MOURNING DEPRESSION IN TEENAGERS

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Abstract: The article discusses the causes of adolescent depression, and analyses a case of depression resulting from grief caused by loss. Depression after a loss can be treated through a combination of cognitive-behavioral therapy, positive psychotherapy, autogenic training and medication for a period of minimum 6 months. The previously mentioned therapeutic strategies are efficient in diminishing the intensity of the symptoms. They also favor personal growth, the development of self awareness, as well as the positive modification of adaptive cognition processes.

Keywords: depression, therapeutic plan, self-monitoring, behavioral experiment, behavioral prescriptions, autogenic training.

INTRODUCTION: Depression is an affective disorder which may appear at any age and may have repercussions on the adaptive capacities of a person. In adolescence, the risk of complications caused by depression is very high, especially in the case of mourning depression.

The objective of this work is the description of a therapeutic plan structured in sessions containing methods and techniques such as cognitive-behavioral therapy, positive psychotherapy, neuro-linguistic programming and autogenic training. Every session is described with the objectives and intervention techniques used. Self-knowledge and personal development of the patient are main targets of the therapy. Therapeutic intervention emphasizes the active participation of the patient in structuring the sessions by self-monitoring and his collaboration with the therapist in choosing the techniques.

In adolescence, the causes of depression are multiple. They include biological factors as well as hormonal changes, communication deficiencies with parents, mono-parental family, negative behavioral patterns, social and economic difficulties, abusive consumption of alcohol and drugs. Other factors are the fragility of the psychological structure and the difficulties in choosing the most important life goals.

Depression can take various clinical forms and intensities - mild, moderate, severe - suicidal behavior being the major complication. It may be associated with a variety of psychopathological disorders, and irrespective of the clinical and evolutionary particularities, it requires early diagnosis (1).

Depressive symptoms are highly polymorphic and include affective, cognitive, behavioral, somatic and relational symptoms, which in most cases determine the decrease in self-esteem, feelings of loss and self-depreciation. These are the reasons why an elaborated therapeutic approach is required.

The most useful therapeutic formula combines medication and psychotherapy. Mild forms of depression can be approached with psychotherapeutic techniques such as CBT, positive, alderian, psychodynamic psychotherapy, hypnosis, and systemic strategic psychotherapy.

When the clinical picture clearly suggests a shortage of neurotransmitters, drug intervention is recommended. The most complex and lengthy therapeutic strategies are necessary in the case of depression caused by major psychotrauma, especially in cases of pre-morbid predispositions or adaptive difficulties.

In adolescence clinical and evolutionary aspects of depressions may often be confused with the psychological peculiarities of the age. Hypersensitivity, affective and self-image instability, alternation between stubbornness and suggestibility, nonconformity, and selective sociability may influence the onset and evolution of depressive states. They can also increase the risk of suicide considered the major complication in depressions.

In teenagers, the mourning reaction shows a specific depressive symptomatology. Thus the teenager experiences profound unhappiness, anxiety manifested through bouts of anger towards family members, and sleep and appetite disorders which can last for several months. Other associated manifestations are self-blaming and self-depreciation, the decrease in school performance and in interpersonal relationships.

In time, the evolution of the state of the patient is usually a favorable one, but there is a tendency to believe that if a teenager suffers from mourning depression, when he become an adult he is more prone to mental disorders.

The following discusses the case of a teenager suffering from depression after mourning the loss of his mother for an extended period.

CASE: M.T. 17 years old, severe depression

The child's father comes to the psychologist very concerned that his son does not study any more, has absences from school, smokes, is sad, isolates himself in his room. He has joined a neighborhood gang, has verbally and physically assaulted his baby sister, is messy and does not take care anymore of his personal hygiene.

Case description

M. T. shows up for consultation with a sad face, slouching, a lost gaze, dressed sloppy, smelling of cigarettes. During the interview, the young man shows motor agitation (kicks, shifts a lot in the chair, asks if he may smoke), avoids eye contact, sometimes stutters, says he feels lost, avoids eye contact, sometimes stutters, says he feels lost, avoids eye contact, sometimes stutters, says he feels lost,
cannot find his balance, his place, says that everything seems pointless, and sees an uncertain future. He has trouble sleeping, cannot eat, smokes a lot, no longer likes school. His only joy remains football and his new friends, with whom he goes out clubbing every night. He admits that he does not get along with his family anymore, and that he recently broke up with his girlfriend. He says his mother died a year ago and he has still not recovered from it. He has also recently broken up with his girlfriend. He frequently quarrels with his father, bullies his baby sister and ignores her most of the time. In the last 4 weeks he has had conflicts with colleagues (he fought at school) and has been punished with a low conduct mark. He wants to recover, to be again the diligent and composed boy, but does not know how to do it. He feels like he is losing control and is afraid of going crazy, also because he's worried about his condition and is ridden by feelings of guilt. He thought about suicide but has been afraid to go through with it.

**Working hypothesis:**
His mother's death and break-up with his girlfriend have activated MT's beliefs regarding his value as a person. These events have triggered on one hand a state of sadness and avoidant behaviors, and on the other hand, periods of conflict, quarreling and physical aggressiveness. The decrease in both the quality and quantity of his social relationships and activities feed his depressive symptoms and enhance his fragile self-esteem. In view of all these peculiarities, the treatment plan must include a two-fold approach, the remission of depressive symptoms, and the recovery of self-esteem and positive social relationships.

**Identification of personal resources:**
The contextual factors, that is, the people from his entourage who can help him, are: a compassionate father who is eager to help him, friends and schoolmates who want to help, and his homeroom teacher who is interested in his recovery.

The personal factors which can play a positive role are: a high IQ (128), his ability to tolerate mental discomfort, perseverance, ability to adapt to different situations, strong will to change, a pleasant manner of interrelating and communication skills. All these are discovered and discussed with the patient during therapy sessions.

Predisposing factors that have predisposed the mourning reaction are: automatic negative thoughts "I am not good enough", "I will not succeed," isolation and loneliness tendencies.

Favoring factors that have accelerated the depressive moods are the negative influences of the friends from his entourage.

**Diagnosis on 5 axes (3)**
- **Axis I (mental disorder/disease):** Major depressive episode (Beck, score 30);
- **Axis II (disorder in the personality aria):** Dependent personality disorder, with bouts of aggressiveness;
- **Axis III (medical):** nothing;
- **Axis IV (social):** stressors of moderate and high intensity - group of friends, teachers' criticism
- **Axis V (Global Assessment of Functioning GAF):** 65

**Cognitive and behavioral changes**
1. Setting the objectives (it is performed together with the patient)
   a) General objectives are referred to:
   1. Detection of automatic negative thoughts and replacing them with alternative thoughts/cognitions.
   b) Specific objectives regarding the following goals:
   1. To accept his mother's death and break-up with girl friend
   2. To quit smoking
   3. To reduce anxiety
   4. To be able to rest and focus
   5. To give up conflicts and have harmonious relationships with his family and classmates
   6. To go to school
   7. To quit the delinquent group he has joined and going clubbing
   8. To improve school participation and performance
   9. To be more responsible

The main problems determine the ones on the surface.

**II. Accomplishing the therapeutic plan**
In accomplishing the therapeutic plan, we focused on the cause-effect, meaning that while the cause could not be changed (mother's death, break-up with girlfriend), the effects can be changed (smoking, aggression, isolation, insomnia, skipping school) in parallel with the processing of negative emotions related to loss. In determining the therapeutic plan, the opportunity for the patient to get involved in solving the tasks has been taken into account. The problems are dealt with in the order of priority, of their significance to the patient. Each problem was analyzed, searching the causes, the circumstances in which they occur and the consequences. After analyzing each problem, we worked simultaneously on several issues, in the patient's order of priority.

**Methods and procedures:**
CBT, positive psychotherapy, and autogenic training have been used. Throughout the therapy the patient had to keep a journal for his mother and at every session he was given a homework with an objective, so that at the next session we could work on the results of the homework.

The techniques used considered the patient's ability to communicate and his good intellect. Thus, behavioral experiments, behavioral prescriptions, therapeutic dialogue, role playing techniques were used.

**III. Sessions structuring (therapeutic plan)**
Session 1 had as an objective a mutual acquaintance and self-knowledge and feedback. This exercise has both the role of acceptance, honesty and respect. A role play in which each of them expresses an opinion that they occur and the consequences. After analyzing each problem, we worked simultaneously on several issues, in the patient's order of priority.

Introducing each other supposes empathy, mutual acceptance, honesty and respect. A role play in which each exposes their good and weak sides is used, then the tables are turned when each of them expresses an opinion that has made about the other. In the end each may be like a character in a novel or film, in order for the introduction to become more interesting. This exercise has both the role of mutual acquaintance and self-knowledge and feedback.

Session 2 has as an objective getting to know the patient. The patient is assessed through projective tests, Beck's inventory, standard Raven and WISC tests.
The Family Drawing Test shows low self-esteem. Although his mother died, she appears in the drawing above the other characters, there is also a cross and a footpath. His father is depicted as a monster, and the patient appears isolated from the other characters. Above there are clouds and raindrops, and in a corner there is the sun which represents hope.

The Tree Test reveals a complex personality, a strong temperament, with tendencies towards adventure and novelty, sinuous and lonely, which hides something - the tree is hollow and has stumps.

Beck's Inventory reveals a mild to severe depression which indicates the patient should take medication treatment for appeasement and sleep regulation for a period of 4-6 months, combined with the mentioned therapies.

IQ testing by samples belonging to WISC and the standard Raven test show an IQ of 128, which demonstrates that the patient has a good adaptive ability and information processing ability. In conclusion, there may be chosen therapy techniques based on reasoning, involving intelligence, memory and attention were chosen.

Session 3 had the objective of establishing a therapeutic contract.

The therapist explains the cognitive and affective aspects of the diagnosis and the therapeutic plan to the patient, and a therapeutic contract is drawn up and signed by both parties.

**Therapeutic Contract** (4)

Concluded today, between and psychologist

I, undertake to respect and follow the decisions taken together with the psychologist, to do my homework given during the therapy sessions and follow the treatment exactly as prescribed by the doctor, without skipping doses, not interrupting it without the doctor's knowledge and by my own decision, and in the case of changes related to my condition, to tell immediately the doctor and the psychologist. Also I commit to myself, to my family, to friends and to the psychologist not to have any suicide attempt during treatment and therapy or after it ends.

I, psychologist I commit to to respect the code of ethics regarding the psychologist profession related to privacy and to ensure a quality service to the client, respecting his personality, ideals and not interfering at all in his development and evolution, but to guide him to find his own way in life using his own qualities and in compliance with his ideals and wishes.

Date

Client's signature

Psychologist's signature

Session 4 had as an objective drawing up the list of problems
A list of problems is set and prioritized together with the patient. The final list contained:
1. Mother's death and girlfriend's break-up
2. Smoking
3. Sleeping problems and lack of concentration
4. Conflicts with family and friends
5. Disinterest for school and skipping classes
6. Postponing assignments
7. Difficulties in interpersonal relationships and isolation

Together with the patient, a multilevel analysis of the problems was performed thus: (5).

Behavioral level (what he actually does): isolates himself, smokes excessively, fights with the others, skips school.

Cognitive level (what he thinks): "I no longer have control over my life"; "I want to make a change, but I don't know how", "I'm tired of the life I live".

Subjective level (what he feels): sadness, anger, worry, fear, blame.

Physiological level: excessive sweat and palpitations when confronted with conflicting situations.

At the end of the session he received a homework, which lasted throughout the entire therapy, and besides this homework he also had other things to do for each problem. The permanent assignment was to keep a journal for his mother, in which he had to write to his mother beautiful thoughts, stories from childhood that reminded them of her, everything that he would have wanted to say to her and did not, everything that he would have wanted her to know about him. The journal stayed open throughout the entire therapy and afterward.

Session 5 had as an objective managing the feelings related to his mother.

All the aspects of his journal writing were discussed. The patient's emotions were directly confronted and the patient was encouraged to recognize and explain them and their causes.

Quotes from the journal: "I know I was wrong and I'm sorry. My biggest mistake was starting to smoke and when we fought about it you told me I was wrong, but I did not want to listen to you. I got angry because I felt misunderstood, but you were right."

"I miss your cherry cake and even the days when you criticized me saying that I wasgrumpy and things won't go well for me if I disregard everyone's opinion."

"I remember when I was 4 and we went to the seaside and you were lying on the beach with open arms and said to me: "Who comes to mom? And I ran to you and then I entered the water. You wanted to teach me to swim and I was afraid. See, now I will have to go to a swimming course."

"You know going to school is no longer as it used to be. When you were nagging me all day, I used to learn also because I was afraid of you. Now my heart is no longer in it. I wonder if I pass the class."

"I think you would wish for me: to finish high school with honors and graduate; to go to a good college, you always used to talk to me about going to medicine university; to be a champion at football; to help dad with house chores; to take care of my sister; to become a responsible man and showing good judgment."

This session had a strong emotional charge. It was important for the patient to manage some emotions and unresolved issues related to the relationship with his mother and to leave mentally stable.

This type of session was repeated, inserted between the other sessions when the patient felt ready to face again an encounter with the emotions related to his late mother.

Session 6 had as an objective managing the feelings related to his girlfriend, to the break-up (managing the feelings of loss).

Methods used are discussion/dialogue and autogenic training.
Discussion focused on the journal and the letter he received from his girlfriend at the time of their break-up. He was encouraged to tear up and throw away the letter, throwing away with it all the resentments and fears about the relationship. Thus, he could obtain an emotional detachment from his girlfriend and start the process of forgiving her for having abandoned him after the death of his mother. He was advised to do a daily exercise related to his ex-girlfriend such as repeating in his mind several times the following phrase: "I, T., forgive you, C., for all you have done to me. I forgive you and release you.", until he felt that he forgave his girlfriend for the break-up in their relationship.

He was also told to make a list of all the qualities he wanted in a future girlfriend, and decide on a period when he would want to meet her- neuro-linguistic programming. He would keep the list and review it whenever he felt the need and was relaxed.

Session 7 had as an objective fighting smoking.

His homework was to continue writing in his journal and make a self-monitoring grid regarding smoking. The techniques used were behavioral experiment, behavioral prescription, conversation and autogenic training.

Every time he got angry he would smoke a cigarette which calmed him down. During treatment he replaced the cigarette with drops and learned to control his anger by anticipating the moment of irritation, being aware of the symptoms and seeking alternative methods for relief.

A behavioral experiment is performed where the patient is challenged to light a cigarette, then he is taught to recognize his symptoms, record them, anticipate them and replace the cigarette with drops.

He was also given several behavioral modification suggestions to reduce the number of cigarettes. Thus, every day he reduced the cigarette consumption by one cigarette. When he wanted to smoke he replaced it with a mentholated drop. He also bought a few cigarettes instead of a pack, and for a single day at a time. His father was asked not to give him large amounts of money so he would not be able to buy "secretly" more cigarettes. The patient also assumed the responsibility not to borrow from friends.

At the end of each session autogenic training was introduced in order to teach the patient to relax. He was encouraged to communicate with others and engage himself in group activities.

Session 8 had as an objective discussing the conflict situations in his entourage and reducing their number and intensity.

The following techniques are used: conversation, relationships map, behavioral prescriptions.

A map of the patient's relationships is drawn up followed by a discussion of its disturbing factors, and ways of saving them. The goal is for the patient to acknowledge the real cause of these conflicts, in a reasonable manner and to want to rebuild the damaged relationships by taking a fair and objective stand on them.

The techniques used were therapeutic dialogue, therapeutic exercise, behavioral prescriptions and autogenic training. The therapeutic methods regard the positive and negative reward.

Discussion during this session focused on the self-monitoring grid regarding school activity and finding the causes for his absenteeism. The fear of failure and of receiving low grades are the most important. The patient made a list of positives and negatives related to his group of friends, concluding that the negative influence was dominant and was also a cause of his attitude toward school.

The behavioral agreement was to avoid skipping classes and keeping away from his friends for a week at a time. The ultimate reward was that if he succeeded to do this for a whole month, he would go on a trip organized by his father.

We also drew up an "Addendum" to the Therapeutic Contract in which he committed not to skip classes anymore and not getting together with the neighborhood group anymore. In case he broke the agreement, his laptop would be taken away and he would lose his pocket money for a month.

These exercises were designed to help the patient realize that he was responsible and in control of his own life.

At the end of the session autogenic training was performed in order to learn to relax.

Session 10 had as an objective fighting self-isolation.

The techniques used were therapeutic dialogue, behavioral prescription and autogenic training.

As a result of all the techniques, the patient came to understand conclusion that he isolated himself because he felt ashamed of his situation. He isolated himself especially at school to avoid discussions about girlfriends, when he felt nostalgic about his late mother, and when he could no longer cope with the situation.

He was encouraged to communicate with others and engage himself in group activities.

This session also ended with autogenic training.

Session 11 had as an objective fighting procrastination.

The techniques used were: therapeutic discussion, behavioral exercise, behavioral prescription and autogenic training.

During discussion, the patient realized that his procrastination was caused by fear of failure in performing the task.

The behavioral exercise which consisted of the patient saying repeatedly to himself "I must do it now", improved his self-control.

The reward for this modified behavior was to spend a night out in the company of his family.

At the end of each one of these therapy sessions, the homework consisted of journal writing in preparation for the issues to be discussed in the following sessions.

Throughout psychotherapy, the patient also received pharmacological treatment with Sertralin, Alprazolam, Zolpidem, Ginko Biloba, and multivitamins in moderate doses during the first weeks of the three months long treatment, and in low doses in the second half.
RESULTS

Subsequently to the therapy sessions we obtained the following results: the patient made an orderly schedule of life and school; gave up the group from his neighborhood, and increased his school performance. He met a new girlfriend, became neat and pedantic, and quit smoking. His many new friendships were based on school interests and hobbies, and he decided to go to medical school. The relationship with his father and sister became positive, and he discovered new hobbies such as photography, painting, skiing, swimming and travel in his spare time. He also passed the English Cambridge exam. He decided to make a family album and intends to write a book about his mother.

CONCLUSIONS: The results of the therapeutic plan were positive. The emotional and behavioral problems diminished and the maladaptive cognitions were replaced with adaptive cognitions.

When treating teenager depression it would be good to consider both the individual particularities of the teenager as well as the specifics of the case, and to combine techniques from various psychotherapeutic approaches.

REFERENCES:

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