

# Understanding Subjective Depressive Experiences of Adolescents: Its Implications to Intervention

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## Abstract

Subjective experiences of depression are easily ignored by professionals in working with adolescents with depression. Professionals may only diagnose and label rather than listen, understand and communicate these subjective experiences. In this paper, the writer asserts the importance of the subjective experiences of adolescent clients with depression in intervention. All these experiences influence the expression, communication and coping of clients in facing their depression. The writer suggests ways to reconstruct the subjective experiences of adolescent clients with depression. Based on this, the writer constructs a model in intervention with adolescent clients with depression.

## Key words

Adolescent depression; Subjective experiences

## Introduction

Adolescent depression has long been a problem in our society.<sup>1-3</sup> Internationally, according to adolescents' self report, about 20% to 35% of boys and 25% to 40% girls experienced depressed mood.<sup>4</sup> In Hong Kong, by means of the Depression Self Rating Scale, a local survey on 3,786 adolescents in schools in 1992 showed that about 31% of adolescents suffered from depressed mood or episodes.<sup>5</sup> Comparing to adult depression, adolescent depression tends to have less differentiation in manifestation of depression symptoms. Also, adolescents with depression usually have a wide range of comorbidity of other disorders such as anxiety disorder, conduct disorder, personality disorder and substance abuse. There are various perspectives in interpreting the course of adolescent depression. The biochemical perspective stresses that there is a deficit of neurotransmitters which may lead to depression. Imbalance

of serotonin may produce many of the common symptoms of depression such as increase in sleep problem, irritability and anxiety. Similarly, an improper amount of norepinephrine produces fatigue and depressed mood.<sup>6-8</sup> The cognitive perspective stresses that predisposition is created during childhood. The individual develops a negative self-schema in his or her childhood. This refers to a tendency to view oneself, the environment and the future in a negative way.<sup>9</sup> The behavioural perspective asserts that adolescents with depression do not possess enough operant behaviours to seek rewards or reinforcements. They do not develop adequate self-regulatory processes in handling stress.<sup>10-12</sup> The developmental perspective formulates that adolescents' depression originates from the loss of self-esteem and intensification of the confusion in identity formulation.<sup>13</sup> The psychodynamic perspective affirms adolescent depression is caused by problems in mother-child attachment. Bowlby (1973) describes that depression appears in a form of despair when a child responds to the loss of the mother.<sup>14</sup> Winnicott (1965) says that depression involves a mental mechanism of introjection of the mourning of the lost object.<sup>15</sup> While all these schools of thought tend to anchor various platforms to analyze and interpret depression and facilitate diagnosis and intervention, they do not play enough attention to the subjective experiences of depression faced by the adolescent

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clients. Very often, a continuous ignorance of clients' subjective experiences of depression may easily lead to an objective fixation on cause and effect, problem and solution as well as confusion and control in perceiving and dealing with depression in adolescent clients. In this paper, by means of case illustration, the writer asserts the importance of the subjective experiences of depression faced by adolescent clients. Ways to re-anchor the subjective experiences of depression in understanding and intervention of adolescent clients are also suggested.

### **Subjective Experiences of Depression in Adolescents: Importance and Neglect**

Depression is far more complicated than a group of symptoms or a diagnosis. Donahue (2000), according to her own experiences in depression, asserts that depression is a totality of self during that episode of time.<sup>16</sup> It is difficult to describe and to be understood by others. Karp (1996) also affirms that the inner experiences of depression are too complicated to describe to others.<sup>17</sup> Karp is a sociologist who has suffered from the depression disorder for more than twenty years. According to his full narration of own experiences,<sup>17</sup> the subjective experiences of depression can be roughly described into five areas. They are the subjective experiences and feelings:

1. of depression symptoms;
2. of depression diagnosis and label;
3. in treatment and rehabilitation;
4. in others' perceptions; and
5. of the cause of depression.

All these five areas of subjective experiences and feelings are related to one another. By means of case illustration, the writer describes these subjective experiences in detail.

#### **I. The Subjective Experiences of Depression Symptoms**

Adolescent clients are accustomed to describing their depression symptoms, especially their feelings of fatigue, sadness, frustration, meaninglessness and senses of loss and guilt. Below is the self-narration of a Chinese female adolescent in Hong Kong, A.

*'I feel thoroughly exhausted, everyday I wake up I do not want to go to school. I have a feeling of being swallowed by my inner heaviness and loneliness. Life seems to be meaningless. Sometimes, I want to die or*

*hurt myself so as to escape from my endless sense of emptiness.'*

Facing all these types of subjective experiences of depressive symptoms, many professionals may only try to diagnose rather than empathetically listen to or understand them genuinely. Diagnosis concerns the form of related symptoms. In making a diagnosis, professionals have to fit the depressive experiences of clients into related categories of symptoms. In empathetic listening, professionals have to be concerned with the details and contents of the clients' depressive experiences. A professional with a diagnostic mind may only care about the sense of fatigue, sadness, and loss of interest in daily activities. A professional with an empathetic ear may go into the details – when, what, how, to whom, under what conditions and in what context the sense of fatigue, sadness and loss of interest in daily life occur.

#### **II. The Subjective Experiences of a Depression Label**

For adolescents with depression, it is really frustrating to accept the label of "a depression patient". The label implies that they have to be dependent on antidepressants. The label confirms that they are weaker than others or they have done something wrong that make them become mentally ill. The label concurs that they are incompetent in social functioning. This label is really threatening for the adolescent clients who should be energetic, developmental, and fast growing. B, a Chinese female Chinese adolescent client voiced out the following frustration in facing her label as a patient with depression.

*'I was really frustrated by the diagnosis given by my psychiatrist. I knew that I had something wrong in my mind and my body. But to be mentally ill is another matter. My psychiatrist and my social workers confirmed that I suffered from depression. I needed anti-depressants. I had a lot of worries. I was afraid that I had to depend on medication for my whole life. I was anxious that my mental illness would make me unable to finish my secondary school education.'*

Facing all these subjective experiences of the depression label of the adolescents, a caring professional may have to comfort the adolescent clients by affirming their strengths, developmental needs and concerns. However, an uncaring professional may easily push the clients to cast their hope of recovery totally on medication. If they fail to comply with medication, they may be labelled as non-compliant

patients who needed close supervision in taking medication. The role of the professional would confine to pushing, supervising or threatening clients to accept both the "depression patient" label and the medication.

### **III. The Subjective Experiences of Others' Perception**

Adolescent clients with depression are very sensitive to the labelling and stigmatisation by others. The feelings of being labelled as "depression patients" always intensify their sense of frustration and self-blaming mechanism. The following self-narration from a Chinese male adolescent client, C, can show this type of painful experience.

*'Indeed, it is very painful for me to admit that I am a depression patient. My classmates label me as a 'dead log' or 'crying baby'. I am furious at their labelling. But I cannot do anything. My teacher knows that I am a depression client. Some come and show concern to me. Some gossip behind me. Some of my close friends begin to separate from me saying that they do not know how to tackle me. They are afraid of my potential 'danger' of being insane or crazy. Some fear that their words may provoke my committing suicide. The feeling of having a depressive mood is already dreadful. But the perception of others towards a depression client is even more dreadful and unbearable. I do have an impulse to jump from the top floor of the school to end all these unbearable struggles and labelling from others. Indeed, I am hopeless and worthless.'*

Managing an adolescent faced with all these labelling and others' perception, many professionals may only remind the adolescent client with depression to bear the unbearable social environment by cognitively restructuring the negative comments to positive regards. They may ignore the oppressive and demoralising social environments faced by adolescent clients with depression.

### **IV. The Subjective Experiences of Cause**

Clients with depression may easily track back their causes of depression by attribution to events or loss happening in their past.<sup>14,15</sup> Unresolved introjection of loss always produces anger and hatred feelings towards oneself and others. The fixation on loss and anger always intensifies the clients' feelings of helplessness, worthlessness and meaninglessness. Perhaps the following self-narration from an adolescent client, E, may demonstrate the impact of these subjective experiences.

*'I was very angry at the leaving of my mother. She was such an irresponsible woman, dumping three children to meet another man in Canada. I hate myself also. My father said I was an unlucky girl bringing bad fate and misfortune to my family. Ever since I was born, my uncle, grandfather and elder sister died of accidents and cancer. My mother went away partly because I was so sick that my mother found it hard to look after a sick girl and two young children only two and four years old. My body was weak and my academic work always lagged behind others. I was hopeless.'*

Instead of helping adolescents to ventilate introjected anger constructively, some professionals may simply classify this as symptoms that require drug treatment. The impact of the antidepressants may lessen the low ebb of negative emotion but may not be able to resolve all the unresolved anger.

### **V. The Subjective Experiences in Treatment and Rehabilitation**

The subjective experiences in treatment and rehabilitation are easily neglected by professionals in the process of intervention. Very often, frustrating experiences in the process of treatment and rehabilitation may simply intensify the clients' feeling of helplessness, worthlessness and meaninglessness. Frustration in treatment may be caused by the institutionalised hospital setting or by professionals or workers with apathetic attitudes. The following narration from a Chinese adolescent client, F, may demonstrate the clients' feeling in this type of experience.

*'I was so frustrated by the poor result of my examination. I went to the top floor of the school and wanted to jump down. The whole school was alarmed and then I was hospitalised in a mental hospital. The treatment process was frustrating. I was forced to put on a restrainer jacket. It tied me down on my bed as a means to prevent my suicidal gestures. The more I complained that I was unfairly treated, the more I was regarded as mentally unstable and the more I was tightly restrained. After two days' struggle, I was totally worn out and the injection made me sleepy and inert. I finally admitted that I was sick and mentally ill. I was a patient with a major depression disorder and suicidal tendency. I began to keep deady quiet and refuse to communicate to*

*any professional concerned. I hated them, they were apathetic to my feelings. Frankly speaking, the unpleasant experiences in the mental hospital made me feel totally helpless, worthless and meaningless.'*

Yip's (1995) study shows that under the institutionalised mental health service setting, not only clients are institutionalised, professionals are easily institutionalised to the extent that the need of the institution is far more important than the clients' rights and feelings.<sup>18</sup> Within a highly institutionalised setting, clients are highly suppressed to the extent that their institutionalised nature, such as inertness, passivity, withdrawal and chronicity, hinders their motivation to recovery far more than their mental symptoms.<sup>19,20</sup>

## **The Problems in Understanding Subjective Experiences**

### ***Fixation on Objectivity***

The importance of the subjective experiences of clients with depression is undeniable but it is not easy for professionals to acknowledge these experiences because of their fixation on objectivity. That is a fixation on cause and effect; problem and solution, as well as confusion and control in delivering intervention and services to clients with depression.<sup>16,17,21-23</sup> A fixation on cause and effect implies that the professionals are busy to explore, to analyse and interpret the causes of depression, so as to ensure the effects of treatment modalities. A fixation on problem and solution implies that by labelling the problems of clients, professionals propose solutions to cure all these problems. A fixation on confusion means that depression causes confusion to various parties and measures of social control are thus sanctioned. Without an empathetic understanding of clients' subjective experiences of depression, different theories and perspectives, ranging from biochemical to psychosocial theories are only ways to justify the power of the professionals and society to apply medication, hospitalisation, or psychotherapy as effective ways to control clients with depression. Very often, apathetic treatments are justified as solutions by labelling the problems of adolescents with depression. Inappropriate involuntary admission or detention in hospital is legalised by confirming the clients' confusion in depression. As what mentioned in Foucault's (1980) analysis of power, truth and knowledge,<sup>24</sup> in treatment of depression, professionals may

easily rationalise their power to control by claiming that they know the problem and solution as well as the cause and effect of adolescent depression.

### ***The Gap between Objective Fact and Subjective Experiences***

The objective facts of depression and the subjective experiences of adolescents in depression may form an unreachable gap between adolescents with depression and their significant others. Facing the complexity of the above-mentioned subjective experiences, adolescents cannot, or do not want to elaborate their subjective experiences. However, other persons only observe the manifestation of depression symptoms in forms of deficits in self-motivation, self-control, positive thinking, social functioning and interests in daily life. All related parties try to interpret them by means of their 'objective interpretation'. Psychiatrists diagnose all these as 'symptoms'. Psychotherapists assess them as problems. The adolescents' teachers and parents may label them as confusion. All of them want to do something about the adolescents' depression, yet, without an empathetic mind and genuine understanding. Psychiatrists assert medication for symptoms and illness.<sup>17</sup> Psychotherapists and social workers affirm psychotherapies and psychosocial intervention.<sup>16</sup> Teachers and parents want to regain control by sending the troubled and confused adolescents into hospitals. Only a few of them try to understand the clients' subjective experiences behind symptoms and problems.<sup>22,23</sup>

### ***Personal Struggle Vs Professional Authority***

Adolescents with depression certainly have a hard struggle against their label, diagnosis and treatment of depression.<sup>16,17,22,23</sup> Apart from frustration in treatment, they always contain hidden anger of being misunderstood and being labelled either as 'biochemical human animals' with no inner experience or persons with failure in self-control. This anger and frustration is due to the unreachable gap between external objectivity and internal subjectivity of depression. Professionals may fail to understand the feelings of clients in facing the label and treatment of depression. They simply assume that they have done the best for their adolescent clients with depression. In terms of their professional authority and training, they assert that they understand depression more than their clients. They come to diagnose, to assess and to treat adolescents' clients with depression. The adolescent clients' subjective experiences of depression are oppressively interpreted as symptoms,

problems or confusion. Facing professional authority and affirmation, some adolescent clients with depression are forced to be subordinate to such diagnosis, label and control. Some may even rebel against adult authority in forms of further confusion and symptomatic manifestation.

## Understanding Adolescents' Subjective Experiences in Depression

### *Causal Understanding and Genuine Understanding*

To bridge this unreachable gap between fixation on objectivity and subjective experiences of depression, professionals may need to understand the adolescent clients' subjective experiences in depression. Jaspers (1946/1963) distinguished two types of understanding, causal understanding and genuine understanding,<sup>25</sup> in working with clients with mental illness. Causal understanding is a search for cause and explanation. Genuine understanding is empathetic listening to clients' feelings and situations with genuine orientation towards clients' subjective feelings and experiences. Hoenig (1991) had a good summary on Jaspers' genuine understanding.<sup>26</sup>

1. We listen to the patient while he describes his experience.
2. We listen to him and question him while we put ourselves in his shoe.
3. It engenders us to bring clearly before our eyes the psychic states which the patients actually experience, and it considers how these states are related to one another.
4. It defines them as precisely as possible, showing how they differ from each other and gives them definite names, that is, it creates a precise terminology.
5. We come to recognise such phenomena in elements of unusual or abnormal experiences.
6. Since we can never perceive the psychic experience of others in any direct fashion, we can only make some kind of representation of them.
7. There has to be an act of empathy, invited by the patient's description of all the characteristics of his experience – including often a description of what is not (26, p. 219).

According to Jaspers and Hoenig's description, professionals' fixation on objectivity may be due to the fact that they attend to causal understanding instead of genuine understanding. They consider searching for causes and

effects, problems and solutions, confusion and control as the only way to understand the adolescents' depression. However, they fail to achieve a genuine understanding of adolescents' subjective experiences in depression.

### *Developing Genuine Understanding of Subjective Experiences*

To achieve this sort of empathetic and genuine understanding, professionals may have to unload their fixated objectivity and recognise that there is still room in understanding the adolescent clients' subjective feelings and experiences in depression. They have to discharge their presumed professional authority and recognise that subjective experiences and feelings are highly individualised and unique for every client with depression. Hoenig's (1991) summary of Jaspers' genuine understanding<sup>26</sup> can be further developed as procedures for professionals to achieve genuine understanding of adolescents' subjective experiences in depression.

1. We listen to adolescent clients while they describe their subjective experiences in depression. We try not to analyse, to explain, or to interpret in our own views or knowledge.
2. We listen to every detail within these subjective experiences narrated by adolescent clients. By doing that we try to put ourselves into clients' own situation – how they feel and how they experience within different psychosocial contexts.
3. We consider how clients' subjective experiences in symptoms, being diagnosed and labelled, being perceived by others, treatment and rehabilitation services and causes are related to one another.
4. These experiences may be regarded as abnormal or even pathological within the eyes of others. However, the labelling of abnormality, deficits, symptoms cannot enrich our genuine understanding. Also such labelling cannot decrease the importance and impact of these experiences on the individual client.
5. These subjective experiences are unique and meaningful to the individual adolescent client with depression.
6. Though with every way of precision, we still have to admit that there is still room we do not understand as these experiences are subjectively felt by clients themselves.
7. Thus, we have to be humble ourselves and develop our empathy and genuineness towards adolescent clients with depression. To achieve genuine understanding, we

have to put down our presumed professional authority, status and training. We have to learn from clients' own descriptions, feelings and experiences.

### **Acknowledging the Personal Struggle of the Adolescent Client**

Empathetic and genuine understanding also includes recognition of adolescent clients' struggle in facing their symptoms, their labels, others' perception and problems in treatment and rehabilitation. Personal struggle not only implies stress, threat and problems but also implies coping, adaptation and adjustment. It is very important that professional workers can understand clients' effort in coping, adapting and adjusting. The psychodynamic approach describes that depression is an introjection of anger towards the loss of a beloved or highly attached object.<sup>14,15</sup> The cognitive perspective depicts a self-blaming schema. However, introjected anger can be interpreted as a way of coping and a personal struggle against unwanted loss. The self-blaming schema can also be interpreted as a way of coping with the adverse social environment. Along this line of thinking, adolescent clients with depression are actually have their own ways in:

1. coping with others' labelling;
2. coping with sadness, anger;
3. coping with diagnosis and label of depression;
4. coping with others' perception;
5. coping with bad past memory of loss; and
6. coping with oppression in the treatment and intervention process.

Professionals should fully acknowledge the clients' effort in coping by understanding the clients' feelings in facing all these experiences, recognising oppression in the adverse social environment, and appreciating the clients' effort to adjust themselves in facing stress and conflicts.

### **Reconstructing Clients as Holistic and Humanistic Beings**

Adolescent clients with depression are not only patients with problems, deficits and mental illness, they are also:

1. adolescents with normal development processes;
2. adolescents with normal developmental needs;
3. adolescents with normal interests and hobbies;
4. adolescents with normal strengths and capabilities; and
5. adolescents with at least some supportive peers, family and significant others.

All these aspects should be explored, recognised, developed and further strengthened by professional workers, teachers and family members in the process of intervention.

### **Conclusion**

In conclusion, this paper is an attempt to describe the importance of the subjective experiences of adolescent clients with depression. To achieve a genuine understanding, professional workers have to beware of the following:

1. avoiding fixation on objectivity in forms of problem and solution, confusion and control as well as cause and effect;
2. developing genuine understanding by empathetic listening, putting one into clients' situation and relating clients' subjective experiences in a holistic and meaningful way;
3. admitting that we still have room of not knowing clients' real feelings in facing their depression experiences; and
4. recognising the clients' effort, struggle, coping and adjustment in facing their symptoms, label, diagnosis, treatment and others' discrimination.

Being equipped with all these caution, awareness and attitudes, professional workers begin to recognise the importance of the subjective experiences of adolescent clients with depression. In working with adolescent clients with depression, genuine understanding of subjective experiences can establish trust, rapport and cooperation of adolescents in the process of treatment and rehabilitation. It also helps adolescent clients to revitalise their potentials and strengths in coping with adverse situation. It also nurtures adolescent clients' self respect and self esteem feeling that there is still someone in the world who can understand, listen and recognise their plight, suffering and struggle in facing life stress and depression. Perhaps, the following narration from an adolescent client can remind us of the important impact of genuine and empathetic understanding subjective experience on the process of intervention.

*'I have had a painful process in facing professionals. It seemed that they did not understand how I felt and how I experienced. The feeling of being depressive was horrible. All day long, I experienced the downfall of my own emotions. I experienced an insurmountable*

*sense of emptiness and a sense of anger burning in my heart saying I was worthless and useless. Other people also looked down on me. Why did they think that being a mental patient meant something wrong in our mind (they named it as cognition, or self blame schema), or something wrong in our brain (they called it hormone: serotonin)? But no one went into the details of my dreadful experiences of being labelled, being discriminated while facing endless sadness and emptiness. They simply regarded these as symptoms, problems or confusion. Their persistence in using these terms intensified my sense of worthlessness and frustration. Finally one day, my school social worker, who declared that she was under the supervision of a professional consultant, tried to explore my subjective experiences in facing my symptoms, label, discrimination and treatment process. She tried not to label my experiences. She tried not to pretend that she knew everything better than me. She simply listened with interest and empathy. She helped to recognise my effort in my personal struggle. She pointed that I was using all my effort to cope and adjust. She revitalised my inner strengths. I got a good feeling of being treated as a holistic normal person with respect. With that sort of good feeling in mind, I began to look back at my unresolved anger and my sense of loss from the leaving of my boyfriend, and the way that I tried to blame myself and others. She reminded that behind all these unpleasant feelings and experiences, I was actually coping and struggling through difficulties and trying to work through life hurdles.'*

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