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Dr. Ellis has been a clinical psychologist in practice in the Gwinnett area since 1980. She works with children, families, and adults. Her specialties are: evaluating children with ADHD, treating adolescents, and conducting court ordered evaluations of families in child custody matters. She was recently invited by the Romanian government to do extensive training with their staff in court ordered evaluations. She is the author of two books:

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...

New research in the field of neuroscience has found that alcohol affects the growing adolescent brain more negatively than it does the adult brain. Regular binge drinking can cause destruction of cells in the hippocampus, the area of the brain involved in short term memory and learning new information. It also causes damage to the prefrontal cortex, the area involved in attention, concentration, and controlling impulsive behavior. We'll look at new research on alcohol abuse in teens in the next issue.

The Adolescent Behavior Disorders Alert

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UNDERSTANDING DEPRESSION IN TEENS, PART 2

Elizabeth Ellis, PhD

In the Fall 2013 issue of this newsletter we looked at how clinicians separate normal teen moodiness from symptoms of depression. Adjustment Disorder with Depressive Symptoms, the most common and mildest diagnosis of depression, was described, along with an analysis of how teen depressive symptoms are somewhat different from those seen in adults. They are more likely to show symptoms that are transient (depressed one day, happy the next); they are more irritable with others; and they are more likely to have occasional suicidal thoughts. They are also more likely to abuse drugs and alcohol and to act out against authority. The family environment is important. Teens who come from unstable, unhappy families and from homes where mom is a single parent with financial and emotional strains of her own are more likely to present with depression.

In this newsletter, we'll review the two more serious diagnostic categories of depression and the standard treatments for them. We'll also review the somewhat controversial use of antidepressant medication with teens.

Dysthymia

Some teens present with symptoms of a rather chronic, mild to moderate depression which is called Dysthymia. This depressive disorder has undergone name changes over the last 20 years and was once called Reactive Depression and Neurotic Depressive Disorder. Recently, some experts voted to change the name to Depressive Personality, but ultimately voted to keep the name Dysthymia. This disorder is characterized by a set of personality traits and a particular way of thinking about themselves and the events in their lives, or cognitive style. Adolescents with Dysthymia tend to be rather inhibited socially out of fear that others will dislike them or reject them. They would like to have more friends but are passive in new situations and wait for others to speak to them first. They are prone to chronic and obsessive worrying—about day to day problems which may be rather ordinary and about problems that may arise in the distant future. They take setbacks very keenly and have a difficult time persisting toward a goal in the face of obstacles. They are extremely self conscious and overly sensitive to criticism.

Teens with Dysthymia have a cognitive style that is characterized by the triad of worthlessness, hopelessness, and helplessness. When faced with a disappointment, a mistake, or failure, they tend to be overly critical and punitive toward themselves. They use phrases like "I'm no good." "I'm stupid." "I'll never get this math." "No girl would ever go out with me." "I mess up everything I do." Their passivity and reluctance to assert themselves contribute to a general feeling that they are helpless in the face of overwhelming obstacles. Ordinary problems seem like mountains to climb. They view the future with a sense of hopelessness. "Nothing will ever get better." "I'll always be a failure." "I'll always be alone."

Adolescents with Dysthymia have a common set of distortions in their way of thinking about themselves and the events in their lives. We call these "thinking errors" or "cognitive distortions." For example, they tend to generalize from one instance to the whole picture. Example: "My boyfriend cheated on me, so you can't trust anybody. People will hurt you." "I worked hard on that art project and only got a B-. Why bother? I'm no good at art." Another feature of this cognitive style is catastrophizing. By this we mean that the teen takes one example and forecasts a pattern of falling dominoes that extend into the future. Ex. "I'm getting a C in chemistry. That means I'll never get into a good college, so I can forget getting into nursing school. I'll probably be flipping burgers at McDonald's like my teacher said, or be a bum."

Along with personality traits and a gloomy cognitive style, teens with Dysthymia are likely to report rather chronic problems with poor sleep (even on weekends), low energy, and complaints of being tired. Their mood is often sad, down, or blue. They report difficulty concentrating and may say that they study but they don't remember what they just read. They don't find much enjoyment out of life and frequently complain that they "don't like" their teachers or the students at school or the food that is served, that "nothing makes me feel good," or "there's no point in going because I won't like it anyway." They report little enthusiasm for activities outside the house and are uninterested in sports or extracurricular activities. Many will avoid even their friends. They can be irritable if pushed to "get going," to join in family activities, or spend time with the family.

Cognitive Behavior Therapy

Teens with Dysthymia can often be helped with CBT. This is a form of treatment which targets specifically the adolescent's faulty thinking style. The first step of CBT is to have the teen keep a mood chart for a few weeks. He or she will be asked to write down, several times a week, something that happened that caused an upset feeling—anger, sadness, worthlessness—and to rate that feeling on a scale of 1 to 10. In step two the therapist asks the teen to begin charting the "automatic thoughts" that occur in that upsetting situation. Automatic thoughts are statements we say to ourselves, often without being aware of it. Examples might be, "Nobody likes me." "I'm no good at schoolwork." "I'll never catch up." "Everything in my life goes wrong." These thoughts are generally triggered by common events such as rejection, disappointment, a setback, or a challenge to overcome. The teen is helped to see that not all people react the same way. A friend, for example, may have very different thoughts about the same problem or difficulty.

In step three, the therapist uses a range of techniques to try to un-

cover the underlying faulty beliefs that shape these automatic thoughts. For example, the teen that is distressed over the possibility that someone might be mad at her is helped to see that she has an underlying belief, "I must be liked by all people at all times. If I'm not, that would be horrible." A boy who is afraid to ask a girl out is helped to see that he has an underlying belief, "If a girl turns me down it means I'm no good and I'll be alone forever."

In step four, the teen learns about 10 different problematic "thinking errors." For example, one common one is called "binocular vision." This occurs when we magnify something to look much bigger (and much worse) than it really is. Another thinking error is called "dark glasses." This involves looking at a situation pessimistically, only considering everything bad in the situation and everything that could go wrong. Another one is called "personalizing." This is when we assume that the cause of a problem is due to some deficiency in ourselves and not looking at the situation in a balanced way and seeing the external factors. Black and white thinking occurs when we use language like "always," "never," "everything" and "nothing." For example, "If I don't get straight A's, then I'll never be successful."

Step five involves changing automatic thoughts and beliefs. The teen does homework which now involves a mood chart with five or six columns. He is asked to write down at least one situation each week and enter it into the chart. The headings will be: Situation—Emotional reaction—Automatic thoughts—Thinking error—Irrational Belief--Rational thought—Emotional outcome. The therapist uses a number of techniques to help the teen challenge the thinking errors and replace them with more rational thoughts. One technique is called Consider Alternative Hypotheses. This is used when the teen is over-personalizing. When the teen is seeing through Dark Glasses, the therapist might use the technique of Look for Contradictory Evidence. He or she would be asked to look for evidence that the gloomy assumptions are not altogether true. If she feels she must be liked by everyone, the therapist might go through the Pro-Con exercise, having her write out the pros and cons of maintaining this belief. The therapist might role-play with the adolescent, having them act out the rational beliefs, while the therapist voices the irrational beliefs. CBT is best used with older adolescents, but can be used with younger adolescents with some simplification of the exercises.

Major Depressive Disorder

MDD is the most serious category of depression among adults as well as teens. It is a recurring problem throughout the lifespan and nearly always requires medical intervention—antidepressant medication (sometimes a combination of two or three medications), cognitive behavior therapy, and occasionally hospitalization. In rare cases electroconvulsive treatment (ECT) is used and is highly effective. The following are the nine primary groups of symptoms of MDD, with an emphasis on how those symptoms are seen in adolescents.

1. Depressed Mood. Feeling "down," hopeless, discouraged, "blue," must be present for most of the day, every day for two weeks. Adolescents may report simply feeling "bad" or unhappy. The family may report that the teen has been chronically irritable and in a negative mood. "Nothing suits him." Some are hypersensitive to the slightest criticism and cry easily or become argumentative.

2. Anhedonia. This is an old term used to mean diminished pleasure in all or almost all activities. It must be present almost all of the time for two weeks to meet criteria for the diagnosis of MDD. An adolescent who reports that he doesn't care for school and doesn't want to hang out with his parents any more may not have anhedonia. But an adolescent boy who no longer wants to listen to his favorite music or play the guitar, who doesn't care any more for his favorite video games, and who turns down an invitation to play football with his friends, may have anhedonia. It may be difficult to determine whether this is a loss of enjoyment in life or an age related shift toward new interests.

3. Weight loss or gain. Adults who are clinically depressed typically lose weight because they simply have no appetite. Food doesn't taste very good. Appetite loss along with weight loss is very rare in adolescents, since they are growing and the drive to eat is strong. One is more likely to see an adolescent who has withdrawn from others and is engaging in compulsive eating and weight gain out of boredom and a lack of concern with their health and appearance.

4. Insomnia/hypersomnia. This symptom is fairly easy to record in adults, but not so easy in adolescents. Adolescents routinely sleep less than usual through the week and sleep late on the weekends. The clinician looks for a change in sleep pattern—i.e., an inability to get to sleep and stay asleep even on weekends, or the refusal to get out of bed on the weekend to do something the teen had been looking forward to.

5. Psychomotor agitation/retardation. Agitation refers to a change in behavior that involves being much more restless than normal. It, too, is difficult to distinguish from normal adolescent restlessness and impatience. Here the clinician is looking for a change in behavior in the direction of being defiant and disrespectful, of being quick to argue and pick fights with others.

6. Fatigue/loss of energy. This symptom may overlap with the lethargy described above. The teen reports being "tired" even on the weekend after getting 10 to 11 hours of sleep. Small tasks are refused because they seem "too hard" to do

7. Worthlessness. This symptom is seen in adolescents who complain openly that they are dumb, stupid, ugly, guilty, etc. The complaint is chronic and is not affected by the efforts of parents and friends to reason with them.

Some adolescents, lacking insight, are not able to verbalize this feeling. They may project blame onto others with comments like, "Why bother studying for that class? The teacher hates me." Or "I don't want to go to that school any more. The students are all mean." The 17 year old may refuse to look for a job, saying, "Nobody will hire a 17 year old anyway. You have to be 18." Others may exaggerate small shortcomings. The girl with average weight may focus on asserting she has no friends because she's "fat."

8. Decreased Concentration. Adults with this symptom will report that they have difficulty remembering important information, begin a task and get distracted, or can't read for very long and recall what they read. Adolescents may or may not be aware of this problem, but grades going down—along with a call from the teachers who have noticed the student being distracted in class—may provide some external confirmation of the problem.

Several times a year I am contacted by a parent who wants a teenager evaluated, for the first time, for Attention Deficit Hyperactivity Disorder (ADHD). I gently explain to them that ADHD is a disorder that you are born with, that is manifest by age seven, or maybe not until age eleven in very mild cases. It is not a disorder that you get at 14, 15, or 16.

9. Suicidal thoughts. This symptom is difficult to sort out because, as noted above, suicidal thoughts are common in teens. In the vast majority of cases it is a passing thought without form or substance. Teenagers have little life experience coping with loss and demoralization and they can become frustrated or discouraged when they encounter a problem they don't know to deal with. With their newly acquired ability to anticipate the future, they are prone to assuming that they way they feel now is the way they will feel forever. Those they are prone to concluding, "Well, I guess I can kill myself." On the other hand, a teen who says, "I have looked at this pipe in the basement and figured I could hang myself from that pipe" is having a serious thought of suicide.

Writing a suicide note or writing out the lyrics to songs that contain the word suicide, is fairly common among teens. Whether it is done for "drama," or whether it should be taken seriously must be sorted out on a case by case basis.

The diagnosis of MDD is made when 5 of the above symptoms are present, every day, all day, for two weeks, and at least one of those is 1. Depressed Mood or Anhedonia.

Antidepressant Medication

Medications that were developed specifically to treat depression were first developed in the 1960's. The group of medications in use at that time, and throughout the 1970's and early 1980's, were called tricyclic antidepressants. "Tricyclic" referred to the specific chemical structure of these medications. When studies were done on use of tricyclic medications with adolescents, the results were disappointing. Several studies done in the 1980's and early 1990's indicated that about 50% of teens improved on TCA's, but about 50% also improved on placebo pills (dummy pills). A textbook of mine which was published in 1993 concluded that antidepressant medication does not work with teens.

In the mid 1980's Prozac was developed, and was soon followed by Zoloft and Paxil. These antidepressant medications were biochemically different from the TCA's. Because they increased levels of serotonin in the brain, they were called Selective Serotonin Reuptake Inhibitors, or SSRI's. (The TCA's affected levels of both norepinephrine and serotonin). By the 1990's they were being used to treat depression in teens. In August of 2003 the *Journal of the American Medical Association* published a major study which indicated that they were effective with teens. Of those teens who were treated for depression with Sertraline (marketed as Zoloft by Pfizer), 69% showed improvement. However, all effectiveness studies are countered by the placebo effect. Fully 59% of the teens showed improvement on the placebo pills. Thus the rate of improvement was a modest 10% above dummy pills. These rates are very similar to effectiveness rates found in adults who are prescribed antidepressants.

This good news was quickly countered by results that were coming in which suggested that teens who were on antidepressant medications showed an increase in rates of suicide attempts. The first alarm was sounded in June of 2003 in Britain when some unpublished data suggested that destructive and suicidal behaviors were 1.5 times to 3.2 times higher in teens who took Paxil than those who took a dummy pill.

In April of 2004 the British journal *Lancet* published the results of research in Britain and announced that antidepressants used to treat children and adolescents were unsafe, ineffective, or both. In its careful scientific review, the authors specifically warned that prescribing Paxil, Zoloft, Effexor, and Celexa could be dangerous to children and teens. The American Psychiatric Association had looked at the same data and saw no cause for alarm. After considerable debate, the APA and the FDA agreed to put a "black box" warning on antidepressants, suggesting that their use in teens should be closely monitored.

After the black box warning was made, physicians and psychiatrists all over the country discontinued use of antidepressants with many teens and children and were reluctant to prescribe them in new cases. By 2007 the results called into question whether the black box warning was appropriate. *Newsweek* magazine's July 16, 2007 issue reported that prescriptions for this group had dropped by 50% between 2003 and 2005. However, during this same period, the number of teen suicides jumped a record 18% between 2003 and 2004. Did the suicide rate increase because these teens weren't on medication for depression? Many experts thought so.

Researchers at the University of Pittsburgh School of Medicine analyzed data on 5,310 children and teenagers from 27 studies. They found that for every 100 kids treated with an antidepressant, there was an increase of about 1 child who showed worsening suicidal feelings above the level that was seen in the untreated group. There were no completed suicides in any of the studies. Clearly, the benefits outweighed the risks of using antidepressants. The medications appeared to work best when used to treat anxiety. They worked moderately well when treating obsessive compulsive disorder. They worked less well, but were still modestly effective, when used to treat depression.

Since these studies were published in 2007, physicians have been prescribing antidepressants to teens with minimal concern about the dangers they might pose. As a rule of thumb, Paxil is not recommended for use in teens. Prozac and Zoloft have consistently been found to be the safest medications to use. Physicians caution parents to monitor the teen closely in the first two weeks on the medication and to note any unusual change in behavior. Physicians as well as psychologists routinely ask teens on antidepressant medications if they have experienced any increase in suicidal feelings.

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