The Adolescent Behavior Disorders Alert

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UNDERSTANDING DEPRESSION IN TEENS, PART 1

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Ashley's mother is worried about her. She reports that Ashley is moody and unpredictable—irritable with the family but overly excited around her friends. Ashley tells her that it takes forever to fall asleep at night. Ashley's mother reports that her daughter has pulled away from the family and is uncommunicative. She stays in her room a lot. Ashley listens to music with dark themes about being miserable and dying— "emo" music. Her grades are going down. Ashley's mother recently saw a small scar on her arm and asked her about it. Ashley admitted she cut herself, but she said it was no big deal. "Lots of girls do it, and I only did it once." Is Ashley depressed? The answer is maybe yes, maybe no.

Normal Teen Moodiness

A mild to moderate level of the above symptoms may be within normal limits for a 15 to 16 year old adolescent. It is common for teens to be moody-- to be easily frustrated when something doesn't go their way, to be down in the dumps when a friend seems to have betrayed them, to blow up at you if you criticize them. (see back issue, "What Makes My Teen So Moody?" Spring 2007). This is not due to "raging hormones" but to changes in brain structures that occur in adolescence. The centers that fuel intense emotion are growing faster than the areas which regulate and contain strong emotion.

It is also normal for teens to have a hard time going to sleep at night. This has to do with changes in melatonin levels in the brain making sleep onset later at night (see back issue, "Sleep Deficit in Teens," Spring 2012). Studies show that teens typically don't get sleepy till around 12:00 a.m. and are not fully alert in the morning till around 9:00 a.m. (Gwinnett county school schedules not withstanding). It is a common pattern for teens to get by with less sleep than they need during the week and sleep late on weekends.

It is also normal, even healthy, for teens to spend more time alone and to pull away from dependence on family. This is her way of getting ready to cut the ties that bind her to parents. She is likely up in her room exploring how she wants to dress or wear her hair, how she wants to be seen by others and what kind of music she likes. Scanning Facebook, sorting out which friends are loyal and supportive and which friends should be let go, is likely consuming a good deal of her time also.

What about listening to "emo" music and wearing black? This may or may not reflect depression in teens. Teen music, dress, and hairstyles are strongly influenced by their peers, sometimes by only one peer. Teens are trying on different styles and different identities throughout adolescence. She may have lost an old group of friends because of a move or because the group broke up, and she might be searching for a new group.

Grades going down? This problem can have many causes. Most commonly, the problem is one of lack of motivation. High school work is more complex than middle school, it is more abstract, and requires a higher reading level. Students who could get A's on tests through elementary and early middle school without studying find that they are not able to do that in high school. Doing well academically in late middle school and high school requires more effort, at a time when their social life has become all important. At least half of all students are content to make C's while enjoying a busy social life, hours and hours of video games, and hanging out at the Mall or the Cineplex. They are average students making average grades. They do not have Attention Deficit Hyperactivity Disorder or clinical depression or a learning disorder. They are happy and well adjusted.

What about cutting? Is this an indication that Ashley is suicidal? Rarely. Making small cuts on the arms has become fairly common among teenage girls over the last 20 years (see back issue, "Cutting Among Teens: A Dangerous Trend?" Fall, 2008). It is not unusual for an adolescent girl to be upset and to experiment with making a cut on her arm. She likely heard about it from a friend who said it made her feel better when she was upset.

If the above problems are not indicative of depression, then what signs and symptoms should a parent be concerned about? As a general rule, the most troubling symptom that I see is isolating herself from friends. A teen who is moping about and irritable with parents but talks to her friends with animation and laughter is not significantly depressed. If the friends invite her to go to the movies and she says no, she doesn't feel like going, that would be worrisome. Likewise, any lack of interest or enjoyment in things she used to enjoy would be a focus of concern—be it her favorite ice cream, her favorite television show, or going to social media sites. One episode of superficial cutting is likely due to experimentation. When parents find out, the teen is often embarrassed and doesn't do it again. But deep cuts, done repeatedly, even after parents and friends beg her to stop, is unusual and very serious.

Epidemiology of Depressive Symptoms in Adolescents

Depression is adolescents is different from depression in adults. It is more transient in nature, subject to intensifying but also easing up more unpredictably. Teenagers may report symptoms of depression when you ask them about it, yet their parents often state they hadn't noticed any changes in their teen's behavior. Irritability is more characteristic of depressed teens, causing parents to attribute their behavior to "being angry and acting out." Serious cutting and self mutilation is almost exclusively seen in adolescent girls who are depressed but is not seen in adults. Almost 50% of depressed teens have a comorbid, or co-occurring disorder. While it is common for both depressed teens and adults to report high levels of anxiety, depressed teens are also likely to be diagnosed with ADHD, Conduct Disorder (juvenile delinquency), and Oppositional Defiant Disorder (chronic problems with authority). Thus, the depressed teen is more likely than adults are to abuse drugs, to violate rules at home and at school, and to change peer groups, choosing to hang out with other teens who are depressed and acting out.

Adolescents, especially teen girls, are also more easily influenced by the mood of their best friends. Whether they seek out friends with similar levels of depression, or whether they become more depressed by association with unhappy friends, isn't well established, but they seem to occur together (Giletta, et al., 2000, Van Zalk, 2010). In fact, these studies show that girls' friendships tend to end when the level of depression among the two friends is very different. Researchers have found that what seems to be going on in these friendships is "co-rumination"—the tendency to rehash problems and negative feelings with their friends (Stone, 2011)

Measuring depression in adolescents is more challenging than measuring depression in adults. Adolescents are far more likely to report transient symptoms because their moods fluctuate greatly from day to day. In a study of a large sample of adolescents (Emslie, et al., 1990), 3,294 students in a large urban high school filled out two questionnaires that measured symptoms of depression. On one measure, the BDI, 18% of the students scored in the moderately to severely depressed range. Of the different ethnic groups, Hispanic girls had the highest rates of self-reported depression (30%) and Caucasian boys had the lowest rate (8%).

Reports of suicidal thinking were even more common. Three per cent of the sample responded positively to the statement, "I would kill myself if I had the chance." On the other measure, the WSAS, 26% of the students agreed with the statement, "Sometimes I wish I were dead," and 23% answered yes to "Sometimes I have thoughts of killing myself, but would not carry them out."

These survey studies—where a random sample of teens fills out a checklist of depressive symptoms—yield results that vary widely with the criteria used to diagnose depression and with the demographics of the group Fleming, et al. (1989) surveyed 1,127 teenagers and found that 36% of the boys reported significant symptoms of depression, as did fully 53% of the girls.

In June of 2012 the Centers for Disease Control released its annual Youth Risk Behavior Surveillance report. That survey of over 15,000 teens from both public and private schools found that 28.5% of the sample said that they had felt sad and depressed nearly every day for two or more weeks, to the extent that they had stopped doing schoolwork. Rates were higher among girls (36%) than among boys (21.5%). Rates were highest among Hispanic girls (41%).

Rates of suicidal thoughts were also high. Fully 16% of high school students reported they had seriously considered suicide during the previous year. The rate was highest among Hispanic females (21%) and lowest among Black males (9%). Fully 13% had gone so far as to create a plan for ending their lives, and 8% said they had in fact attempted to kill themselves. Rates of suicide attempts among Hispanic females, 13.5%, were nearly twice that of males in the study, 6%. Of these attempts, 2.4% of the suicide attempts were serious enough that they resulted in a poisoning or injury that had to be treated by a doctor.

Risk Factors for Depression

Rates of major depression in childhood are about equal between boys and girls. However, after puberty, the rate of depression rises to a level where girls outnumber boys in a ratio of two to one. Low socioeconomic status, or poverty, has been associated with higher rates of depression in adults, and this is true of children and adolescents as well. Costello, et al (2008) found that depression in teens was highest among girls from poor and minority families—whether Black, Hispanic, or Asian—and among those who use alcohol, tobacco, or illegal drugs on a regular basis and engaged in delinquent activities. While diminished opportunities in life may be an important factor operating here, it is also likely that the high rate of divorce and growing up in a single parent home are likely to be big factors too. I have seen first hand that single parents, no matter how hard they work, have significant financial constraints, less time and attention to give their children, and high levels of emotional stress

This leads into another factor associated with depression in adolescence—family relationships. Loss of a parent through death is a well-documented risk factor for depression in adolescence. Abandonment by a parent through divorce, residential move, incarceration, or simple lack of interest may be a bigger risk factor than parental death. The quality of family relationships is also a risk factor for depression, particularly the factors of warmth, cohesiveness, and punitiveness. Studies have shown that adolescents from families with high rates of cohesiveness (i.e., "we eat dinner together and go to church together") and warmth ("my mom hugs me often and tells me she's proud of me") have lower rates of depression than those with low rates of cohesion and warmth. These high risk families are more often low income families where the parent may work rotating and evening shifts leaving the adolescent on his own a lot. The parent may isolate herself from the children because she is depressed as well.

Higher levels of depression in the parent are often associated with higher levels of conflict with the adolescent. This elevated level of conflict in the home seems to contribute to higher levels of depression in teens in several ways. Teens are more sensitive to perceiving anger in parents, even when it is only mild (see the back issue, "Why is My Teen so Moody?" Spring 2007). Also, teens are prone to self blame when the parent is angry (Ehrmantrout, 2011; Fear, 2009). The depressed parent's interactions with the adolescent are often characterized as angry, punitive, and controlling. A major study found depression in children and teens associated with

mother's low warmth, high irritability, and withdrawal (Puig-Antich, et al., 1985).

And, finally, there is strong evidence that major depression runs in families. One study found that children of depressed parents are three times as likely to have major depression in adolescence as children from families with no mental illness in the parents. This association seems to come from a combination of genetic predisposition, environmental stresses, and poor parenting skills.

When major depression is diagnosed in teens, it can be treated, but it tends to have a chronic course. In one study, 40% of teens who were hospitalized with major depression had still not recovered one year after they were first diagnosed. Two thirds had had another episode of major depression in the subsequent five years. Teens with MDD are more likely to have persistent difficulty getting along with others, have trouble maintaining friendships, and are more likely to cut ties to their families. They are at higher risk for drug abuse and conduct disorder (juvenile delinquency), and suicide attempts. They are more likely to continue to have depressive episodes as adults. (These studies are summarized in Mufson, et al., 1994).

There are three types, or levels, of depression which vary by severity and chronicity. These will be described below.

Adjustment Reaction with Depressive Features

The mildest form of depression is situational depression. The formal name for this is Adjustment Reaction with Depressive Features. By this is meant that the teen is having some symptoms of depression, but the depression is occurring directly in response to a change in the teen's life. The symptoms are fairly mild and are likely to resolve in three to six months.

Most depression in most teens is situational and temporary. By this we mean that the teen has hit a rough spot in the road of life and is struggling. The most common source is interpersonal. She may have had a breakup with a boyfriend. She learns that her best friend has turned against her and is spreading rumors about her. He has moved to a new school district and can't seem to make any friends. He has just learned that his girlfriend is interested in another boy.

The family can also be a big source of emotional distress. Parental divorce, or post divorce conflict, or conflicts with mom's new boyfriend, dad's new girlfriend and her children, take away from the time and attention that teens would like to have with their parents. Though they may isolate themselves in their rooms, they still want one-on-one time with parents, and they want to feel they are important to their parents. Conflicts with parents over dress, music, low grades and chores not done may escalate to shouting matches and derogatory statements being made. Some parents escalate to making extreme threats to send the teen away. These battles can make the teen feel worthless, hopeless, and uncared about.

Worries about grades do make some teens depressed, but typically only the very best students. These are the highly academically motivated, perfectionistic teens who feel the world will come crashing down if they make a B in Chemistry.

We must keep in mind that teens are young people and thus inexperienced at life. Most of the problems they will have in high school they have not had before. They are learning. Those with good coping skills will get through the dilemma in time and grow stronger and more mature once they have mastered the problem. The vast majority of us parents had similar difficulties when we were young, and we managed to get through high school without psychotherapy or antidepressant medication.

A great deal of research has been conducted over the last 40 years in coping skills—both in adolescents and adults. We know that having good coping skills is probably the most important factor in teens turning into happy, productive adults. By coping skills we mean the tools the teen uses to solve his or her situational problem and control strong emotion. For example—asking for help. Healthy teens will talk to their friends about their parents, and, vice versa, talk to their parents about a problem with their friends. They will go to the teacher and ask for help in a class, or talk to the guidance counselor about rumors and bullying at school. Physical exercise is a good coping skill—taking the dog for a walk, going for a run, doing some mountain biking. Chronic sleep loss is a big contributor to depressed mood. I have seen a simple change like getting more sleep to make a big difference in a teen's mood.

Some teens will write in a journal to organize their thoughts and work out a plan. In my office we often develop an "academic action plan" to figure out what to do about low grades. I have also worked out "time management plans" with the overwhelmed student, and an "anti procrastination plan" for those who put things off till they are in a crisis.

Prayer and church attendance are, of course, good coping skills. They give a teen a sense of meaning and community and provide a guide for decision making. But many kinds of quiet reflection help teens cope—reading poetry, sitting quietly in their favorite spot in the woods, yoga exercises, or drawing and painting, also quiet the mind and help us feel centered.

What are poor coping skills? There are essentially two—avoidance and angry acting out. Teens who may be more prone to situational depressions, and have more serious and frequent low mood episodes, typically avoid dealing with their problems. They do not want to talk to anyone—not friends or family. They seek to escape problems through over-eating, spending all their time alone on electronic media, over sleeping, or getting high whenever possible. Some will go to any lengths to be with friends where "everybody accepts me" and they can simply have fun and hang out.

When confronted, teens with poor coping skills also tend to blow up and challenge parents with escalating verbal altercations that may become physical. They blame parents, friends and teachers for their difficulties. Some will get into fights at school and get suspended.

For teens with situational depression, most can be helped with individual and family therapy. Individual sessions are important in helping the teen to identify the problem, explore it with a neutral, interested person, and develop communication skills. They may also develop some solutions to their problems by brainstorming options and weighing out the merits of each idea. Family therapy is vital is helping the teen establish better communication with parents and to help the family work out behavior contracts. Sometimes it is the parent who needs help—with his or her own problems, but also with developing better parenting skills. Sometimes parents need to be coached to remain calm and be a good listener. This is important because their calmness is the anchor which helps the teen regain control.

In most cases teens with situational depression do not need anti-depressant medication. In many cases, the situational problem will resolve itself over time even without treatment.

Please email Dr. Ellis for a complete copy of the reference list.

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Raising a Responsible Child (Birchlane Press, 1995), and *Divorce Wars* (American Psychological Association, 2000). Her son, Andrew, is 27, and daughter, Sarah, is 22. She enjoys bicycling, writing, photography, and travel.

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Coming Soon...

In the next issue we'll learn more about Dysthymia and Major Depressive Disorder in teens.

Is antidepressant medication safe for teens to take?

Can we predict suicide attempts in teens?

We'll explore these issues as well.