that shapes teen development. Lev Vygotsky's (1978) theory of social learning explores development from a social perspective and aims to dissect the cognitive pieces of development via social settings. Social learning theory can be described as the cognitive process of developing culturally-relevant beliefs, values, and meaning through social interactions with others. Vygotsky nuanced the idea that sociocultural settings profoundly influence cognitive development; individual psychology does not exist without reference to the environment and culture. Vygotsky introduced the notion of a bidirectional relationship between the individual and the environment (Vygotsky, 1978). This theory of development provides a framework for investigating the rise in teen depression and the factor of isolation and its influence on development.

Pew Research Center (2022) reported that more than 95% of teens use at least one social media platform and 56% of teens believe that it would be hard to give up social media (Vogels et al., 2022). Teenagers notice the negative outcomes, despite their ingrained use of social media. O'Reilly et al. (2019) utilized a qualitative approach through a teen focus group with targeted questions on perceptions of social media and mental health. Teenagers self-reported negative mental health patterns such as depression, anxiety, and body image issues due to social media sites (O'Reilly et al., 2019). In contrast, the same researchers studied the decreasing stigma of mental health issues through the perspectives of high school students. O'Reilly et al. (2019) used the qualitative model of focus groups to analyze the positive forces of social media. They found that this age group of young people may be more open to discussing their mental health and wellness on social media and in person (O'Reilly et al., 2019). Because social media usage is a relatively new phenomenon, it is essential to study its impact. The researchers discovered that it can be a helpful or harmful tool in light of mental health. Social media can increase feelings of

depression, anxiety, and lower self-esteem and it also has the potential to improve mental health awareness.

Identity

The sociocultural level of identity is another component of teen depression. According to the biopsychosocial model, family systems and broader communities affect the psyche of the individual. The relationship between social inequality and mental health issues is one of the many outcomes that marginalized groups face. Smith and Possel (2022) collected data on daily discrimination instances in marginalized adolescents across races and measured depressive symptoms through self-report. The researchers discovered a link between perceived everyday discrimination experiences and higher accounts of depressive symptoms in adolescents. The authors found that strategies used to cope with perceived everyday discrimination such as brooding (focusing on negative mood states) can increase or exacerbate depression (Smith & Possel, 2022). The detrimental effects that systemic oppression burdens on an individual specifically correlate to experiencing depression. Marginalized groups facing systemic oppression via microaggressions, exclusion, hate, discrimination, etc., are more likely to be impacted in their mental health and well-being.

Systemic racism is a potent factor related to mental health. People of color face higher levels of stress than white people, according to minority stress theory (Ching et al., 2022). Ching et al. (2022) found that racial oppression results in elevated instances of pathologies, such as depression. Using this data, the researchers developed a minority stress model to capture the cyclical nature of oppression. This model specifically addressed the intrapsychic workings of self-perceived stress and the ability to cope. The article reported that a less accepting and positive environment was related to worse stress management, which was associated with more

severe depression symptoms (Ching et al., 2022). Prejudiced climates correlated with severe depressive symptoms amongst teens of color. This highlights the relationship between systemic oppression and mental health. As the research continues to investigate the causal factors of depression in teens, scholarship must consider the cultural nuances that actively contribute to depressive symptoms. The contributions of Ching et al. (2022) illuminate the intrapsychic, interpersonal, and systemic forces that impact mental health.

It is worthwhile to examine the cascading effects that marginalization imposes on depression symptoms. A study by Flanders et al. (2019) examined the disparities between LGBTQ+ people of color and LGBTQ+ white people in accessing mental health services. This preliminary investigation revealed the inherent inequity in mental well-being and identified the various discriminatory factors. The research indicated that the bisexual POC demographic had less access to services than bisexual white people because there were no support groups available to this demographic nationwide (Flanders et al., 2019). The researchers compared mental health factors such as depression and anxiety, and discovered there were higher rates of depression in youth than adults and POC versus white people (Flanders et al., 2019). Not only do LGBTQ+ community members have higher instances of depression, but they also have limited treatment options. Mental health care has historically denied marginalized groups equitable access to treatment.

When working with a teen with depressive symptoms, it is significant to take intersectional identity into consideration. Intersectionality is a term coined by Kimberlee Crenshaw (1997) that captures the experiences of people that have two or more marginalized aspects of identity. Social identities such as sexuality, gender, race, ethnicity, class, and more, all contribute to the individual's worldview. Evans and Erickson (2019) measured the intersectionality of identity and the prevalence of depression in a longitudinal 13-year-long study

of a nationally representative sample of more than 15,000 adolescents and young adults. Using recently developed statistical analysis, Evans and Erickson utilized this methodology to classify aspects of identity and to also measure intersectionality and its relationship to mental health outcomes. Intersecting inequalities of race, gender, class, and immigration status significantly correlated with elevated depression scores consistently over 13 years compared to non-marginalized groups (Evans & Erickson, 2019). These components of identity, when combined, show higher rates of depression-like symptoms in identity-based interactions, meaning that perceptions were influenced by one or more pieces of identity (Evans & Erickson, 2019). The data on intersectionality revealed negative mental health outcomes when individuals were a part of multiple oppressed social groups. Participants' depression scores endured over the course of a 13-year period. Furthermore, participants provided higher scores as they encountered more frequent and negative identity-based interactions (Evans & Erickson, 2019). Understanding identity, culture, and intersectionality are important factors when conceptualizing a teen living with depression. Societal inequities and systemic oppression impact assessment, diagnosis, and treatment; and mental health is not an exception to these underlying forces.

Common Approaches to Treating Teen Depression

Both formal and innovative treatment strategies that target depression continue to evolve as society combats the widespread pervasiveness of depression. According to the Mayo Clinic (2020), some common methods include medication, psychotherapy, and alternative approaches such as Eastern practices of acupuncture, yoga, mindfulness, etc. (Mayo Clinic, 2020). Treatment plans are highly individualized; for example, specific criteria of symptoms, mental health history, and age are relevant. The option of working with a health care provider is a privilege, and not everyone has access to health insurance or health care. There are other forms of treatment that

are not accepted by the mainstream medical model. Yet for some, alternative options may be the only way to treat symptoms of depression. Because of inequity, access to treatment varies according to identity, power, and privilege.

Medication

For teens, medication is a common approach to treating depression. A Gallup poll (2005) reported that 5% of teens had been prescribed medication to treat depression (Gallup Poll Panel, 2005). Primary care physicians can prescribe antidepressants to teens and most commonly choose SSRIs (selective serotonin reuptake inhibitors) and the FDA has approved Lexapro and Prozac for teenage use (Mayo Clinic, 2022). Doctors can refer teens to psychiatrists, who also prescribe them antidepressants. The most widespread treatment used in the United States to treat mild to severe depression is medication, according to the National Library of Medicine (2020). In a meta-analysis reviewed in 2015, Linde et al. analyzed 66 studies with more than 15,161 patients to examine the efficacy of antidepressants versus placebo control groups. When treating depression, all of the common antidepressants were found to be significantly more efficacious compared to placebo groups (Linde et al., 2015). SSRIs had the most significant results, yet still had a small effect size compared to the placebo treatment. Antidepressants are efficacious and an acceptable form of treatment for teen depression.

There are benefits as well as undetermined risks for youth taking antidepressants. Another study examining the effects of antidepressants specifically on youth had mixed results. The psychiatry team at the University of Washington (2012) systematically gathered over 27 published and unpublished randomized, double-blind studies regarding second-generation antidepressants. Henry et al. (2012) studied the impact of antidepressants on teens struggling with depression. The results indicated moderate to mild benefits across depressive symptoms

However, the findings also indicated a correlation between antidepressant use and suicidal or parasuicidal behaviors (Henry et al., 2012). Antidepressants can often cause a common side effect of increased suicidality among children and teens (NIMH, 2022). Because of this common side effect, finding the right medication can be a time-consuming process or may turn off the individual entirely to the idea of antidepressants. Also known as the "black box warning," the FDA (2019) advised that children and teens taking antidepressants stay hypervigilant for any signs of suicidality, especially within the first two months of treatment and any dosage adjustment thereafter (FDA, 2019). This warning is universal for all children and teens taking antidepressant medications and there are other common side effects for teens such as physical symptoms of weight gain, sleep disruption, gastrointestinal issues, and sexual dysfunction (FDA, 2019). The risks and benefits of medication are highly individualized and may not work for everyone.

The National Library of Medicine (2020) stated that the benefits and risks of antidepressants are understudied, and there are safety and developmental concerns to take into account when prescribing antidepressants to youth (NLM, 2020). The current recommendation of the NLM (2019) supports the use of SSRIs for mixed anxiety and depression disorders. SNRIs (serotonin-norepinephrine reuptake inhibitors) still have less evidence for efficacy in children and adolescents and TCAs (tricyclic antidepressants) are efficacious however there can be lethal consequences in overdose (NLM, 2019). Because teen depression is often comorbid with other disorders such as anxiety, obsessive-compulsive disorder, or attention deficit hyperactivity disorder, SSRIs are considered to be the benchmark for antidepressants in children because of their effectiveness, safety standards, and their ability to treat other mental health challenges (NLM, 2019). Teens living with depression still possess a variety of options when it comes to medication depending on diagnosis, clinical opinion, and personal preferences.

Psychotherapy

The National Institute of Mental Health (2022) and the Anxiety and Depression Association of America (2022) recommend psychotherapy for depressed individuals with or without medication use. Primary care physicians can refer patients to community mental health clinics, in-patient programs, and private practices to receive therapy services. According to the NIMH (2022), two empirically-validated forms of counseling to treat depression are cognitive-behavioral therapy and various forms of interpersonal therapy. CBT targets unhelpful thought processes in depressed clients and IPT emphasizes strengthening relationships and social networks, as well as setting realistic expectations to improve mood (NIMH, 2022). These two recommended forms of talk therapy help reduce symptoms. According to the Anxiety and Depression Association of America (2022), each form of treatment (medication and talk therapy) can be successful on its own. However, recent empirical evidence indicates that combining both treatments can be highly effective for most individuals (ADAA, 2022). These standard approaches work well for most adults and teens with depression. A combination of medication and psychotherapy is most often recommended for individuals diagnosed with depression (NIMH, 2022). Depending on the severity of the symptoms and preferences of the individual, combinations of therapy can be tailored appropriately with the guidance of a healthcare professional.

Cognitive behavioral therapy is the most popular form of psychotherapy for treating depression. The National Library of Medicine (2012) compiled various meta-analyses and systematic reviews to study the effectiveness of psychotherapy for depressed teens. In adolescent depression, psychotherapy has strong effects on the treatment of depression through building coping skills, improving interpersonal relationships, practicing social participation, and engaging in pleasurable activities (NLM, 2012). The variety of techniques dedicated to this outcome all

shows to be useful if they are utilized to work towards these goals. The effectiveness of psychotherapy is well-established for adolescents and adults alike.

Because of CBT's widespread use and accessibility, a team of Norwegian researchers (2014) aimed to study psychotherapy's effectiveness in a real-world setting. Their methodological approach developed a course designed to serve adolescents coping with depression. The pretest, posttest, and six-month follow-up indicated that the intensive CBT course improved depressive symptoms. At the six-month mark, participants' symptom improvement maintained or continued to increase (Garvik et al., 2014). This study highlighted the effectiveness of psychotherapeutic interventions to resolve depressive symptoms in the short term and to prolong improvement, even after treatment stopped.

Furthermore, it is relevant to consider the relationship between trauma and depression, and how the presence of trauma can impact the identification, assessment, and treatment of depressive symptoms. A study led by Heim et al. (2008) took a neurobiological approach in identifying the links between traumatic experiences and depressive symptoms in neurotransmitters, hormones, and reshaped brain structures. Using the neurobiologically informed measurement of the psychoneuroendocrine stress response, the physiological markers indicated blocks in resiliency pathways in the brain (Heim et al., 2008). Trauma-based depression is important to identify because it is not always responsive to regular psychotherapy, but differential approaches can be modified and applied more effectively. Interpersonal as well as systemic forms of trauma may impact the overall effectiveness of treatment. A recent study conducted by Shirk et al. (2014) recruited 43 participants living with depression and a history of interpersonal trauma. The study concluded differences between groups when comparing CBT to usual care (humanistic psychotherapy) (Shirk et al., 2014). The unique nature of trauma-based depression is often comorbid with post-traumatic stress disorder, which has a differential set of

assessment and treatment protocols. Ensuring a proper diagnosis or dual diagnosis appropriately informs the treatment planning aspect. It is relevant to note that some forms of psychotherapy may not be culturally appropriate for all teens with depression, due to cultural backgrounds, lived experiences, and intersectionality. Dominguez (2021) examined pre-existing studies on trauma-focused treatment (TFTs) in the context of treating depression. Eye Movement Desensitization and Reprocessing (EMDR) proved to be a statistically significant TFT in psychotherapy. Trauma and dual diagnoses complicate the nature of treating depression symptoms (Dominguez, 2021). Although psychotherapy and CBT are widely used and recommended, they may not be the best treatment option for everyone, including teens living with depression and a history of trauma.

Alternative Approaches

A few other approaches are commonly used either separately or conjointly with medication and psychotherapy. Physical exercise is recommended to stay healthy physiologically, and it also can benefit mental health and well-being. A study by Nabkasorn et al. (2006) measured the effects of physical exercise on adolescent females displaying depressive symptoms. The participants took a pre and post-test of hormones and self-reported symptoms in the experimental group and there was a control group that partook in regular daily activities. The exercise regimen consisted of five 50-minute group jogging sessions over the course of eight weeks, and the results demonstrated that group exercise had a positive effect on adolescent females with mild to severe depressive symptoms (Nabkasorn et al., 2006). Physical exercise is a treatment approach to depression and it also serves as a preventative measure against depression or other mental disorders (NIMH, 2022). Exercise extends beyond mental health as well, it is recommended for living a healthy lifestyle.

Alternative approaches, such as a nutritious diet and consistent exercise are the recommendation of the Cleveland Clinic (2020). Along with other medical associations and government programs, recruiting alternate methods of preventing and treating depression is routinely understudied (Cleveland Clinic, 2020). Some recommendations include yoga, deep breathing, meditation, exercise, massage, acupuncture, and more. The gap in the research on alternative methods of treatment shed light on the lack of information on treating depression for the teenage population specifically and how these possibly underutilized options could increase accessibility, prevention, and awareness in mental health.

Summary

Teen depression is an ever-evolving mental health crisis. It is undetermined what initially causes the onset of depression or how it is to be properly treated. The unknowns that surround depression in teens have influenced assessment, diagnosis, treatment, and other components of the mental health care process. Understanding the factors and nuances of teen depression is essential for increasing effective screening and assessment protocols, as well as developing practical and scalable treatment approaches. Integrating intersectional identity and a multi-tiered mental health approach is crucial to conceptualize and work with individuals that mental health care systems have historically excluded. Chapter I looked at the pressing issue of teen depression; Chapter II synthesized current research on these mental health challenges, including significant factors and current treatment options; Chapter III focuses on the proposed intervention; and Chapter IV concludes by noting limitations and assumptions.

Definitions of Terms

The following terms are used in this chapter:

Assessment: The ability to evaluate and identify the nature, quality, depth, or length of symptoms with a formal measurement.

Depression: A cluster of symptoms and experiences outlined in the DSM-V TR (2022) as feelings of sadness, hopelessness, emptiness, or irritability; loss of interest or pleasure in once enjoyable activities; weight loss or gain; sleep changes; fatigue; feelings of worthlessness or guilt; decreased concentration or focus; and possible suicidal ideation or attempts. To receive a Major Depressive Disorder diagnosis, 5 or more criteria must be met for at least two weeks (American Psychological Association, 2022). Depressive symptoms or depression may be categorized as experiencing any of the listed symptoms for any length of time.

Diagnosis: A defined label that meets symptom criteria and the nature of the disorder.

Treatment: The plan and process to reduce symptoms related to the disorder or diagnosis.

Chapter III

Intervention

The proposed intervention consists of a group counseling format that tailors to working with teens struggling with depression. Devising a theoretical foundation and applying relevant techniques and tools will be effective in unpacking the depressive symptoms that teens bring into the group. The proposed intervention integrates noteworthy psychotherapy theories that target depression symptoms and have been studied with the teen population. The group format of counseling promotes symptom reduction and healing and it also provides increased accessibility for the assessment and treatment of teen depression, as will be discussed in this chapter (Thimm & Antonsen, 2014).

Theoretical Orientation

Rationale

The proposed intervention combines various psychotherapy theories, techniques, and modalities to optimize treatment for teen depression. The primary theory used in the group format is cognitive behavior therapy originally developed by Aaron Beck in the 1960s to specifically treat depression (Chand et al., 2022). The basis of CBT for understanding people struggling with depression is that the majority of thoughts and internal messages are harmful to the person. The thoughts and behaviors need to be modified in order to see a change in psychological functioning. CBT's ability to be adaptive to brief interventions have made it a widely accepted practice in psychotherapy to work with depression. This approach was studied in clinical settings and has demonstrated effectiveness to treat depression (Chand et al., 2022).

Additionally, Cognitive Behavioral Therapy can be modified and tailored to specific populations and treatment goals. CBT had a profound influence on postmodern psychotherapy

theories such as narrative therapy or solution-focused therapy. A widespread iteration of CBT is traced back to Jon Kabat-Zinn (1990) and his development of Mindfulness-based Stress Reduction protocol and Mindful CBT. The ancient yet revolutionary twist revitalized CBT to treat depression in effective and long-lasting ways. Numerous studies and anecdotes have highlighted the efficacy of mindfulness as a form of physical and mental well-being, as written in Kabat-Zinn's book *Full Catastrophe Living* (1990). Research has found mindfulness to be an effective avenue toward holistic well-being when it comes to psychotherapy and other healing practices such as yoga, trauma therapy, substance use counseling, and pain management (Kabat-Zinn, 1990). Trauma-informed approaches and bottom-up regulation tools continue to become more mainstream; however, mindfulness integration has yet to be implemented into standard practices of psychotherapy.

MBCT is grounded in the belief that mindfulness is critical for unlocking more profound healing of depression and other mental ailments. Mindfulness, as defined by Jon Kabat-Zinn (1990) is a practice of non-judgmental, present-moment awareness. His book *Full Catastrophe Living* (1990) examined the process of implementing Mindfulness-Based Stress Reduction programs into a chronic disease treatment group according to the members' treatment plans to lower stress levels. Kabat-Zinn remarked that decreasing participants' stress levels not only lessened the impact of the effects of chronic diseases on physiological health, but there were cascading benefits of mindful stress reduction such as decreased levels of target symptoms, improved prognosis, increased levels of satisfaction of life, and more (Kabat-Zinn, 1990). Later on, the program of MBSR evolved into MBCT to combine the best practices of CBT with the profound implications of practicing mindfulness. The group protocol was initially designed to treat depressive symptoms, therefore targeting common signs and experiences of depression. The

handbook titled *Mindfulness-Based Cognitive Therapy for Depression* created by Segal et al. (2012) developed a user manual for clinicians to apply MBCT to decrease depressive symptoms effectively. The book *The Mindful Way through Depression* written by Williams et al. (2007) also co-authored with Kabat-Zinn takes a closer look into the complex underpinnings of how mindfulness approaches to psychotherapy and to life support clients to find satisfaction and happiness. These two books serve as valuable resources for the proposed intervention because of the in-depth explanations of techniques and how to effectively apply them in group counseling. As the book details, the mindfulness component provides bottom-up regulation while the CBT aspect invites top-down meaning-making in the psychotherapy process. The two books succinctly integrate mindfulness with CBT, making the practice more accessible to clinically trained therapists who may not have expertise in mindful practices.

The MBCT program is highly adaptive to various populations and problems. In the proposed intervention, MBCT is altered to work with teens in a high school setting. Additionally, MBCT's mindfulness component is more emphasized than the traditional protocol, and the strengths-based approach with social justice values is prominent in this intervention. MBCT is effective as a stand-alone, however, it is understudied with this specific population, and stress levels of today's teens with the unprecedented circumstances of lack of sleep, high expectations, increased loneliness, and more mental health comorbidity need to be rigorously accounted for. Strengths-based CBT incorporates self-esteem techniques to bolster self-confidence and resilience. Framing the devastating issues that teens face today is counterbalanced with the positive psychological underpinnings that strengths-based CBT invites.. The social justice foundations of the proposed intervention acknowledge the privileges and disadvantages that different groups endure. Social justice tenets provide group norms that work to ensure the safety

and well-being of all people. Inclusion and equity are essential to group norms required for psychotherapy.

Benefits of Group Therapy

Group therapy formats uplift members' struggles through the means of relating, connecting, and empathizing with one another. Authors Thimm and Antonsen (2014) studied the effectiveness of group and individual CBT to treat depression and found that the group setting improved the participants' depressive symptoms when compared to individual counseling (Thimm & Antonsen, 2014). Group counseling formats have been shown to be effective through various studies examining different mental disorders and varying clusters of symptoms. High school students specifically may benefit through a group counseling format, and depression is often treated with psychotherapy and group psychotherapy. Considering the unprecedented factors contributing to the widespread issue, creative interventions must be utilized to meet the need. Barriers to assessment and treatment need to be deconstructed and responded to with action steps. A group format can increase accessibility to teens by using a high school setting during school hours to eliminate issues of transportation, cost, and other recruitment barriers. Moreover, a group of teens can have the logistical benefit of having one counselor per four to eight students in one hour of time. The effectiveness of the proposed intervention takes into consideration the identified obstacles to the assessment and treatment of teen depression.

Clinically, a group format allows the environment for emotional safety and peer connections. The compounding factors correlated with staggering rates of teen depression may indicate underlying symptoms unique to teens such as loneliness and lack of belonging. A group format inherently promotes connection and relationships by simply having teens together in the same room and engaging with each other. The various modalities of treatment target specific

symptoms of depression, and the group meeting consistently is a modality in and of itself. Connection can reduce stress and feelings of loneliness, making the group format a necessity to treat teen depression.

Intersectionality and Identity Inclusion

Inclusion of all identities and intersectionality is paramount to the proposed intervention. Examining the clinician's inherent privilege in a position of power is a social justice foundation of the group. A leader that is continually self-educating and practicing social justice in professional and personal settings is an example for group members. A lifelong learner and a curious approach are helpful for creating group culture, as well. Community agreements set group norms and establish expectations for all members' safety and dignity. This understanding invites the participation of everyone and encourages the sharing of lived experiences. As stated previously, the research points out the disproportionate mental illness rates of marginalized groups, meaning that experiences of oppression and discrimination can affect all aspects of the individual. Taking all lived experiences into account is necessary for rapport building, psychological safety, and genuine healing.

Moreover, mindfulness and strengths-based adjustments to CBT create more client-centered approaches compared to traditional CBT. The Rogerian emphasis is ingrained in these two flavors of CBT, meaning that the clinician holds the client to be the expert of their life and views the client in unconditional positive regard. The Rogerian core conditions of genuineness, empathy, and unconditional positive regard create the space to hold lived experiences and process them void of judgment, questioning, disregard, or reliving traumatic experiences. Compassion and acceptance are fundamental values of the group that are exemplified by the clinician and the group members towards each other and themselves. The

client-centered approaches of mindfulness and strengths-based CBT promote a positive atmosphere for group differences and individualized experiences to come forth.

Recruitment

Recruitment for the proposed intervention involves self, staff, and parent referrals. 'Mindfulness for Self-Discovery' is the working title of the group. This reframing of centering positive psychology and destigmatizing advertisements may attract more members to the group. An online referral form allows more accessibility for students, staff, families, and community members to refer students. The high school setting at a counseling center mitigates barriers to access and can assist recruitment by displaying flyers, using word of mouth, and counselor referrals. A sample of the flyer is located in Appendix A. The efficacy of the group format streamlines services to more students than individual sessions, meaning that an increased number of students can be served via the school counseling center.

Pre-Group Interview

The threshold of the group is four to eight students. Once four to eight referrals have been made, the interview process can begin. The pre-group interview is an individual meeting with the counselor and potential group member to review and discuss the following: the purpose of the group, informed consent, confidentiality, previous services received, reasons for wanting to join, necessary risk assessments, and other questions or concerns of the potential member. A sample of the informed consent document is located in Appendix B. The pre-group interview format is itemized however it uses a semi-structured interviewing style to allow for rapport building and a relaxed atmosphere. The reviewed topics will be covered by the clinician in a casual manner to convey the necessary information while also allowing for genuine questions and concerns that may be posed by the interviewee.

Rules & Guidelines

Although the proposed intervention values client-led exploration, there are required rules and guidelines to ensure structure for the group. In the pre-group interview, the clinician educates the interviewee on the definition of confidentiality, its exceptions, and the privacy risks posed by group settings. Furthermore, informed consent documents with the signature of the student and parent is a requirement. The informed consent document highlights school policies, confidentiality limits, and risks of counseling along with the structure and purpose of the group. The student is required to consent to services and although parental consent is not legally mandated, the school prefers it. The form is taken home to be signed by a parent or guardian to understand the nature of the therapeutic relationship, confidentiality, and the group structure. Informed consent is the foundation for group safety legally, ethically, and stylistically.

Group Structure & Session Outline

Table 1

Session Outline

Session #	**Stage**	**Tools and Activities**	**Notes**
1	Rapport	Introductions, community agreements, review of informed consent/confidentiality, and overview and origins of mindfulness	Build rapport and insert fun into introductions and community agreements. Promote a relaxed atmosphere.
2	Rapport	Opening meditation/check-in, review community agreements and informed consent/confidentiality, and play the ‘speed friending’ game	Continue to build rapport and slowly integrate mindfulness in activities and games.
3	Intervention	Opening meditation/check-in, introduction to body scan meditation and practice, and group discussion on awareness	Start to develop a routine for the group with the opening warm-up and check-in.

			Allow space for student contributions and lived experiences.
4	Intervention	Opening meditation/check-in, introduction to loving-kindness meditation and practice, and group discussion on self-compassion	Contextualize and model self-compassion.
5	Intervention	Opening meditation/check-in, body-scan meditation, private journal reflection on mediation, and group discussion on perspective	Engage in personal disclosure when appropriate and encourage the sharing of lived experiences.
6	Intervention	Opening meditation/check-in, loving-kindness meditation, expressive art technique of 'drawing the experience', and pair-share reflection	Honor the privacy and uniqueness of their experiences
7	Termination	Opening meditation/check-in, reminder of termination, body scan meditation, and group discussion on mindfulness in everyday life	Provide a safe thinking space to imagine and apply mindfulness outside of the group
8	Termination	Opening meditation/check-in, loving-kindness meditation, termination group art project, group discussion on takeaways and lessons	Give an opportunity for closure and reflection on newly formed connections and self-discovery

The group structure consists of eight weekly sessions with a break halfway through. The proposed intervention utilizes the 'academy' period (free period) on Fridays to meet. The meetings are held in the counseling center on campus. The period is 55 minutes long, allowing for 5 minutes to transition into the therapeutic space and 5 minutes to transition back into the school day. Once the door is locked, the session begins. The group structure maintains consistency throughout by meeting at the same time and same place weekly. Also, the start of a

session is established with a student-led activity. Although the techniques, tools, and activities vary, a predictable routine is created to provide psychological safety.

The first session is devoted to introductions of the therapist, group members, and the purpose of the group. Music, snacks, and detailed touches welcome the group members and create a warm environment. Once the students sit in a circle, introductions begin and they review the purpose of the group. Informed consent is revisited by passing out blank copies of the forms and inviting the members to express concerns and ask questions. Confidentiality is also examined in a group discussion format with the clinician sharing a definition and the members contextualizing examples of confidentiality. This shared understanding of confidentiality is the first community agreement. The subtle transition into devising community agreements of group norms, rules, and expectations. The clinician affirms the agreements and suggests alternatives and deeper critical thinking to inappropriate or off-base guidelines. The first session ends here and if there is leftover time, a group icebreaker activity is introduced such as the game 'telephone' or 'two truths and a lie.' The group members are invited to share a final thought or reflection by going around the circle with the option to pass.

The following session starts to establish a routine. The clinician grounds the group through a body scan meditation, derived from the MBCT protocol (Kabat-Zinn, 1990). The meditation promotes grounding and a signal that the session has started. From there, the group engages in a check-in, varying in forms such as a 'temperature check' or 'rose and thorn of the day.' Each member is allowed to pass or share for up to one minute. The clinician explains the routine nature of the opening ritual. Every session starts with a meditation and a check-in. Subsequently, the clinician broaches informed consent and confidentiality again and invites questions and concerns. Any transgressions are processed in the group setting unless it involves

immediate risk or safety concerns. Discussion is welcomed and then the clinician transitions to review the community agreements, in which amendments are encouraged. The group then moves into the main activity of the session. The second session is dedicated to rapport-building and supporting the members in getting to know each other. The activity is ‘speed friending’ (substitute for speed dating) where the chairs are reorganized in pairs to face each other and the therapist states aloud one question or prompt for each pair to share. One person shares for a minute and then they switch. This technique creates rapport building and trust between the members. The group comes back together to discuss takeaways, observations, likes and dislikes about the activity. The routine of a mindful reflection closes out the session.

Subsequent sessions follow a similar format of welcoming members into the space, meditation, checking in, reviewing community agreements, engaging in an activity, and then reflecting to close out the session. The agenda is announced by the facilitator during the welcome. The main activities vary, however, MBCT and strengths-based CBT are the theoretical foundations for selection. A few ideas based on MBCT and strengths-based approaches combined with clinician creativity are effective to maintain structure and consistency while adding stylistic flair to the group. Ideas for the proposed intervention include dyad interviewing, partner affirmations, art projects, journaling activities, and mindful creativity. The activities can also be chosen by the members if they gravitate towards one activity or want to revisit one. The structure creates consistency and creativity supports novelty. The agenda for each session is established but it can change as needed to ensure student support. The flow of the session begins with a warm-up and check-in, followed by the main activity, and concluded with a final group share.

Termination

High school students joining the group may display resistance to the termination. The clinician will keep this in mind as the program progresses, giving reminders at the end of the session to declare the number of sessions remaining. This practice is necessary to do in the last half of the program. The consistency of reminding the members of the remaining session allows them to start the process of termination. The last session, of course, is termination. Termination marks an official ending to the program and helps members process the impact of the group and assimilate a new understanding of the self and relating to others. The final session starts with the opening ritual and the main activity is to autograph and write a note to each member. Every member can decorate and design a large canvas of construction paper or cardstock with their name at the top and each member of the group rotates to sign every canvas with an affirmation or reflection. This signifies the impact that every member had on each person and is a tangible reminder of the strength, resilience, and vulnerability that each member possesses. The group comes together for one last time to share out final reflections and insights that will stay with them beyond the group. The termination of the group is the final therapeutic effort that reinforces the inner courage and wisdom that lies with each individual.

Summary

The proposed intervention integrates various theories and modalities to robustly support and empower teens and their journey through depression. It takes correlational factors of depression into consideration in the treatment. Depending on the student's needs, the structure can easily be modified to adapt to pressing concerns and the demographic makeup of the group. Chapter I examined the problem of teen depression; Chapter II reviewed the manifestation, causes, correlations, and common approaches to treating teen depression; Chapter III proposed

the clinician intervention as a form of treating teen depression; and Chapter IV concludes with limitations, assumptions, and final reflections.

Chapter IV

Discussion

In general, psychotherapy aims to relieve mental health disorders and promote positive changes within the client. A mindfulness lens supports this notion and encourages the examination of the inner landscape of the individual as well as the external vitality of communities. According to ancient practice, the individual practice of mindfulness increases awareness of the health and well-being of groups and systems. The protocol uses a grounded theoretical orientation to examine the intersectionality between oppression and mental health, and more specifically, the manifestation of teen depression. The intervention highlights the pressing need to develop an intervention that addresses issues of equality and equity while also using evidence-based practices to target symptoms.

A mindfulness intervention that is cost-effective, timely, and relevant to the population can also be trauma-informed and socially just. This research project explored the current implications of mindfulness as well as the historical exploration of original Buddhist and Hindu influences that founded the practice. The project raises questions about the racism, classism, and cultural appropriation that taints the mindfulness practice as well as its intersection with the discipline of Western counseling. Concerns implying diversity, equity, inclusion, and safety at the centerfold of research and practice alike may pose additional barriers. Lastly, designing a mindfulness intervention that can provide useful therapy tools and incorporate a somatic and/or spiritual lens is still a far reach away. All of the implications listed are acknowledged and continue to guide the conversation regarding the literature.

Closing research gaps and equity disparities combine multiple forces of therapy that can transcend the therapy office and promote safer relationships, healthier communities, and a more

mindful society. This project may continue to unfold cascading issues on the matter that perhaps may inspire more investigation. Through conscientious research, mindfulness may be a practical, inclusive, trauma-informed, and social justice-minded approach that can improve mental health outlooks for individuals, groups, and communities, and may also transcend the mental health space and transform former obstacles into opportunities.

Strengths of the Proposed Intervention

The proposed intervention integrates various theories and approaches to treating general depression as well as teen-specific depression. The theoretical underpinnings of cognitive behavioral therapy, humanism, and mindfulness support a holistic and integrative approach that considers universal and unique experiences of depression. The use of effective, data-driven techniques and practices is a clear strength of the intervention. Moreover, research not only has demonstrated efficacy in the proposed interventions, but research also indicated teens are a vulnerable population. The developmental, circumstantial, social, and emotional facets of teens make understanding the manifestations of depression challenging. This theoretical foundation acknowledges the inequities teens have faced regarding mental health support and attempts to reduce the gap between research and practice.

The setting for the intervention is another strength. Considering that a significant portion of teens attends school, hosting an intervention on campus dismantles accessibility obstacles significantly. Holding group meetings during school hours for free promotes equity in accessing treatment options. The group format in particular bolsters community building and peer connections, which research pointed out as a protective factor for teen mental health. The multitude of benefits that the school setting and group format inherently provides is in and of itself a part of the treatment and social justice initiatives.

Mindfulness in CBT still needs to be utilized, even in school settings. Introducing mindfulness to teens at this impressionable age may facilitate the progression of self-discovery, self-care, and overall positive decisions. Mindfulness has been shown to provide long-lasting benefits, beyond the therapeutic setting. A tool that can be independently incorporated into daily living prolongs the impact of therapy and maintains progress made.

Limitations of the Proposed Intervention

As with every devised plan, there are limitations and assumptions made along the way. The first limitation is the population itself. Teens may not be willing to be vulnerable and open in a group setting. There is tremendous stigma and shame about mental health challenges. This could heavily impact the recruitment of the group. Despite the optimistic title, attracting members to the voluntary counseling program is unlikely to be popular. Additionally, teens have a more limited awareness and practice of their mental health status and may be hindered in accurately assessing their feelings and moods as an issue. The role of families and obtaining parental consent is another obstacle in accessing mental health care in some cases.

Another major limitation of the proposed intervention is the difficulty in measuring the effectiveness and impact of this program. This specific protocol has not been validated or studied in a lab or real-world setting. The clinical interpretation of impact and significance has not been examined or practiced yet. Finally, the limitations of school-based counseling are apparent in current individual counseling practice as well as proposed groups. Although groups can reach more students, it does not imply that group counseling is not superior or more effective in treating depression in teens.

Clinical Implications

There is still a looming gap in the research that fails to critically examine the systemic barriers to successful mindfulness intervention. Implementation of mindfulness therapy is an integral aspect, and it is often overlooked in the research. An article by Ennis (2018) reveals that biases of the facilitator can impact the effectiveness of mindfulness training. Specifically, Ennis insinuates that undetected bias needs to be considered in mindfulness research because the cultural context of the administrator and the client population matters (Ennis, 2018). A lack of meta-analyses is also linked to this issue of measurability and operationalized variables because of the fluid nature of the variable of mindfulness. As the topic of mindfulness as a therapeutic intervention soars in popularity, there is a noticeable trend of defining and developing mindfulness treatments differently based on researchers' personal experiences, as noted in a meta-analysis of mindfulness conducted in 2014 (Zoogman et al., 2014). The limitation is rooted in a lack of clarity and cohesion across disciplines when it comes to defining mindfulness and the dependent variables of interest.

Furthermore, mindfulness has often been studied without consideration of systemic oppression. Similar to the point that Ennis (2018) touched on, the Westernization and commodification of mindfulness have leaked into researchers' biases in devising hypotheses, methodology, and drawing conclusions. The research components of studying the problem and implementing interventions have both failed to incorporate diverse samples (Chin et al., 2019). The mindfulness revival has also been dominated by white people in public discourse and in the literature. This raises questions about applicability and generalizability when expanding therapeutic approaches to diverse communities involving the currently shared understanding of mindfulness. Furthermore, mindfulness is not accessible to many marginalized communities

because of the cost and location. Health and wellness spaces are not developed and localized in communities that are oppressed.

There are quite a few assumptions that this niche topic is generating in its discussion of limitations. A common assumption made by researchers and practitioners alike is the notion that clients want to practice mindfulness if exposed to it, and that the long-term goals of mindfulness interventions accomplish the goals that the client wants to achieve. Both of these assumptions can hinder the development of mindfulness interventions as well as the implementation of the practice.

Suggestions for Future Research

Adults creating interventions for teens must take student perspectives into account to cohesively design a program that works towards the goals of the clients themselves. Researchers may want to integrate methodologies such as conducting focus groups, interviews, and mass surveys to identify underlying causes, manifestations of symptoms, and desired goals noted by the population. From there, protocols can be created and developed to fully meet the developmental needs and symptomatology criteria. Additionally, researchers and practitioners of varying disciplines, perspectives, and cultural backgrounds would greatly benefit the literature and those receiving the intervention.

Conclusion

In summary, this rapidly growing topic demonstrates hope that Eastern and Western practices may be stronger together. Mindfulness interventions may become a commonplace therapeutic approach across populations, theoretical orientations, and healing modalities. As it is a newly studied phenomenon in Western research, a mindfulness intervention that can be

replicated and generalized beyond the initial sample holds the potential for effective and nuanced mental health treatment for high school students.

Chapter I described the problem of depression in the teenage population as well as the theoretical framework to conceptualize the problem. Chapter II covered the literature review on current treatment options for depressed teenagers as well as current approaches to mindfulness therapy with young people. Chapter III presented the proposed intervention and its application to decrease the client's depressive symptoms. Lastly, Chapter IV concluded the project with the outcomes, discussion, and future directions for research on teen mental health and mindfulness in psychotherapy.

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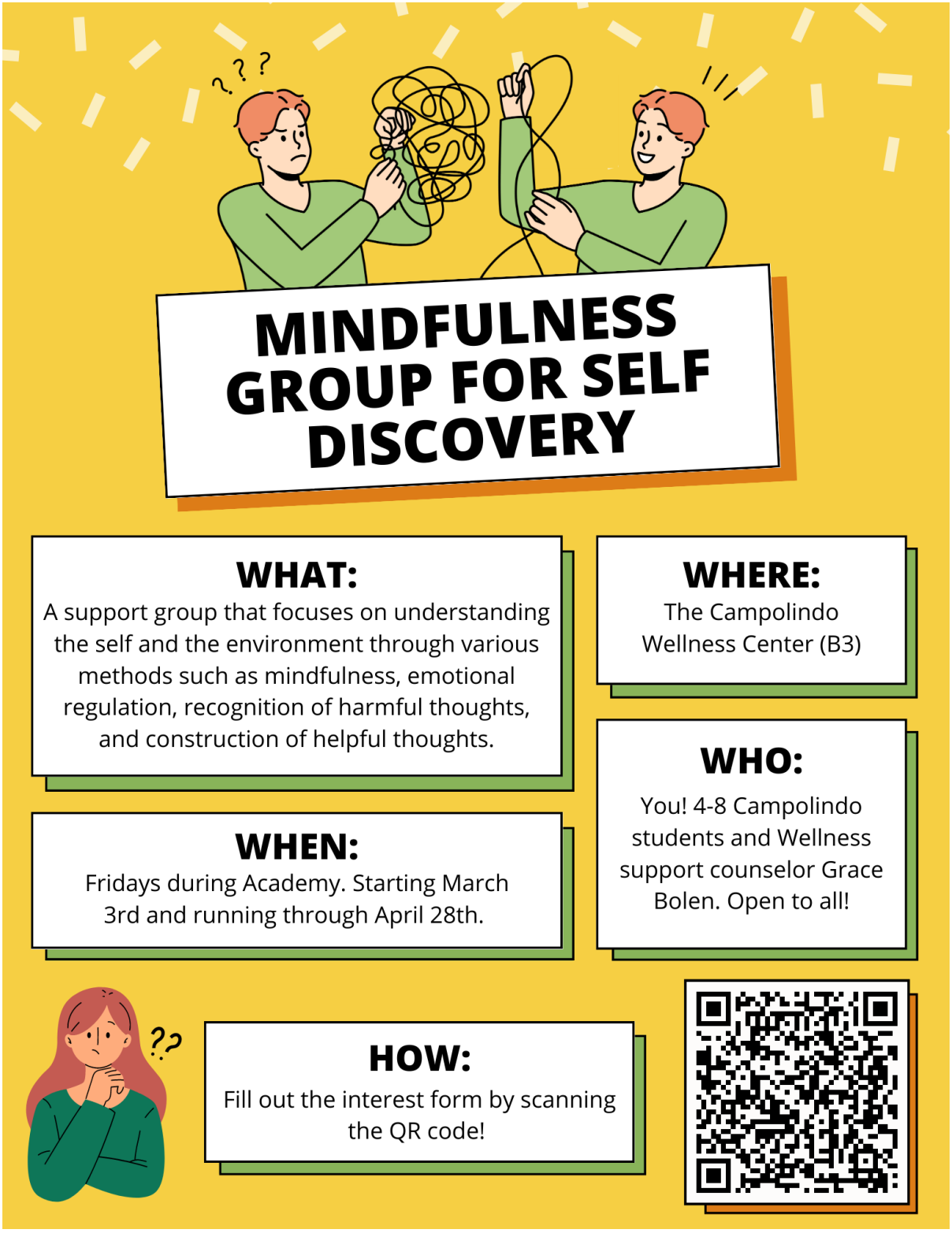
Appendix A

Recruitment Flyer



Appendix B

Sample Informed Consent

Informed Consent for Group Therapy

Modified for Grace Bolen, an MFT trainee (Supervised by an LMFT)

Group Therapy Overview:
Group therapy is a process in which the therapist and group members discuss a myriad of issues, events, experiences, and memories for the purpose of creating positive change so members can experience their lives more fully. This group primarily focuses on mindfulness-based and strengths-based cognitive behavioral therapy as treatment.

Meeting:
This group will meet on Fridays during Academy starting March 1st and ending May 15th. There are no fees. The group will meet at the Wellness Center on campus. Sessions may be held on zoom with advanced notice and the therapist will communicate with the members if an online transition is necessary. If you need to cancel please give at least a 24 hour notice. Notice is required, even if the meeting is less than 24 hours away. All cancellations must be communicated through phone or email.

Participation Risks:
Group therapy is often beneficial to well-being, however, participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings, and experiences, with a specific focus on depressive symptoms. It can cause distress or harm in extreme cases. The participant has the right to not disclose personal information and maintains the right to not participate in any activity. The member is responsible for talking to the leader if any issues with the group process arise and impact the overall experience.

Confidentiality:
All information disclosed within sessions is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. The participant's confidentiality is held under FERPA. The group leader cannot guarantee confidentiality to be held by other participants.

Limits of Confidentiality
Those situations include but are not limited to:

- As a supervised trainee, I'm required to consult cases with my supervisor on a weekly basis to ensure best practices
- When there is reasonable suspicion of abuse to a child or to a dependent or elder adult
- When the client communicates a threat of harm to self, others, or knowledge of another person wanting to harm the client
- When there is a violation of Title IX
- When disclosure is required in a legal proceeding

- Lastly when the client gives explicit permission to relay information to noted parties, either verbally or in writing

Group Confidentiality

- Although the therapist maintains confidentiality, it cannot be guaranteed that group members will abide by the agreement of confidentiality. The community agreements and group norms require confidentiality, however, a breach of personal information is possible. Please keep this in mind as a potential risk to group therapy.

Minor Consent:

According to California policy SB534 passed in 2011, minors under the following circumstances can consent to mental health services without parental consent.

- Minor is age 12 or older
- Minor can intelligently participate in treatment
- The therapist deems it inappropriate to contact parents/guardians or communication attempts have been left without a response

Best practices for the therapist, Wellness Center, and the school highly encourage parental consent.

Termination:

Ending therapy is a vital aspect of the therapeutic relationship and process. The therapist reserves the right to terminate treatment at their discretion. The clients also maintain the right to discontinue therapy and withdraw consent at any time. If termination is decided as the proper course of action, appropriate referrals and recommendations will be made.

Substance Use & Violence Zero Tolerance

Clients cannot participate in the group under the influence of alcohol or other mind-altering substances (apart from prescribed medications). Violence or violent threats made in the group will not be tolerated and will be reported appropriately.

I certify by my signature below that I have read, fully understand, and agree to abide by the stated policies.

Signature of Student	Print name	Date Signed

Signature of Parent	Print name	Date Signed