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DEPRESSION IN YOUTH©

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DEPRESSION SYMPTOMS IN YOUTH

Depression and suicidal thoughts are common in young people. These feelings should be taken very seriously.

Remember kids *lack skills for communicating their feelings well;* so when they feel down, they often express themselves through moodiness, irritability, behavioral problems, or withdrawal. The class clown could be covering up sadness; the rebel could be hiding inadequacy feelings; the drug user or drinker may feel more normal and less empty when using; early sexual activity could be a way to feel less alone.

Treatment begins with a careful assessment of the symptoms, the child, the family interaction patterns, and the history of changes in the child's life.

When 3 or more of these symptoms are present, we may be dealing with *adolescent depression*:

MOOD SYMPTOMS
---Emotionally sensitive, reactive to failure & disappointment
—Severe mood swings, often suicidal thoughts
—Crying spells
---*Anhedonia*, the inability to enjoy life or feel pleasure
---Feels sad, alone, uncared about, rejected
---Difficulty concentrating
---Boredom, agitation
---Flattened emotions, dull mood without much joy

SELF-WORTH CHANGES
---Sees self as inadequate, bad, unacceptable
---Self-reproach, cuts self down, feels worthless
---Guilt feelings, self-blame for family problems

PHYSICAL SYMPTOMS
---Changes in the care taken in appearance and grooming
---Fatigued, constant tiredness, excessive sleeping
---Sleep changes, 'nothing to get up for' feeling, or suddenly begins staying up very late
---Loss of energy
---Physical pain may express emotional pain -- headache, stomach ache
---Loss of appetite, weight loss (sometimes, rapid weight gain)

SOCIAL SYMPTOMS
---Feels no one understands or listens
---Dropping out of familiar interests and activities
---Withdrawal from friends and family, such as extended time alone in bedroom, online, or playing online games
---Shift in friends and activities, which may include truancy, drugs, and drinking, group drug use
---Onset of behavior problems
---Drop in grades and poor concentration in school
---Gravitates to other depressed or troubled youth
---Irritable with others

TYPES OF ADOLESCENT DEPRESSIONS

A. Normal or Reactive Depressed Feelings. Brief upsets, moodiness, or sadness, often over disappointments and losses. These states are temporary and they do not undermine self-image. Includes "Reactive Depression," known as "Exogenous Depression" or "Adjustment Disorder with Depressed Mood," which is the result of the loss of a relationship or of the hope of attaining an important goal or accomplishment. Adjustment-reaction depressions, for example, might occur after failure to make a team, moving away from cherished friends, ending a dating relationship, developing a serious illness.

B. Major Depression. Often incapacitating, lasting for weeks, showing 4 or more of the symptoms of depression. Known as "Clinical Depression" and sometimes as "Endogenous Depression." May feel "I have nothing to live for." Can range from Mild (just a few symptoms) to Severe (presence of many of the symptoms of depression).

C. Dysthymia. One-two year period of mild-to-moderate depressed mood. Can function in daily life, however; in contrast, Major Depression leads to impairment in ordinary functioning.

D. Bipolar Disorder. Swings from periods of severe depression to one or more periods of euphoria, agitation, lack of sleep. Formerly known as 'Manic-Depressive Illness.' We distinguish Bipolar I, with more severe manic episodes, from Bipolar II, in which the 'up' phase is mild.

E. Cyclothymia. Milder than Bipolar, swings from periods of excessively up moods to excessively down moods.

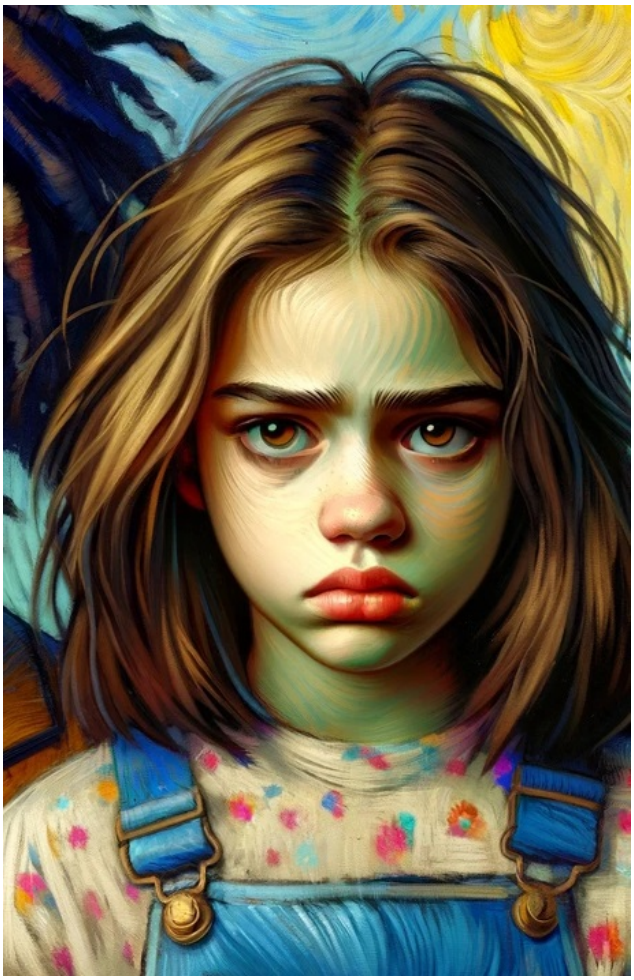
F. DMDD - Disruptive Mood Dysregulation Disorder. Severe irritability, outbursts of hostility and temper, that are frequent, severe, and do not yield to comforting or reason, low tolerance from frustration, extreme upset, for 1 year or more. Not technically a depression, but the behavior has some similarities to Bipolar, only milder.

G. Drug-Related Depression. Many drugs produce depression. Regular use of alcohol, marijuana, cocaine, and other drugs produce down moods either when using the drug or afterwards during the 'crash.' Because the mood problems often clear up after stopping use, accurate evaluation of the depression requires several weeks of abstinence.

H. Depression May Be Preliminary to Suicide. Depression is the most common precursor to suicide attempts. Suicide rates have doubled among adolescents in recent decades. All references to suicide, such as giving away possessions, wishing to be dead, and threats of self-harm should be taken seriously and should be discussed with a mental health professional. When depressed, impulsive youths and those who drink are especially at risk.

No, children are not as resilient to changes as myth has us believe and upheavals can impact them in ways they cannot manage.

Because youthful depressions are so often *masked* by behavior problems, irritability, hostility, physical complaints, physical symptoms, school avoidance, experimenting with drugs, or self-cutting, uncovering the causes of the underlying depression may take many hours of exploration.



Depression in youth is treatable with psychotherapy, cognitive behavioral therapy, family therapy, and, sometimes, medication.

Sometimes, insight into the stressors behind the depression, removing those stressors, sharing feelings, receiving family support, and improvement in the family's patterns may resolve the depression. The psychotherapist will help the family make these changes.

'Psychotropic' medication often helps the more severe cases and may also be tried in milder cases in order to get the person moving and functional sooner. Antidepressants such as Prozac (fluoxetine), Zoloft (sertraline), Effexor (venlafaxine), Celexa (citalapram), Lexapro (escitalapram), are the most commonly used types of meds for depression. You may see other meds for depression being tried, such as Bupropion (Wellbutrin), Lithium, Lamictal (lamotragine) Valproate (Depakote). Drugs for behavior management or thinking problems may be used in combination with antidepressants. All these medications work more effectively when taken for at least 4-6 weeks and they may be taken for an extended period of time to prevent recurrence of symptoms.

Note: there is a warning for adolescents taking anti-depressants. Increased suicidal thinking may occur in some youth when they start to feel less down.

INNER FEELINGS DURING DEPRESSION

Depressed youths feel the same things as depressed adults.

If you want to understand depression, this list of 15 depressive feelings is crucial.

- ✓ a failure to achieve valued goals, often goals set too high
- ✓ a deep sense of loss
- ✓ helplessness and hopelessness
- ✓ disappointment
- ✓ unwanted
- ✓ not accepted or understood
- ✓ overly high standards
- ✓ self-blame and guilt over family problems
- ✓ a burden to others
- ✓ unloved and/or unlovable
- ✓ weak and inadequate
- ✓ deeply alone
- ✓ life is not worth living
- ✓ not seeing any positive future
- ✓ thinks he or she will die young

PSYCHOTHERAPY AND FAMILY THERAPY TREATMENT

The good news is that psychotherapy is very effective with most cases of depression. Depression is thought of as a stress-related illness in that it usually begins with some event that is experienced negatively. Usually these are experiences that elicit feelings of loss, hurt, or disappointment. So, it is important to map out when depressive episodes began.

In a child who is prone to negative thinking, stressful life-change events, such as being teased or bullied or not being chosen for a team, can lead to depressed mood. The child may feel self-doubts and crushed with negative self-talk.

A therapist using crisis psychotherapy, psychodynamic psychotherapy, cognitive behavioral therapy, and/or family therapy will work to understand all these patterns.

✓ We help the youth and the family determine the sources of the depression and what

events that set it in motion.

- ✓ A major intervention is family therapy in which the family is enlisted to understand why the child has been depressed.
- ✓ We will look at changes that have occurred within the family context.
- ✓ We trace out the depressive reaction pattern in the person's thinking.
- ✓ We'll help the family to understand the pattern of thinking, feeling, and reacting that they used as a reaction to the depressed family member. Often, these patterns unwittingly reinforce the depression. For example, many children who are depressed have experienced a lot of criticism in their family and criticism is a predictor of a relapse. So, we will help the family shift its support and improve the quality of attachments.
- ✓ We'll help understand the episode or event from every angle and help them learn more effective ways to cope.

So, we want the family to focus on reinforcing positive behaviors and strengths that the child has. We also will want the family to work on the strength of attachments. Once depression improves, with help, many of these children can become more resilient.

The exception is Bipolar Disorder or Dysphoric Mood Dysregulation Disorder, which tend to have a much more lasting course and first appear often in early or middle adolescence. For those we work not on resolving them, but on managing them effectively. In addition to the list above, we will use stress reduction and stress inoculation techniques, family therapy training to manage bipolar disorder, support and family education about the nature of bipolar illness, and with encouraging steady adherence to medication.

Advice on listening to depressed kids boils down to 4 A's

- ☐ *attention, fully loving attention, with curiosity*
- ☐ *acceptance of whatever your youth says and whatever the behavior may be (short of being destructive or harming others), accept the whole child even with these depressed feelings*
- ☐ *attunement – concern with empathy*
- ☐ *appropriate action, non-punitive, non-rejecting, non-judging, such as calling for help, spending time together, sitting with the child*

Is Depression a Brain Illness?

We think of depression as a stress-response to changes. We also know that up to 80% of depressive episodes can be resolved with therapy, without medication. So, if we think of brain illness narrowly as a problem of the structures in the brain and how they work, then most of the time depression is not a permanent structural quality of the brain. It's a thinking and reaction pattern.

However, there are what is called treatment-resistant depressions and bipolar disorder which are thought of as having features on the brain level, in how some of its structures work. So, the answer to the question is mostly not, but sometimes yes.

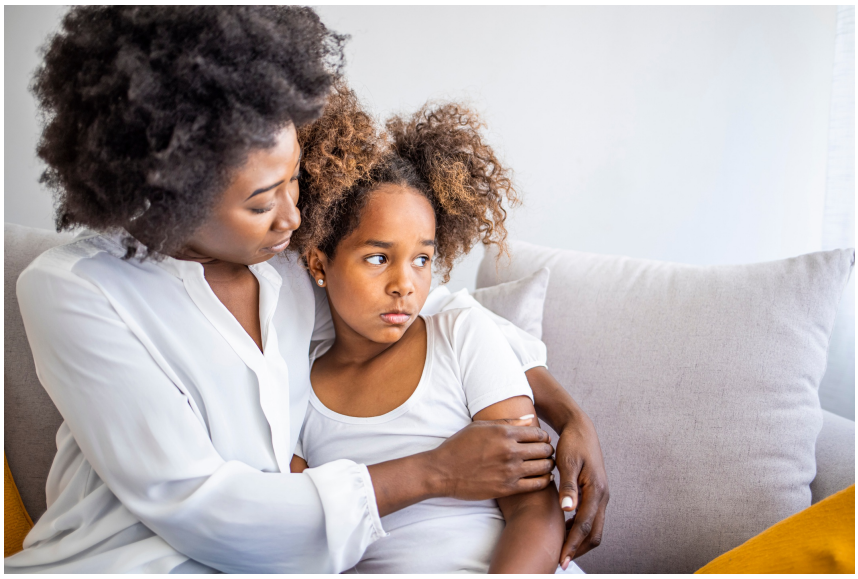
How We Talk About Depression Does Matter

For the individual

We sometimes hear people talk about "My depression" as if it were a permanent feature of that person. It's not. Depression is most often not a permanent quality, but rather a reaction pattern and an emotional state. This is especially true in cases of mild-to-moderate depressive states. Instead of "your depression," we would be wise to say "state of depression" or "depressed reaction."

For Family and Friends

Therapists think of depression as a state a person cannot change without insight into its causes and an improvement in the patterns of reaction that led to the depression. Those patterns, as you have seen, as in dysfunctional thoughts, unresolved life experiences, cycles of withdrawal, and inner pain.



As a result, telling a loved one "It's just (merely, only) a little sadness," "You'll get over it," or "Get going and you'll feel better," only make the person feel worse. They can't live up to those expectations. Letting a child stay awake all night and spend more and more time

in his or her room is also not helpful. It reinforces withdrawal. Ignoring depressed mood lets it get more severe. Diminishing the child's feelings ("It's only ....) makes the child go further away. And never ignore hints about suicide.

The themes in all advice on listening to depressed kids boils down to 4 A's

- ☐ *attention, fully loving attention, with curiosity*
- ☐ *acceptance of whatever your youth says and whatever the behavior may be (short of being destructive or harming others), accept the whole child even with these depressed feelings*
- ☐ *attunement – concern with empathy*
- ☐ *appropriate action, non-punitive, non-rejecting, non-judging, such as calling for help, spending time together, sitting with the child*

If may be effective to sit with the youth, even if it is in silence.

Work on empathy, using the tools above, to try your best to understand the youth's inner state.

Comment on the events that have happened and what you know about how those affected the youth. If you went through them as well, comment on how they affected you and share that.

Ask about non-suicidal self-harm, such as self-cutting, without rancor, but with concern.

Let them know you can't know everything they are going through, but you want to try.

If the child is hostile, do your best not to be put off, to get angry back, or to take it personally – even if it is aimed at you. You can acknowledge the youth is angry, and that it may be a cause of, or a symptom of, being depressed, and (whether you think the source of the anger is logical or not) you will accept the child no matter what, even if angry.

If you see the youth withdrawing, show curiosity about them sleeping more than they have before or being withdrawn from family or friends.

Ask your child what is bothering him or her and what it is like for them now.

As about suicide, ask if the child is thinking about death. And listen.

The more quickly you seek professional help, the faster your youth will likely recover. We can make the appropriate evaluation and treatment plan.

Delay in getting treatment tends to allow more and more reinforcement of withdrawal from family, friends, and school, and falling behind peers in development. As you can imagine, that makes recovery investigation. While we're difficult. If you have a depressed youth, or, for that matter, a depressed adult, in your family, the faster you get help the better.

Call 414-540-2170 for an evaluation.

Shorehaven Behavioral Health Inc is a licensed mental health clinic with three locations in the Milwaukee-Racine areas and we provide telehealth throughout Wisconsin.

Helping You Find Your Strength and Serenity